COLLABORATIVE SETTLEMENT AGREEMENT

The City of Cincinnati ("City"), the Cincinnati Retirement System ("CRS"), Mayor John Cranley ("Mayor"), City Manager Harry Black ("City Manager"); Nick Sunyak ("Sunyak") Jeffery Harmon ("Harmon"), Jill Allgeyer ("Allgeyer"), Kim Kappel ("Kappel"), Waleia Jackson ("Jackson"), Finley Jones ("F. Jones"), and Richard Ganulin ("Ganulin"), individually and on behalf of the classes and sub-classes of current City employee plaintiffs later defined herein; Thomas A. Gamel, Sr., ("Gamel"), Paul Smith ("Smith"), Mark K. Jones ("M. Jones"), Dennis Davis ("Davis"), Ely Ryder ("Ryder") and Ann DeGroot ("DeGroot"), individually and on behalf of the class of intervening City retiree plaintiffs later defined herein; and the American Federation of State and Municipal Employees Ohio Council No. 8 ("AFSCME") ("the Parties") do hereby enter into this Collaborative Settlement Agreement ("Agreement" or "Collaborative Agreement") on May 7, 2015. This Collaborative Agreement constitutes a full and complete settlement of any and all claims asserted against the City, the CRS and related City Defendants, or that could have been asserted, in consideration of the mutual promises of the Parties and pursuant to the terms and conditions set forth below, all subject to the approval of the Court.

INTRODUCTION

The Parties have litigated complex questions about the management of the CRS – and the respective rights of plan participants – for nearly five years. This litigation has addressed, *inter alia*, benefits levels, eligibility requirements, healthcare benefits and funding mechanisms. While some of these lawsuits have been subject to conclusive appellate rulings, many pertinent legal and factual questions remain. In past years, each new set of proposed CRS reforms have invited a new round of legal challenges – including, but not limited to, questions of procedural and substantive due process as raised by both current employees, future retirees and current retirees.

The Parties have concluded that continued litigation would be wasteful and counterproductive. Any dispositive rulings on the pending issues would likely take years to achieve – years during which the CRS' accruing unfunded liability would continue to grow and the City's bond rating may become ever more endangered. Given these facts, the Parties determined it was in their best interests and the public interest to craft a collaborative mediation process in which all issues relating to the CRS are addressed. These efforts culminated in the terms of this Collaborative Agreement.

VALUE STATEMENT

This Collaborative Agreement represents a sincere effort to "share the pain" of complex and much-needed pension reforms. It is the product of many months of cooperative, collaborative and iterative negotiations amongst the City, representatives of employees, a labor union which represents many of them, and representatives of City retirees.

The reforms promulgated in this Collaborative Agreement constitute a comprehensive strategy to stabilize the CRS while also securing sustainable and competitive retirement benefits for both current and future City retirees. The terms of this Collaborative Agreement will greatly improve the City's long-term financial position and will meaningfully address concerns regarding the City's creditworthiness as determined by both governmental entities and national credit rating agencies.

GOALS OF COLLABORATIVE SETTLEMENT AGREEMENT

While this Agreement primarily addresses the accruing unfunded liability that has destabilized the CRS during the past decade, its overall goals go far beyond actuarial calculations. The Parties acknowledge that years of poor communication among the various stakeholders has created suspicion and occasional animosity. This contentious atmosphere has often rendered substantive discussions impossible. Thus, this Agreement addresses both

material issues within the CRS and the less tangible (but equally important) issues of trust, access and transparency that have long hampered reform efforts. Accordingly, the Parties have adopted the following overarching goals in regards to the structure and implementation of this Agreement:

First Goal: Stabilize the overall financial position of the CRS so that both current and future retirees can expect to receive meaningful and competitive benefits in the future, specifically pension, including a Cost of Living Adjustment ("COLA"), and healthcare benefits.

Second Goal: The pension trust fund will be funded at actuarially appropriate levels, with the goal of establishing a projected 100 percent funding ratio in 30 years, and will remain so funded for the balance of this Agreement, pursuant to its terms and provisions.

Third Goal: The trust fund for healthcare benefits is to be funded at actuarially appropriate levels sufficient to provide the healthcare benefits set forth herein for the remaining term of this Agreement, subject to the terms of this Agreement.

Fourth Goal: Reduce the CRS's accruing unfunded liability so that national credit rating agencies and state agencies will no longer threaten the City with potentially devastating downgrades directly related to such liability.

Fifth Goal: Set forth a long-term plan to ensure the provision of pension benefits for future generations of City employees, while also maintaining flexibility to address unexpected market downturns and upturns as well as new opportunities. Specifically, the City must be able to consider and respond to possible merger opportunities with other large public retirement systems. The City must also retain its ability to adapt to changes in the healthcare marketplace, especially those changes precipitated by federal law.

Sixth Goal: Retirees have made irrevocable elections of retirement benefits, expecting the City to guarantee those promised benefits, and thus understandably seek stability in those benefits. They must have confidence that those retirement benefits will be funded by the City and that the City will not ignore its funding commitment for those benefits. They must also have confidence that neither the City nor the other Parties will attempt to alter these benefits outside of the parameters set forth in this Agreement.

Seventh Goal: Increase the transparency of CRS-related decisions so that both current and future retirees may better understand and exercise their collective rights as members of the system.

Further, this Agreement will resolve the issues raised by the various pending complaints and motions for preliminary injunction, as well as the pending writ of mandamus filed by AFSCME on behalf of its Cincinnati-area members in the Hamilton County Court of Common Pleas.

The Parties, their agents, successors and all persons in active concert or participation with any of them shall abide by the terms of this Agreement. It is understood and agreed that the terms and implementation of this Agreement are not intended to (and shall not be construed to) violate the terms of any collective bargaining agreement by and between the City and any other entities representing employees of the City. Additionally, it will not include any terms and conditions of employment that must be negotiated by and between the City, the Parties and any other such representative entities.

The Parties also acknowledge that asset performance and the macro-economic environment are beyond the control of the CRS stakeholders and the Court.

JURISDICTION

This Collaborative Agreement memorializes the terms by which the Parties fully and finally resolve the allegations and claims set forth in two consolidated cases pending before the Honorable Michael R. Barrett in the United States District Court for the Southern District of Ohio: (1) *Sunyak v. City of Cincinnati,* Case No. 1:11-cv-445; and (2) *Harmon v. City of Cincinnati,* Case No. 1:12-cv-329. In addition, this Agreement fully and finally resolves the allegations and claims set forth in the litigation titled *State ex rel. Council 8 AFSCME, et al.* v. *City of Cincinnati, et al.,* Case No. A 1104791, pending before the Hamilton County Court of Common Pleas.

Central to this Agreement is the Consent Decree which is attached hereto as Exhibit 1 and which fully incorporates by reference the terms of this Agreement. The Consent Decree establishes that the Court shall retain jurisdiction over the implementation, interpretation, administration, and enforcement of this settlement following the Effective Date.

The Parties agree that, after Finality, they will: (1) dismiss with prejudice the claims asserted in the Actions; and (2) approve the terms and conditions of this Agreement and the related Consent Decree, such that these Actions and the claims shall be finally and fully resolved, settled, and compromised based upon and subject to the terms and conditions set forth both in this Agreement and attached Consent Decree.

DEFINITIONS

Wherever used in this Agreement and the attached Consent Decree, the following boldface terms have the meanings specified below:

"115 Trust Fund" means the fund to be created under Section 115 of the United States Internal Revenue Code and those funds to be held in trust and invested for the sole purpose of funding secured health care benefits for eligible retired members of the CRS.

"401(h) Account" means the funds presently held and invested for the purpose of funding retirees' medical benefits.

"Actions" or **"Litigation"** mean the following cases now pending: *Sunyak v. City of Cincinnati,* Case No. l:11-cv-445 (S.D. Ohio); *Harmon v. City of Cincinnati,* Case No. 1:12-cv-329 (S.D. Ohio); and *State ex rel. Ohio Council 8 AFSCME, et al.* v. *City of Cincinnati, et al.,* Case No. A 1104791 (Hamilton County Ohio Court of Common Pleas).

"AFSCME" means the plaintiff in the litigation titled *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.,* Case No. A 1 104791, pending before the Hamilton County Ohio Court of Common Pleas.

"Class Counsel" means Current Employees Class Counsel and Retirees Class Counsel.

"Class Member(s)" means an individual who is either a Current Employees Class member or a Retirees Class member.

"Class Notice" or **"Notice"** means the settlement notice set forth below, the text of which shall be substantially similar to the notice attached hereto as Exhibit 2.

"Classes" means the Current Employees Class and the Retirees Class.

"COLA" means cost of living adjustment to a pension annuity payment.

"Consent Decree" means the decree to be entered, a copy of which is attached hereto as Exhibit 1.

"Court" means the United States District Court for the Southern District of Ohio, Western Division, which is presiding over this settlement and the *Sunyak* and *Harmon* actions.

"Covered Payroll" means the annual amount of pensionable salaries for full-time employees who are members of the CRS. The City represents and warrants that this amount has been employed in the actuarial calculations referenced throughout this Agreement, including, but not limited to, the calculation of the City's Annual Contribution. This definition only applies to the terms and provisions of this Agreement.

"CRS" means the Cincinnati Retirement System.

"CRS Pension Trust Fund" means those funds to be held in trust and invested for the purpose of funding benefits, other than medical benefits, for the CRS.

"Current Employees Class" means the approximately 2,900 current City employees (approximately 2,400 are employed as of the date of this Agreement) defined as follows: All individuals who participated in the CRS with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011, and who are members of Group C, Group D, Group E, or Group F as these terms are defined by Cincinnati Municipal Code ("CMC") §203-1-Ml (b), (c), (d), and (e). The Current Employees Class also includes the Dependents and/or the Surviving Beneficiaries of any Current Employees Class member who are entitled to the retirement benefits which are the subject of this Agreement and Consent Decree. As detailed below in the subclass descriptions, members of the Current Employees Class have experienced significant increases in their pension contributions, reductions in their eventual retirement benefits, extensions of the years of work required to be eligible for unreduced pension benefits, and significant increases in current healthcare costs during their employment, including an increase of more than 100 percent in their premiums in recent years.

"Current Employees Class Counsel" means Marc D. Mezibov, Esq., Robert D. Klausner, Esq., Christian A. Jenkins, Esq., and Jeffrey S. Goldenberg, Esq.

"Current Employees Class Representatives" mean the Current Employees Plaintiffs designated in this document.

"Defendants" or **"City Defendants"** mean the Defendants in any of the Actions who are: (1) the City, (2) the Mayor, (3) the City Manager, (4) the Vice-Mayor, (5) the City Council Members, (6) the CRS; and (7) the Board of Trustees of the CRS ("Board").

"Defendants' Counsel" means Steven P. Goodin, Esq. and John Pinney, Esq. (and the law firm of Graydon Head and Ritchey, LLP) and the City Solicitor for the City of Cincinnati, Paula Boggs Muething.

"Dependents" means spouses and eligible dependent children and orphans of members of the Current Employees Class and the Retirees Class.

"Effective Date" or **"Effective Date of the Settlement"** means the day after which all of the following events have occurred: (1) this Settlement Agreement is fully executed by all the Parties; (2) the Court enters the Preliminary Approval Order as set forth below; and (3) the Court enters the Order Granting Final Approval as set forth below.

"Fairness Hearing" means the hearing before the Court at which time the Court considers:

(1) Whether this Agreement, including the Exhibits to this Agreement, should be approved as fair, adequate, and reasonable;

(2) Whether an Order Granting Final Approval as set forth below should be entered;

(3) Whether the applications of Class Counsel for payment of attorneys' fees, costs and expenses should be approved; and

(4) Any other matters addressed by the Court, including any objections properly raised by Class Members.

"Finality" means: (1) If no timely appeal has been taken from the Order Granting Final Approval, the day after the day on which all periods of time for any Party or Class Member to appeal have expired; or (2) If any timely appeal is undertaken, the day after the day on which any such appeal shall have been fully resolved, the Final Order shall have been affirmed in all

material respects, and no further appeal to, or discretionary review remains in any court (whether by expiration of the time for any further appeal or otherwise).

"Funded Ratio" means the actuarial value of assets divided by the actuarial accrued liability at a given period in time.

"Group C Sub-Class" means the Current Employees Class members who are also members of Group C.[1] The Group C Sub-Class is represented by Jill Allgeyer. The adoption and enforcement of Ordinance No. 84-2011 negatively impacted members of Group C because they no longer would receive a death benefit of at least $5,000.

"Group D Sub-Class" means the Current Employees Class members who are also members of Group D.[2] The Group D Sub-Class is represented by Kappel, Jackson, and Ganulin. The adoption and enforcement of Ordinance No. 84-2011 negatively impacted members of Group D because they no longer receive a death benefit of at least $5,000 and a three percent COLA compounded annually. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent. Members of Group D who did not retire on or before January 1, 2014 were automatically assigned to Group E.

"Group E Sub-Class" means the Current Employees Class members who are also members of Group E.[3] The Group E Sub-Class is represented by F. Jones. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group E no longer receive a death benefit of at least $5,000, a three percent per year COLA compounded annually, and a retirement benefit amount calculated based on the highest 36 months final average salary with a

[1] CMC §203-1-MI (c) defines Group C as those employees who had at least 30 years of service credit before July 1, 2011, or who were at least 60 years old with 5 years of service credit before July 1, 2011.
[2] CMC §203-1-MI (d) defines Group D as those employees who have at least 30 years of service credit by December 31, 2013, or employees who reach age 60 with at least 5 years of service credit by December 31, 2013.
[3] According to the CMC §203-1-MI (e), Group E consists of those employees originally assigned to Group D who did not retire on or before January 1, 2014.

2.22 percent or 2.5 percent multiplier applicable to all years of creditable service ("Higher Benefit Amount"). Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent and replaced the Higher Benefit Amount with a less generous formula to calculate the benefit accrued from January 1, 2014 until retirement - limiting the multiplier applicable to such years to two percent for years over 30 years of service and 2.2 percent for all other years after January 1, 2014 and using the highest 60 months final average salary for years after said date.

"Group F Sub-Class" means the Current Employees Class members who are also members of Group F.[4] The Group F Sub-Class is represented by Sunyak and Harmon. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group F no longer receive the Higher Benefit Amount, and the right to retire with unreduced benefits upon reaching 30 years of service - regardless of age. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent, replaced the Higher Benefit Amount with a new formula to calculate the benefit accrued from July 1, 2011 until retirement - limiting the multiplier for years after July 1, 2011 to 2.2 percent for years of service up to 30 and two percent for years of service over 30. It also used the highest 60 months final average salary for years after July 1, 2011, and replaced the 30 years of service requirement with a requirement that such employees also must be 60 years of age to receive full unreduced benefits.

"Higher Benefit Amount" means a death benefit of at least $5,000, a three percent COLA compounded annually, a retirement benefit amount calculated based on the highest 36

[4] The Current Employees Class only includes those members of Group F who had at least 5 years of creditable service on July 1, 2011 and who were not assigned to Group C, D, or E.

months' salary with a 2.22 percent or 2.5 percent multiplier applicable to all years of creditable service.

"Notice Date" means the first day on which the Notices are mailed.

"Notice Program" means the process by which information about this Settlement shall be made available to the Current Employees Class members and the Retirees Class members as set forth below.

"Order Granting Final Approval" or **"Final Order"** means the Order from the Court granting final approval to this Settlement and ordering that this Court retain jurisdiction over the administration, enforcement, and interpretation of this settlement pursuant to and consistent with the Consent Decree.

"Ordinance No. 84-2011" means City Ordinance No. 84-2011 which became effective on July 1, 2011.

"Ordinance No. 85-2011" means City Ordinance No. 85-2011 which became effective on July 1, 2011.

"Original Plaintiffs" or **"Current Employees Plaintiffs"** mean the following plaintiffs in the *Sunyak* and *Harmon* cases: (1) Sunyak, (2) Harmon, (3) Allgeyer, (4) Kappel, (5) Jackson, and (6) Ganulin, each of whom were active City employees at the time the *Sunyak* and *Harmon* cases were filed. Current Employees Plaintiffs also include F. Jones, who is to be added as a party to this litigation pursuant to the Preliminary Approval Order.

"Parties" mean: (1) the Current Employees Plaintiffs; and (2) the Current Employees Class, (3) the Retiree Plaintiffs; (4) the Retirees Class; (5) AFSCME; and (6) the Defendants.

"Plaintiffs" mean the Current Employees Plaintiffs, the Retiree Plaintiffs, and AFSCME.

"Preliminary Approval Date" means the date on which the Court enters the Preliminary Approval Order.

"Preliminary Approval Order" means the Order from the Court granting preliminary approval to this Settlement.

"Retiree Plaintiffs" mean the following retirees who initially filed a Motion to Intervene in the *Sunyak* and *Harmon* cases on March 17, 2014: Gamel, Beets, Smith, M. Jones, Davis, Ryder, and DeGroot.

"Retirees Class" means the approximately 4,400 individuals formerly employed by the City of Cincinnati, the University of Cincinnati, the University Hospital f/k/a General Hospital and Hamilton County, who retired on or before July 1, 2011 and have received retirement benefits from the City and their Dependents and/or their Surviving Beneficiaries who are entitled to those benefits. Pursuant to the adoption and enforcement of Ordinance No. 84-2011 and Ordinance No. 85-2011, members of the Retirees Class no longer receive a death benefit of $7,500, having been reduced to $5,000, no longer receive premium-free healthcare separately identified as a benefit on documents signed by retirees upon retirement and which premiums totaled as much as $1,125 in 2014, no longer receive dental and vision insurance coverage both of which premiums totaled $875 in 2014, no longer receive reimbursement for Medicare premiums of over $1,200 per year (over $2,400 per year including spouse), have a smaller healthcare provider network and many no longer qualify for "carve-out" benefits owing to a more stringent criteria. Members of the Retirees Class and their beneficiaries lost over an estimated $4,000 per capita per year in healthcare benefits as a result of benefit reductions imposed in 2010 through 2012. Additionally, Members of the Retirees Class are prepared to sacrifice an additional $2,800 per capita per year in pension in order to gain long-term stability

in healthcare benefits which had been reduced. These costs have been and will be imposed on retirees whose average pension is $35,000. Further, other Retirees Class benefits have been threatened by the huge growth in CRS unfunded liabilities, which is a result, in part, of the City's failure to contribute to the CRS Pension Fund in accordance with the funding formula set forth in §203-93 CMC. The Retirees Class is also concerned about the potential loss of their Death Benefits of $5,000 per retiree.

"Retirees Class Counsel" means Robert A. Pitcairn, Jr., Esq., James F. McCarthy, III, Esq., Peter J. O'Shea, Esq. and the law firm of Katz, Teller, Brant & Hild.

"Retirees Class Death Benefit" A lump sum of $5,000 available only to the members of the Retirees Class in accordance with the provisions of CMC § 203-47, in effect January 1, 2015.

"Retirees Class Healthcare Benefits" means those benefits provided by the CRS to the Retirees Class. The benefits include: (1) the specific benefits described in the Medical Benefits Booklet for City of Cincinnati Retirees administered by Anthem, effective January 1, 2014, subject to the limitations and exclusions, copayments, deductibles and coinsurance requirements specified in that booklet (a copy of that booklet is attached as Exhibit 3); (2) the "exclusion approach," as used in 2014, for the coordination of Medicare benefits; (3) Rx formulary as administered in 2014 by Optum (and as set forth on the Optum website at www.optumrx.com);[5] (4) the limitations, exclusions, copayments, deductibles and coinsurance requirements as prescribed in the contract by and between the City and Optum in effect in 2014 (a copy of that agreement is attached as Exhibit 4); (5) Rx Coach program which provides no-copay prescriptions for lipids reduction, high blood pressure regulation, and diabetes control for patients who participate in provider counseling programs; (6) no lifetime limit on benefits; (7) all

[5] Members must create an account to sign into the website. Once logged in, members should select the link titled "Formulary" to view the list of approved drugs. A hard copy of the Formulary for December 31, 2014 shall be retained by Retirees Class Counsel.

"preventative health care" and "essential health care" benefits, as mandated by the State of Ohio or the federal government; and (8) such treatment and formularies which are generally accepted best medical practices. This definition is subject to the terms of this Agreement.

"Retirees Class Representatives" mean the Retiree Plaintiffs as identified in this document.

"Settlement Administrator" means the entity responsible for issuing notice to Current Employees Class and the Retirees Class.

"Settlement Date" means the date on which this Agreement becomes fully executed by all the Parties.

"Settlement Website" means the Internet website described herein.

"Surviving Beneficiaries" means spouses and eligible dependent children and orphans of members of the Current Employees Class and the Retirees Class.

"Tax Receipts" means the gross annual amount of funds collected by the City from all taxes, income and property.

GENERAL ALLEGATIONS PROVIDING CONTEXT FOR SETTLEMENT

Generally, the Original Plaintiffs allege in their Amended Consolidated Complaint that the Defendants unlawfully revoked and impaired their vested retirement benefits by adopting and enforcing Ordinance No. 84-2011.

The Original Plaintiffs seek declaratory and injunctive relief for themselves and all others similarly situated who participated in the CRS and had earned or purchased as provided in this Agreement at least five years of creditable service prior to July 1, 2011, and who are members of Group C, Group D, Group E or Group F as these Groups are defined by Cincinnati Municipal Code § 203-1-Ml(b), (c), (d), and (e).

Allgeyer is a member of Group C. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group C no longer receive a death benefit of at least $5,000. Allgeyer will represent the Group C Sub-Class of the Current Employees Class.

Kappel, Jackson, and Ganulin are members of Group D. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group D no longer receive a death benefit of at least $5,000 and a three percent COLA compounded annually. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent. Members of Group D who did not retire on or before January 1, 2014 were automatically assigned to Group E. Kappel, Jackson and Ganulin will represent the Group D Sub-Class of the Current Employees Class.

F. Jones is a member of Group E. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group E no longer receive the Higher Benefit Amount. Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent and replaced the Higher Benefit Amount with a less generous formula to calculate the benefit accrued from January 1, 2014 until retirement – thus limiting the multiplier applicable to such years to 2.2 percent up to 30 years and two percent for each year of service accrued thereafter. F. Jones will represent the Group E Sub-Class of the Current Employees Class.

Sunyak and Harmon are members of Group F. Pursuant to the adoption and enforcement of Ordinance No. 84-2011, members of Group F no longer receive the Higher Benefit Amount, and the right to retire with unreduced benefits upon reaching 30 years of service - regardless of age. For Group F, Ordinance No. 84-2011 replaced the three percent compounding COLA with a simple indexed COLA not to exceed two percent, replaced the Higher Benefit Amount with a

less generous formula to calculate the benefit accrued from July 1, 2011 until retirement - limiting the multiplier to 2.2 percent for years of service up to 30 and two percent for years of service over 30 and using the highest 60 months final average salary, and replaced the 30 years of service requirement with a requirement that such employees also must be 60 years of age to receive unreduced benefits. Sunyak and Harmon will represent the Group F Sub-Class of the Current Employee Class.

Generally, the Retiree Plaintiffs allege that the City has already unilaterally and significantly curtailed retiree health benefits and threatened and continues to threaten to further suspend or significantly curtail retiree health benefits, reduce the Retiree Plaintiffs' COLA from the current three percent compounding COLA with a simple indexed COLA not to exceed two percent, and to suspend the COLA for a period of years.

Pursuant to the adoption and enforcement of the Ordinance No. 84-2011 and Ordinance No. 85-2011, Members of the Retirees Class no longer receive a death benefit of $7,500, having been reduced to only $5,000, no longer receive premium-free healthcare separately identified as a benefit on documents signed by retirees upon retirement and which premiums totaled as much as $1,125 in 2014, no longer receive premium-free dental and vision insurance coverage both of which premiums totaled $875 in 2014, no longer receive reimbursement for Medicare premiums of over $1,200 per year (over $2,400 per year including spouse), have a smaller healthcare provider network and many no longer qualify for "carve-out" benefits owing to more stringent criteria. Members of the Retirees Class and their beneficiaries estimate their losses to be over $4,000 per capita per year in healthcare benefits as a result of benefit reductions imposed in 2010 through 2012. Additionally, Members of the Retirees Class are prepared to sacrifice an additional estimated $2,800 per capita per year in pension in order to gain long-term stability in

healthcare benefits which had been reduced. These costs have been and will be imposed on retirees whose average pension is $35,000. Further, other Retirees Class benefits have been threatened by the huge growth in CRS unfunded liabilities, which is a result, in part, of the City's failure to contribute to the CRS Pension Fund in accordance with the funding formula set forth in §203-93 CMC. The Retirees Class is also concerned about the potential loss of the Retiree's Class Death Benefit. These concerns are based upon numerous communications from and discussions with City officials.

The Members of the Retirees Class are also concerned that the adjudication of the Original Plaintiffs' claims in the Amended Consolidated Complaint will prejudice them by "adversely affecting" the financial viability and ability of the CRS to pay benefits, and that any settlement related to the Original Plaintiffs' Amended Consolidated Complaint could prejudice the Retirees Class Members' ability to independently assert their claims at a later date. The Plaintiffs are also concerned that, in the absence of a global resolution, the CRS Pension Fund, which is approximately 36 percent underfunded as of December 31, 2013, is likely to be unable to pay out future benefits. Consequently, the City is likely to eliminate or substantially modify and/or further reduce the retirement benefits.

AFSCME, which represents approximately 1,800 current employees of the City, filed an action in mandamus in the Hamilton County Court of Common Pleas alleging that the City failed to adequately fund the CRS in violation of the terms of the Cincinnati Municipal Code. AFSCME and its members are concerned that the adjudication or settlement of the Original Plaintiff's claims in the Amended Complaint will prejudice them by adversely affecting the City's ability to adequately fund the CRS and to pay future benefits to AFSCME's members. AFSCME's members are also concerned that in the absence of a global settlement and with any

continued underfunding of the CRS, the City would face fiscal challenges in balancing the General Fund and in the downgrading of the City's bond rating that would result in reduction or loss of City services, layoffs, increased employee benefit and CRS contributions and/or reduced health care benefits.

The City contends that it faces several imminent fiscal and regulatory challenges that require immediate action to stabilize the CRS. These challenges include, but are not limited to, the following:

i. The ongoing negative impact on the City's general obligation bond rating if the City cannot reduce or eliminate the CRS' accruing unfunded liability;

ii. The concern that the Ohio Auditor could place the City on fiscal caution, watch, or emergency pursuant to relevant provisions of the Ohio Revised Code;

iii. The concern that the CRS Pension Fund has an unfunded liability in excess of $829 million and is only 63.2% funded as of December 31, 2013; and

iv. Contemplated legislation in the Ohio General Assembly, which if approved, will require pension systems in the State to be 100% funded within a 30-year period.

The City thus contends that it is in a position of substantial fiscal challenge which may adversely affect its long-term ability to sustain the CRS.

Further, recent jurisprudence involving retiree healthcare, including but not limited to *M&G Polymers USA, LLC v. Tackett,* 574 U.S. ____ (2015), may limit the ability of the Retirees Class to effectively litigate their rights to any such benefits. Moreover, recent jurisprudence has failed to provide clarity about common law and statutory entitlement to set COLA levels and

other retirement benefits. Thus, there is risk to all Parties concerning the possible result of continued litigation. The Parties agree that a judicially-supervised collaborative resolution of these issues is in the best interest of the Parties.

CLASS CERTIFICATION

The Parties agree that the goal of securing the implementation of the terms of this Agreement shall be accomplished through certification of plaintiff class actions (and related subclasses) under Fed. R. Civ. P. 23(b)(1)(a), 23(b)(1)(b) and 23(b)(2) covering the Classes. The Original Plaintiffs shall serve as class representatives of the Current Employees Class and the Retiree Plaintiffs shall serve as class representatives of the Retirees Class. The Parties acknowledge that AFSCME members are included within the Current Employees Class and related sub-classes. The Parties agree to the certification of the mandatory Classes for settlement purposes only under Fed. R. Civ. P. 23(b) subject to the Court's approval.

The Parties agree that they are entering into this Agreement for settlement purposes only. Any acquiescence or agreement to the class certification in this case does not constitute an admission of liability or fault by the City, the City Defendants, or any of their officials, agents, or employees, and may not be used as evidence in any proceeding by any member of the Classes except proceedings under this Agreement and the related Consent Decree. Further, by agreeing to class certification for settlement purposes only, the Parties agree that any resulting classes or sub-classes do not constitute classes or sub-classes in other proceedings. The City agrees to be responsible for the issuance of any notices to interested parties required to implement this Agreement. The City agrees to pay any costs associated with such notice(s) including the cost to engage the Settlement Administrator.

CLASS COUNSEL

The following are hereby designated class counsel by agreement of the Parties subject to the final approval of the Court pursuant to Rule 23(g): (1) Christian A. Jenkins, Esq., Minnillo & Jenkins, Co. LPA, 2712 Observatory Avenue, Cincinnati, Ohio 45208; Marc D. Mezibov, Esq., Law Office of Marc Mezibov, 401 E. Court Street, Suite 600, Cincinnati, OH 45202; Jeffrey S. Goldenberg, Esq., Goldenberg Schneider, LPA, One West Fourth Street, 18th Floor, Cincinnati, Ohio 45202; and Robert D. Klausner, Esq., Klausner, Kaufman, Jensen & Levinson, 7080 Northwest Fourth Street, Plantation, FL 33317 and shall serve as the Current Employees Class Counsel; and (2) Robert A. Pitcairn, Jr., Esq., James F. McCarthy, III, Esq., Peter J. O'Shea, Esq., and the law firm of Katz Teller Brant & Hild, 255 East Fifth Street, Suite 2400, Cincinnati, Ohio, 45202 shall serve as the Retirees Class Counsel.

The Parties do hereby stipulate that the Current Employees Class Counsel and the Retirees Class Counsel are competent to handle the matters described herein and have relevant experience in same. None face any disqualifying conflict of interest or ethical duty and undertake such duties with full knowledge of all attendant obligations and responsibilities.

OTHER PARTIES' COUNSEL

For the purposes of the execution of this Agreement only, R. Sean Grayson, Esq., AFSCME, Ohio Council 8, 6800 North High Street, Worthington, OH 43085-1918, shall serve as counsel for AFSCME and Steven P. Goodin, Esq. and John B. Pinney, Esq., Graydon Head, 1900 Fifth Third Center, 511 Walnut Street, Cincinnati, OH 45202, of counsel to City Solicitor Paula Boggs Muething, shall serve as counsel for the City and all City Defendants.

OPERATIVE SETTLEMENT TERMS

The Parties agree, stipulate and warrant to the following terms of settlement:

1. CRS Funds: All funds held in the CRS Pension Trust Fund shall be used solely for the benefit of the members of the CRS.[6]

2. CRS Pension Trust Fund: The funds held in the CRS Pension Trust Fund shall be subject to this Agreement and the following: (1) all funds held and invested are to pay retirement benefits, excluding healthcare benefits; (2) the funds shall not be subject to the claims of creditors; (3) the City may not grant any security interest or creditor interest in the CRS Pension Trust Fund; (4) the board of trustees of the CRS may not grant any security or creditor interest in the funds held in the CRS Pension Trust Fund; and (5) upon agreement of the Parties or by order of the Court, expenses and fees outlined in this Agreement may be paid from funds in the CRS Pension Trust Fund.

3. 115 Trust Fund: The City shall create a 115 Trust Fund prior to the Effective Date for the purpose of holding and investing funds to provide Retirees Class Healthcare Benefits, Current Employees Class Healthcare upon Retirement and healthcare benefits upon retirement to members of the CRS as provided pursuant to the CMC, subject to the terms and conditions in this Agreement. The City shall be obligated to fund the 115 Trust Fund at actuarially appropriate levels sufficient to provide these benefits for the term of this Agreement. The funds held in the 115 Trust Fund shall be subject to this Agreement and the following: (1) the funds held and invested are to pay Retirees Class Healthcare Benefits, Current Employees Class Retirement Healthcare Benefits and retiree healthcare benefits for any eligible City employees; (2) the funds shall not be subject to the claims of creditors, except as may be required by the terms of this Agreement; (3) the City may not grant any security interest or

[6] This Agreement shall not bind the Defendants or the CRS regarding individuals not covered by this Agreement. Subject to applicable law and collective bargaining rights, the City retains the exclusive authority to set benefit levels for those current and future employees who are not subject to this Agreement.

creditor interest in the 115 Trust Fund; and (4) the board of trustees of the CRS may not grant any security or creditor interest in the funds held in the 115 Trust Fund.

4. Transfer of Funds to the 115 Trust Fund: The City shall transfer from the CRS 401(h) account to the 115 Trust Fund such funds as may be required to fund healthcare benefits at actuarially appropriate levels sufficient to provide the healthcare benefits set forth herein for the term of this Agreement. The Parties will allow a reasonable period to complete this transaction, with the understanding that those funds will likely be unavailable for transfer until the 401(h) liabilities have been paid out.

5. Projected Healthcare Savings Applied to Pension: The Defendants shall apply at least $200 million but not more than $220 million from the 401(h) Account to the CRS Pension Trust Fund to reduce its unfunded liability. Any savings from the healthcare modifications must be realized consistent with the projections outlined in the Cavanaugh MacDonald report attached as Exhibit 5 and must allow the 115 Trust Fund to remain at actuarially appropriate levels sufficient to provide the benefits.

6. Retirees Class and Current Employees Class Rights: All members of the Current Employees Class and the Retirees Class have guaranteed rights in their pension, including COLA, and healthcare benefits, subject to the terms and provisions of this Agreement and the Consent Decree.

7. CRS COLA Calculation: Effective January 1, 2016 or the Effective Date, whichever is later, the COLA for current and future retirees in the Current Employees Class and the Retirees Class, except as provided in this Agreement, will be a three percent fixed simple adjustment[7] (as opposed to the three percent compounded COLA currently received by most

[7] The simple three percent COLA will be applied on the anniversary date as follows: Assume a retiree has an annual pension of $10,000 per year. The three percent COLA is equal to $300. Each succeeding COLA amount is

members of the Retirees Class and the simple COLA indexed to inflation not to exceed two percent currently applicable to most members of the Current Employees Class). Until such time, the Retirees Class and current and future retirees in the Current Employees Class shall receive the COLA, compounded or simple, to which they were entitled as part of their pension pursuant to the terms of the CMC as of December 31, 2014. For those Members who retired prior to July 1, 1987, the new COLA calculations will commence on January 1, 2016. For those Members who retired on or after July 1, 1987, the new COLA calculations will commence on their retirement anniversary date, subject to the rights of Current Employees Class Members to receive payments under Paragraph 16 below as if said COLA was in effect at the time of their retirement.

8. CRS Retirees' Class COLA: The basis for the calculation of the simple COLA set out in Paragraph Seven for Members of the Retirees Class will be the gross monthly pension payment payable on January 1, 2016 but shall include all previously granted COLAs and the compounded COLA earned in 2015.

9. Current Employees Class COLA Delay Period: Each Current Employees Class member shall be subject to a three-year COLA delay period during which he or she will not receive a COLA. For those members of this Class yet to retire, the three-year COLA delay period begins on the one-year anniversary date following their date of retirement. These individuals shall not receive a COLA in their second, third and fourth years of retirement, but shall receive a COLA in all years after their fourth year of retirement. For those members of this Class who retired after July 1, 2011 and on or prior to January 1, 2016, the three-year COLA

---

aggregated with the prior COLA payment. In the first year in which a COLA is applied, the annual benefit would be $10,300. The next COLA payment of $300 would take the annual benefit to $10,600. The third COLA payment of $300 would take the annual amount to $10,900. This process would continue on an annual basis.

delay period begins to run on their next retirement anniversary date or on January 1, 2016, whichever is later.

10. Retirees Class COLA Suspension Periods: Beginning January 1, 2016, or January 1 of the year following the Effective Date, no Member of the Retirees Class shall be entitled to a simple COLA for a period of three years except as provided elsewhere in this Agreement. The suspension period shall commence upon January 1, 2016, or the anniversary date of the individual member's retirement, whichever date is later, pursuant to the applicable provisions of the Cincinnati Municipal Code effective December 31, 2014. Members of the Retirees Class shall receive a one-time payment calculated at three percent of their base pension annuity benefit (but in any event, capped at $1,000) at the commencement of the third year of their respective COLA suspension period.

11. COLA Poverty Exception: Any member of the Retirees Class or the Current Employees Class (or their surviving dependent entitled to continuing CRS benefits) who retired (or retires) with at least five years of creditable service and whose household income is below 150% of the U.S. Department of Health and Human Service's updated annual poverty guideline pursuant to 42 U.S.C. 9902(2) will receive the above-referenced three percent compounding COLA without being subject to any COLA delay or suspension. If for that year and any subsequent year their household income (as defined in CMC § 203-44) exceeds 150 percent of the federal poverty guidelines, these retirees will receive the three percent simple COLA described above, after appropriate notice has been provided to the qualifying retirees.

12. Current Employees Class Retirement Eligibility: Current Employees Class members can retire with unreduced pension benefits pursuant to the terms of this Agreement upon reaching 30 years of service or at age 60 with five years of service.[8]

13. Retirement Benefit Multiplier Calculation: When calculating a retirement benefit for a Current Employees Class Member, the CRS administrator shall utilize a 2.5 percent multiplier[9] for the greater of: (a) 20 years of service or (b) the number of years of service prior to July 1, 2011 for Current Employees Class members in Group F and the number of years of service prior to January 1, 2014 for Current Employees Class members in Group E. A 2.2 percent multiplier shall be used for all other years of service unless a higher multiplier would apply under Ordinance No. 84-2011, in which case such higher multiplier shall apply. The Parties agree that the two percent multiplier for years of service in excess of 30 as provided by Ordinance No. 84-2011 shall be superseded by the foregoing multipliers.

14. Final Average Salary Calculation: The Final Average Monthly Salary ("FAS") component used to calculate the pension benefits of members of the Current Employees Class upon their retirement shall continue to be determined in the same manner as it has been for each respective class since adoption of Ordinance No. 84-2011. Specifically, this means that: (1) Members of Group C and D will have an FAS based on their highest 36 months of service including pensionable lump sum payout for 2.22 percent members; and (2) Group E will have an FAS with two separate components based upon: a) years of service through December 31, 2013,

[8] Those employees who are veterans shall be permitted to purchase service credit for their years of active duty military service prior to July 1, 2011 in accordance with existing CRS policies. Any service credit purchased in this manner will count toward obtaining five years of creditable service prior to July 1, 2011 thereby enabling veterans to vest for purposes of the benefits afforded under this Agreement regardless of when purchased or otherwise accrued.

[9] Those Class Members who previously elected to utilize a 2.22 percent multiplier for all earnings during the applicable years, including without limitation overtime hours, shall be subject to the 2.22 percent multiplier in the same manner as the 2.5 percent multiplier under this provision.

on the highest 36 consecutive months of earnings during entire membership in CRS from first day of membership through last day of paid employment; and b) years of service on and after January 1, 2014, on the highest consecutive 60 months of earnings during entire membership in the CRS; and (3) Group F will have an FAS based upon the following two components: a) for years of service through June 30, 2011, on the highest 36 consecutive months of earnings during entire membership in CRS from first day of membership through last day of paid employment; and b) for years of service after June 30, 2011 on the highest consecutive 60 months of earnings during entire membership in CRS.

15. Early Retirement Eligibility: The following Early Retirement Eligibility changes shall occur for the benefit of the Current Employees Class members: (1) the age 57 and 15 years of service requirement formula established Ordinance No. 84-2011 shall be superseded by the terms of this Agreement; and (2) the age 55 and 25 years of service requirement that existed prior to Ordinance No. 84-2011 shall be reinstated; and (3) the retirement option for those employees who reach age 60 and have at least five years of service that existed prior to Ordinance No. 84-2011 shall be reinstated.

16. Annuity Adjustments: The pension annuity benefits for Current Employees Class members in Groups D and members of Groups E and F who retire before January 1, 2016, or the Effective Date, whichever is later, will be adjusted prospectively by being increased to the amount that their benefits would have been had the Consent Decree been in effect on the date of their retirement. In addition, these Current Employees Class members will receive a payment designed to compensate for the difference between the amount of pension benefits they received from the date of their retirement until the effective date of the Agreement and the amount they would have received had the Agreement been in effect on the date they retired. These payments

shall be made no later than 120 days after the Effective Date of the Agreement. Current Employees Class Counsel shall be entitled to review and confirm that these payments are accurate and in compliance with this provision prior to these payments being issued.

17. Employee Contributions: Pension contributions made by Current Employees Class members shall not exceed nine percent of pensionable wages during the term of the Consent Decree, subject to this Agreement and the Consent Decree. Any reduction in pension contributions may not adversely affect benefits as defined in this Agreement for members of the Classes.

18. Group C Settlement Payment and Retirement Healthcare Benefits: Because members of the Group C Sub-Class, upon their retirement, would have been entitled to a three percent compounding COLA from July 1, 2011 until January 1, 2016,[10] or the Effective Date, whichever is later, they shall receive a one-time Group C Settlement Payment pursuant to the following schedule to be paid no later than 90 days after the Effective Date of this Agreement or within 90 days following the member's retirement, if later:

i. Retired after July 1, 2011 through December 31, 2011: $125

ii. Retired on or after January 1, 2012 through December 31, 2012: $250

iii. Retired on or after January 1, 2013 through December 31, 2013: $375

iv. Retired on or after January 1, 2014 through December 31, 2014: $500

v. Retired on or after January 1, 2015 or remained employed by the City as of the effective date of the Consent Decree: $625

In addition, notwithstanding any language in this Agreement to the contrary, all members of Group C, including both those who have retired prior to the Effective Date and those who have

[10] Members of the Group C Current Employee Sub-Class were entitled to retire with full benefits (other than the retirement death benefit) as of July 1, 2011 but remained employed by the City.

not, shall be entitled to Retirees Class Healthcare Benefits on the same terms as members of the Retirees Class, including specifically but not limited to continued eligibility for retiree health benefits with 15 years of creditable service. The City renders no opinion, and accepts no liability, in regards to any tax consequences related to such payments.

19. City's Annual Contribution to CRS Pension Trust Fund: The City shall contribute to the CRS Pension Trust Fund no less than 16.25 percent of Covered Payroll annually for the duration of the Consent Decree (30 years) notwithstanding any contrary calculations claimed by any Party or non-party under any provision of the CMC or any other basis.

20. Additional Contributions to CRS Pension Trust Fund:

i. The City, recognizing the risk typically borne by the employer in a defined benefit plan, shall contribute to the CRS Pension Trust Fund an additional three percent of Covered Payroll for three consecutive years before requesting an Annual Minimum Funded Ratio Re-opener as defined in Paragraph 35 (iii) of this Agreement. Following that three-consecutive-year supplemental contribution, the City may seek an Annual Minimum Funded Ratio Re-opener only if the City complies with the requirements of the Annual Minimum Funded Ratio Re-opener set forth in Paragraph 35 (iii) for the term of this Agreement.

ii. If the City sells an asset or privatizes any City service or otherwise transfers or loses a City function which results in a reduction of total Covered Payroll, the City shall provide or secure funding for any remaining pension and healthcare liabilities to remedy any impact on the CRS.

iii. Recognizing the need for additional cash contributions, the City shall make an additional contribution equal to or greater than the remaining liability on the Early Retirement Incentive Program (ERIP) through a judgment or settlement bond with the consent of the Parties and the Court or continue current required payments.

21. Deferred Retirement Option Plan ("DROP"): Beginning with the completion of 30 years of creditable service, Current Employees Class members may effectively retire and freeze their accrual of years of service in the CRS plan and defer receipt of retirement benefits, including health care benefits for retirees, for a period not to exceed five years while continuing City employment. Current Employees Class members will be subject to the COLA delay period set forth in Paragraph 9 at the close of their individual DROP periods, and shall not be paid COLAs during the DROP period. The deferred pension benefits of DROP participants shall accumulate during their participation in the DROP in an individual account together with any individual employee contributions during such period. All amounts credited to individual DROP accounts shall be 100 percent vested in such individuals and shall not be subject to forfeiture under any circumstances. Such amounts shall experience earnings but in no event less than zero percent per year. At or before the end of the five-year deferral period, such employees must separate from service. The deferred amount either must be distributed or rolled over into a qualified account within 120 days of said separation from service. The DROP program shall be cost neutral to the CRS Pension Trust Fund and shall not negatively impact the CRS Funded Ratio and may be primarily administered by a third party entity. If insurance coverage for the CRS to guard against negative performance can be obtained on reasonable terms, the City shall acquire such coverage at the expense of each DROP participant. If such insurance is not

available, the City shall assess reasonable and sufficient fees, payable from each DROP account, to insure against negative performance and to cover the cost of administration and expenses to the CRS. The Parties agree to facilitate an independent actuarial analysis of the DROP during the fifth year of its implementation. If, based upon that analysis, the program is not cost-neutral to the CRS Pension Trust Fund, the Parties shall then submit the matter to the Court for possible reformation or closure of the DROP, as warranted by the facts and determined by the Court to assure the DROP is cost neutral, provided that any individual who has entered the DROP shall be entitled to participate in the DROP for five full years. The establishment of the DROP is a material element of the Settlement for both the Current Employees Class and AFSCME. Any dispute over the terms, conditions and administration of the DROP shall be referred to the Court for resolution.

22. Retirees Class Healthcare Benefits: For each year following the Effective Date, co-pay, deductibles and out of pocket amounts shall not increase for the term of this Agreement. The premiums charged shall be five percent of the CRS healthcare costs for the previous year, net of copays, deductibles, and out of pocket expenses paid by retirees.

23. Current Employees Class Retirement Healthcare Benefits: Current Employees Class members shall be entitled to retirement healthcare benefits as provided in this Agreement if they retire with at least 30 years of creditable service regardless of age, or at or after age 60 with at least 20 years of creditable service (except for members of Group C, who shall be entitled to the same retirement healthcare benefits as members of the Retirees Class if they retire with at least 15 years of creditable service). These Current Employees Class members shall receive the most favorable plan available to active employees (excluding police and fire) at the time of their respective retirements.

24. Current Employees Class Retirement Healthcare Premium Percentages[11]:

i. Pre January 9, 1997 Hire Date: Current Employees Class members hired prior to January 9, 1997 shall pay the same percentage of premium for retiree healthcare benefits as paid by active employees at the time of their retirement. However, in no event shall these Current Employees Class members pay greater than 10% of their premium.

ii. January 9, 1997 or later Hire Date: Current Employees Class members hired on or after January 9, 1997 shall pay the percentage of premium for retiree healthcare benefits according to a revised Point System to be negotiated which will address the perceived inequities in the current Point System. For example, under the current Point System (attached as Exhibit 8) a Current Employees Class member retiring with 30 years of service at age 59 would pay 25% of the premium, whereas a Current Employees Class member retiring with 30 years of service at age 60 would pay only 5% of the premium. The goal of such negotiations between the Parties will be to provide retiree healthcare benefits at a cost of 10% of the premium to as many future retirees as possible without reducing the funding ratio of the 115 Trust Fund below actuarially appropriate levels and cost neutral to the 115 Trust Fund. If the Parties cannot agree to a framework for such reforms within six months of the Effective Date, then the matter shall be submitted to the Court for a final resolution and/or determination. If this issue is submitted to the Court, the Court shall not increase any Current Employees Class Member's premium percentages beyond those contained in the Point System as of January 1, 2015 and the Court cannot alter the funding ratio of the 115 Trust Fund

[11] Pursuant to Paragraph 18 above, the provisions set forth in Paragraph 24 do not apply to Group C.

below actuarially appropriately levels or materially increase costs to the 115 Trust Fund.

25. Healthcare Modifications for Retirees: To be effective January 1 of the year following the Effective Date, the City shall:

i. Establish an Employer Group Waiver Plan ("EGWHP") to maximize prescription-drug-related reimbursements from federal healthcare programs. The EGWHP will provide substantially similar benefits to the Retirees Class Healthcare Benefits;

ii. Implement a voluntary, medical expense reimbursement program ("MERP"); and

iii. Alter retirement health care eligibility requirements for members of the Current Employees Class in accordance with this Agreement.[12]

26. Healthcare Funding Obligation: The City shall develop and present to the Parties a proper funding policy for the 115 Trust Fund no later than 30 days prior to the Fairness Hearing. The funding policy will satisfy all consent decree requirements including but not limited to the City's obligation to fully fund the 115 Trust at actuarially appropriate levels for the term of this Agreement.

27. Retirees Class Death Benefit: The Retirees Class Death Benefit shall be paid to the designated beneficiaries of the members of the Retirees Class who will be entitled to a Retirees Class Death Benefit.

28. Consent Decree Duration: The Consent Decree shall remain in force for 30 years from the Effective Date.

[12] This provision is not applicable to members of Group C who will receive benefits as set forth in the other applicable provisions of this Agreement.

29. Assumed Rate of Return: A 7.5 percent annual assumed rate of return shall be applied to any and all actuarial calculations related to the valuation of the CRS Pension Trust Fund and the 115 Trust Fund for purposes of this Agreement.

30. Pension Board Reforms: The Parties agree to negotiate in good faith reforms for the administration of the CRS including the composition of the Board of Trustees and the administration of the CRS. If the Parties are unable to reach agreement on such reformation within 120 days of the execution of this Agreement, the Court shall determine the composition, structure and function of the Board. In such an event, the Parties agree that the Court will honor the following parameters:

i. A Board of Trustees shall be established. The Board shall have nine members. Four members shall be appointed by the Mayor, three members shall be elected by retired members and two members shall be elected by employee members. The Board is subject to and bound by the terms and provisions of this Agreement.

ii. The Mayor's appointees shall be made with input from City Council and subject to any subsequent ordinances adopted by City Council.

iii. The members shall elect a chair and vice-chair who shall each serve two-year terms. The chair (or vice-chair in the absence of the chair) shall be responsible for communicating the concerns of the Board to the CRS administrator, setting Board meeting agendas and, after consulting with the board as a whole, establishing priorities for the CRS administrator (Director of Retirement Department) and CRS staff.

iv. The Board shall administer the CRS for the benefit of the members of the CRS. The Board shall have the exclusive authority to administer the CRS Pension Trust

Fund and the 115 Trust Fund, subject to the terms and provisions of this Agreement and the Cincinnati Municipal Code, provided that, in the event of any conflict, this Agreement and Consent Decree shall control. Each member of the Board shall have fiduciary responsibility as defined under the laws of the State of Ohio. The fiduciary responsibility shall be solely to the active and retired members of the CRS.

v. The City Manager shall be the appointing authority for the Director of the Retirement Department and shall supervise his or her performance. The Board will actively participate in any searches for a new Director, whether by committee or otherwise, and may present candidates for consideration. The City Manager and the Board shall develop formalized procedures for the evaluation of the Director and the Board's annual written evaluation of the Director's performance shall be submitted to the City Manager at the close of each fiscal year. The City Manager may also dismiss the Director if warranted by circumstances and performance. The City Manager shall dismiss the Director of the Retirement Department at the request of a two-thirds majority of the Board of Trustees.

vi. The Board will follow the City's established procurement process for its selecting and contracting with any actuaries, investment advisors and other professionals deemed necessary for the administration of the CRS. Any investment manager(s) and firms hired shall be experienced and reputable professionals in the field. They shall have experience and competencies in the areas of management of funds for large public pension plans. They shall be experienced in assessing index funds, assessing, comparing, choosing and administering appropriate asset

allocation plans, and satisfying objectives. Any firm(s) chosen shall also have records of achievement regarding integrity and attaining plan goals. The term of investment firm and manager contract(s) shall be two years, with two additional two year extensions, for a maximum term of six years. Prior to the end of the six-year term, these contractual services must be rebid, but nothing herein is intended to preclude selection of the former contractor.

vii. The Board may determine the format and content of any reports from the actuary and investment managers. However, the Board shall not limit, in any way, the right and duty of the actuary or investment manager(s) to provide content deemed by the actuary or investment manager(s) to be important for the Board, the members, staff and public. All reports shall be provided to the members of the Board, and members of the Board may request additional reports as needed.

viii. Any deposits, expenditures, transfers, loans, or withdrawals for the CRS Pension Trust Fund, the 115 Trust Fund, or staff funds that were not identified in the annual budgets must be approved by a vote of two-thirds of the members present. All such actions shall be included and identified as a line item in the budget which shall be approved annually by the board by a two-thirds vote of those present. The payment of attorneys' fees and expenses as approved by the Court pursuant to this Agreement is not subject to this provision.

ix. Board and committee meetings shall be considered meetings of a public body and be open to the public subject to lawfully convened executive sessions.

31. No Disgorgement: Neither as a result of this Agreement nor the related Consent Decree shall any retirement benefit being received by any retiree be reduced. Likewise, no

retiree shall be required to repay or otherwise disgorge any amounts received from the CRS after the Effective Date as a result of this Agreement. The City reserves the right to attempt to recoup overpayments made due to administrative error.

32. Actuarial Confirmation: The City shall provide to the Current Employees Class Counsel, the Retirees Class Counsel and Counsel for AFSCME confirmation of the actuarial data utilized during the mediation process. Any dispute as to whether confirmation of this actuarial data has occurred shall be resolved by the Court no later than 30 days prior to the Fairness Hearing. The City shall also provide, as requested by Current Employees Class Counsel, the Retirees Class Counsel and Counsel for AFSCME other information related to class membership, pension statistics, or other similar data or information to facilitate final approval of this Settlement. Any dispute as to whether confirmation of this actuarial data has occurred shall be resolved by the Court no later than 30 days prior to the Fairness Hearing.

33. Contingency and Lack of Severability: Given the unique nature of this Agreement and Consent Decree and the interlocking nature of their terms, the Parties hereby expressly agree that the terms and provisions set forth in this Agreement and Consent Decree are contingent upon one another. The reforms contained herein are cumulative, iterative and based upon actuarial projections, and must be enforced *in toto*.

34. Attorney's Fees: The Parties agree that Current Employees Class Counsel and Retirees Class Counsel may submit an application for an award of attorneys' fees to the Court no later than twenty-one days prior to the deadline for Class Members to object to the terms of the Settlement Agreement. Attorneys' fees and expenses awarded by the Court shall be paid within 20 business days following the Effective Date. Defendants and Current Employees Class Counsel further agree and stipulate that any class counsel fees associated with representation of

the Current Employees Class will be ultimately paid back to the CRS Fund by members of that class from their pension benefits over time in a fair manner consistent with the terms of the Class Notice. The Defendants and the Current Employees Plaintiffs acknowledge and agree that Current Employees Class Counsel fees shall be based upon the value of the pension and healthcare benefits conferred upon the Current Employees Class as determined by the Court. The Defendants and Current Employees Class Plaintiffs stipulate that said benefit is at least $40 million. The Retirees Class Representatives do not stipulate to any aspect of this proposed fee arrangement.

35. RE-OPENERS: The events or circumstances described below, upon presentation of adequate evidence to satisfy the Court that such conditions exist, shall constitute sufficient reason to re-open the Consent Decree based upon the continuing jurisdiction of the Court as set forth in Paragraph 42. The Parties acknowledge that contributions, costs, expenses, and benefits (except pension) are subject to modification to resolve a reopener.

Reopeners shall only be pursued as a last resort and must specifically meet the criteria stated for the reopener.

The Parties recognize that the pension typically provides life's basic needs for a retiree including food, clothing, shelter, and healthcare are critical to providing for their long-term financial and physical well-being. The Parties further acknowledge that, owing to age and often ill-health, the opportunity for retirees to improve their revenue stream is typically very limited. As a result, the Parties agree that no further reductions to the monthly pension annuities, including COLA, of those already retired at the time the reopener is sought will be a part of any re-opener during the Consent Decree.

The continued provision of Retirees Class Healthcare Benefits is considered a material part of the Settlement and Consent Decree. Reductions in benefits or increases in cost for Retirees Class Healthcare Benefits shall occur only with the express approval of the Court and be shared as equitably as possible among all Parties, taking into account the necessity for any solution sought, the impact on the well-being and affordability to retirees and current employees, the impact of retiree and current employee benefit reductions since 2007, the disparity, if any, in healthcare benefits being provided to retirees and current employees, and the negotiation of tradeoffs in organized labor contracts, and the availability of alternative vehicles providing substantially similar benefits.

Recognizing that it is very likely that the methods, organization, regulation, and institutional systems for delivering healthcare benefits to retirees will change during the life of the Consent Decree, the Parties agree that the process for changing the methods, organization, and/or institutional systems for delivering healthcare benefits to retirees should be something other than an adversarial reopening of the Consent Decree. If the federal or state government, or the organizational entities that customarily deliver healthcare benefits (e.g. doctors, clinics, hospitals, insurance companies) require a modification to deliver healthcare services to retirees, the parties agree to amicably negotiate the transition to available methods, organizations, regulations, and institutional systems to provide the healthcare benefits as described in this Agreement.

The Party who believes that a reopener condition exists shall issue written notice to the other Parties and to the Court explaining the basis for such reopener. It shall be the burden of the Party issuing such notice to convince the Court that there has been a material change in circumstances which meet the stated criteria warranting a reopening of the Consent Decree.

When any of the following reopener conditions is triggered by the above process, the Parties shall negotiate in good faith, subject to the Court's oversight, management, and administration, to reach an amicable resolution regarding any necessary modifications to CRS, the funds managed by the CRS, operations, benefit levels, contributions, funding sources or any other related issue consistent with this Agreement and Consent Decree. Should the Parties be unable to reach an amicable resolution regarding any necessary modification, then the Party who gave notice of the reopener must file a motion with the Court setting forth in detail the nature and/or grounds of the request for reopener and the requested modification to the CRS, the funds managed by the CRS, operations, benefit levels, contributions, funding sources or any other related issue which is sought. The Party requesting the modification shall have the burden of convincing the Court that the requested modification is in the best interest of the City, the CRS, and the members of the CRS in light of and giving due consideration to the purposes, objectives and goals of this Agreement and the Consent Decree. The Court may grant a modification to this Agreement and the Consent Decree when the requested modification is both necessary and appropriate based on the clear and convincing evidence of any of the following:

i. There is an annual change in City total tax receipts of greater than ten percent that remains at or outside that range for five consecutive fiscal years;

ii. There is an actual reduction in Covered Payroll of ten percent or more that has occurred or will occur and which will cause the CRS Pension Trust Fund to be 90 percent funded or less by the end of the term of the Agreement;

iii. The actuaries of the CRS will create a Schedule of Funded Ratios (Preliminary). This chart will show the Annual Target Funded Ratio (Column 1), which, if achieved throughout the term of this Agreement, would result in the CRS Pension

Fund being fully funded at its expiration. It will be incorporated into this Agreement by reference. The Annual Minimum Funded Ratio (Column 2) will be equal to 90 percent of each year's Annual Target Funded Ratio. The Maximum Funded Ratio (Column 3) will be equal to 110 percent of each year's Annual Target Funded Ratio. If the Funded Ratio remains below the yearly Annual Minimum Funded Ratio or above the Maximum Funded Ratio for five consecutive years, any party may seek to reopen the Consent Decree. However, if the five-year annualized actual CRS return for that stated period has not exceeded the blended five year annualized actual return for that period of 75 percent of the S&P 500 Index and 25 percent of the Barclay (formerly Lehman) US Bond Index, no request for an Annual Minimum Funded Ratio reopener shall be made. The Parties further agree that the above-referenced Schedule of Funded Ratios will be revised every five years to more accurately reflect the assets and liabilities of the CRS;

iv. The City proposes a plan to transition healthcare benefits to a Medicare exchange portal/HRA model effective no earlier than ten years after the Effective Date, so long as the model does not negatively affect healthcare benefits;

v. CRS becomes subject to the so-called "Cadillac Tax" (as defined by the Affordable Care Act) for Retirees Class Healthcare Benefits. The City agrees to make all reasonable efforts to avoid the implementation of said tax. If the CRS becomes subject to a tax greater than ten percent of the annual cost of healthcare to the CRS for the previous fiscal year, any Party may move to reopen this Agreement;

vi. The City proposes a plan to merge CRS functions with another public pension plan on terms that would require the assuming plan to honor all pension and other benefit commitments and costs provided for in this Agreement and the Consent Decree. The City may not propose a plan to merge for ten years following the Effective Date;

vii. The average CPI-U Index for the most recently completed calendar year and for the previous four consecutive calendar years exceeds five percent;

viii. If a restructuring or modification of funding healthcare through government regulation or legislation results in the 115 Trust Fund being no longer required to fund healthcare benefits for retirees, the Consent Decree may be reopened as to the use of the 115 Trust Fund;

ix. If any cause or condition exists or comes to exist which would reduce the 30-year projected funding ratio for either the CRS Pension Trust Fund or the Section 115 Trust Fund to 90 percent or less; or

x. If otherwise agreed upon by all the Parties.

36. Denial of Liability: Defendants dispute Plaintiffs' claims, deny that the Classes are entitled to any relief, and have asserted numerous defenses to the allegations at issue in the Actions, and would continue to do so in the event these Actions did not settle. Defendants have agreed to enter into this Settlement Agreement and the related Consent Decree without any express or implied acknowledgment, in any way, of any fault or liability to anyone, including the Plaintiffs herein. Defendants have concluded that settlement, on the terms set forth in this Agreement and the related Consent Decree, is in their best interests, taking into account, among other concerns, the inconvenience, distraction, delay, and expense associated with and the

unpredictable nature of further litigation and in an attempt to quell all controversy and to avoid additional and costly expenses, including but not limited to disruption of its business and also the burdensome, disruptive and costly litigation necessary to defend these Actions. Throughout the course of these Actions, and otherwise at all times, Defendants have denied all allegations of wrongdoing or liability whatsoever asserted and/or which could have been asserted in these Actions. Defendants continue to do so and neither this Settlement Agreement nor the related Consent Decree, nor anything contained herein, or offered and exchanged between the Parties as negotiated and/or leading to this Settlement Agreement and the related Consent Decree, may be used or construed by any person or entity as an admission or concession by Defendants of the truth of any of the allegations in the Actions, or of any liability, fault, or wrongdoing of any kind on the part of any Defendant. Other than the procedures adopted by the Consent Decree, this Settlement Agreement and related Consent Decree shall not be offered or received in evidence in any action or proceeding in any court, administrative panel or proceeding, or other tribunal, as an admission or concession of liability or wrongdoing of any nature on the part of any Defendant. In the event the Settlement Agreement and related Consent Decree are not finally approved for any reason, Defendants retain the right to contest the Actions and/or any other case on any ground.

37. Settlement Administrator and Administration: The Parties agree that the City will propose for Court approval that Class Action Administration, Inc. be designated as the Settlement Administrator. The Settlement Administrator shall (i) oversee the provision of Notice to the Current Employees Class and the Retirees Class; (ii) oversee and maintain the settlement website; (iii) audit and confirm the issuance of payments made to any Current Employees Class member pursuant to this Agreement; and (iv) provide a certification to the

Court regarding the issuance of Notice as set forth herein. Defendants shall pay the reasonable costs of administering the Settlement once Preliminary Approval is granted by the Court from general revenue funds. Such costs will include, for example, the reasonable costs of notifying the Current Employees Class members and the Retirees Class members, mailing the Class Notice, creating and maintaining a settlement website, and creating and maintaining an automated toll-free telephone number to answer frequently asked questions. The City agrees to supply to the Settlement Administrator names and last known addresses for each Current Employees Class member and each Retirees Class member. The City shall provide such information on a timely and responsive basis and in a readily usable format so as to enable the Settlement Administrator to satisfy the requirements of the Notice Program described below. For any Current Employees Class member or Retirees Class member for whom a current address cannot be located, the City shall provide the Settlement Administrator with the last known address for the representative or agent of each such Current Employees Class member and Retirees Class member.

38. Notice to Class Members: The Notice Program will consist of the following: (i) mailing of the Notice (the text of which shall substantially conform to Exhibit 2 hereto) to Current Employees Class members and Retirees Class members by first-class mail; (ii) creating and maintaining the Settlement Website (the text of which shall substantially conform to Exhibit 2 hereto) which will include a copy of the Notice, the Settlement Agreement, Consent Decree and other information relating to the terms of the Settlement; and (iii) establishing a toll free number containing answers to frequently asked questions (the text of which shall substantially conform to Exhibit 2 hereto). No later than 30 days after the Preliminary Approval Date, the Settlement Administrator shall mail the Notice by first-class mail to each Current Employees Class member and each Retirees Class member. The first day on which the Notices are mailed

shall constitute the Notice Date. The Settlement Administrator shall certify to the Court the Notice Date in writing. As necessary, the Settlement Administrator shall locate or update all addresses for Current Employees Class members and Retirees Class members prior to mailing the Notices. If any Notices are returned as undeliverable, then the Settlement Administrator shall, to the extent it is reasonably able to locate a current address, re-send all such Notices by first-class mail. If the Settlement Administrator cannot reasonably locate a current address for those Notices returned as undeliverable, then the Settlement Administrator may send such Notices by first class mail to the last known address of the agent or representative of each of these Current Employees Class members and Retirees Class members, if available.

39. Objections to the Settlement: Any Class Member who wishes to object to the fairness, reasonableness or adequacy of this Settlement Agreement, the Consent Decree, or to the requested amount of attorneys' fees and expenses must, by the date specified in the Class Notice (which will be 60 days after the Notice Date) deliver to Class Counsel and Defendants' Counsel and file with the Court a statement of the objection, as well as the specific reason(s), if any, for the objection, including any legal support and any evidence the Class Member wishes to introduce in support of the objection. Any Class Member may so object either on their own or through an attorney hired at their own expense. Any Class Member who files and serves a written objection, as described in this Section, may appear at the Fairness Hearing, either in person or through personal counsel hired at that Class Member's expense, to object to the fairness, reasonableness or adequacy of this Settlement Agreement or to the requested attorneys' fees and expenses. Class Members or their attorneys intending to make an appearance at the Fairness Hearing pursuant to their objection must no later than 14 days prior to the Fairness Hearing: (1) file a notice of intention to appear with the Court; (2) deliver to Class Counsel and

Defendants' Counsel a copy of such notice of intention; and (3) identify any documents they will seek to introduce or witnesses they intend to call at the Fairness Hearing. The Parties and their respective counsel shall not solicit or encourage any objections.

Any Class Member who fails to comply with this Section shall waive and forfeit any and all rights that the Class Member may have to appear separately or object, or to take any appeal of the orders or judgments, and shall be bound by all the terms of the Settlement Agreement, the Consent Decree and by all proceedings, order, and judgments related thereto, including but not limited to the Order Granting Final Approval. The Parties and their respective counsel will not solicit Class Members to submit written objections to the Settlement or appeal from the Court's Order Granting Final Approval.

40. Preliminary Approval Order: On or before May 6, 2015, an application will be made to the Court for an order that will, among other things:

i. Preliminarily approve this Settlement Agreement and related Consent Decree as fair, reasonable, and adequate so as to warrant sending notice to the Classes;

ii. Conditionally certify the Current Employees Class and the Retirees Class pursuant to Fed. R. Civ. P. 23(b)(1) and (b)(2) and appoint Current Employees Class Counsel and Retirees Class Counsel to represent the respective classes;

iii. Approve the notice methodology described herein and the proposed Class Notice for mailing;

iv. Direct the Settlement Administrator to mail or to cause the appropriate Class Notice to be mailed to each Class Member's last known address within 30 days from entry of the Preliminary Approval Order;

v. Direct the Settlement Administrator to create and maintain the Settlement Website and to establish a toll-free telephone number to answer frequently asked questions within 30 days from entry of the Preliminary Approval Order;

vi. Find that the Class Notice to be provided to Class Members: (a) is the best practicable notice; (b) is reasonably calculated to apprise Class Members of the terms of this Settlement and their right to object to the proposed Settlement; (c) is reasonable and constitutes due, adequate, and sufficient notice to all persons entitled to receive notice; and (d) meets all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law;

vii. Require each Class Member who wishes to object to submit a valid and timely statement of objection pursuant to the terms of this Agreement;

viii. Require any attorney hired by a Class Member for the purpose of objecting to the fairness, reasonableness or adequacy of this Settlement Agreement and the Consent Decree, to any terms of the Settlement Agreement or Consent Decree, or to the proposed attorneys' fees and expenses, to file with the Court and deliver to Class Counsel and Defense Counsel a notice of appearance no later than 14 days prior to the Fairness Hearing;

ix. Require any Class Member who files and serves a written objection and who intends to make an appearance at the Fairness Hearing, either in person or through counsel hired at that Class Member's expense, to deliver to Class Counsel and Defense Counsel and file with the Court no later than 14 days prior

to the Fairness Hearing, a notice of intention to appear and a statement identifying any documents the Class Member will seek to introduce or witnesses the Class Member will seek to call at the Fairness Hearing;

x. Preliminarily enjoin Class Members from filing, commencing, prosecuting, intervening in, or participating (as Class Members or otherwise) in any lawsuit in any jurisdiction based on the claims in the Actions;

xi. Schedule the Fairness Hearing no later than 120 days after the Notice Date;

xii. Stay any and all litigation activities except for activities related to the approval and implementation of this Settlement;

xiii. Direct Class Counsel to file their requests for attorneys' fees and expense reimbursements no later than 21 days prior to the deadline for Class Members to file any objections to this Settlement; and

xiv. Contain any additional provisions that might be necessary to implement and administer the terms of this Settlement Agreement and the related Consent Decree.

The proposed Preliminary Approval Order is attached hereto as Exhibit 6.

41. Dismissal of *State ex rel. Council 8 AFSCME, et al.* v. *City of Cincinnati*: Within ten business days of Finality, the parties to *State ex rel. Council 8 AFSCME, et al.* v. *City of Cincinnati, et al.,* Case No. A 1 104791, pending before the Hamilton County Court of Common Pleas will stipulate to a dismissal of that action.

42. Continuing Jurisdiction Over *Sunyak* and *Harmon v. City of Cincinnati*: The Parties agree that the Court shall retain exclusive jurisdiction to oversee, enforce, interpret, implement, and administer this Settlement Agreement and the Consent Decree through the

pending consolidated actions, *Sunyak v. City of Cincinnati,* Case No. 1:11-cv-445 (S.D. Ohio) and *Harmon v. City of Cincinnati,* Case No. 1:12-cv-329 (S.D. Ohio). Each of the Parties expressly and irrevocably submits to the jurisdiction of the Court in connection with any proceedings related to the oversight, enforcement, interpretation, implementation, or administration of this Settlement Agreement or the Consent Decree.

43. Order Granting Final Approval of Settlement: After the conclusion of the Fairness Hearing, and upon the Court's approval of this Settlement Agreement and related Consent Decree, the Parties shall seek and obtain from the Court an Order Granting Final Approval, which shall, among other things:

i. Find that the Court has personal jurisdiction over the Parties, and the Court has subject matter jurisdiction to approve the Settlement Agreement, including all Exhibits to the Settlement Agreement;

ii. Approve this Settlement as fair, reasonable, and adequate, consistent and in compliance with all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law, and in the best interests of each of the Parties and the Class Members;

iii. Certify the Current Employees Class and the Retirees Class pursuant to Federal Rule of Civil Procedure 23(b)(1) and (b)(2) and finally approve and appoint Current Employees Class Counsel and Retirees Class Counsel to represent their respective class.

iv. Direct the Parties and their counsel to implement and consummate this Settlement Agreement according to its terms and provisions;

v. Declare this Settlement Agreement and related Consent Decree to be incorporated into the Order Granting Final Approval and to be binding on all Class Members and preclusive in all pending and future lawsuits or other proceedings;

vi. Find that the Class Notice and the notice methodology implemented pursuant to this Settlement Agreement:

1. Constituted the best practicable notice;
2. Constituted notice that was reasonably calculated, under the circumstances, to apprise Class Members of the terms of the Proposed Settlement, their right to object or exclude themselves from the proposed Settlement, and their right to appear at the Fairness Hearing;
3. Were reasonable and constitute due, adequate, and sufficient notice to all persons entitled to receive notice; and
4. Met all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law;

vii. Find that Class Counsel and the Class Representatives adequately represented the Classes and Sub-Classes for purposes of entering into and implementing the Settlement and that Class Counsel is entitled to the payment of attorneys' fees in the amounts approved by the Court;

viii. Order that AFSCME take all necessary actions to dismiss with prejudice *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1 104791, within 10 days of Finality, without fees or costs to any Party except as provided in this Settlement Agreement; and

ix. Without affecting the Finality of the Order Granting Final Approval for purposes of appeal, retain jurisdiction as to all matters relating to the administration, consummation, enforcement, and interpretation of this Settlement Agreement, the Order Granting Final Approval, the Consent Decree, and for any other necessary purpose.

The proposed Order Granting Final Approval is attached hereto as Exhibit 7.

44. Plaintiffs' Representations: Current Employees Plaintiffs and Retirees Plaintiffs represent and certify that: (1) they have been willing, able, and ready to perform the duties and obligations of representatives of the Classes; (2) they have read the pleadings in this Action, including the complaints, and have had the contents of such pleadings described to them; (3) they have been kept informed of the progress of the Actions and the settlement negotiations among the Parties, and they have either read this Settlement Agreement and related Consent Decree or have received a description of it from Class Counsel, and have agreed to the terms of the Settlement Agreement and related Consent Decree; (4) they have consulted with Class Counsel about the Actions, this Settlement Agreement and related Consent Decree and the obligations of a representative of the Classes; (5) they support this Settlement Agreement and the related Consent Decree and have agreed to execute this Settlement Agreement; and (6) they will remain and serve as representatives of the Classes until the Court authorizes their withdrawal as Class representatives. Should any Class representative withdraw, or if any Class representative

is found to be no longer capable of performing any responsibilities as a Class representative, the remaining Class representatives shall nominate replacement representatives subject to Court approval.

45. Enforcement: This Agreement is to be final and binding on all Parties and enforceable by the Court. Neither the City, City Council, nor the Board shall have any authority to take any action which is contrary to this Agreement, or which would undermine, obviate or otherwise avoid any of the material provisions contained herein. Should the City fail to take any action or make any payment required under this Agreement, the City waives any and all defenses, including, without limitation, jurisdictional defenses, and the Court's judgment shall be immediately enforceable through all means available under applicable law.

46. Governing Law: This Agreement and the Consent Decree shall be governed by and interpreted according to Ohio law.

47. Continuing Jurisdiction: The Parties agree and stipulate to the continuing jurisdiction and venue of the Court. Any action to enforce this Settlement Agreement or the related Consent Decree (including enforcing any re-opener provision) shall be commenced and maintained only in the Court. The administration, execution, interpretation, consummation, and enforcement of the Settlement Agreement and the related Consent Decree shall be under the authority of the Court. AFSCME shall have standing to enforce this Agreement and to assert any reopener.

48. No Presumption Against Drafter: The Parties agree that this Settlement Agreement and the related Consent Decree was drafted by counsel for the Parties at arm's length, with substantial input from all Parties and their counsel, and no reliance was placed on any representations other than those contained herein. The Parties agree that the Settlement

Agreement and the Consent Decree shall be construed by its own terms, and not by any presumption against the drafter; and that no parol or other evidence may be offered to explain, construe, contradict, or clarify its terms, the intent of the Parties or their counsel, or the circumstances under which the Settlement Agreement and related Consent Decree were drafted or executed.

49. No Tax Opinions: No opinion concerning the tax consequences of the proposed Settlement to individual Class Members is being given or will be given by Plaintiffs, Class Counsel, Defendants, or Defendants' counsel; nor is any representation or warranty in this regard made by virtue of this Settlement Agreement or the Consent Decree.

50. Counterparts Permitted: This Agreement and related Consent Decree may be signed in counterparts, each of which shall constitute a duplicate original. Electronic or facsimile transmitted copies of the signatures shall constitute a duplicate original.

51. Successors and Assigns: The provisions of this Agreement, the related Consent Decree, and all Exhibits and documents relating thereto shall be binding upon and inure to the benefit of the respective successors and assigns of the Plaintiffs, members of the Classes, Class Counsel, and Defendants.

52. General Compliance Reviews: In order to monitor and report on the implementation of this Agreement and Consent Decree, the City and Class Counsel shall regularly conduct compliance reviews to ensure that Defendants have implemented and continue to implement all measures required by this Agreement. Each Party shall designate counsel to serve as liaisons to the Court for compliance purposes. This counsel shall serve as a liaison between the City and the Court, and shall assist with the City's compliance with this Agreement. The City will provide access to such public documents as are required to properly ensure

compliance with the terms set forth in this Agreement. Liaison counsel will be permitted to apply for an award of fees for any services rendered to be paid by the City. The City shall be liable for payment of liaison counsel fees up to $5,000 in any given year.

53. Regular Status Reports: Beginning six months after the Effective Date, and every 12 months thereafter until this Agreement is terminated, the City and Class Counsel shall file a status report with the Court, including any supporting documentation, delineating all steps taken during the reporting period to comply with this Agreement. These reports shall track the Defendants' attainment of the requirements and goals contained in this Agreement, identify any areas of alleged non-compliance, instruct the Court as to how the Parties intend to remedy any areas of alleged non-compliance and, if necessary, request that the Court issue orders on compliance as necessary. If the Court issues any such order to ensure compliance with this Agreement and the related Consent Decree, the Party or Parties subject to the Order shall have 60 days from receipt of such Order to cure the asserted failure. On or before the termination of this 60 day period, the Party or Parties subject to the Order shall file an additional report with the Court documenting efforts taken to comply with the Court's Order. The Court may award reasonable attorneys' fees incurred by any party to secure compliance with this Agreement and require the responsible Party or Parties to this Agreement to pay the same.

54. Record Keeping Requirements: During the term of this Agreement and the Consent Decree, and subject to record retention requirements and procedures imposed by federal, state or local law, or any relevant collective bargaining agreement, the City and Class Counsel shall maintain all records documenting compliance with this Agreement and all documents required by or developed pursuant to this Agreement. These records shall be made

available to all Parties upon request in accordance with all state and federal laws requiring open records provisions.

55. Arms-Length Negotiations: This Agreement is the product of extensive arms-length negotiations by competent legal counsel for the Parties.

56. No Admission of Liability: The Parties agree that they are entering into this Agreement for settlement purposes only. Any acquiescence or agreement to the class certification in this case does not constitute an admission of liability or fault by the City and may not be used as evidence in any proceeding for damages by any member of the Classes.

57. No Retaliation: No Party shall retaliate in any manner against any other Party, including any members of the Classes, for their participation in the Actions or this Settlement.

58. Obligation to Cooperate and Use Best Efforts: All Parties hereto agree to exercise their best efforts and to take all reasonable steps necessary to effectuate the Settlement set forth in this Agreement.

59. Entire Agreement: This Agreement and the related Consent Decree constitute the entire agreement and accord among the Parties with regard to the subject matter of this Agreement.

60. Notice: Any notice, request, instruction, Order, or other document to be given hereunder by any Party hereto to any other Party (other than class notification) shall be in writing and delivered personally or sent registered or certified mail, postage prepaid, to the Parties as follows:

To: City of Cincinnati

City Manager Harry Black or his successor as Chief Executive Officer of the City of Cincinnati
with a copy to City Solicitor Paula Boggs Muething or her successor as Chief Legal Officer of the City of Cincinnati

City Hall
801 Plum Street
Cincinnati, OH 45202

Steven P. Goodin
John B. Pinney
Graydon Head & Ritchey LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202

To: Current Employee Class Counsel

Christian A. Jenkins
Minnillo & Jenkins Co., LPA
2712 Observatory Ave.
Cincinnati, OH 45202

Marc Mezibov
401 E. Court Street, Suite 600
Cincinnati, OH 45202

Robert D. Klausner
Klausner Kaufman Jensen & Levinson
7080 Northwest Fourth Street
Plantation, FL 33317

Jeffrey S. Goldenberg
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202

To: Retiree Class Counsel

Robert A. Pitcairn, Jr.
James F. McCarthy, III
Peter J. O'Shea
Katz Teller
255 East Fifth Street, 24th Floor
Cincinnati, OH 45202-4724

To: AFSCME Council No. 8

R. Sean Grayson
6800 N. High Street
Worthington, Ohio 43085-2512

61. Public Document: This Agreement is a public document and shall be posted on appropriate websites maintained by the City and the CRS.

62. Modification: This Agreement may only be modified in writing and with consent of the Parties, subject to the approval of the Court or by order of the Court.

63. Termination: This Agreement will terminate 30 years after the Effective Date.

64. Implementation Date: Any provision of this Agreement which is silent as to the implementation date shall be implemented on the Effective Date or January 1, 2016, whichever is later.

The below Parties have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Current Employees Plaintiffs and Putative Current Employees Class Representative

/s/ Nick Sunyak Nick Sunyak	April 29, 2015 Date
/s/ Jeffrey Harmon Jeffrey Harmon	April 29, 2015 Date
/s/ Jill Allgeyer Jill Allgeyer	April 29, 2015 Date
/s/ Kim Kappel Kim Kappel	April 29, 2015 Date
/s/ Waleia Jackson Waleia Jackson	April 29, 2015 Date
_____ Richard Ganulin	April 29, 2015 Date
/s/ Finley Jones Finley Jones	April 29, 2015 Date

The below Parties have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Retirees Plaintiffs and Putative Retirees Class Representatives

/s/ Thomas A. Gamel, Sr_ May 7, 2015
Thomas A. Gamel, Sr., Date

/s/ Paul Smith_____ May 7, 2015
Paul Smith Date

/s/ Mark K. Jones_____ May 7, 2015
Mark K. Jones Date

/s/ Dennis Davis_____ May 7, 2015
Dennis Davis Date

/s/ Ely Ryder_____ May 7, 2015
Ely Ryder Date

/s/ Ann DeGroot_____ May 7, 2015
Ann DeGroot Date

The below Parties have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Defendants:

/s/ John Cranley _____ April 29, 2015
Honorable John Cranley Date
Mayor of City of Cincinnati

/s/ Harry Black _____ April 29, 2015
Harry Black Date
City Manager of Cincinnati, on behalf of City Defendants

/s/ Paula Boggs Muething _ April 29, 2015
Paula Boggs Muething Date
On behalf of City Defendants

The below Counsel have read and agree to the terms of this Collaborative Settlement Agreement and related Consent Decree:

Current Employees Class Counsel:

/s/ Jeffrey S. Goldenberg — May 7, 2015
Jeffrey S. Goldenberg — Date

/s/ Christian A. Jenkins — May 7, 2015
Christian A. Jenkins — Date

/s/ Robert D. Klausner — May 7, 2015
Robert D. Klausner — Date

/s/ March Mezibov — May 7, 2015
Marc Mezibov — Date

Retiree Class Counsel:

/s/ Robert A. Pitcairn, Jr. — May 7, 2015
Robert A. Pitcairn, Jr. — Date

/s/ James F. McCarthy, III — May 7, 2015
James F. McCarthy, III — Date

AFSCME Council No. 8:

/s/ R. Sean Grayson — May 7, 2015
R. Sean Grayson — Date

Counsel for City of Cincinnati:

/s/ Steven P. Goodin — May 7, 2015
Steven P. Goodin — Date

EXHIBIT ONE

PROPOSED CONSENT DECREE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

SUNYAK, et al.,	:	**Case Nos. 1:11-cv-445**
	:	**1:12-cv-329**
v.	:	
	:	**Judge Michael R. Barrett**
CITY OF CINCINNATI, et al.,	:	
	:	
(City of Cincinnati Pension Litigation)	:	

[PROPOSED] CONSENT DECREE

Pursuant to the Court's authorization and approval as demonstrated by its signature below, the City of Cincinnati ("City"), the Cincinnati Retirement System ("CRS"), John Cranley ("Mayor"), and City Manager Harry Black ("City Manager"), the Vice Mayor, the Members of City Council , and the Board of Trustees of the CRS (collectively, the "Defendants"), and Nick Sunyak, Jeffery Harmon, Jill Algeyer, Kim Kappel, Waleia Jackson, Finley Jones, and Richard Ganulin, on behalf of themselves and the Current Employees Class they represent, and Thomas A. Gamel, Sr., Paul Smith, Mark K. Jones, Dennis Davis, Ely Ryder, and Ann DeGroot, on behalf of themselves and the Retirees Class they represent, and the American Federation of State and Municipal Employees Ohio council No. ("AFSCME"), collectively "the Parties," consistent with and in furtherance of implementing the Collaborative Settlement Agreement ("Settlement Agreement" or "Settlement") approved by the Court on _____, 2015 (Doc. No. _____) which completely resolves and settles the City of Cincinnati Pension Litigation, do hereby agree, stipulate and consent to following:

1. This Consent Decree adopts and incorporates by reference in its entirety the Settlement Agreement, including all defined terms therein.

2. This Consent Decree establishes that the Court shall retain exclusive jurisdiction to oversee, enforce, interpret, implement, and administer the Settlement Agreement and this Consent Decree through the pending consolidated actions, *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445 (S.D. Ohio) and *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329 (S.D. Ohio).

3. This Consent Decree establishes that each of the Parties expressly and irrevocably submits to the jurisdiction of the Court in connection with any proceedings related to the oversight, enforcement, interpretation, implementation, or administration of the Settlement Agreement or this Consent Decree until Termination.

4. This Consent Decree establishes that AFSCME shall have standing to enforce the terms of the Settlement Agreement and this Consent Decree.

5. The Parties shall, at all times prior to Termination, work together in good faith to effectively and efficiently implement all the terms of the Settlement and this Consent Decree. Further, each Party recognizes that they have an obligation to cooperate and use their best efforts in this regard and to take all reasonable steps necessary to effectuate the terms of the Settlement. These terms include, but are not limited to:

a. The creation of the CRS Pension Trust Fund and the 115 Trust Fund (Collaborative Settlement Agreement, at p. 21)

b. Transfer funds to the 115 Trust Fund (Id. at p. 22)

c. CRS COLA Calculation (Id. at p. 22)

d. Current Employees Class COLA Delay Period (Id. at p.23)

e. Retirees Class COLA Suspension Period (Id. at 24)

f. COLA Poverty Exception (Id.)

g. Current Employees Class Retirement Eligibility (Id. at p. 25)

h. Retirement Benefit Multiplier Calculation (Id.)

i. Final Average Salary Calculation (Id.)

j. Early Retirement Eligibility (Id. at p. 26)

k. Annuity Adjustments (Id.)

l. Employee Contributions (Id. at p. 27)

m. The Group C Settlement Payments (Id.)

n. The City's Annual Contribution to the CRS Pension Trust Fund (Id. at p. 28)

o. Additional contributions to the CRS Pension Trust Fund (Id.)

p. Deferred Retirement Option Plan ("DROP") (Id. at p. 29)

q. Retirees Class Healthcare Benefits (Id. at p. 30)

r. Current Employees Class Retirement Healthcare Benefits (Id.)

s. Current Employees Class Retirement Healthcare Premium Percentages (Id.)

t. Healthcare Modifications for Retirees (Id. at p. 32)

u. Healthcare Funding Obligation (Id.)

v. Retirees Class Death Benefit (Id.)

w. Assumed Rate of Return (Id.)

x. Pension Board Reforms (Id. at p. 33)

y. Disgorgement provision (Id. at p. 35)

z. Actuarial Confirmation provision (Id.at p. 36)

aa. Reopeners provision (Id. at p. 37)

bb. Enforcement Reporting (Id. at p. 50)

cc. Compliance Reviews (Id. at p. 52)

dd. Recordkeeping (Id. at p. 53)

6. This Consent Decree shall be governed by and interpreted according to Ohio law.

7. Any action to enforce this Consent Decree (including enforcing any re-opener provision) shall be commenced and maintained only in the United States District Court for the Southern District of Ohio.

8. This Consent Decree may be signed in counterparts, each of which shall constitute a duplicate original. Electronic or facsimile transmitted copies of the signatures shall constitute a duplicate original.

9. The provisions of this Consent Decree, and all exhibits and documents relating thereto shall be binding upon and inure to the benefit of the respective successors and assigns of the Plaintiffs, members of the Classes, Class Counsel, and Defendants.

10. Additional Current Employees Class Representatives, additional Current Retirees Class Representatives, or additional counsel for any of the Parties may be approved by the Court as necessary due to health, availability, or other concerns or issues that may arise prior to Termination.

11. To assist the Court in monitoring the Parties' implementation of the Settlement Agreement, the Parties shall regularly conduct Compliance Reviews to ensure that they have implemented and continue to implement all measures required by this Agreement. Each Party shall designate counsel to serve as liaisons to the Court for compliance purposes. This counsel shall serve as a liaison between the City and the Court, and shall assist with the City's compliance with this Agreement. The City will provide access to such documents, records and other information reasonably needed to ensure compliance with the terms set forth in the Settlement Agreement and this Consent Decree.

12. Beginning six (6) months after the Effective Date, and every six (6) months thereafter until Termination (unless a different time period is ordered by the Court), the Parties shall file a joint status report with the Court, including any supporting documentation, delineating all steps taken during the reporting period to comply with the terms of the Settlement Agreement. These reports shall track the Parties' attainment of the requirements and goals contained in the Settlement Agreement, identify any areas of alleged non-compliance, instruct the Court as to how the Parties intend to remedy any areas of alleged non-compliance and, if necessary, request that the Court issue orders on compliance. If the Court issues any such order to ensure compliance with this Agreement and the related Consent Decree, the Party or Parties subject to the Order shall have 60 days from receipt of such Order to cure the asserted failure. On or before the termination of this 60 day period, the Party or Parties subject to the Order shall file an additional report with the Court documenting efforts taken to comply with the Court's Order.

13. For all periods of time until Termination of the Settlement Agreement, and subject to record retention requirements and procedures imposed by federal, state or local law, or any relevant collective bargaining agreement, the Parties shall maintain all records documenting compliance with the Settlement Agreement and all documents required by or developed pursuant to the Settlement Agreement.

14. No Party shall retaliate in any manner against any other Party, including any member of the Classes, for their participation in the this Settlement or for their participation in any actions related to the enforcement or reporting or recordkeeping provisions of this Settlement and this Consent Decree.

15. Any notice, request, instruction, Order, or other document to be given hereunder by any Party hereto to any other Party (other than class notification) shall be in writing and delivered personally or sent registered or certified mail, postage prepaid, to the Parties as follows:

To: City of Cincinnati

City Manager Harry Black
with a copy to City Solicitor Paula Boggs Muething
City Hall
801 Plum Street
Cincinnati, OH 45202

Steven P. Goodin
John B. Pinney
Graydon Head & Ritchey LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202

To: Current Employees Class Counsel

Christian A. Jenkins
Minnillo & Jenkins Co., LPA
2712 Observatory Ave.
Cincinnati, OH 45202

Marc D. Mezibov
401 E. Court Street, Suite 600
Cincinnati, OH 45202

Robert D. Klausner
Klausner Kaufman Jensen & Levinson
10059 Northwest 1st Court
Plantation, FL 33324

Jeffrey S. Goldenberg
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202

To: Retirees Class Counsel

Robert A. Pitcairn, Jr.
James F. McCarthy, III
Katz Teller Brant & Hild
255 East Fifth Street, 24th Floor
Cincinnati, OH 45202-4724

To: AFSCME Council No. 8

R. Sean Grayson
6800 N. High Street
Worthington, Ohio 43085-2512

16. This Consent Decree is a public document and shall be posted on appropriate websites maintained by the City and the CRS.

17. Unless otherwise provided herein, this Consent Decree may only be modified in writing and with consent of the Parties, subject to the approval of the Court.

18. This Consent Decree will terminate 30 years after the Effective Date.

The below Parties have read and agree to the terms of this Consent Decree:

Current Employees Plaintiffs and Putative Class Representatives

Nick Sunyak	Date
Jeffrey Harmon	Date
Jill Allgeyer	Date
Kim Kappel	Date
Waleia Jackson	Date
Richard Ganulin	Date
Finley Jones	Date

The below Parties have read and agree to the terms of this Consent Decree:

Retirees Plaintiffs and Putative Class Representatives

Thomas A. Gamel, Sr.,	Date
Donald C. Beets	Date
Paul Smith	Date
Mark K. Jones	Date
Dennis Davis	Date
Ely Ryder	Date
Ann DeGroot	Date

The below Parties have read and agree to the terms of this Consent Decree and have been duly authorized and empowered to execute the Settlement Agreement and this Consent Decree as binding and lawful obligations of the Defendants:

Defendants

_____ _____
Honorable John Cranley Date
Mayor of City of Cincinnati

_____ _____
Harry Black Date
City Manager of Cincinnati, on behalf of City Defendants

_____ _____
Paula Boggs Muething Date
City Solicitor of Cincinnati

As indicated below by their signatures, Counsel for the Parties affirm that they have read this Consent Decree, have conferred with their respective clients about the same who support this Consent Decree, agree to the provisions contained herein and shall be bound hereby:

_____ _____

Steven P. Goodin Date
John B. Pinney
GRAYDON HEAD & RITCHEY LLP
1900 Fifth Third Center
511 Walnut Street
Cincinnati, OH 45202-3157
Of Counsel for the City Solicitor

_____ _____

Marc D. Mezibov Date
Susan M. Butler
401 East Court Street, Suite 600
Cincinnati, OH 45202
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

_____ _____

Christian A. Jenkins Date
Minnillo & Jenkins, Co. LPA
2712 Observatory Ave.
Cincinnati, OH 45202
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

_____ _____

Jeffrey S. Goldenberg Date
Goldenberg Schneider, LPA
One West Fourth Street, 18th Floor
Cincinnati, OH 45202-2012
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

_____ _____

Robert D. Klausner Date
Klausner Kaufman Jensen & Levinson
7080 NW 4th Street
Plantation, FL 33317
Counsel for Current Employees Plaintiffs and Putative Current Employees Class

_____ _____

Robert A. Pitcairn, Jr. Date
Katz, Teller, Brant & Hild
255 East Fifth Street, Suite 2400
Cincinnati, OH 45202
Counsel for Retirees Plaintiffs and Putative Retirees Class

_____ _____

R. Sean Grayson Date
6800 North High Street
Worthington, OH 43085-2512
General Counsel for Ohio Council 8, AFSCME

This Consent Decree governing the resolution of the Cincinnati Pension Litigation is authorized and approved this ___ day of _____, 2015.

_____
Judge Michael R. Barrett

EXHIBIT TWO

PROPOSED SETTLEMENT NOTICE

Notice of Proposed Class Action Settlement
Concerning the Cincinnati Retirement System

IMPORTANT- A FEDERAL COURT AUTHORIZED THIS NOTICE
YOUR RIGHTS WILL BE AFFECTED WHETHER YOU ACT OR DO NOT ACT
PLEASE READ THIS NOTICE CAREFULLY

I. NOTICE OF YOUR RIGHTS

This Notice provides a summary of the proposed class action Settlement of two consolidated cases pending before the Honorable Judge Michael R. Barrett in the United States District Court for the Southern District of Ohio: (1) *Sunyak v. City of Cincinnati*, Case No. 1:11-cv-445; and (2) *Harmon v. City of Cincinnati*, Case No. 1:12-cv-329. You are covered by the proposed Settlement because the City of Cincinnati's records indicate that you are a member of either the **Current Employees Class** or the **Retirees Class.**

The **Current Employees Class** includes City of Cincinnati employees who participated in the Cincinnati Retirement System ("CRS") with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011 and who are members of Group C, D, E or F as defined by Cincinnati Municipal Code § 203-1-M1 (b), (c), (d), and (e). The Current Employees Class also includes City of Cincinnati employees who had at least five years of creditable service on July 1, 2011 and who retired on or after that date, as well as veterans who purchase service credit sufficient to satisfy the requirement to have five years of creditable service as of July 1, 2011.

The **Retirees Class** includes retired City of Cincinnati, University of Cincinnati, University Hospital f/k/a General Hospital and Hamilton County employees (or the Dependent and/or Surviving Beneficiaries of a former employee) who participated in the CRS and: (a) Currently receive retirement or pension benefits, including healthcare benefits; and (b) retired on or before July 1, 2011.

This Notice generally describes the proposed Settlement and your rights as a member of either the Current Employees Class or the Retirees Class. Additional information about this proposed Settlement can be found at www.CRSPensionSettlement.com. The Court will conduct a Fairness Hearing at 10 a.m. on _____, 2015 at the United States District Court for the Southern District of Ohio, 100 East 5th Street, Courtroom ---, Cincinnati, Ohio 45202.

II. BACKGROUND

The Plaintiffs are current employees of the City of Cincinnati ("City") and retirees participating in the CRS who filed federal class action lawsuits claiming that the City and others improperly changed vested retirement benefits by adopting and enforcing City Ordinance No. 84-2011 (the "Ordinance") effective July 1, 2011, and/or that the City has threatened to make additional improper changes to retirement benefits, including the suspension or reduction of retiree health

benefits and the annual Cost of Living Adjustment ("COLA"). The City and the other Defendants deny these allegations and believe their actions were proper. Following extensive litigation and negotiations, the Plaintiffs, the Current Employees Class, the Retirees Class, the City, and the CRS (the "Parties") have entered into a Settlement Agreement. This Settlement is a compromise of disputed claims and defenses. The Court has reviewed and preliminarily approved the Settlement as fair, reasonable, and adequate and has approved the content and mailing of this Notice.

III. SUMMARY OF THE PROPOSED SETTLEMENT

The proposed Settlement provides that the CRS will be subject to a 30-year Consent Decree enforced by the Federal Court. Once the Settlement becomes effective, no changes to the CRS benefit provisions can be made during that 30-year time period without prior approval of the Court through a re-opener process. Under the proposed Settlement, current monthly pension benefits received by members of the Retirees Class cannot be reduced from their current levels. Specific provisions of the Settlement apply to the Current Employees Class and Groups C, D, E and F as defined by the Ordinance, as well as to the Retirees Class. The complete detailed Settlement Agreement and all other documents relating to the proposed Settlement can be obtained from the Settlement website at www.CRSPensionSettlement.com or by calling [insert]. The following is a summary of the basic terms of the proposed Settlement which are scheduled to be implemented on January 1, 2016 if the Court grants final approval:

Cost of Living Adjustment: Effective January 1, 2016, the COLA for all current and future retirees in the Current Employees Class and the Retirees Class will be a 3.00 percent fixed simple COLA. This means that an annual pension benefit of $10,000 will increase to $10,300 in the first year that the COLA applies, $10,600 in the second year, $10,900 in the third year, and so on.

COLA Delay or Suspension: Current Employees Class Members and Retirees Class Members are both subject to a three-year COLA delay or suspension period, to begin on the date of retirement for members of the Current Employees Class or on January 1, 2016 for the Retirees Class. Members of the Retirees Class shall receive a one-time payment calculated at three percent of their base pension annuity benefit (but in any event, capped at $1,000) at the commencement of the third year of their respective COLA suspension period. This one time payment will not be added to the base benefit or affect the amount of future benefits.

Retirement Eligibility: Current Employees Class Members can retire with full benefits upon reaching 30 years of service without regard to age, or at age 60 with five years of creditable service.

Retirement Benefit Multiplier Calculation: Current Employees Class Members' retirement benefits will be computed with a 2.5 percent multiplier for the greater of 20 years of service or the number of years of service prior to July 1, 2011 for members of Group F and the number of years prior to January 1, 2014 for members of Group E. A multiplier of 2.2 percent will apply to all other years, including years of service in excess of 30 years. Final average salary calculation will continue as provided in the Ordinance.

Early Retirement Options: For Current Employees Class members, the early retirement options for individuals age 55 with 25 years of service and age 60 with at least five years of service that existed prior to the Ordinance will be reinstated.

Group D, E, and F Pension Annuity Adjustments: Current Employees Class members in Groups D, E and F who retired (or will retire) prior to January 1, 2016 will have their pension benefits increased on January 1, 2016 to reflect the provisions of this Settlement, and such individuals will receive a lump sum payment reflecting any amounts they would have received from their date of retirement until January 1, 2016 had the Settlement been in effect when they retired.

Current Employees Class Contributions: Pension contributions made by Current Employees Class Members shall not exceed nine percent of pensionable wages during the term of the Consent Decree.

Group C Settlement Payment: Current Employees Class members in Group C will receive a one-time payment between $125 and $625, depending on their date of retirement, as compensation for the compounding COLA they would have received, if any, during the period prior to January 1, 2016. In addition, members of Group C will be entitled to the same rights with respect to retiree health care as members of the Retirees Class, including continued eligibility for retiree health benefits for those who retire with at least 15 years of creditable service.

City's Annual Contribution Rate: The City will contribute 16.25 percent of its payroll to the CRS annually during the 30-year duration of the Consent Decree.

Voluntary Deferred Retirement Option Plan: A voluntary Deferred Retirement Option Plan ("DROP") will be implemented for Current Employees Class members which will allow them to cease accruing service credit in, and contributing to, the CRS when they obtain 30 years of service while continuing their City employment for up to five years. DROP participants will accrue their monthly retirement benefits on a pre-tax basis for up to five years of continued City employment, during which time such amounts may experience earnings but not losses. The DROP will be evaluated within five years after the Settlement goes into effect to ensure that it is cost neutral to the CRS.

Retirees Class Healthcare: Members of the Retirees Class will continue to receive healthcare benefits according to the plan in effect on December 31, 2014, as specifically provided in the Settlement. In addition, the City will implement an Employee Group Waiver Plan ("EGWP") for retirees to maximize reimbursement from federal healthcare programs. The City will also implement a voluntary medical expense reimbursement program ("MERP") to reimburse CRS participants who elect to enroll in benefits packages not funded by the CRS.

Current Employees Class Healthcare: Members of the Current Employees Class who retire in the future will be eligible for retiree healthcare benefits at that time under the most favorable terms available to current employees of the City if they have 30 years of creditable service at the time of their retirement or are at least 60 years old and have at least 20 years of service at the

time of their retirement. The cost of these healthcare benefits will be limited to ten percent of the applicable premium for individuals hired before January 9, 1997. Individuals hired after January 9, 1997 who qualify for retirement healthcare benefits will pay no more than the percentage of premium provided by the "point system" in the Cincinnati Municipal Code as of January 1, 2015. The Settlement also provides for a process to negotiate improvements in the "point system" for these individuals within six months after the Effective Date. However, these provisions will not apply to Subgroup C of the Current Employees Class. Subgroup C members are entitled to the same retirement healthcare as the Retirees Class on the same terms received by the Retirees Class as long as Subgroup C members retire with at least 15 years of creditable service.

Additional important terms and details are described in the complete Settlement Agreement available at www.CRSPensionSettlement.com, and answers to frequently asked questions can be obtained by calling **[[insert]]**.

IV. YOUR LEGAL RIGHTS REGARDING THIS SETTLEMENT

This Notice explains your rights under the Settlement and provides you with information intended to help you understand the terms of this Settlement and how it will affect you. **You may not exclude yourself from or opt out of this Settlement. If the Court grants final approval, you will be covered by this Settlement.** The following table provides a summary of the actions you can take under this Settlement:

YOUR LEGAL RIGHTS AND OPTIONS IN THIS SETTLEMENT	
DO NOTHING	You will be included in the Settlement and covered by its terms if the Settlement is approved by the Court. You waive your right to object to the Settlement or to take any appeal of any orders of judgment including but not limited to the Order Granting Final Approval.
OBJECT	If you wish to object to the fairness, reasonableness, or adequacy of the proposed Settlement, or to the requested attorneys' fees and expenses, you must send your **written statement** to the Court, Class Counsel, and Defendants' Counsel postmarked no later than **(insert date)** as described below in Section V, Paragraph 10.
ATTEND FAIRNESS HEARING	The last step in the Settlement approval process is the Fairness Hearing, at which time the Court will hear all evidence and arguments necessary to conclusively evaluate whether to grant final approval to the Settlement. Attendance at the Fairness Hearing alone does

	not allow you to object to the Settlement. Only the written statement described above permits you to object.

Please note that this Notice does not contain all the terms and conditions of the Settlement. A copy of the actual Settlement Agreement is available at www.CRSPensionSettlement.com, or upon request by calling (**insert number**).

V. FREQUENTLY ASKED QUESTIONS AND ANSWERS

What is this lawsuit about?

The Plaintiffs in this lawsuit are current and former employees (or their survivors entitled to pension benefits) of the City who filed class action lawsuits alleging that Defendants improperly impaired or revoked their vested retirement benefits by adopting and enforcing a city ordinance which became effective July 1, 2011 (the "Ordinance"). The Ordinance substantially modified the future retirement benefits and eligibility rules for current employees by requiring them to contribute more of their earnings to the CRS and work more years to obtain lower retirement benefits than previously provided by the CRS. The Ordinance also modified the health benefits available to retirees by increasing deductibles, costs for prescriptions, and out-of-pocket caps for healthcare. The Retirees were also very concerned that the City would make additional changes to their retirement benefits, including the suspension or reduction of retiree health benefits and the annual COLA. The Defendants deny Plaintiffs' allegations and believe their actions were legal and proper.

What is a class action?

In a class action, one or more people called class representatives sue on behalf of people who have similar claims. Together they are called the "Class." Individuals in the Class are called "Class Members." In a class action, one court resolves the issues for all Class Members.

Why is this lawsuit a class action?

The Court has preliminarily decided that this lawsuit can proceed as a class action for purposes of settlement because it meets the requirements of Federal Rule of Civil Procedure 23, which governs class actions in federal court. When, as here, the Parties propose to settle a class action, the Court must determine whether the Settlement is fair, adequate, and reasonable for all members of the Classes.

Has the Court decided who is right? Why is there a Settlement?

No, the Court has not decided whether Plaintiffs or Defendants are correct. There has been no trial or final ruling on the Plaintiffs' claims or the Classes' claims, nor is this Settlement an admission of any wrongdoing on the part of the City or any Defendant. Instead, the Parties determined it was in their best interests and the public interest to participate in a collaborative mediation process in which all issues relating to the CRS plan were addressed in an open,

comprehensive, and exhaustive manner. Without this collaborative exercise, the possibility that the City or one or both of the Classes may have suffered serious consequences was likely. Under Ohio law decided before this case was brought, the City was authorized to curtail or even eliminate all retiree healthcare benefits for both current and future retirees. The proposed Settlement preserves significant retiree healthcare benefits for current and future retirees. This proposed Settlement is a result of that process, and if approved by the Court, will allow all Parties to avoid the costs, delays, and uncertainties of a trial and appeals, will provide relief to Class Members as described above, and protect the CRS so that it may continue to provide benefits into the future.

Why did I get this Notice? Am I a part of this Class Action Settlement?

You are receiving this Notice because the City's records show that you are a member of either the Current Employees Class or the Retirees Class. As a Class Member, you are covered by this Settlement.

What are the terms of the proposed Settlement?

The terms have been summarized above in Section III of this Notice. More information about this Settlement is available at www.CRSPensionSettlement.com or by calling (insert number).

When will the Settlement go into effect for me?

There will be a Fairness Hearing on **[insert]**. The Court will then decide whether to approve the proposed Settlement. Class Counsel does not know how long it will take for the Court to make this decision.

If the Court grants final approval of the Settlement, the Settlement should go into effect on January 1, 2016.

Do I have an attorney in this case?

Yes. The Court has preliminarily approved attorneys Christian A. Jenkins, Jeffrey S. Goldenberg, Robert D. Klausner, and Marc D. Mezibov to represent the Current Employees Class and James F. McCarthy, Peter J. O'Shea, Robert A. Pitcairn, Jr., and the law firm of Katz, Teller, Brant & Hild to represent the Retirees Class. These attorneys are called Class Counsel. They are experienced in handling class actions against large entities, including municipalities.

You may, but do not need to, hire your own attorney because Class Counsel are working on your behalf. If you want your own attorney, you will have to pay for that attorney. For example, you can ask him or her to appear in Court for you if you want a lawyer to argue your objection to the Settlement or if you want someone other than Class Counsel to speak for you.

How will the attorneys for the Classes be paid?

Class Counsel will ask the Court to approve the payment of attorneys' fees and expenses related to this litigation via an attorney fee application that will be filed with the Court no later than ---- - -, 2015. It will be up to the Court to determine the amount of fees and expenses to be paid to Class Counsel.

Current Employees Class Counsel's fee request will be based upon the value of the benefits conferred upon the Current Employees Class by this Settlement and will not exceed $5,000,000. Current Employees Class Counsel estimate that the value of the benefits conferred upon the Current Employees Class by this Settlement exceed $50,000,000.

The Current Employees Class Counsel will request that the amount of attorneys' fees and expenses awarded by the Court to Current Employees Class Counsel be paid by the CRS on behalf of the Current Employees Class members and then recouped in a fair manner from the benefits these members receive in the future over a 20-year period. Current Employees Class Counsel will ask the Court to assign a higher share of attorneys' fees to those Current Employees Class members who, as a result of this Settlement, have the opportunity to retire with full pension benefits prior to age 60. If the Court awards $5,000,000 in attorneys' fees to Current Employees Class Counsel, it is estimated that these Current Employees Class members (those who will be able to retire with full pension benefits prior to age 60) will pay approximately $_____ per month while the other Class members will pay approximately $_____ per month

Retirees Class Counsel's fee request will be based upon calculating how many hours were spent on the Litigation and multiplying those hours by a judicially-determined reasonable rate. This is known as a lodestar calculation. In addition, Retirees Class counsel will request an enhancement of fees. The amount of the enhanced fees and costs requested will not exceed $500,000. Retirees Class Counsel will request that the Court require the City to pay this sum from its General Fund. The City objects to paying any amount from its General Fund and will request that this amount come from the CRS Pension Fund.

How can I object to the Settlement?

You and/or an attorney you hire at your own expense may object to the proposed Settlement if you do not like any part of it, but you must follow these procedures for the Court to consider your objection:

(a) The objection must be in writing. A letter is sufficient. It must contain your name, your current address, specific reasons why you object to the Settlement (including any legal authorities), and a description of the evidence (documents or testimony) that you propose to introduce in support of the objection. You and/or your attorney you hire at your own expense must sign the objection.

(b) Your written objection must be filed with the Court **and** postmarked and mailed to the below addresses for Class Counsel and Defendants' Counsel no later than _____, 2015.

(c) If you have hired an attorney, that attorney must file a notice of appearance with the Court **and** postmark and mail such notice to the below addresses for Class

Counsel and Defendants' Counsel no later than _____, 2015.

The Court's address is: United States District Court for the Southern District of Ohio, 100 East 5th Street, Cincinnati, Ohio 45202.

Class Counsel's addresses are:

Current Employees Class Counsel: Marc Mezibov, The Law office of Marc Mezibov, 401 East Court Street, Suite 600, Cincinnati, Ohio 45202

Retirees Class Counsel: James F. McCarthy, Katz Teller Brant & Hild, 255 East Fifth Street, Suite 2400, Cincinnati, Ohio 45202

Defendants' Counsel: Steven P. Goodin, Graydon, Head & Ritchey, LLP, Fifth Third Center, 511 Walnut Street, Suite 1900, Cincinnati, Ohio 45202

If you do not follow the above procedures, including filing the objection by the date provided, you waive your right to object to the Settlement Agreement or take an appeal from any Court order, including the Order Granting Final Approval.

Do I have to come to the Fairness Hearing?

No, but you are welcome to attend. The last step in the Settlement approval process is the Fairness Hearing, at which time the Court will hear all evidence and arguments necessary to conclusively evaluate the Settlement to determine whether it is fair, adequate, and reasonable and whether final approval is warranted.

You and/or an attorney you hire at your own expense may, but do not have to, appear at the Fairness Hearing to talk to the Court about your objections. Class Members or their attorneys intending to make an appearance at the Fairness Hearing, pursuant to their written objection, must do the following **no later than 14 days prior to the Fairness Hearing**:

(a) File a notice of intention to appear with the Court;
(b) Deliver to Class Counsel and Defendants' Counsel at the addresses above a copy of such notice of intention; and
(c) Identify any documents they will seek to introduce or witnesses they intend to call at the Fairness Hearing.

Other matters to be considered at the Fairness Hearing will be a determination as to whether an Order Granting Final Approval of the Settlement should be entered, whether the application of Class Counsel for payment of attorneys' fees and expenses should be approved, and any other matters the Court sees fit to address.

How do I get more information?

Go to the Settlement website at www.CRSPensionSettlement.com or call (insert phone number)

for answers to frequently asked questions. You may also contact Current Employees Class Counsel or Retirees Class Counsel at the addresses listed above. Do not contact the Court.

What if my mailing address changes?

If your address changes, you must provide your updated address to the Settlement Administrator in writing at **[insert]**. The Settlement Administrator is responsible for issuing Notice to the Class Members.

EXHIBIT THREE

ANTHEM BOOKLETS FOR CITY RETIREES

MEDICAL BENEFIT BOOKLET

For

CITY OF CINCINNATI RETIREES

Administered By

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Customer Service at the number on Your Identification Card.

Effective 1-1-2014

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by Your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Customer Service Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Anthem Blue Cross and Blue Shield, or "Anthem" dba Anthem Blue Cross and Blue Shield has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Ohio. Although Anthem is the Claims Administrator and is licensed in Ohio, You will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Verification of Benefits
Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

MEMBER RIGHTS AND RESPONSIBILITIES 4
SCHEDULE OF BENEFITS 6
ELIGIBILITY 10
SUMMARY OF BENEFITS 14
HEALTH CARE MANAGEMENT - PRECERTIFICATION 16
BENEFITS 23
CLAIMS PAYMENT 37
YOUR RIGHT TO APPEAL 44
COORDINATION OF BENEFITS (COB) 48
SUBROGATION AND REIMBURSEMENT 53
GENERAL INFORMATION 55
WHEN COVERAGE TERMINATES 60
DEFINITIONS 64
HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW 75

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have certain rights and responsibilities when receiving Your health care. You also have a responsibility to take an active role in Your care. As Your health care partner, the Claims Administrator is committed to making sure Your rights are respected while providing Your health benefits. That also means giving You access to the Claims Administrator's Network Providers and the information You need to make the best decisions for Your health and welfare.

These are Your rights and responsibilities:

You have the right to:

- Speak freely and privately with Your doctors and other health providers about all health care options and treatment needed for Your condition. This is no matter what the cost or whether it's covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Expect us to keep Your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
  - The Claims Administrator's company and services.
  - The Claims Administrator's network of doctors and other health care providers.
  - Your rights and responsibilities.
  - The rules of Your health care plan.
  - The way Your health plan works.
- Make a complaint or file an appeal about:
  - Your Plan
  - Any care You get
  - Any Covered Service or benefit ruling that Your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future. This includes the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of Your illness, Your treatment and what may result from it. If You don't understand certain information, You can choose a person to be with You to help You understand.

You have the responsibility to:

- Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (doctor), also called a PCP, if Your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers. Call their office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your doctors or other health care Providers to make a treatment plan that You all agree on.
- Follow the care plan that You have agreed on with Your doctors or health care Providers.

- Give the Claims Administrator, Your doctors and other health care professionals the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health and insurance benefits You have in addition to Your coverage with the Plan.
- Let the Claims Administrator's customer service department know if You have any changes to Your name, address or family members covered under Your Plan.

The Claims Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If You need more information or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

How to Obtain Language Assistance
Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of Your ID card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Calendar Year Deductible		
Individual	**$0**	**$0**
Family – All eligible Members combined	**$0**	**$0**
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	**80%**	**50%**
Member Pays	**20%**	**50%**
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out of Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year Includes Coinsurance. Does NOT include Copayments, precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services, services deemed not medically necessary, pharmacy claims and human organ and tissue transplants.		
Individual	**$500**	**$1,000**
Family – All eligible Members combined	**$1,000**	**$2,000**
The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.		

Benefits	Network	Out-of-Network
Allergy Care		
• Testing and Treatment	**20%**	**50%**
Behavioral Health / Substance Abuse Care		
Hospital Inpatient Services	**20%**	**50%**
Outpatient Services	**20%**	**50%**
Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with federal law.		
Clinical Trials Please see Clinical Trials under Benefits section for further information.	**Benefits are paid based on the setting in which Covered Services are received**	**Benefits are paid based on the setting in which Covered Services are received**
Dental, Oral Surgery and TMJ Services		
• Accidental Injury to natural teeth Treatment must be completed within **12** months of the Injury)	**20%**	**50%**
• Oral Surgery and TMJ	**20%**	**50%**
Diagnostic Services	**20%**	**50%**
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Care, Urgent Care and Ambulance Services		
Emergency room for a Medical Emergency	**20%**	**20%** **(See note)**
Non-emergency use of the emergency room	**Not Covered**	**Not Covered**
Urgent Care clinic visit	**20%**	**20%** **(See note)**
Ambulance Services (when Medically Necessary) Land / Air	**20%**	**20%** **(See note)**
Note: Care received Out-of-Network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. Care may also be approved as an Authorized Service. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		

Benefits	Network	Out-of-Network
Eye Care (Non-Routine)		
• Office visit – medical eye care exams (treatment of disease or Injury to the eye)	20%	50%
• Treatment other than office visit	20%	50%
Hearing Care (Non-Routine)		
• Office visit – Audiometric exam / hearing evaluation test	20%	50%
Home Health Care Services	20%	50%
• Maximum Home Care visits (includes Private Duty Nursing benefit)	Unlimited	30 visits per calendar year
Hospice Care Services	20%	20% (Covered at Network Level)
Hospital Inpatient Services	20%	50%
Maternity Care & Other Reproductive Services		
• Maternity Services	20%	50%
• Infertility services (Benefits only for the diagnosis of Infertility)	20%	50%
• Sterilization Services	20%	50%
Medical Supplies and Equipment		
• Medical Supplies	20%	50%
• Durable Medical Equipment	20%	50%
• Orthotics Foot and Shoe	20%	50%
• Prosthetic Appliances (external)	20%	50%
Nutritional Counseling for Diabetes	20%	50%
Online Visits from LiveHealth Online Provider	20%	Not Covered
Physician Services (Home and Office Visits)	20%	50%
Preventive Services	Covered at 100%	50%
Note: Preventive Services are defined as any claim submitted with a "well" diagnosis.		

Benefits	Network	Out-of-Network
Skilled Nursing Facility	**20%**	**50%**
Surgical Services	**20%**	**50%**
Therapy Services (Outpatient)		
• Physical Therapy	**20%**	**50%**
• Occupational Therapy	**20%**	**50%**
• Speech Therapy	**20%**	**50%**
• Cardiac Rehabilitation	**20%**	**50%**
• Chiropractic Care	**20%**	**50%**
• Radiation Therapy	**20%**	**50%**
• Chemotherapy	**20%**	**50%**
• Respiratory Therapy	**20%**	**50%**
• Vision Therapy	**20%**	**50%**
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Benefits for physical Therapy and occupational therapy are limited to **60 combined visits** per calendar year, combined Network and Out-of-Network.		
Benefits for speech therapy are limited to **20 visits** per calendar year, combined Network and Out-of-Network.		
Benefits for chiropractic care are limited to **12 visits** per calendar year, combined Network and Out-of-Network.		

Transplants Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, including Medically Necessary preparatory myeloablative therapy.	**Center of Excellence**	**Network Transplant Provider**	**Out-of-Network Transplant Provider**
• Covered Transplant Procedure during the Transplant Benefit Period(excluding kidney and cornea transplants)	**Covered at 100%**	**50%**	**50%**
• Kidney and Cornea Transplants	**NA**	**20%**	**50%**
• Eligible Travel and Lodging	**Covered at 100%**	**50%**	**50%**

ELIGIBILITY

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Coverage for the Retiree

This Benefit Booklet describes the benefits an Retiree may receive under this health care Plan. The Retiree is also called a Subscriber.

Coverage for the Retiree's Dependents

If the Retiree is covered by this Plan, the Retiree may enroll his or her eligible Dependents. Covered Dependents are also called Members.

All enrolled eligible, unmarried children will continue to be covered:
1. To the End of the Month in which the child attains age 19; or
2. To the End of the Month in which the child attains age 24 if the child qualifies as a Full-time Student at an accredited school (at least 7 months) and qualifies as a Federal Tax Exemption.

Eligibility will also be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Benefits are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

If you are eligible to enroll as a Member, you must enroll at the time agreed upon by the Plan. Otherwise, you may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Eligible Dependents (Spouse):

- The Retiree's Spouse. For the purposes of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from the enrolling Retiree.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Any Employer waiting period which was not satisfied under previous Creditable Coverage must be satisfied under this Plan. However, credit will be given for the length of time already served.

Late Enrollees

If the Retiree or the Retiree's Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Retiree or the Retiree's Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Retirees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or Employer contributions toward coverage were terminated.

An individual who declined coverage must have certified in writing that he or she was covered by another health plan when he or she initially declined coverage under this Plan in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions or placement for adoption. An unenrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by the Retiree or the Retiree's prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Retirees and Dependents may also enroll under two additional circumstances:

- the Retiree's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Retiree or Dependent becomes eligible for a subsidy (state premium assistance program)

The Retiree or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Retiree applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires.

Changing Coverage
There may be an annual re-enrollment period during which time Members may elect to change their options. Retirees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Types of Coverage
The types of coverage available to the Retiree are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)
You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Retiree has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren
An Retiree may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Retiree does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the **"Late Enrollees"** provision in this section.

Newborn and Adopted Children
You must contact Your Employer within 31 days to add a newborn or adopted child.

OBRA 1993 and Qualified Medical Child Support Orders
The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).
An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final.
  - An "adopted child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Retiree of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Retiree has received an MCSO (a "Medical Child Support Order") which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").
  - Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Retiree and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Retiree and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Changing Coverage or Removing a Dependent
When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches terminating age (see "When Coverage Terminates");
- Enrolled Dependent child becomes totally or permanently disabled.

Portability Provision

Any newly eligible Retiree, Member, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 63 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision the Employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Plan.

SUMMARY OF BENEFITS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the "Definitions" Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets You get Covered Services at the Network cost-share when You are traveling out of state and need health care, as long as You use a BlueCard Provider. All You have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send Your claims to the Claims Administrator.

If You are out of state and an Emergency or urgent situation arises, You should get care right away.

In a non-Emergency situation, You can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to **Inter-Plan Programs** in the **Claims Payment** section for more information on BlueCard.

Care Outside the United States – BlueCard® Worldwide

Prior to travel outside the United States, check with Your Group or call Customer Service at the number on your Identification Card to find out if Your Plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your current Identification Card.
- In an emergency, go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- **Participating BlueCard Worldwide Hospitals.** In most cases, when You make arrangements for hospitalization through BlueCard Worldwide, You should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then You can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.
- You must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits.**

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for You to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

If You have any questions regarding the information contained in this section, You may call the Customer Service telephone number on Your Identification Card or visit www.bcbsga.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. The Claims Administrator will review Your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review– A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A PENALTY WILL APPLY AND YOUR OUT OF POCKET COSTS WILL INCREASE.

The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
    - Diagnosis of Sleep Disorders
    - Gene Expression Profiling for Managing Breast Cancer Treatment
    - Genetic Testing for Cancer Susceptibility
- DME/Prosthetics
    - Bone Growth Stimulator: Electrical or Ultrasound
    - Communication Assisting / Speech Generating Devices
    - External (Portable) Continuous Insulin Infusion Pump
    - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
    - Microprocessor Controlled Lower Limb Prosthesis
    - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
    - Pneumatic Pressure Device with Calibrated Pressure
    - Power Wheeled Mobility Devices
    - Prosthetics: Electronic or externally powered and select other prosthetics
    - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Implantable or Wearable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries

- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Surgical Treatment of Migraine Headaches
- Occiptal nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
- Plastic/Reconstructive surgeries:
    - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
    - Blepharoplasty
    - Brachioplasty
    - Buttock/Thigh Lift
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/Injection of Prosthetic Material Collagen Implants
    - Liposuction/Lipectomy
    - Procedures Performed on Male or Female Genitalia
    - Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
    - Procedures Performed on the Trunk and Groin
    - Repair of Pectus Excavatum / Carinatum
    - Rhinoplasty
    - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
    - Intensity Modulated Radiation Therapy (IMRT)
    - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease

- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - Donor Leukocyte Infusion

Mental Health/Substance Abuse (MHSA):

Pre-certification Required

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- ABA- Applied Behavioral Analysis

Outpatient Therapy

- May be required after the initial twelve (12) visits. Please call the customer service number on Your ID card for details. Generally speaking no precertification is required for this service.

Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria as determined by the Claims Administrator's Corporate Medical Policy or Clinical Guidelines.

Referrals:

Requests for Out of Network Referrals for care that the Claims Administrator determines are Medically Necessary may be pre-authorized, based on network adequacy and Medical Necessity

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification?	
Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	**Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.**

Provider is responsible for Precertification.	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Employer's Group Health Plan Document takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request. To request this information, contact the Customer Service telephone number on Your Identification Card.

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Claims Administrator's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

Just because the Claims Administrator exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Claims Administrator will do so in the future, or will do so in the future for any other Provider, claim or Member. The Claims Administrator may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of your ID card.

Request Categories:

- **Urgent** – A request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

> **Verbal:** oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
> **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:

1. You must be eligible for benefits;
2. the service or surgery must be a covered benefit under Your Plan; and
3. the service cannot be subject to an exclusion under Your Plan
4. You must not have exceeded any applicable limits under Your Plan.

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Claims Administrator's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

The Claims Administrator's Case Management programs are confidential and voluntary. These programs are given at no extra cost to You.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet your identified health care needs. This is reached through contact and team work with You and/or your chosen representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service through the Claims Administrator's Case Management program. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator will make its decision case-by-case, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or your representative in writing.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

- For ground ambulance, You are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, You are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or your home.

Hospital to Hospital Transport
If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, your family, or your Provider prefers a specific Hospital or Physician.**

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment
See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care
Covered Services include:

- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

Breast Cancer Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery
Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation
Covered Services are provided as outlined in the **Schedule of Benefits.**

Clinical Trials
Benefits include coverage for services given to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services

i. The Experimental/Investigative item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Dental Services

Related to Accidental Injury
Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury, except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the Schedule of Benefits.

Other Dental Services
Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes
Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Dialysis Treatment
The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment
This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder.

Emergency Care

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.
- Dietician services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care Services

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent Semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

Outpatient Hospital Services

The Plan provides Covered Services when the following Outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

To maximize your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the customer service telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Claims Administrator for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Out-of-Network Transplant Provider Facility.

Transportation and Lodging
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits.** Speech Therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care & Infertility Services
Covered Services are provided for Network Maternity Care subject to the benefit stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic) - Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

Infertility Services
Your Plan also includes benefits for the diagnosis of Infertility.

Medical Care
General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling
Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

Out-of-Network Freestanding Ambulatory Facility
Any services rendered or supplies provided while You are a patient or receiving services at or from a Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits
If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **"Schedule of Benefits"** section.

Obesity
Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan. Precertification is required, and coverage is only provided for gastric bypass, vertically banded gastroplasty and adjustable gastric banding procedure (lap band).

Online Visits
When available in Your area, Your coverage will include online visit from a LiveHealth Online Provider. Covered services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Online visits are not covered from Providers other than those contracted with LiveHealth Online. Non Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

Oral Surgery
Covered Services include only the following:
- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the Schedule of Benefits after the accident.

Other Covered Services
Your Plan provides Covered Services when the following services are Medically Necessary:
- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Outpatient CT Scans and MRIs
These services are covered at regular Plan benefits.

Outpatient Surgery
Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Physical Therapy, Occupational Therapy, Chiropractic Care
Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services
You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care
Covered Services in the Physician's or Specialist Physician's office or independent lab include, but are not limited to:

- Treatment or preventive services including periodic health examinations for adults and Dependent children. Employment or insurance-related physicals are not covered;
- Well child care;
- Preventive lab and x-ray;
- Immunizations;
- Flu injections;
- Gynecological (well woman) exams;
- Annual Pap smear;
- Annual prostate screening;
- Annual routine mammogram (also covered in the Hospital setting);
- Colorectal cancer screening including fecal occult blood test, sigmoidoscopy, and colonoscopy;
- Audiometric exams; and
- Routine eye exams.

Prosthetic Appliances
Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are **excluded:** corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery
Precertification is required. Reconstructive surgery does not include any service otherwise excluded in this Benefit Booklet. (See "Limitations and Exclusions.")

Reconstructive surgery is covered only to the extent Medically Necessary:

- to correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or

- to correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

LIMITATIONS AND EXCLUSIONS

The following section indicates items, which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items, which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.

2. Services for Custodial Care. Services for custodial or convalescent care, rest cures or long-term custodial Hospital care.

3. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.

4. Charges for treatment received before coverage under this option began or after it is terminated.

5. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.

6. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.

7. Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.

8. Shoe inserts, orthotics (will be covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary.

9. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

10. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.

11. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.

12. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.

13. Outpatient prescription drugs prescribed by a physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for Outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under your medical benefits when rendered in a Hospital, in aPhysician's office, or as part of a Home Health Care benefit. Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in your Physician's office.

14. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

15. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

16. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be medically necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be medically necessary.

17. Services for Hospital confinement primarily for diagnostic studies.

18. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when medically necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

19. Donor Search/Compatibility, except as otherwise indicated.

20. Hearing aids, hearing devices or examinations for prescribing or fitting them.

21. Contraceptive drugs, except for any above stated covered contraceptive devices.

22. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.

23. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.

24. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

25. Christian Science Practitioner Services.

26. Smoking Cessation Products including gum, patches and prescription drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.

27. Services provided in a Residential Treatment Center (RTC).

28. Services provided in a Halfway House.

29. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.

30. Routine care services, unless specified in this Benefit Booklet.
31. Services or supplies provided by a member of your family or household.
32. Charges or any portion of a charge in excess of the Allowed Amount as determined by the Claims Administrator.
33. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.
34. Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
35. Services for any form of telecommunication
36. Charges for any of the following:
    a. Failure to keep a scheduled visit;
    b. Completion of claim forms or medical records or reports unless otherwise required by law;
    c. For Physician or Hospital's stand-by services;
    d. For holiday or overtime rates.
    e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
    f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
37. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.
38. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
39. Surgical care or medical treatment or study related to the modification of sex (transsexualism) and related services, or the reversal thereof.
40. Reversal of vasectomy or reversal of tubal ligation.
41. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes.
42. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
43. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
44. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
45. Services for weight loss programs, services and supplies. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss).

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.bcbsga.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Programs for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;

- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.bcbsga.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Network Provider or visit the Claims Administrator's website at www.bcbsga.com.

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out of Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Member Cost Share
For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist

who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services
In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. **If services are performed by Out-of-Network Providers,** then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Claims Administrator for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;

- the amount for which You are responsible (if any); and
- general information about Your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

Inter-Plan Programs

Out-of-Area Services
Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of Anthem's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's service area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program
Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, You may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem. But in no

event will You be entitled to benefits for healthcare services, wherever You received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation
When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating healthcare providers, the amount You pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

Exceptions
In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator will make for the Covered Services as set forth in this paragraph.

If You obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Out-of-Network care, and You may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on Your ID card or go to www.bcbsga.com.com for more information about such arrangements.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

YOUR RIGHT TO APPEAL

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA if You appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist You

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent

with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g., urgent care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided
When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care

professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal
If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Appeal Denial
If Your appeal is denied, that denial will be considered an adverse benefit determination.The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals
If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, You may be eligible for an independent External Review pursuant to federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

A request for a External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal. However, You are encouraged to submit any additional information that You think is important for review.

For pre-service claims involving urgent/concurrent care, You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To proceed with an Expedited External Review, You or Your authorized representative must contact the Claims Administrator at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other benefits under this health care plan. There is no charge for You to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Retiree, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Retiree, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the Spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this

rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a Dependent of an employee, member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary
To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare
If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source.

Recovery
A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation
The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement
If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal Injury or illness to You occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

The Plan Sponsor has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal Injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the customer service number on Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under

any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payor, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same *Covered Services*. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
  If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *Covered Services*.
- **If You Are Under Age 65 With Other Disability**
  If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed *Subscriber* or the enrolled Spouse or child of the actively employed Subscriber.
- **If You Are Age 65 or Older**
  If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case **only** if You are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in Your Explanation of Benefits is the final determination and You will not receive notice of an adjusted cost share amount as a result of such recovery activity.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator's notice to the Employer will constitute effective notice to the Member. It is the Employer's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.

Anthem Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. 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 Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Governmental Health Care Programs

Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group

benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer's cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Certification of Prior Creditable Coverage

If Your coverage under this Plan is terminated, You and Your covered Dependents will receive a certification that shows Your period of coverage under this health benefit plan. You may need to furnish the certification if You become eligible under another group health plan. You may also need the certification to buy, for yourself or Your family, an individual policy that does not exclude coverage for medical conditions that were present before Your enrollment. You and Your Dependents may request a certification within 24 months of losing coverage under this health benefit plan.

You may also request a certification be provided to You at any other time, even if You have not lost coverage under this plan. If You have any questions, contact the customer service telephone number listed on Your Identification Card.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
For Retirees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Retiree's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Retiree's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Retiree	36 months
For Dependents: Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event
If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual
If You don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 72.5% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to You, You may continue COBRA coverage only until these limitations cease;
- a covered individual becomes entitled to Medicare after electing COBRA; or
    - the Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the

military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa*.

DEFINITIONS

Accidental Injury
Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement
The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Ambulance Services
A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)
A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

Behavioral Health Care
Includes services for Mental Health Disorders, and Substance Abuse.

Mental Health Disorders
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Substance Abuse or Chemical Dependency
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. Substance Abuse services include:

Substance Abuse Rehabilitation Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans;

Substance Abuse Services within a General Hospital Facility (a general Hospital facility that provides services, on an Inpatient, 24-hour basis, for medical Detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Excellence (COE) Network
A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator
The company the Plan Sponsor chose to administer its health benefits. Community Insurance Company was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance
If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

Combined Limit
The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy
Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly
A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery
Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease

state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Creditable Coverage

Coverage under another health benefit plan is medical expense coverage with no greater than a 63 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a Spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage. The Claims Administrator will issue a certificate of Creditable Coverage upon request or when a Member leaves the Plan. Call the Customer Service number on Your Identification Card to request such a certificate.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services.

Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally

retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

Experimental/Investigative

Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;

- Has been determined by the FDA to be contraindicated for the specific use; or

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;

- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or

- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Medical records; or

- The opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Group Health Plan or Plan

An employee welfare benefit plan (as defined in Section 3(1) of ERISA, established by the Employer, in effect as of the Effective Date.

Health Plan Document

This Benefit Booklet in conjunction with the Health Plan Document, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Health Plan Document and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Health Plan Document, the Health Plan Document shall control.

Home Health Care

Care, by a licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate agency.

Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;

- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider
A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

Inpatient
A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees
Late Enrollees mean Retirees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount
The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medical Emergency
"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

Medical Facility
A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

Medical Necessity or Medically Necessary
An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the 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 the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

New Hire
A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider
A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given calendar Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services, exclusive of Copayments and other scheduled charges.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator
The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Primary Care Physician
A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization
The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order
A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Retiree is entitled under the plan; and includes the name and last known address of the Retiree and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.
An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Retail Health Clinic
A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

Retiree
A person who was engaged in active employment with the Employer and is eligible for Plan coverage under the retirement regulations of the Employer. The Retiree is also called the Subscriber.

Semiprivate Room
A Hospital room which contains two or more beds.

Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

Spouse
For the purpose of this Plan, a Spouse is defined as a person who is married to a person of the opposite sex from that of the enrolling Retiree.

Therapeutic Equivalent
Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by a designee of the Claims Administrator. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

Urgent Care
Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review
A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

You and Your
Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Grandfathered Health Plan

This Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator or Your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Schedule of Benefits.**

If You would like more information on WHCRA benefits, call Your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If You or Your Spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends.

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Retirees and Dependents may also enroll under two additional circumstances:

- the Retiree's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Retiree or Dependent becomes eligible for a subsidy (state premium assistance program)

The Retiree or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.

EXHIBIT FOUR

2014 OPTUM

CONTRACT WITH

CITY OF CINCINNATI

PRESCRIPTION DRUG BENEFIT ADMINISTRATION AGREEMENT

This Prescription Drug Benefit Administration Agreement, effective January 1, 2014 ("***Effective Date***"), is between City of Cincinnati ("***Client***" or "***City***") and OptumRx, Inc., a California corporation ("***Administrator***").

The parties agree as follows:

1. PRESCRIPTION DRUG BENEFIT SERVICES

1.1 **Engagement.** Client engages Administrator as its exclusive provider of the core prescription drug benefit plan services, mail order pharmacy services, specialty pharmacy services and retiree drug subsidy services set forth on **Exhibit B** ("***Services***") to support Client's Benefit Plans, and Administrator accepts this engagement, subject to the terms of this agreement.

1.2 **Performance Standards.** Administrator will perform the Services in a diligent and professional manner by personnel or contractors who are trained, qualified and competent to perform or deliver the Services, supervise and monitor the performance and satisfy all requirements that apply to the Services as set forth in this agreement, on condition that Client performs or complies with its obligations under this agreement. Administrator will provide the performance guarantees set forth on **Exhibit E.**

1.3 **Additional Services.** If Client asks, and Administrator agrees to perform any service in addition to the Services ("***Service Change***"), then the parties will amend this agreement to include the Service Change and the increase in rates, fees and reimbursements to be charged to Client. Administrator will not be obligated to perform the Service Change until the amendment for the Service Change is executed. A Service Change will not arise from an obligation required by Administrator or its subcontractor (including a Network Pharmacy) for the Services to comply with Laws and Regulations in effect as of the Effective Date. If a change in Laws and Regulations materially burdens Administrator, requires Administrator to increase payments for Covered Prescription Drugs or materially changes the Services, then the Services, rates, fees, reimbursements or Rebates will be modified appropriately so the parties are returned to their comparable economic position as of the Effective Date.

1.4 **Compliance with Laws.** Each party will comply with all Laws and Regulations applicable to its respective business and the performance of its obligations under this agreement, including maintaining any necessary licenses and permits. If a party's performance as required by this agreement is prohibited by or conflicts with any applicable Laws and Regulations, then the party whose performance is owed or required will be required to perform, but only to the extent permitted by applicable Laws and Regulations. Any provisions now or hereafter required to be included in this agreement by applicable Laws and Regulations or any Governmental Authority will be binding and be enforceable against the parties and deemed incorporated in this agreement, irrespective of whether these provisions are expressly provided for in this agreement.

1.4.1 **Equal Employment Opportunity Program.** This agreement is subject to the Client's Equal Employment Opportunity Program contained in Chapter 325 of the Cincinnati Municipal Code. Said chapter is hereby incorporated by reference into this agreement.

1.4.2 **Small Business Enterprise Program.** This agreement is subject to the provisions of the Small Business Enterprise Program contained in Chapter 323 of the Cincinnati Municipal Code. Section 323-99 of the Cincinnati Municipal Code is hereby incorporated into this agreement.

Details concerning this program can be obtained from the Office of Contract Compliance, Two Centennial Plaza, 805 Central Avenue, Suite 222, Cincinnati, Ohio 45202, (513) 352-3144.

Administrator shall utilize best efforts to recruit and maximize the participation of all qualified segments of the business community in subcontracting work, including the utilization of small, minority, and women business enterprises. This includes the use of practices such as assuring the inclusion of qualified small business enterprises in bid solicitation and dividing large contracts into small contracts when economically feasible.

1.5 **Use of Subcontractors**. Administrator will not subcontract any Service to a subcontractor without Client's prior notification, which shall not be unreasonably withheld. unless the subcontract satisfies the requirements of this section. The subcontractor will perform the subcontracted Services in accordance with the terms of this agreement and all applicable Laws and Regulations. Administrator will provide Client with a list of all subcontractors, which list will be updated annually.

2. TERM AND TERMINATION

2.1 **Term**. The initial term of this agreement begins on the Effective Date and expires on December 31, 2016. After the initial term, this agreement automatically renews for two successive 12-month renewal periods on each applicable anniversary date (the renewal periods together with the initial term, the "***Term***"), unless either party provides the other party with notice of non-renewal no later than 90 days before the end of the initial term or a renewal period.

2.2 **Termination**. This agreement may be terminated as set forth in this section or as specified elsewhere in this agreement.

2.2.1 For Cause. If either party materially defaults in performing any of its material obligations under this agreement (a "***Default***"), the party not in Default, at its election, may terminate this agreement either in its entirety or only for the affected Services; unless the party in Default cures the Default within 30 days following notice of the Default given by the party not in Default. The notice will specify in reasonable detail the nature of the Default, the actions required to cure the Default, if the Default is curable, and whether the party not in Default is seeking to terminate either this entire agreement or only the affected Services. If the party in Default does not cure the Default to the reasonable satisfaction of the other party by the end of the 30-day cure period, then this agreement or the applicable Services, as the case may be, will terminate upon expiration of the 30-day cure period without any further notice or other action by the party not in Default. If the Default is cured before the 30-day cure period expires, then this agreement will remain in effect. Notwithstanding the foregoing, the 30-day opportunity to cure a Default will not apply to a payment default described in section 2.2.2.

2.2.2 Payment Default. If Client fails to pay any amount due on a validly submitted invoice (for which no objection is filed in good faith in accordance with section 3.3) within five business days after the applicable Payment Due Date (as defined in section 3.2), then Administrator may immediately upon written notice to Client terminate this agreement in its entirety or only for the applicable, affected Services or withhold or suspend Services until payment is received.

2.2.3 Automatic Bankruptcy Termination. This agreement will terminate automatically in the event of a Bankruptcy Event affecting either Administrator or Client. "***Bankruptcy Event***" means that Client or Administrator: (a) cannot pay its debts generally as they become due; (b) makes a voluntary assignment for the benefit of creditors; (c) is declared insolvent in any proceeding; (d) commences a voluntary case or other proceeding seeking liquidation, reorganization or other relief for itself, any of its property, assets or debts

under any bankruptcy, insolvency or other similar laws now or hereafter in effect or petitions or applies to any tribunal for the appointment of a receiver, liquidator, custodian or trustee for the party under any bankruptcy, reorganization, arrangement, insolvency, readjustment of debt, liquidation, or dissolution law of any jurisdiction now or hereafter in effect; (e) is named as a debtor or party in the petition, application, case or proceeding and indicates its approval thereof, consents thereto, acquiesces therein or acts in furtherance thereof, or if the petition, application, case or proceeding is not dismissed or stayed for 60 days after it begins, or is the subject of any order appointing any such receiver, liquidator, custodian or trustee or approving the petition in any such case or proceeding; or (f) the sum of the party's debts (including contingent obligations) exceeds the fair market value of the party's assets, exclusive of any property transferred, concealed, or removed with the intent to hinder, delay or defraud the party's creditors.

2.2.4 Adverse Legal Determination. Subject to section 7.3, either party may terminate this agreement immediately upon notice to the other party (a) following a Judgment (as defined in section 6.1) or change in any applicable Laws and Regulations that would make performance of this agreement, in all material respects, unlawful or illegal for the terminating party, or (b) if a Governmental Authority requires either party to terminate this agreement.

2.2.5 For Convenience. After the first anniversary of the Effective Date, either party may terminate this agreement without cause upon 90 days prior notice of termination to the other party. If Client terminates without cause within the first three years of the Term, (a) Administrator will have no obligation under any guarantees under this agreement for the contract year (*i.e.*, each 12-month period following the Effective Date) in which Client terminates, if the portion of the contract year before the effective date of Client's termination is less than 12 full months and (b) Client will reimburse Administrator no later than 30 days before Client's termination for Administrator's implementation costs (maximum of $40,000) and the implementation allowance paid or credited to Client by Administrator under Exhibit C. The amount owed by Client for Administrator's implementation costs and the implementation allowance paid or credited to Client by Administrator under Exhibit C will both be prorated monthly over the first three years of the Term.

2.3 **Effect of Termination**. Upon termination of this agreement for any reason, Client will pay Administrator all undisputed amounts for Services performed through the date this agreement terminates in its entirety. Termination of this agreement will not alter Client's obligation to pay any disputed amounts owing to Administrator under this agreement that are subsequently resolved. Termination of this agreement for any reason will not relieve either party from liability for any obligations required of the party before this agreement terminates.

2.4 **Transition Assistance Following Termination**. Upon termination of this agreement for any reason, Administrator will, as directed by Client, provide Client or its designee with the following files: (a) existing Mail Order or Specialty Pharmacy open refill transfer files for Members, as based upon Client's most current eligibility files; (b) Client's claims history file; (c) Client's prior authorization files; and (d) Client accumulator files. Each file will be sent using Administrator's standard format and delivered using a media agreed to by the parties. Administrator will send up to three transmissions (i.e., one full test file, one production file, and one lag file) of each file. After the first set of files transmitted Client will pay or reimburse Administrator $1,500 for each file transferred.

2.5 **Phase-Out Period for Network Pharmacies**. Despite section 2.4, and only to the extent required by any applicable Laws and Regulations and if requested by Client, Administrator will continue to provide Covered Prescription Services through Network Pharmacies and Administrator's Mail Order Pharmacies and Specialty Pharmacy for up to 180 days, or longer if required by applicable Laws and Regulations, following, as applicable, (a) the date this

agreement was to have terminated in its entirety as described in sections 2.1 or 2.2 or (b) the date Administrator no longer owns or operates a Mail Order Pharmacy or Specialty Pharmacy.

3. COMPENSATION AND BILLING

3.1 **Compensation**. Client will pay Administrator the rates, fees and reimbursements set forth on **Exhibit C** for the Services. If the total number of Members on the Effective Date reduces by 10% or more during the Term, Administrator may modify the rates, fees or guarantees in **Exhibit C**, effective the date of the change, upon notice to Client.

3.2 **Payment Terms**. Administrator will invoice Client at semi-monthly billing cycles that run from the 1st through the 15th and from the 16th through the end of the month. Administrator will submit invoices to Client that accurately reflect the Services performed during the invoice period and include Prescription Claims information to support the invoiced amounts at no charge. At Client's expense, Administrator may provide electronic claims files to Client's third party service provider, subject to the third party's execution of Administrator's form confidentiality agreement. Client will pay Administrator all undisputed invoiced amounts, via electronic fund transfer or other reliable means, no later than five business days after Client receives the invoice and supporting claims detail file (***"Payment Due Date"***).

3.3 **Timely Notice of Overpayment**. Client may object to any amounts on Administrator's invoices that Client believes do not comply with the Pharmacy Plan Specifications. Client must notify Administrator of Client's objection no later than 60 days after the invoice date stating the disputed charges. If Client fails to object within this 60-day period, Client will be deemed to have acknowledged that the invoiced amounts comply with the Pharmacy Plan Specifications. This section will not preclude Client's right to audit Administrator's Services described in section 4.2.

3.4 **Late Payments and Late Fees**. Any amounts Client owes under this agreement that are not paid by the Payment Due Date will bear interest from the Payment Due Date pursuant to Chapter 319 of the Cincinnati Municipal Code.

3.5 **Right of Recoupment**. Administrator may withhold, deduct, net or recoup from future amounts owed or reimbursable to Client under this agreement any undisputed amounts Client owes to Administrator that are outstanding beyond their applicable Payment Due Date.

3.6 **Payment from Members**. Except as permitted by applicable Laws and Regulations, Administrator will not bill, charge, collect a deposit from, have recourse against or otherwise seek payment from a Member for Covered Prescription Services or amounts due to Administrator from Client, other than Cost-Sharing Amounts, returned checks or collection costs. Administrator will require, under the terms of its Network Pharmacy Agreements, each Network Pharmacy to comply with the requirements of this section.

3.7 **Claims Processor Fees**. Administrator may retain as part of its compensation under this agreement any claims processor fees received from Network Pharmacies in connection with the Prescription Drugs dispensed to Members under the Benefit Plans, including: (a) a per claim communications charge for on-line electronic claims processing by point-of-service communication; (b) a charge for each claim submitted to Administrator via paper, tape or a medium other than point-of-service communication; (c) surcharges for canceled or reversed claims; and (d) a charge if a Network Pharmacy requests an evidence of benefits report in a tape medium.

4. MAINTENANCE OF RECORDS; AUDITS

4.1 **Records**. Administrator will maintain accurate, complete and timely books and records of all transactions occurring from Administrator performing the Services to Members, including Covered Prescription Services, health care cost, Rebate data (including Rebate calculation and,

if applicable, Rebate allocation between Client and Administrator), encounter data and other data, based upon information available to Administrator at the time of data collection or calculation. Client will keep and maintain accurate, complete and timely books and records relating to operation of the Benefit Plans. Administrator and Client each will retain these books and records during the Term and for seven years following the date of their creation or for a longer time period, if required by applicable Laws and Regulations or an on-going audit or investigation of Administrator by Client, a Governmental Authority or another person or entity, and will make these books and records available to a Governmental Authority to the extent required by applicable Laws and Regulations.

4.2 **Client Audits.** Upon reasonable advance notice and at reasonable times, Client may audit once annually Administrator's performance of the Services, including concurrent eligibility, Formulary compliance and, when applicable, Rebates, for the period not to exceed 24 months immediately preceding the audit. No later than 45 days after receipt of Client's written audit request, Administrator will compile and prepare all claim detail information Client requires to perform its requested audit and furnish this information to Client in an agreed upon format. Client may audit Administrator through an audit firm of its choice, so long as: (a) the auditor does not have a conflict of interest with Administrator; (b) the audit firm executes Administrator's form Auditor Protocol and Confidentiality Agreement; (c) Client pays all costs associated with the audit, excluding Administrator's cost in compiling, copying, and making available the claim detail information necessary for the audit; and (d) Client does not compensate the audit firm, in whole or in part, on a basis that is contingent upon the results of the review of Administrator's records or the contents of the audit report. No audits may be initiated or conducted during December or January because of annual renewal period demands. Administrator will provide Client's auditor with access to all relevant data, records, contracts, files, personnel, books and other information reasonably necessary for Client's auditors to audit Administrator, subject to Administrator's third party confidentiality obligations. The audit information Administrator provides will be limited to Client-specific information necessary for Client to verify Administrator's performance under this agreement. Other documentation (*e.g.* policies and procedures) requested during the course of an audit, other than that needed to determine the accuracy of Client claims payments, will be provided at Administrator's reasonable discretion. Any Client requests for an auditor to audit will constitute Client's direction and authorization to Administrator to disclose this Client-specific information, including Member information and PHI, to the auditor.

5. DATA PROTECTION AND OWNERSHIP

5.1 **Data Ownership.** Client owns and will continue to own Client Data and Administrator owns and will continue to own Administrator Data, despite data use or possession by the other party or its subcontractor in accordance with an authorized subcontract. Each party will use commercially reasonable efforts to maintain the proprietary character of the other party's respective Client Data or Administrator Data.

5.2 **Data Use.** Each party grants the other party a non-exclusive, nontransferable, non-sublicensable, royalty free license to use its Marks and Content in furtherance of this agreement, except that neither party is granted any license to, and will not be permitted to use, the other party's Marks or Content except as pre-approved in writing by the other party. The parties will agree on use of the other's Marks, Content or words or phrases identifying the other party in any promotional or other materials, any advertisements identifying the other party, and in connection with Client identifying the Benefit Plans, or in any public announcement or press release, including agreeing on the timing and content of any public release. Despite any contrary provisions in this agreement, during the Term and for a reasonable period after termination of this agreement, Client grants Administrator the right to use and disclose to third parties Member drug and related medical data to perform Administrator's responsibilities under this agreement and to use in Administrator's research, cost analyses, and cost comparison studies. All research, cost analyses, cost comparisons and other similar studies or reports Administrator conducts or prepares will be Administrator's sole and exclusive property.

Administrator may aggregate this information with that of other clients and de-identify it to protect Client and Member confidentiality.

5.3 **Confidentiality**

5.3.1 Confidentiality Obligations. Each party ("***Recipient***") will, and will use commercially reasonable efforts to cause each of its Representatives to, keep confidential the Confidential Information of the other party ("***Discloser***") and not disclose any Confidential Information without Discloser's prior written consent or as permitted by this Agreement. Confidential Information may be disclosed to either party's employees, contractors or another third party ("***Representative***") as reasonably necessary to carry out the purposes of this agreement, on condition that the Representative agreed to keep confidential the Confidential Information with obligations at least as comprehensive as the obligations in this agreement. Recipient will be responsible for any breach of this agreement by any Representative to which it discloses Confidential Information.

5.3.2 Definition of Confidential Information. "***Confidential Information***" means: (a) the terms of this agreement; (b) all Discloser material, non-public information, materials or data, in any form, that Recipient knows or has reason to know is confidential or proprietary to Discloser, including Client Data or Administrator Data; (c) any other information that Discloser marks or designates clearly as confidential or proprietary; and (d) Discloser trade secrets, know how, inventions, current and future business plans, marketing plans and strategies, financial and operational plans, business methods and practices, customer or prospect data, records, information and profiles, supplier or vendor information and data, historical or prospective financial information, budgets, cost and expense data, employment records and contracts and personnel information as well as software, technology, inventions (whether or not patentable) that Discloser owns, licenses or uses. Confidential Information will not include information that: (a) is generally available to the public; (b) becomes available to Recipient on a non-confidential basis from a source, other than Discloser or its Affiliates or agents, not bound by a confidentiality agreement; or (c) that is required to be disclosed by law or pursuant to court order.

5.3.3 Exceptions to Confidentiality Obligations. The obligations in this section 5.3 will not restrict or limit disclosures by Recipient: (a) to offer or administer the Benefit Plans; (b) to comply with Rebate reporting or other data collection, maintenance, security or submission requirements; (c) to perform functions or responsibilities required by applicable Laws and Regulations; (d) as required or compelled by applicable Laws and Regulations or a Governmental Authority with competent jurisdiction over Recipient, on condition that Recipient will: (i) give prompt notice to Discloser after learning of the need to disclose (if allowed by applicable Laws and Regulations); (ii) disclose only that portion of Discloser's Confidential Information that Recipient's outside legal counsel advises is legally necessary to comply with the Laws and Regulations or Governmental Authority order; and (iii) assist Discloser if it objects to the disclosure; or (e) as provided in the next paragraph.

The parties acknowledge that Client is governed by the Ohio Public Records Laws and agree to comply with all applicable provisions of the Ohio Public Records Laws, despite contrary provisions in this agreement. Records (as defined by Ohio Revised Code §§ 149.011 and 149.43) related to this agreement may be subject to disclosure under the Ohio Public Records Laws. Client shall have no duty to defend the rights of Administrator or any of its agents or affiliates in any records requested to be disclosed. Upon receipt of a public records request, Client will notify Administrator in accordance with Section 7.1 of this agreement of its intent to release records to the requestor. Beginning with the date it receives notification, Administrator shall have the lesser of: (a) ten (10) business days or (b) a "reasonable amount of time" as that term has been interpreted by Supreme Court of Ohio and as notified by Client to Administrator in order to respond to Client by either accommodating the requestor or pursuing legal remedies to stop the Client's release of

requested information. Administrator and its agents and affiliates shall have the right to pursue legal and/or equitable remedies to stop or limit disclosure at their sole expense. Administrator will defend and hold harmless Client, including any reasonable and actual attorneys' fees awarded against Client under O.R.C. section 149.43 to the extent the claim is related to Administrator's designation of certain records as exempt from public disclosure as a trade secret ("Claim"). Client will promptly notify Administrator of the Claim, and will allow Administrator to control the defense and settlement thereof.

5.4 **Return of Confidential Information**. Upon Discloser's request, for any reason whatsoever and at any time, Recipient will return immediately all Discloser's Confidential Information within Recipient's possession or control. If any Confidential Information is contained in analyses, compilations, studies or other documents prepared by Recipient or its contractors, Recipient will promptly destroy, and instruct its Authorized Representatives to destroy, these items and certify to Discloser that this destruction has occurred. Recipient and its Authorized Representatives may retain one copy of Discloser's Confidential Information for archival purposes or as otherwise required by applicable Laws and Regulations.

5.5 **Protected Health Information**. The parties will execute and abide by the Business Associate Agreement in the form of **Exhibit D**, which outlines the parties' obligations for use and disclosure of PHI.

5.6 **Equitable Relief**. The parties acknowledge that it would be difficult to measure damages resulting from any breach of their respective obligations in this section 5, injury from this breach would be impossible to calculate and money damages would be an inadequate remedy. Consequently, in addition to any other rights or remedies available under this agreement, the parties may seek injunctive and other equitable relief, without bond or other security, for a party's actual or threatened breach of this section 5. The obligations, rights and remedies of the parties under this section 5 are cumulative and in addition to, and not in lieu of, all obligations, rights or remedies created by applicable patent, copyright or other laws, including statutory and common laws governing unfair competition and misappropriation or theft of trade secrets, proprietary rights or confidential information.

6. INDEMNIFICATION; INSURANCE; LIMITATION OF LIABILITY

6.1 **Indemnification**. Each party ("***Indemnitor***") will be solely financially responsible for, and will defend and indemnify the other party, its Affiliates and their respective directors, officers, employees, representatives, agents, successors, successors-in-interest and assigns ("***Indemnitee***") from and against all claims, legal or equitable causes of action, suits, litigation, proceedings (including regulatory or administrative proceedings), grievances, complaints, demands, charges, investigations, audits, arbitrations, mediation or other process for settling disputes or disagreements, including any of the foregoing processes or procedures in which injunctive or equitable relief is sought ("***Claims***") made by a third party against Indemnitee arising or resulting from, or to the extent attributable to, Indemnitor's material breach of this agreement or its negligence or intentional misconduct (including fraud), except to the extent the liability results from Indemnitee's negligence, willful misconduct or breach of this agreement. Indemnitor will pay promptly and satisfy fully in connection with an indemnified Claim all (a) losses, damages of any kind or nature, assessments, fines, penalties, deficiencies, interest, payments, expenses, costs, debts, obligations, liabilities, liens or Judgments that are sustained, incurred or accrued; (b) judgments, writs, orders, injunctions or other orders for equitable relief, awards or decrees of or by any Governmental Authority ("***Judgments***"); and (c) costs, expenses and fees, including settlement costs, attorneys' fees, accounting fees and expert costs and fees incurred in connection with Claims. Each party will provide prompt notice to the other party upon learning of any occurrence or event that may result in an obligation of the other party under this section. A party's failure to provide prompt notice of a Claim will not relieve the other party of its obligations under this section, except to the extent that the omission results in a failure of actual notice to the other party and the other party suffers damages because of the

failure to notify.

6.1.1 Notwithstanding any statement in section 6.1 (Indemnification) above, the City's obligation to indemnify Administrator shall be limited to the remaining amount of funds, if any, which have been previously certified to this contract by the City's Director of Finance pursuant to O.R.C § 5705.41 and C.M.C. § 301-1. The City is under no obligation to certify additional funds to this contract to meet any request for indemnification.

6.2 **Insurance Requirements.** The parties acknowledge that Client does not maintain commercial insurance and is self-insured for workers compensation insurance purposes. Administrator will maintain: (a) during and for a reasonable period of time after the Term, reasonable and customary insurance (whether through third party carriers or self-insured arrangements or retentions), as to type, policy limits and other coverage terms, to cover the risks of loss faced by companies similar to the party in size, industry and business operations; and (b) all insurance coverage, bonds, security and financial assurances as applicable Laws and Regulations may require from time-to-time. All authorized Administrator subcontracts will require the subcontractors to maintain adequate and customary insurance. Administrator, at its sole cost and expense, will procure and maintain (a) workers compensation insurance coverage, (b) comprehensive general liability insurance, including personal injury, and (c) automobile liability, including non-owned and hired auto coverage, of not less than $1,000,000 per occurrence. Administrator shall have Client named as an additional insured on Administrator's general liability and automobile liability insurance policies.

6.3 **Limitation of Liability.** The parties' liability to each other under this agreement will not exceed the actual damages caused by breach of this agreement. The parties will have no liability under this agreement for any loss of profit or revenue or for any consequential, indirect, incidental, special or punitive damages, even if they are aware of the possibility of the loss or damages.

7. GENERAL TERMS

7.1 **Notices.** All notices, requests, consents, demands or other communications under this agreement will be in writing and deemed to have been duly given either (a) when delivered, if delivered by hand, sent by United States registered or certified mail (return receipt requested), delivered personally by commercial courier or (b) on the second following business day, if sent by United States Express Mail or a nationally recognized commercial overnight courier; and in each case to the parties at the following addresses (or at other addresses as specified by a notice) with applicable postage or delivery charges prepaid.

If to Administrator:

OptumRx, Inc.
2300 Main Street
Irvine, California 92614
Attn: Vice President, Client Management

Copy to:

OptumRx, Inc.
2300 Main Street
Irvine, California 92614
Attn: General Counsel

If to Client:

City of Cincinnati
Risk Management

805 Central Avenue
Cincinnati, OH 45202
Attn: Risk Manager

7.2 **Amendment**. Except as otherwise provided in this section or elsewhere in this agreement, this agreement may be modified, changed or amended only by a dated written instrument executed by the parties. If, despite section 1.4, any Governmental Authority or Laws and Regulations require that this agreement be amended, including to incorporate specific required terms, Administrator may amend this agreement to comply with this requirement by providing 30-days prior notice to Client. This amendment will become effective at the end of the 30-day notice period or a shorter period if necessary to comply with the requirement, unless Client can demonstrate conclusively in writing that the amendment is not necessary to comply with the Governmental Authority or Laws and Regulations.

7.3 **Waiver; Severability**. The failure of any party to insist in any one or more instances upon performance of any term of this agreement will not be construed as a waiver of future performance of the term, and the party's obligations for the term will continue in full force and effect. The provisions of this agreement are severable. The invalidity or unenforceability of any term or provision in any jurisdiction will be construed and enforced as if it has been narrowly drawn so as not to be invalid, illegal or unenforceable to the extent possible and will in no way affect the validity or enforceability of any other terms or provisions in that jurisdiction or of this entire agreement in that jurisdiction.

7.4 **Assignment**. A party may not assign, delegate or transfer this agreement without the prior written consent of the other party, except that Administrator may assign this agreement to any Affiliate upon 30-day notice to Client, so long as Administrator remains obligated under this agreement. This agreement will bind the parties and their respective successors and assigns and will inure to the benefit of the parties and their respective permitted successors and assigns.

7.5 **Governing Law**. This agreement and each party's rights and obligations under it will be governed by and construed in accordance with the laws of Ohio, without giving effect to conflicts of law principles.

7.6 **Certification as to Non-Debarment.** Administrator certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in the transaction covered by this Agreement. Administrator acknowledges and agrees that if it or its principals is/are presently debarred then it will promptly return to Client any funds received pursuant to this Agreement. In such event, any materials received by Client pursuant to this agreement will be retained as liquidated damages.

7.7 **Force Majeure**. If any party is prevented from performing or cannot perform any of its obligations under this agreement because of any cause beyond the reasonable control of and not the fault of the party invoking this section, including any act of God, fire, casualty, flood, earthquake, war, strike, lockout, epidemic, destruction of production facilities, riot, insurrection or material unavailability, and if the non-performing party has been unable to avoid or overcome its effects through the exercise of commercially reasonable efforts, this party will give prompt notice to the other party, its performance will be excused, and the time for its performance will be extended for the period of delay or inability to perform due to such occurrences, except that if performance is extended under this section for more than 60 days, then at any time before reinstatement of the performance, the other party may terminate this agreement upon notice to the non-performing party. Administrator will maintain commercially reasonable business continuity and disaster recovery plans.

7.8 **Relationship of the Parties; Third Party Beneficiaries**. The sole relationship between the parties is that of independent contractors. This agreement will not create a joint venture,

partnership, agency, employment or other relationship between the parties. Nothing in this agreement will be construed to create any rights or obligations except among the parties; no person or entity will be regarded as a third party beneficiary of this agreement.

7.9 **Taxes.** Member, and not Administrator, will be responsible for any transfer, consumption, sales, use or other tax levied on the transfer of items dispensed or on any of the Services if assessed or required by local, city, state or other government authority.

7.10 **Survival.** Any term of this agreement that contemplates performance after termination of this agreement will survive expiration or termination and continue until fully satisfied, including section 5, which will survive so long as the information is Confidential Information or the data is proprietary to either party or its successors, successors-in-interest or assigns, and section 6, which will survive indefinitely.

7.11 **Dispute Resolution.** If a dispute occurs between the parties, the complaining party may request a meeting by executive officers of each party who will attempt to resolve the dispute in good faith before beginning a legal action, except for matters subject to injunctive relief. If the parties' executive officers do not resolve the dispute within 45 days after the notice, each party will retain all rights to bring an action regarding such matter in accordance with law.

7.12 **Integrated Agreement; Interpretation; Execution.** This agreement constitutes the final entire agreement between the parties regarding its subject matter and supersedes all prior or contemporaneous written or oral agreements, representations, negotiations or understandings between the parties regarding its subject matter. The language in this agreement will be construed in accordance with its fair meaning, as if prepared by all parties and not strictly for or against any party. The legal doctrine of construction of ambiguities against the drafting party will not be employed in any interpretation of this agreement. Whenever approval of any party is required under this agreement, the approval will not be unreasonably withheld or delayed. For all terms in this agreement, unless otherwise specified: (a) a term has the meaning assigned to it in the Schedule of Definitions attached as **Exhibit A** or elsewhere in this agreement; (b) "or" is not exclusive; (c) "including" means including without limitation; (d) "party" and "parties" refer only to a named party to this agreement; and (e) any reference to an agreement, instrument or statute means that agreement, instrument or statute as from time-to-time amended, modified or supplemented and any applicable corresponding provisions of successor statutes or regulations. The headings in this agreement are provided for convenience only and do not affect its meaning. An electronic signature of this agreement, or a signature on a copy of this agreement that a party receives by facsimile, email or other means, is binding as an original, and the parties will treat an electronic or photo copy of this signed agreement as an original. The parties may sign this agreement in two or more counterparts, and as so signed this agreement will constitute one and the same agreement binding on the parties.

[signature page follows]

The parties' duly authorized representatives are signing this Prescription Drug Benefit Administration Agreement as of the Effective Date.

CITY OF CINCINNATI

By: _____

Name: David L. Holmes

Title: Asst Cm

OPTUMRx, INC.

By: _____

Name: Wayne Miller

Title: SVP, Client Services

RECOMMENDED BY:

_____
Karen Alder, Risk Manager

APPROVED FOR COMPLIANCE

_____
Contract Compliance Officer

APPROVED AS TO FORM

_____
Assistant City Solicitor

CERTIFICATION OF FUNDS

Date: DEC 31 2013

Funding: 711x135x3511/3521x7432

Amount: $2,064,000.00

_____
Reginald Zeno, Finance Director

Exhibits:

Exhibit A, Schedule of Definitions
Exhibit B, Services
Exhibit C, Compensation
Exhibit D, Business Associate Addendum
Exhibit E, Performance Guarantees

EXHIBIT A

SCHEDULE OF DEFINITIONS

Capitalized terms used in this agreement are defined below or elsewhere in this agreement.

"Administrator Data" means: (a) all data and information Administrator submits or transmits to Client regarding Administrator or its formulary advisory committee, Administrator's formularies, Network Pharmacies or Pharmacy Network; (b) all data, records and information generated in Administrator's business or operations; (c) all information pertaining to any programs, services or products Administrator or any of its clients market or offer; (d) all Administrator Content, Marks and Intellectual Property, together with all derivative works of the Administrator Content, Marks and Intellectual Property; (e) Administrator's software and any tangible or readable embodiments of such software, (f) Member specific information received or generated by Administrator's Mail Order or Specialty Pharmacies in connection with dispensing Prescription Drugs; and (g) for any matters referenced in the foregoing clauses (a) through (f), data, records or information occurring in any form, including written, graphic, electronic, visual or fixed in any tangible medium of expression and whether developed, generated, stored, possessed or used by Administrator, Client or a third party. Administrator Data does not include any claims data or data or information that relates exclusively to Client or its business, operations or activities or to another Client customer or contractor or the customer's or contractor's business, operations or activities.

"Affiliate" means for any person or entity, any other person or entity that directly or indirectly controls, is controlled by or is under common control with this person or entity.

"AWP" means the average wholesale price of a Prescription Drug or other pharmaceutical products or supplies based on the Pricing Source. For Prescription Drugs or other pharmaceutical products or supplies not dispensed by Administrator's Mail Order Pharmacy or Specialty Pharmacy, AWP is based on the NDC of the drug dispensed. For Prescription Drugs or other pharmaceutical products or supplies dispensed by Administrator's Mail Order Pharmacy or Specialty Pharmacy, AWP is based on a package size of 100 units for pills, capsules and tablets and 16 ounce quantities for liquids (or the next closest package size if these quantities or sizes are not available) or the manufacturer's individual pre-packaged item (*e.g.*, tube, drop dispenser, etc.). Administrator will rely on the Pricing Source as updated by Administrator no less frequently than every seven days to determine AWP for purposes of establishing the pricing provided to Client under this agreement. Administrator will not establish AWP, and Administrator will have no liability to Client arising from use of the Pricing Source. If Administrator decides to use a pricing benchmark other than AWP or is required to do so because the Pricing Source discontinues publication of AWP and the change would materially affect Client's economic benefit under this agreement, then Administrator will provide Client with proposed modified pricing terms at least 60 days before the effective date of the change. If the parties fail to agree upon the modified pricing terms before the effective date of the modified pricing terms, then Administrator's proposed modified pricing terms will apply until the parties otherwise agree. If the parties are unable to agree to modified pricing terms, then either party may terminate this agreement upon 60 days prior notice to the other party.

"Benefit Plan" means the certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which Client is obligated to provide Covered Prescription Services. Benefit Plan coverage includes any deductible or co-insurance provided for under the coverage.

"Brand Drug" means a Prescription Drug, pharmaceutical product or supply designated as "M," "N" or "O" in Medi-Span's Generic Product Indicator.

"Client Data" means (a) all data and information Client submits or transmits to Administrator, including information about Benefit Plans, Pharmacy Plan Specifications, Members, and Client's other programs, services, products and plans; (b) any data and information submitted or transmitted to Administrator by a Governmental Authority or a third party about Client or Benefit Plans; (c) data, records

and information Administrator generates that relates directly to Administrator performing Services for Client under this agreement, exclusive of information or documentation Administrator generates for use in Administrator's business generally or for use with multiple clients; (d) all Client Content, Marks and Intellectual Property, together with all derivative works of the Client Content, Marks and Intellectual Property; (e) data, records and information Administrator generates about Client's business or operations; and (f) for any matters referenced in the foregoing clauses (a) through (f), data, records or information occurring in any form, including written, graphic, electronic, visual or fixed in any tangible medium of expression and whether developed, generated, stored, possessed or used by Client, Administrator or a third party. Client Data will not include data or information that is generated in or relates exclusively to: (a) Administrator or its business, operations or activities; (b) another Administrator client or contractor or the client's or contractor's business, operations or activities; (c) Administrator's or its personnel or contractor's use other than in performing this agreement; or (d) data or information disclosed, sold, assigned, leased or otherwise provided to third parties in a form that the Client Data has been aggregated with other client's data and cannot be distinguished as Client Data.

"Compound Prescription Drug" means a Prescription Drug that is prepared by a pharmacist who mixes or adjusts one or more Prescription Drugs to customize a medication to meet a Member's individual medical needs. Client's payment to Administrator for providing a Compound Prescription Drug to a Member will include the Network Pharmacy contracted rate for each Prescription Drug included in the medication and one contracted dispensing fee minus any Cost-Sharing amount.

"Content" means any text, graphics, photographs, video, audio or other data or information, including any advertisements used by the applicable party, or in the case of Client by it or its vendors, in its business, operations or in connection with the offering of its products, services, programs or plans.

"Cost-Sharing Amount" means the coinsurance, copay or other cost sharing amount that a pharmacy may collect from a Member for Covered Prescription Services in accordance with the Member's Benefit Plan.

"Covered Prescription Services" means 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 Benefit Plan.

"Drug Manufacturer" means a person or entity that manufactures, sells, markets or distributes Prescription Drugs.

"FDA" means the United States Food and Drug Administration or any successor Governmental Authority.

"Formulary" means the list of Prescription Drugs covered by the applicable Benefit Plan as developed by Administrator and approved and adopted by Client for use with the Benefit Plans. The Formulary will be made available to physicians, pharmacies and other healthcare persons or entities to guide the prescribing, dispensing, sale and coverage of Covered Prescription Services.

"Generic Drug" means a Prescription Drug, pharmaceutical product or supply designated as "Y" in Medi-Span's Generic Product Indicator.

"Governmental Authority" means the Federal government, any state, county, municipal or local government or any governmental department, political subdivision, agency, bureau, commission, authority, body or instrumentality or court that regulates the party's activities or operations.

"Intellectual Property" means any patent, invention, discovery, know-how, technology, software, copyright, authorship, trade secret, trademark, trade dress, service mark, confidentiality, proprietary, privacy, intellectual property or similar rights (including rights in applications, registrations, filings and renewals) that are now or hereafter protected or legally enforceable under state or Federal common laws or statutory laws or under laws of foreign jurisdictions.

"Laws and Regulations" means all common law and any and all state, Federal or local statutes, ordinances, codes, rules, regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any Governmental Authority, including the Financial Modernization Act of 1999, also known as the Gramm-Leach-Bliley Act, and the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as well as any of the preceding Laws and Regulations that from time-to-time may be amended, modified, revised or replaced, interpreted or enforced by any Governmental Authority.

"MAC" means the maximum allowable cost of a Generic Drug as specified on a list established by Administrator. Administrator may have multiple MAC lists, each of which is subject to Administrator's periodic review and modification. The MAC used at Mail Order Pharmacy will perform in the aggregate better than or equal to the MAC used at retail pharmacy.

"Mail Order Pharmacy" means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Members. Mail Order Pharmacy includes pharmacies that Administrator owns or operates.

"Marks" means the names, logos and other proprietary symbols and phrases belonging to a person or entity.

"Member" means an eligible individual legitimately enrolled in a Benefit Plan.

"NCPDP" means that National Counsel for Prescription Drug Programs.

"NDC" means the National Drug Code that is the identifying Prescription Drug number maintained by the FDA.

"Network Pharmacy" means a retail pharmacy, Mail Order Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs to individuals, including Members, and has entered into a Network Pharmacy Agreement. Administrator in its capacity as a Mail Order Pharmacy or Specialty Pharmacy is a Network Pharmacy of Client.

"Network Pharmacy Agreement" means a Prescription Drug Services Agreement between a Network Pharmacy and Administrator or Client to provide Covered Prescription Services.

"Paid Claim" means a Prescription Drug claim that is approved for payment during Administrator's semi-monthly billing cycle or is a reversal during this semi-monthly billing cycle of a Prescription Drug Claim that was approved for payment during a prior semi-monthly billing cycle. A rejected or denied claim or a claim approved for payment and reversed during the same semi-monthly billing cycle is not a Paid Claim.

"Pharmacy Plan Specifications" means the written Benefit Plan descriptions, Member information and instructions Administrator needs to carry out its obligations under this agreement, including Member eligibility and identification requirements, benefit definitions, Formulary, Pharmacy Network, utilization management programs, applicable Cost-Sharing Amounts, number of days' supply for acute and maintenance medications, dispensing and other limitations, manuals and other Benefit Plan or Member information. All Pharmacy Plan Specifications will be either provided by Client or prepared by Administrator and approved by Client.

"PHI" means Protected Health Information, as defined in 45 C.F.R. § 160.103.

"Prescription Claim" means a single request for payment for, or a bill or invoice relating to, a Covered Prescription Service that a Network Pharmacy, other health care provider or Member submits, whether the request, bill or invoice is paid or denied.

"Prescription Drug" means a Generic Drug or Brand Drug that is approved by the FDA and required under applicable Laws and Regulations to be dispensed only as authorized by a written or oral order to dispense a Prescription Drug by an appropriately licensed and qualified health care professional in accordance with applicable Laws and Regulations.

"Prescription Drug Compensation" means the applicable reimbursement, remuneration, compensation or other payment paid by Client to Administrator for the provision of Covered Prescription Services to a Member as described in **Exhibit C.**

"Pricing Source" means the Medi-Span Prescription Pricing Guide (with supplements) or another nationally recognized pricing source determined by Administrator.

"Rebate" means any discount, price concession or other direct or indirect remuneration Administrator receives from a Drug Manufacturer under a Rebate Agreement that is contingent upon and related directly to Member use of a Prescription Drug during the Term. Rebate does not include any discount, price concession or other direct or indirect remuneration Administrator receives from a Drug Manufacturer for direct purchase of a Prescription Drug or any amounts a Drug Manufacturer pays Administrator for providing any products or services, including fees for managing and administering Administrator's rebate program.

"Rebate Agreement" means an agreement, other than a purchase agreement, by Administrator and a Drug Manufacturer for price concessions, direct or indirect remunerations or reimbursements based on projected or actual use of the Drug Manufacturer's Prescription Drugs by members of prescription drug benefit plans that are Administrator clients, including Client. Drug Manufacturer purchase agreements that include volume discounts or rebates resulting from Prescription Drug purchases, rather than member use, will not be Rebate Agreements.

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

"Specialty Pharmacy" means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Specialty Drugs to individuals, including Members. Specialty Pharmacy includes pharmacies that Administrator owns or operates.

"Usual and Customary Charge" means the price, including all applicable customer discounts, such as special customer, senior citizen and frequent shopper discounts, that a cash paying customer pays a pharmacy for Prescription Drugs.

"WAC" means the wholesale acquisition cost of medication drugs or ancillary supplies, as applicable, as dispensed and set forth in the Pricing Source.

"Zero Balance Due Claims" means claims for which Client will not be billed an amount by Administrator. Member is responsible for the full cost of these claims as required in the applicable pharmacy benefit coverage criteria.

EXHIBIT B

SERVICES

1. CORE PRESCRIPTION DRUG BENEFIT SERVICES

1.1 Administrative Support

1.1.1 General. Administrator will provide administrative, management, consultative, claims processing and other general pharmacy benefit management support services to Client in conjunction with administration and operation of the Benefit Plans as set forth in this exhibit. Administrator will administer and support the Benefit Plans in accordance with the most current Pharmacy Plan Specifications that Client has provided to Administrator as required by this agreement.

1.1.2 Reporting. Administrator will provide Client with Administrator's standard reporting package and reports.

1.1.3 Benefit Plan Responsibility. Although Administrator will perform Services under this agreement to support the Benefit Plans, Client retains complete and exclusive discretionary authority over the Benefit Plans and is responsible ultimately for administering, managing and operating the Benefit Plans, including establishing and amending the Formulary, controlling or directing appeals conducted by an independent outside party or independent review organization ("***IRO***") and determining, interpreting and amending all Benefit Plan structures and terms. Except as the parties specifically agree in writing and despite any contrary provisions in this agreement, (a) neither Administrator nor its Affiliates is acting on behalf of any employee welfare benefit plan (as defined in 29 U.S.C. § 1002(1)) or participants or beneficiaries in any such plan, or on behalf of a fiduciary (as defined in 29 U.S.C. § 1002(21)(A)) of any such plan; (b) Client will not name or deem Administrator as a fiduciary for any purpose; (c) Administrator's role in all respects will be limited to that of a provider of "ministerial functions" (as described in 29 C.F.R. § 2509.75-8, D-2) and will be performed within the framework of policies and interpretations established by Client, such that the Services Administrator performs under this agreement will not include the power to exercise discretionary authority over any Benefit Plan's management or operations or plan assets (if any); (d) Client has selected and is solely responsible for each Benefit Plan's benefits and design; and (e) Client retains all discretionary authority for each Benefit Plan, Benefit Plan assets (if any) and administration of each Benefit Plan.

1.1.4 Benefit Plan Eligibility Data. Client will provide Administrator with electronic eligibility data in NCPDP format, or another format agreed to by the parties, for all Members who are entitled to Covered Prescription Services under the Benefit Plans. Administrator will load correctly formatted Member eligibility data no later than three business days after receipt from Client. Administrator will be entitled to rely on the accuracy and completeness of the Member eligibility data. Client will be solely responsible for any errors in Member eligibility data that Client furnishes to Administrator.

1.1.5 Member Notification. Client will apprise Members of the type, scope, restrictions, limitations and duration of Covered Prescription Services to which Members are entitled under an applicable Benefit Plan.

1.1.6 Pharmacy Plan Specifications. Client will provide Administrator with the technical assistance and information Administrator reasonably needs to perform the Services, including information regarding Members, Benefit Plans and Pharmacy Plan Specifications. Client will provide Administrator with the Pharmacy Plan Specifications no later than 45 days before the Effective Date. Client may amend or terminate the Pharmacy

Plan Specifications upon 45 days prior notice to Administrator, unless a Governmental Authority requires that the amendment or termination occur in a shorter time period. Any Client-initiated change to the Pharmacy Plan Specifications, including the Benefit Plan, Formulary, Pharmacy Network or a utilization management program, that impacts Administrator's compensation, cost to provide services or ability to satisfy a guarantee under this Agreement will be a Service Change and Administrator may adjust the rates, fees or guarantees in **Exhibit C,** effective the date of the change, in accordance with section 1.3 of the agreement. Client's failure to provide Pharmacy Plan Specifications within the time periods stated in this section may delay Administrator's implementation of the Services and any applicable performance guarantees. Client is responsible for the accuracy, completeness and timeliness of all Pharmacy Plan Specifications provided to Administrator and acknowledges Administrator's reasonable reliance on the Pharmacy Plan Specifications.

1.2 **Pharmacy Network Administration**

1.2.1 Pharmacy Network. Administrator will establish and maintain a network of pharmacies to provide the Services to Client ("***Pharmacy Network***"). Upon request, Administrator will make available to Client a current list of Network Pharmacies in the Pharmacy Network. Administrator may add or remove Network Pharmacies from the Pharmacy Network. Administrator shall make every effort to maintain its Pharmacy Network so that it is substantially the same in terms of number and locations of Network Pharmacies as were in the Pharmacy Network as of the effective date of this Agreement, excluding changes based on pharmacy closures, pharmacy self-terminations, and pharmacies removed for contract violations,. Administrator will notify Client if any pharmacy chain with 4,000 or more stores leaves or is removed from the Pharmacy Network. Client shall have the right to terminate this agreement if, in Client's determination, Administrator's Pharmacy Network is significantly altered during the term of this agreement, by following the provision in Section 2.2.1 of this Agreement.

1.2.2 Network Pharmacy Credentialing. Administrator will establish and maintain a reasonable process for credentialing Network Pharmacies that includes verifying the good standing of the license of the pharmacy, adopting policies and procedures required by applicable Laws and Regulations. Administrator will use best efforts to contractually require each Network Pharmacy and their pharmacists dispensing Covered Prescription Services to Members to be duly licensed in accordance with all applicable Laws and Regulations in the state or other jurisdictions in which the Network Pharmacy furnishes Covered Prescription Services.

1.2.3 Network Pharmacy Agreements. Administrator has entered into Network Pharmacy Agreements to secure Network Pharmacies for the Pharmacy Network. Administrator will use best efforts to contractually require each Network Pharmacy (a) to comply with all applicable Laws and Regulations and (b) to collect from Members for the provision of Covered Prescription Services a charge that is the lesser of the Cost-Sharing Amount, Usual and Customary Charge or Prescription Drug Compensation, as applicable. The amount Administrator pays to Network Pharmacies for providing Covered Prescription Services to Members shall be the same amount Client pays Administrator for these services under this agreement

1.2.4 Customer Service. Administrator will maintain one or more call centers to provide customer service assistance for Members in connection with Administrator's Mail Order Pharmacy and Network Pharmacies.

1.2.5 Desk and On-Site Audits. Administrator will, as required by applicable Laws and Regulations and at its own expense, conduct real-time and retrospective desk audits and selected on-site audits of the Network Pharmacies to determine whether the Network

Pharmacies are submitting appropriate billings for payment by Client or Members. Administrator will report the results of the audits to Client. Administrator will pay Client, or apply as a credit to invoices payable by Client to Administrator, the amounts Administrator recovers from these audits. Client will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Client that are not required by applicable Laws and Regulations.

1.3 **Claims Process**

1.3.1 Claims Adjudication. Administrator, directly or through a third party claims processor with which Administrator may contract, will adjudicate, process or pay Prescription Claims for Covered Prescription Services by application of the Benefit Plan rules determining eligibility for Covered Prescription Services. Administrator will pay, on Client's behalf, only Clean Claims (a) submitted by the Network Pharmacies in a timely manner through Administrator's point-of-service system in accordance with NCPDP guidelines and the Pharmacy Plan Specifications and (b) properly submitted by Members as requests for reimbursement for Covered Prescription Services. For each Clean Claim submitted by a Network Pharmacy, Administrator will reimburse the Network Pharmacy the amount specified in the Network Pharmacy Agreement for the dispensed Prescription Drug less any Cost-Sharing Amounts. "***Clean Claim***" means a Prescription Claim prepared in accordance with the NCPDP-promulgated standard format that contains all information necessary for processing for a Prescription Claim and submitted for payment no later than 30 days after the date of service, or a longer period of time if required by applicable Laws and Regulations. Administrator will reimburse Network Pharmacies for each Clean Claim no later than 30 days after Administrator's receipt of the Clean Claim, or a lesser period of time if required in the Network Pharmacy Agreement. Administrator will deny Prescription Claims that are not Clean Claims at point-of-service no later than 60 days after request for payment, or a lesser time period if required in the Network Pharmacy Agreement. Administrator will use reasonable efforts to advise the Network Pharmacy of the basis that a Prescription Claim is ineligible for payment and specify any additional information required for Administrator to pay the Prescription Claim. Administrator will not be financially responsible for paying claims submitted by Network Pharmacies, except that Administrator will be financially responsible for claim liabilities to the extent they arise from Administrator error.

1.3.2 Delays. Administrator will not be responsible for any loss, omission or delay of any Prescription Claim by a Network Pharmacy (other than Administrator's Mail Order Pharmacy or Specialty Pharmacy) or other health care professional.

1.3.3 Administrative Grievances and Appeals. At Client's request, and subject to section 1.1.3, Administrator will process initial Benefit Plan coverage determinations and exception requests and support Client in connection with Benefit Plan appeals and grievances in accordance with Pharmacy Plan Specifications and this section 1.3 and to the extent required by applicable Laws and Regulations.

1.3.4 Prior Authorization Appeals

1.3.4.1. *Internal Appeals*. Administrator will not conduct Member appeals of prior authorization denials. For a fee, Administrator will facilitate Member appeals of prior authorization denials with an IRO to perform internal appeals. Client will accept and abide by the IRO's process and appeal decisions. After receipt of the IRO's appeal decision, Administrator will remit the appeal decision to the Member on Client's behalf.

1.3.4.2. *External Appeals*. For all external appeals, Client will contract directly with an independent outside party or, where permitted by Laws and Regulations, if Client

requests and at an additional cost to Client, Administrator will coordinate Client's appeals to an IRO for external review. Administrator contracts with three IROs to perform external appeals for non-insurance clients. The parties will agree upon additional fees for the Client or IRO for external appeals. Client will provide Administrator appropriate and necessary plan documentation needed for the IRO to review the adverse benefit determination (within the meaning of 29 C.F.R. § 2560.503-1(m)(4)).

1.4 **Benefits Administration and Support**

1.4.1 Utilization Management Program

1.4.1.1. *Development and Support*. Administrator will implement its standard utilization management policies, procedures, guidelines and programs for the Benefit Plans to promote cost-effective drug utilization management and to discourage Prescription Drug over and under-utilization. Administrator may, on behalf of Client, (a) communicate with Members to describe health-related products or services (or payment for the products or services) provided by or included in the Plan through the Services, including communications about Network Pharmacies, replacement or enhancement to the Plan, and health-related products or services available only to Members that add value to and are not part of the Plan; (b) conduct population-based activities relating to improving the health of Members and reducing their healthcare costs; and (c) contact Members with health education information and information about Prescription Drugs, treatment alternatives, and related functions. Upon Client's request and at an additional charge to Client, Administrator, in consultation with Client, will develop non-standard utilization management policies, procedures, guidelines or programs for the Benefit Plans. Upon Client's request, Administrator will communicate Client's utilization program requirements to Members through Client-approved information and outreach materials. Although Administrator will recommend utilization management standards and programs that it believes may be appropriate for the Benefit Plans, Client retains complete and exclusive discretionary authority over its utilization management standards and programs and is responsible ultimately for these standards and programs.

1.4.1.2. *Administrator's Prior Authorization Services*. Administrator will respond to properly submitted prior authorization requests from providers, Members or pharmacies using utilization management standards and guidelines established in accordance with section 1.4.1.1 of this exhibit. Client retains complete and exclusive discretionary authority over approval of prior authorization requests, including Benefit Plan overrides; however, to the extent that Client overrides impact Administrator's compensation, cost to provide Services, or ability to satisfy a guarantee under this agreement, this will be a Service Change and Administrator may adjust the rates, fees or guarantees in **Exhibit C** in accordance with section 1.3 of the agreement.

1.4.2 Client Prior Authorization and Overrides. If Client chooses to perform prior authorizations or benefit overrides, then Administrator will provide Client access to the information in Administrator's computer systems that Client needs to perform these functions.

1.4.3 Quality Assurance Program. Administrator will establish a quality assurance program for the Benefit Plans that includes quality measures and reporting systems targeted at reducing medical errors and adverse drug interactions. Administrator will assist in implementing Client's quality assurance and patient safety programs. Administrator will perform activities to support Client's quality assurance requirements under applicable Laws and Regulations. In addition, Administrator will develop and implement systems or

require Network Pharmacies to implement systems to: (a) offer Member counseling, when appropriate; (b) identify and reduce internal medication errors; and (c) maintain up-to-date Member quality assurance and patient safety program information. Upon Client's request, Administrator will communicate Client's quality assurance standards and programs to Governmental Authorities in the manner prescribed by applicable Laws and Regulations.

1.4.4 Targeted Disease Intervention Program. Upon Client's request and for an additional charge to Client, Administrator will help Client develop and operate a targeted disease intervention program for the Benefit Plans that is designed to promote appropriate use of medications and improve therapeutic outcomes for targeted Members. Administrator, on Client's behalf, will coordinate and implement the targeted disease intervention program. Also, upon Client's request and at an additional cost to Client, Administrator will communicate with Members about the targeted disease intervention program through Client-approved information and outreach materials. Notwithstanding anything in this Section 1.4.4, Administrator will not charge Client for any services provided to Client or Members related to Members' participation in Client's diabetic and hypertension coaching program.

1.4.5 Other Clinical Services. Upon Client's request and for an additional charge to Client, Administrator will help Client develop and implement additional quality initiatives, intervention programs or other clinical services.

1.5 **Formulary**

1.5.1 Formulary Adoption. Client will adopt as the Formulary one or more of Administrator's formularies that are developed and maintained by Administrator's formulary advisory committee, as described in section 1.5.4 of this exhibit.

1.5.2 Formulary Management. Administrator will provide Client copies of the Formulary to distribute to plan providers and other appropriate parties semi-annually. Except as provided in this agreement, Client will not copy, distribute, sell or otherwise provide Administrator's formularies, including the Formulary, to another party without Administrator's prior written approval.

1.5.3 Formulary Changes. Administrator will include in the Formulary new FDA-approved medications as required by the Pharmacy Plan Specifications according to the following schedule: (a) if an open formulary, per the Pharmacy Plan Specifications, all new covered FDA-approved medications (formulary and non-formulary) will be included in the Formulary upon publication in the Medi-Span pricing index and loading into Administrator's systems or (b) if a closed formulary, per the Pharmacy Plan Specifications, all new covered FDA-approved medications (formulary only) will be included in the Formulary after review and addition to the Formulary by Administrator's formulary advisory committee. Following changes to the Formulary, Administrator, at Client's request, will provide or make available appropriate notifications of Formulary changes to Client, Members, prescribing physicians, Network Pharmacies and state pharmaceutical assistance programs as required by applicable Laws and Regulations and agreed to by the parties. If Client makes any change to its Formulary, not initiated by Administrator, or Benefit Plan, or adopts any formulary or utilization management program other than one of the options offered by Administrator under its formulary or utilization management programs, Administrator may adjust the rates, fees or guarantees in **Exhibit C**, effective the date of the change.

1.5.4 Formulary Advisory Committee. Administrator's formulary advisory committee will develop and maintain Administrator's formularies by: (a) selecting Prescription Drugs to include in Administrator's formularies based upon objective evaluation of the therapeutic merits, safety and cost of the Prescription Drug; (b) periodically revisiting Administrator's

formularies, evaluating new and therapeutically equivalent Prescription Drugs for inclusion in the formularies; (c) establishing programs and procedures to address cost-effective drug therapy; (d) reviewing requests to include non-formulary Prescription Drugs in Administrator's formularies; (e) implementing client educational programs; (f) advising Administrator on other matters about the use of Prescription Drugs; (g) overseeing client drug utilization review programs or quality assurance programs or auditing and reviewing the programs' results; and (h) reviewing adverse drug reactions and making recommendations to minimize their occurrence. Administrator's formulary advisory committee's functions, deliberations and results, including development and maintenance of Administrator's formulary, constitute opinions only of Administrator's formulary advisory committee and will not bind Administrator.

1.5.5 No Endorsement. Administrator's development and maintenance of its formularies will not be construed as an endorsement of any prescription drug product or drug manufacturer. Administrator will not be responsible for any actions or omissions of its formulary advisory committee or any adverse consequences that may relate, directly or indirectly, to Client's or a Member's reliance on Administrator's formulary advisory committee.

1.6 **Rebate Management**

1.6.1 Rebate Eligibility. Client will have a claim against Administrator for a Rebate if: (a) Exhibit C specifies that Client will be eligible for Rebates; (b) Client satisfies the minimum Rebate contract criteria and has included the Drug Manufacturer's Prescription Drug on its Formulary; and (c) Administrator has received Rebates resulting directly from Client's satisfaction of the foregoing clause (b). Administrator, in its sole and absolute discretion, may enter into Rebate Agreements with Drug Manufacturers that have Prescription Drugs on Administrator's or its clients' formulary. Many factors affect the amount of Rebates, including benefit design, arrangements with Drug Manufacturers, volume of Prescription Claims, formulary structure and Administrator's overall business strategy. Claims that will not be submitted to Drug Manufacturers for Rebates include Prescription Claims: (a) with invalid service provider identification or prescription numbers; (b) where, after meeting the deductible, the Member's Cost-Sharing Amount under the applicable Benefit Plan requires the Member to pay more than 50% of the Prescription Claim; (c) that are manufacturer negotiated fee products not listed on Client's Formulary for devices without a Prescription Drug component; (d) that are re-packaged NDCs; (e) from 340B pharmacies or other entities eligible for federal supply schedule prices (e.g., Department of Veterans Affairs, U.S. Public Health Service, Department of Defense); or (f) that are not for Prescription Drugs (except for insulin or diabetic supplies).

1.6.2 Rebate Guarantees. Except for any Rebate guarantees described in **Exhibit C**, Administrator has no obligation to obtain any particular amount of Rebates for Client. Rebate guarantees are subject to Client's eligibility for Rebates and the Rebate guarantee contingencies described in this section 1.6 and **Exhibit C**.

1.6.3 Collection. Administrator will use commercially reasonable efforts to collect Rebates. Administrator will not be responsible for any non-payments or partial payments by Drug Manufacturers of amounts owing under a Rebate Agreement. Adjustments to Rebates or Rebate guarantees may result from patent expirations or Client changes to Formulary or Benefit Plan design effective the date the expiration or change occurs. To the extent of any overpayment or erroneous payment to Client by Administrator, Client will refund immediately the payment or Administrator may recoup the payment from other sums due Client in accordance with section 3.5 of this agreement. Administrator may dispute any overpayment or erroneous payment to Client no later than 180 days after the payment date, except for Rebate repayments resulting from Drug Manufacturer audits.

1.6.4 Disbursement. Provided there is no payment default under section 2.2.2 of this agreement, Administrator will disburse, apply and allocate all applicable estimated or actual amounts earned on account of Rebates received by Administrator from Drug Manufacturers based upon the provisions set forth in this exhibit. Administrator will pay Client all Rebates within 90 days after the close of each calendar quarter based on cash received and applied during the quarter. Administrator shall reconcile within 180 days after each calendar year. Administrator will pay Client all Rebates collected within 24 months after termination of this agreement.

1.7 **Client Incentives and Purchase Discounts.** If Client, or its Affiliate or agents, contracts with another party, including a Drug Manufacturer, for a discount, utilization limit, rebate or other incentive associated with the utilization of a Prescription Drug, Client will be in material breach of this agreement, and Administrator, in addition to any other remedies available to it under this agreement, may determine in its sole discretion that Client will not be eligible for any applicable Rebates or ASP Guarantees (as defined in **Exhibit C**) under this agreement and adjust or eliminate any guarantees, including Rebate guarantees or ASP Guarantees, described in **Exhibit C**. Client will accept only amounts due under this agreement on account of eligible and legitimate Members. Upon request, Client will cooperate fully with Administrator or a Drug Manufacturer to verify Client's participation in any Rebate program and that all Rebate-related payments were made solely for Covered Prescription Services to eligible and legitimate Members. Administrator, in its capacity as a Mail Order Pharmacy or a Specialty Pharmacy, purchases Prescription Drugs from Drug Manufacturers and receives certain discounts and purchase rebates from Drug Manufacturers in connection with these purchases. Administrator retains these discounts and purchase rebates and does not pass them on to Client.

1.8 **E-Prescribing.** Upon Client's request and at an additional charge to Client, Administrator will provide prescribers with electronic access to Member Benefit Plan information, including: (a) Member eligibility status: (b) Member medication history; (c) Formulary status of the Prescription Drug being prescribed; (d) listing of Generic Drug or Brand Name Formulary alternative medications; (e) Member coverage information where applicable; (f) applicable Cost-Sharing Amount; and (g) drug classification information required by the Centers for Medicare & Medicaid Services or successor Governmental Authority.

2. MAIL ORDER PHARMACY SERVICES

2.1 **Mail Order Services.** Administrator, in its capacity as a Mail Order Pharmacy, will provide Client with Mail Order Pharmacy Covered Prescription Services to Members in accordance with the Pharmacy Plan Specifications for the Prescription Drug Compensation established in **Exhibit C**. Once a prescription for a Covered Prescription Service has been transmitted to Administrator, in its capacity as Mail Order Pharmacy, Administrator will promptly prepare, package and ship the applicable Covered Prescription Service to the Member or other authorized person or entity. Administrator will provide customer service support for Members who use Mail Order Pharmacy Services. Upon request, Administrator will make available to Client mail service brochures for distribution to Members.

2.2 **Standards and Professional Judgment.** Administrator's Mail Order Pharmacies will be duly licensed under applicable Laws and Regulations of the state of the pharmacies' geographic locations and any other jurisdiction as necessary to furnish Covered Prescription Services to Members. Administrator will comply with all Laws and Regulations promulgated by the Board of Pharmacies that apply to the Administrator Mail Order Pharmacies. Administrator will notify promptly Client if the required licensure of Administrator's Mail Order Pharmacies is lost, suspended, limited or conditioned. Duly licensed personnel will provide all Covered Prescription Services at the Mail Order Pharmacies in accordance with applicable Laws and Regulations and generally accepted standards of practice in the local community of pharmacists. Each Mail Order Pharmacy must use independent professional judgment when dispensing Covered

Prescription Services and may refuse to dispense any Prescription Drug based upon the pharmacist's professional judgment.

2.3 **Control of Administrator.** Administrator will solely and exclusively control and supervise the operation and maintenance of Administrator's Mail Order Pharmacies and their respective facilities and equipment and provision of Covered Prescription Services. All decisions respecting the provision of Covered Prescription Services by Administrator's Mail Order Pharmacies will be made solely by Administrator and its duly authorized personnel, and not by Client. The relationship between a Member and a Mail Order Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship. Administrator may exclude from coverage under this agreement a Prescription Drug that cannot be dispensed in accordance with Administrator's mail order pharmacy dispensing protocols or requires special record-keeping procedures.

2.4 **Mail Order Rates.** Prices stated for Prescription Drugs dispensed by the Mail Order Pharmacy are based on the average days supply specified in **Exhibit C**. Mail Order Pharmacy Prescription Drugs dispensed in smaller amounts will be compensated at the retail pharmacy compensation rates stated in **Exhibit C**. Specialty Drugs are not available at mail order rates, even if dispensed by a Mail Order Pharmacy. If Client requests or requires expedited or alternative shipping methods other than Administrator's standard method, Client will be solely responsible for those costs. If USPS rates increase, Administrator may pass these cost increases on to Client.

3. SPECIALTY PHARMACY SERVICES

3.1 **Specialty Services.** Administrator, in its capacity as a Specialty Pharmacy, will provide Client with Exclusive Specialty Drug Covered Prescription Services to Members as specified in **Exhibit C**. Client will receive the Specialty Drugs specified in **Exhibit C** as a Covered Prescription Service exclusively from Administrator's Specialty Pharmacy and not from any other retail, mail, specialty or other pharmacy, including a Network Pharmacy.

3.2 Addition of Newly Acquired or Approved Specialty Drugs

3.2.1 From the date a newly acquired or approved Specialty Drug ("***New Specialty Drug***") becomes available until Client rejects the New Specialty Drug as specified in section 3.2.2 of this exhibit, Client authorizes and directs Administrator to make the New Specialty Drug available to Members as part of the Specialty Drug Covered Prescription Services and during this period will compensate Administrator for the New Specialty Drug at the rate specified in **Exhibit C**. Administrator will not be required to make available to Client or Members a New Specialty Drug that has limited distribution or market access, such as a New Specialty Drug with one distributor or manufacturer.

3.2.2 On a periodic basis, Administrator will review the Specialty Drugs listed in **Exhibit C** and notify Client of the name and price of any New Specialty Drugs to be added to this list of Specialty Drugs. From the date of Client's receipt of this notice, Client will have 30 days to provide Administrator with notice of rejection of additions to the Specialty Drugs listed in **Exhibit C**.

3.2.3 No later than 45 days after Administrator's receipt of Client's notice of rejection of New Specialty Drugs, Administrator will remove the New Specialty Drugs to **Exhibit C** and dispense the New Specialty Drugs to Members at the pricing specified in Administrator's notice. If Client does not notify Administrator of its rejection of the New Specialty Drugs, Administrator will continue to include the New Specialty Drugs as a Specialty Drug made available to Members.

3.2.4 If Client requests that a Prescription Drug be handled as a Covered Prescription Service, but does not want Administrator to handle the Prescription Drug as a Specialty Drug, the parties will consider the request a Service Change and follow the procedures in section 1.3 of this agreement.

3.3 **Standards and Professional Judgment**. Administrator's Specialty Pharmacies will be duly licensed under applicable Laws and Regulations of the state of the pharmacies' geographic locations and any other jurisdiction as necessary to furnish Covered Prescription Services to Members. Administrator will comply with all Laws and Regulations promulgated by the boards of pharmacies that apply to the Administrator's Specialty Pharmacies. Administrator will notify promptly Client if the required licensure of Administrator's Specialty Pharmacies is lost, suspended, limited or conditioned. Duly licensed personnel will provide all Covered Prescription Services at the Specialty Pharmacies in accordance with applicable Laws and Regulations and generally accepted standards of practice in the local community of pharmacists. Each Specialty Pharmacy must use independent professional judgment when dispensing Covered Prescription Services and may refuse to dispense any Prescription Drug based upon the pharmacist's professional judgment.

3.4 **Control of Administrator**. Administrator will solely and exclusively control and supervise the operation and maintenance of Administrator's Specialty Pharmacies and their respective facilities and equipment and provision of Covered Prescription Services. All decisions respecting the provision of Covered Prescription Services by Administrator's Specialty Pharmacies will be made solely by Administrator and its duly authorized personnel, and not by Client. The relationship between a Member and a Specialty Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship.

4. MEDICARE PART D RETIREMENT DRUG SUBSIDY ("*RDS*") SERVICES

4.1. **Administrator's Responsibilities**. Administrator will provide Client with RDS Services as follows:

4.1.1. Administrator will provide Client's monthly data files to Client for Client's submission to Centers for Medicare and Medicaid Services ("***CMS***") in support of Client's claims for federal subsidy payments pursuant to 42 U.S.C. § 1395w-132. Administrator will upload all files and data to CMS through the CMS RDS computer system.

4.1.2. Administrator will, upon request, provide Client with standard reports that meet CMS requirements.

4.1.3. Administrator will submit to Client costs data that reflects any discounts, chargebacks, rebates, and other price concessions given by the manufacturer or pharmacy in the aggregate that are attributable to gross retiree costs between the cost threshold and cost limit as required by CMS.

4.1.4. Administrator is bound by all applicable federal Laws and Regulations, guidance and authorities pertaining to claims and debt collections.

4.1.5. Administrator will maintain the records for Client's RDS Program for six years after the expiration of Client's plan year in which the costs were incurred. CMS or the Office of Inspector General, or their designees, will be provided access to such records upon request.

4.1.6. Administrator agrees that Client's Medicare Drug Plan Members are afforded protection from liability for payment of fees that are Administrator's obligation in accordance with 42 CFR § 423.505(g).

4.2. **Client Responsibilities**. Client will be responsible for the following obligations in connection with Administrator providing Client with RDS Services:

4.2.1. Client will pay administration fees as listed on RDS Compensation Exhibit for Services associated with Client's claims for federal subsidy payments pursuant to 42 USC § 1395w-132.

4.2.2. Client will complete and submit any required updates, revisions, or changes to the application to CMS for approval of subsidy payments pursuant to 42 USC § 1395w-132.

4.2.3. Client will upload all files and data to CMS through the CMS RDS computer system.

4.2.4. Client will upload Member eligibility information and data to CMS. Client will provide Administrator with the final eligibility file generated by CMS.

4.2.5. Client will create and distribute Creditable Coverage statements to Members.

4.2.6. Client will submit information in compliance with the requirements that govern payments set forth in 42 C.F.R. § 423.888.

4.2.7. Client will, at all times, be in compliance with all requirements for continued approval of the federal subsidy program for prescription drug benefits to its Medicare-eligible Members for whom subsidy payments are received from CMS and all Laws and Regulations related to its subsidized pharmacy benefit program.

4.3. **Additional RDS Provisions**

4.3.1. Business Integrity. Administrator will be bound by the provisions set forth at 45 CFR Part 76. In addition to the foregoing, Administrator represents and warrants that neither Administrator nor any personnel furnishing Prescription Drug Services to Medicare Drug Plan Members have been or will be (a) listed as debarred, excluded or otherwise ineligible for participation in federal health care programs or (b) convicted of a criminal felony. If at any time Administrator becomes aware of any violation of this representation and warranty, Administrator will notify Client in writing immediately. If Administrator becomes debarred or ineligible then Client may terminate this agreement immediately upon notice to Administrator without liability to Client or take such other corrective or remedial action as warranted under the circumstances.

4.3.2. Federal Policies; Flow Down Provisions. Because Administrator is furnishing Prescription Drug Services to Medicare Drug Plan Members that are the subject of a contract between Client and CMS, the following obligations are imposed upon Administrator with which Administrator will comply: Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC §§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC § 6101 et seq.); the Vietnam Era Veterans Readjustment Assistant Act (38 USC § 4212); together with all applicable implementing regulations, rules, guidelines and standards as from time-to-time are promulgated thereunder by applicable Governmental Authorities.

4.3.3. Nondiscrimination. The Prescription Drug Services furnished to Medicare Drug Plan Members will be rendered without regard to health status, race, religion, color, creed, national origin, ancestry, religion, physical handicap, medical condition (including HIV status), mental status, age (except as provided by law), marital status, sex, sexual orientation or gender identity. In addition, Administrator will not unlawfully discriminate

against any employee or applicant for employment because of race, religion, color, creed, national origin, ancestry, religion, physical handicap, medical condition (including HIV status), mental status, age, marital status, sex, sexual orientation or gender identity. The evaluation and treatment of Administrator employees and applicants for employment are, and will be, free from this unlawful discrimination. Administrator will comply with all Laws and Regulations relating to equal and fair employment.

4.3.4. Equal Opportunity Employer. As an equal opportunity employer, Administrator will abide by all applicable provisions of Executive Order 11246, as amended (Equal Opportunity/Affirmative Action), 38 USC § 4212, as amended, (Vietnam Era Veterans Readjustment Act), and Section 503 of the Rehabilitation Act of 1973, as amended (Handicapped Regulations), together with the implementing regulations (found at 41 CFR §§ 60-1, & 60-2, 41 CFR § 60-250, and 41 CFR § 60-741, respectively), rules guidelines and standards, as from time-to-time are promulgated thereunder by applicable Governmental Authorities and which are incorporated by reference into this agreement.

4.3.5. Other Laws and Regulations. Administrator will comply with (a) applicable federal Laws and Regulations designed to prevent fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et seq.), and the anti-kickback provision of section 1128B of the Social Security Act; (b) applicable HIPAA Administrative Simplification Security and Privacy rules at 45 CFR parts 160, 162, and 164; and (c) all other applicable federal Laws and Regulations. "

EXHIBIT C

COMPENSATION

Price Summary

OPTUMRx™

Confidential and Proprietary

The following administrative fees and rates are exclusive to **City of Cincinnati** and are based upon provided information and an estimated **13,997** Active, or **6,138** Retiree, or a combined total of **20,135** Active and Retiree eligible members or greater. Rates and fees are effective upon the implementation of services on **01/01/2014**. This summary represents our **Pass-Through** Pricing model. All rates and fees are guaranteed and subject to the applicable terms in this cost proposal unless stated as otherwise.

Retail Network

Discounts and Dispensing Fees

- Access to over 65,000 pharmacies nationwide
- Rates exclude compound and DMR claims

	Active	Retiree	Active + Retiree
Brand:	2014: AWP-14.7% 2015: AWP-15.3% 2016: AWP-15.7% $1.39 DF	2014: AWP-14.7% 2015: AWP-15.3% 2016: AWP-15.7% $1.37 DF	2014: AWP-14.7% 2015: AWP-15.3% 2016: AWP-15.7% $1.38 DF
Generic:	MAC $1.41 Dispensing Fee	MAC $1.39 Dispensing Fee	MAC $1.40 Dispensing Fee

Aggregate average minimum discount off AWP for MAC & non-MAC generics:

2014	AWP –75.3%	AWP –78.4%	AWP –79.7%
2015	AWP –77.0%	AWP –80.2%	AWP –81.4%
2016	AWP –77.2%	AWP –80.4%	AWP –81.7%

OptumRx Mail Service

Discounts and Dispensing Fees

- Postage included
- Rates may vary for claims not covered under pharmacy benefit
- Mail discounts and dispensing fees exclude specialty and certain non-specialty injectable products

	Active	Retiree	Active + Retiree
Brand:	AWP –22.0% $0.00 Dispensing Fee	AWP –22.5% $0.00 Dispensing Fee	AWP –23.0% $0.00 Dispensing Fee
Generic:	MAC $0.00 Dispensing Fee	MAC $0.00 Dispensing Fee	MAC $0.00 Dispensing Fee

Aggregate average minimum discount off AWP for MAC & non-MAC generics:

2014	AWP –80.4%	AWP –80.4%	AWP –82.7%
2015	AWP –81.1%	AWP –82.2%	AWP –83.4%
2016	AWP –81.2%	AWP –82.4%	AWP –83.7%

Price Summary

OPTUMRx™

Confidential and Proprietary

OptumRx Specialty Pharmacy

Discounts and Dispensing Fees		Active	Retiree	Active + Retiree
• Postage included • Rates for these products dispensed from from OptumRx's mail pharmacies are listed in the specialty exhibit	**Brand:**	AWP –15.5% $0.00 Dispensing Fee	AWP –16.0% $0.00 Dispensing Fee	AWP –16.0% $0.00 Dispensing Fee

Rebate Management

Rebate guarantees are contingent upon the following terms:		Active	Retiree	Active + Retiree
• City of Cincinnati's adoption of OptumRx's formulary, formulary management, and utilization management • OptumRx's collection and distribution of funds received • Rebate ineligible paid claims such as those from 340B pharmacies or entities eligible for federal supply schedule prices (e.g., Dept. of Veterans Affairs, US Public Health Service, Dept. of Defense) are excluded from rebate guarantees • A minimum of $10 difference in copayment or 10% difference in coinsurance between preferred and non-preferred branded drugs • Rebates may not include Prescription Claims that require the Members to pay more than 50% of the total annual cost for all Prescription Claims under the applicable Benefit Plan • Any deviations to the Administrator's Formulary and Utilization Management that adversely impacts rebates will result in a proportional adjustment to the corresponding rebate guarantees • Unrestricted access to 90 days supply scripts in retail	**Retail:** (with Specialty)	100% Pass-Through	100% Pass-Through	100% Pass-Through
		Minimum Guarantee:	Minimum Guarantee:	Minimum Guarantee:
	2014	$28.53 / Brand Claim	$27.21 / Brand Claim	$27.74 / Brand Claim
	2015	$32.21 / Brand Claim	$30.40 / Brand Claim	$31.14 / Brand Claim
	2016	$32.63 / Brand Claim	$29.03 / Brand Claim	$30.52 / Brand Claim
	Mail: (Non-Specialty)	100% Pass-Through	100% Pass-Through	100% Pass-Through
		Minimum Guarantee:	Minimum Guarantee:	Minimum Guarantee:
	2014	$84.95 / Brand Claim	$87.24 / Brand Claim	$86.54 / Brand Claim
	2015	$93.66 / Brand Claim	$96.35 / Brand Claim	$95.57 / Brand Claim
	2016	$87.80 / Brand Claim	$89.46 / Brand Claim	$88.91 / Brand Claim
	Mail Specialty:	100% Pass-Through	100% Pass-Through	100% Pass-Through
		Minimum Guarantee:	Minimum Guarantee:	Minimum Guarantee:
	2014	$505.13 / Brand Claim	$315.96 / Brand Claim	$409.75 / Brand Claim
	2015	$666.27 / Brand Claim	$456.04 / Brand Claim	$558.10 / Brand Claim
	2016	$667.31 / Brand Claim	$431.37 / Brand Claim	$545.80 / Brand Claim

Price Summary

OPTUMRx™

Confidential and Proprietary

Standard Services	Active	Retiree	Active + Retiree
Dedicated Implementation and Client Management Team • Client Manager • Project Manager • Client Service Representative • Pharmacist • Business Analyst **Help Desks** – Toll-free access for members, physicians, and pharmacies **DUR and System Edits** – Standard Concurrent DUR and flexible plan designs **Communication Materials** - Welcome Package and standard ID cards **Internet Direct Access** • Real time access to claims and eligibility system • Accounts set up for up to two users **Real-Time Audit** – Filters 100% of claims before payment–outliers sent to audit team **Eligibility Maintenance** – Via FTP or encrypted e-mail **Website Access** – www.optumrx.com **Safety Notifications for Providers and/or Members (e.g., drug recalls)** **Standard Reporting Package** – Integrated retail and mail claim data **Online Reporting Tool** - Software, training and maintenance costs for up to two users	$1.50 per Paid Claim	$1.50 per Paid Claim	$0.95 per Paid Claim

Price Summary

OPTUMRx™

Confidential and Proprietary

Clinical Programs	
Bundled Clinical Programs • Programs Include: DIAP, Geriatric Monitor, Narcotic, and PolyPharmacy	$0.02 PMPM for Bundle of 4 Programs
Generic Strategy Program	$0.05 PMPM
Condition Specific Bundle • Programs Includes: Statin Initiative, Asthma Program and Migraine Prophylaxis	$0.05 PMPM per Bundle of 3 Programs or $0.02 PMPM for each Program selected individually
Adherence Program • Increases medication adherence rates in a number of chronic and high-impact disease states	$0.02 PMPM
Other Standard Programs	$0.02 - $0.05 PMPM per Program selected
Health, Wellness, and Disease Education provided through www.optumrx.com	Included
Customized Clinical Programs	Quoted Separately Upon Request. Client claims data required for custom analysis and presentation.
Clinical Prior Authorization Overrides requiring clinical intervention or evaluation	$30 per Authorization
Physician Reviewed Prior Authorization	$225 per Authorization
Clinical Appeals Services	$550 per Level
Administrative Appeals Services	$180 per Level
Additional Services	
Custom Programming/Report Generation • Minimum $500.00	$150 per Hour
E-Prescribing	Included
Non-Standard or Manual Eligibility Maintenance	$1.50 per Member
Direct Member Reimbursement (DMR) • Entered by OptumRx, includes creation and mailing of letters for denied claims, in accordance with state or federal requirements	$4.50 per claim + Postage
Credits and Allowances	
Implementation Allowance • Based upon documented actual out of pocket implementation costs incurred by Plan	Up to $4.00 Credit per Transitioned Member
Pre-implementation Audit Allowance • Based upon documented actual out of pocket costs incurred by Plan	Up to $30,000 for Audit Up to $3,000 for Travel

Price Summary

OPTUMRx™

Confidential and Proprietary

Pricing Terms

- OptumRx reserves the right to renegotiate in good faith rates, fees, and guarantees if membership, utilization, market conditions or legislation varies materially from the time this quote was provided
- All rates and fees are contingent upon the selection of OptumRx as the exclusive mail provider, and a similar benefit design as applicable to the historical data provided for the purpose of this cost proposal that includes an exclusive Specialty arrangement. All rates and fees are subject to change otherwise
- The rates, fees or guarantees provided to City of Cincinnati for this cost proposal were based on a set of assumptions used by OptumRx ("Administrator") from the data and other pertinent information provided by City of Cincinnati to Administrator. In the event that the data/information is deficient or inaccurate, resulting in a material change to the relative economics of Administrator or City of Cincinnati, some of the rates, fees or guarantees may no longer apply. If such an event were to occur, Administrator will make every attempt to negotiate with City of Cincinnati in good faith to arrive at a solution that is mutually acceptable to both parties involved
- Any reduction in rebates earned by OptumRx as a result of changes to formulary, days supply, and/or benefit design not initiated or approved by OptumRx may result in adjustments to rebate payments or guarantees effective concurrently with such occurrences
- Rebate guarantees and generic AWP discounts may be adjusted proportional to the impact of unexpected releases of generic products to market, or the withdrawal/recall of existing branded products
- Mail discounts and dispensing fees exclude specialty and certain non-specialty injectable products. Rates for these products dispensed from OptumRx's mail pharmacies are listed in the specialty exhibit
- Mail Service rates are based on an average days supply of 84 or greater for all claims with the exception of all specialty and certain non-specialty injectable drugs as listed in the specialty exhibit provided

Specialty Pharmacy Price Summary

Confidential and Proprietary

OPTUMRx™

The rates and terms quoted in this price summary and attached Specialty Pharmacy Pricing Schedule are subject to the accuracy and completeness of the information provided by Client, including the minimum number of Members, and the parties entering into a definitive agreement for the provision of pharmacy benefit management services by the Implementation Date.

Date:	6/20/2013
Client:	City of Cincinnati
Members:	20,135
Implementation Date:	1/1/2014

Drug Pricing • OptumRx dispenses all drug label names on the pricing schedule provided. A comprehensive list of NDCs can be provided upon request.	See attached Specialty Pharmacy Pricing Schedule
Specialty Drugs may include: • Ancillary supplies • Needles • Syringes • Sharp containers	Included at no extra charge
Value Added Services • Monthly Member contact by patient care coordinators • Access to pharmacist around the clock • Distribution of medications to place of choice within the U.S. and its territories • Refill reminder program • Patient assistance programs	Included at no extra charge
Clinical Management Program • Programs include Multiple Sclerosis, Inflammatory Conditions, Transplant, Oral Oncology, HIV/Aids, Hepatitis C, Hemophilia • Member customized care plans • Continuity of care with minimal clinician changes for Members • Personal one-on-one Member phone assessment/reassessment consultation .	Included at no extra charge

Specialty Pharmacy Price Summary

Confidential and Proprietary

Utilization Management • Prior authorization or case review -Review requests for Specialty Drugs to meet Client's utilization management program (including step therapy) and request additional information if needed -Accept Specialty Drug authorization by phone or fax -Verify Member eligibility -Mail denial letters to Members and providers as required by applicable Laws and Regulations	$55 per case
• Physician review of submitted documentation, if needed, as required by applicable Laws and Regulations	$390 per physician reviewed case
• Dose optimization/waste avoidance	Included at no extra charge
Compliance Management • Refill reminder process with three calls to Members starting five days before refill • Notify providers for non-compliance management	Included at no extra charge
Fulfillment Process • Shipping to location of choice within the U.S. and its territories • Monitoring and tracking shipping process • Postage	Included at no extra charge
Standard Reports • Prior authorization / return on investment savings analysis • Member adherence by percent compliance • Annual report • Quarterly utilization reports	Included at no extra charge
Online Reporting Tool • Software and training for up to three users	Included at no extra charge
• Client-requested custom system or reporting configurations	$150 per hour

OPTUMRx™

Specialty Pharmacy Pricing Schedule
Confidential and Proprietary

OptumRx has available in its Specialty Pharmacies the listed Specialty Drugs regardless of package size or NDC. A comprehensive list of NDCs can be provided upon request. Products listed below that are not available to be dispensed directly by OptumRx will be dispensed through a third party vendor at the specified rates.
The rates and terms quoted in this price summary and attached Specialty Pharmacy Pricing Schedule are subject to the accuracy and completeness of the information provided by Client, including the minimum number of Members, and the parties entering into a definitive agreement for the provision of pharmacy benefit management services by the Implementation Date.

Date: 6/20/2013
Client: City of Cincinnati
Members: 20,135
Implementation Date: 01/01/2014
Specialty Service: Exclusive Specialty Pharmacy Program

Product Label Name	Therapeutic Class	Brand Name	Generic Name	Generic Product Identification (GPI)	Post-Rollback Proposed Discount (-)/Markup (+) Relative to AWP (AWP Source: Medi-Span)	Dispensing Fee	Specialty Distribution
ILARIS INJ 180MG	Analgesic & Anesthetic Agents	ILARIS	CANAKINUMAB FOR INJ 180 MG	56460020002120	-16.0%	$0.00	N
KRYSTEXXA INJ 8MG/ML	Analgesic & Anesthetic Agents	KRYSTEXXA	PEGLOTICASE INJ 8 MG/ML (FOR IV INFUSION)	68000050002020	-16.0%	$0.00	Y
PRIALT INJ 100MCG	Analgesic & Anesthetic Agents	PRIALT	ZICONOTIDE ACETATE INTRATHECAL INJ 100 MCG/ML	64154090102020	-13.5%	$0.00	Y
PRIALT INJ 25MCG/ML	Analgesic & Anesthetic Agents	PRIALT	ZICONOTIDE ACETATE INTRATHECAL INJ 500 MCG/20ML (25 MCG/ML)	64154090102010	-13.5%	$0.00	Y
PRIALT INJ 500MCG	Analgesic & Anesthetic Agents	PRIALT	ZICONOTIDE ACETATE INTRATHECAL INJ 500 MCG/5ML	64154090102030	-13.5%	$0.00	Y
TESTOPEL MIS PELLETS	Androgen	TESTOPEL	TESTOSTERONE IMPLANT PELLETS 75 MG	23100030008920	-15.0%	$0.00	N
XOLAIR SOL 150MG	Antiasthmatic & Monoclonal Antibodies	XOLAIR	OMALIZUMAB FOR INJ 150 MG	44600360002120	-11.0%	$0.00	Y
CAYSTON INH 75MG	Antibiotic	CAYSTON	AZTREONAM LYSINE FOR INHAL SOLN 75 MG (BASE EQUIVALENT)	16000005402120	-17.0%	$0.00	N
TOBI NEB 300/5ML	Antibiotics	TOBI	TOBRAMYCIN NEBU SOLN 300 MG/5ML	07000070002520	-16.5%	$0.00	Y
FRAGMIN INJ 10000/ML	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 10000 UNIT/ML	83101010102015	-15.0%	$0.00	N
FRAGMIN INJ 12500UNT	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 12500 UNIT/0.5ML	83101010102053	-15.0%	$0.00	N
FRAGMIN INJ 15000UNT	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 15000 UNIT/0.6ML	83101010102056	-15.0%	$0.00	N
FRAGMIN INJ 18000UNT	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 18000 UNIT/0.72ML	83101010102060	-15.0%	$0.00	N
FRAGMIN INJ 2500/0.2	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 2500 UNIT/0.2ML	83101010102020	-15.0%	$0.00	N
FRAGMIN INJ 25000/ML	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 25000 UNIT/ML	83101010102065	-15.0%	$0.00	N
FRAGMIN INJ 5000/0.2	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 5000 UNIT/0.2ML	83101010102040	-15.0%	$0.00	N
FRAGMIN INJ 7500/0.3	Anticoagulants	FRAGMIN	DALTEPARIN SODIUM INJ 7500 UNIT/0.3ML	83101010102045	-15.0%	$0.00	N
SABRIL POW 500MG	Anticonvulsant	SABRIL	VIGABATRIN POWD PACK 500 MG	72170085003020	-16.5%	$0.00	N
SABRIL TAB 500MG	Anticonvulsant	SABRIL	VIGABATRIN TAB 500 MG	72170085000320	-16.5%	$0.00	N
VORAXAZE INJ 1000UNIT	Antidote	VORAXAZE	GLUCARPIDASE FOR IV INJ 1000 UNIT	21755030002120	-15.0%	$0.00	N
VIVITROL INJ 380MG	Antidotes	VIVITROL	NALTREXONE FOR IM EXTENDED RELEASE SUSP 380 MG	93400030001920	-9.5%	$0.00	Y
EMEND SOL 150MG	Antiemetic	EMEND	FOSAPREPITANT DIMEGLUMINE FOR IV INFUSION 150 MG (BASE EQ)	50280035102130	-5.0%	$0.00	Y
GRANISETRON INJ 0.1MG/ML	Antiemetic	GRANISETRON	GRANISETRON HCL INJ 0.1 MG/ML	50250035102001	-45.0%	$0.00	Y
GRANISETRON INJ 1MG/ML	Antiemetic	GRANISETRON	GRANISETRON HCL INJ 1 MG/ML	50250035102010	-45.0%	$0.00	Y
GRANISETRON INJ 4MG/4ML	Antiemetic	GRANISETRON	GRANISETRON HCL INJ 4 MG/4ML (1 MG/ML)	50250035102015	-45.0%	$0.00	Y
RETISERT IMP 0.59MG	Antiemetic	RETISERT	FLUOCINOLONE ACETONIDE INTRAVITREAL IMPLANT 0.59 MG	88300017102320	-15.0%	$0.00	N
CORIFACT KIT	Antihemophilic Agent	CORIFACT	FACTOR XIII CONCENTRATE (HUMAN) FOR INJ KIT 1000-1600 UNIT	85100033006440	-33.0%	$0.00	Y
SYNVISC INJ 8MG/ML	Antirheumatic	SYNVISC	HYLAN INTRA-ARTICULAR INJ 8 MG/ML	75800040002220	-13.5%	$0.00	Y
JUXTAPID CAP 10MG	Antilipemic Agent	JUXTAPID	LOMITAPIDE MESYLATE CAP 10 MG (BASE EQUIV)	39480050200130	-16.5%	$0.00	N
JUXTAPID CAP 20MG	Antilipemic Agent	JUXTAPID	LOMITAPIDE MESYLATE CAP 20 MG (BASE EQUIV)	39480050200140	-16.5%	$0.00	N
JUXTAPID CAP 5MG	Antilipemic Agent	JUXTAPID	LOMITAPIDE MESYLATE CAP 5 MG (BASE EQUIV)	39480050200120	-16.5%	$0.00	N
FUSILEV INJ 50MG	Antineoplastic & Adjunctive Therapies	FUSILEV	LEVOLEUCOVORIN CALCIUM FOR IV INJ 50 MG (BASE EQUIV)	21755050102120	-15.5%	$0.00	Y
KEPIVANCE INJ 6.25MG	Antineoplastic & Adjunctive Therapies	KEPIVANCE	PALIFERMIN FOR IV INJ 6.25 MG	21755060002120	-13.5%	$0.00	Y
LUMIZYME INJ 50MG	Antineoplastic & Adjunctive Therapies	LUMIZYME	ALGLUCOSIDASE ALFA FOR IV SOLN 50 MG	30907715002120	-13.5%	$0.00	Y
MESNA INJ 1GM	Antineoplastic & Adjunctive Therapies	MESNA	MESNA INJ 100 MG/ML	21758050002010	-18.0%	$0.00	Y
THALOMID CAP 100MG	Antineoplastic & Adjunctive Therapies	THALOMID	THALIDOMIDE CAP 100 MG	99392070000130	-18.0%	$0.00	Y
THALOMID CAP 150MG	Antineoplastic & Adjunctive Therapies	THALOMID	THALIDOMIDE CAP 150 MG	99392070000135	-18.0%	$0.00	Y
THALOMID CAP 200MG	Antineoplastic & Adjunctive Therapies	THALOMID	THALIDOMIDE CAP 200 MG	99392070000140	-18.0%	$0.00	Y
THALOMID CAP 50MG	Antineoplastic & Adjunctive Therapies	THALOMID	THALIDOMIDE CAP 50 MG	99392070000120	-18.0%	$0.00	Y
ABRAXANE INJ 100MG	Antineoplastic Agent	ABRAXANE	PACLITAXEL PROTEIN-BOUND PARTICLES FOR IV SUSP 100 MG	21500012201920	-17.5%	$0.00	Y

ADCETRIS INJ 50MG	Antineoplastic Agent	ADCETRIS	BRENTUXIMAB VEDOTIN FOR IV SOLN 50 MG	21355020202120	-16.8%	$0.00	Y
ADRIAMYC INJ 50MG	Antineoplastic Agent	ADRIAMYC	DOXORUBICIN HCL FOR INJ 50 MG	21200040102115	-18.0%	$0.00	Y
ADRIAMYCIN INJ 10MG	Antineoplastic Agent	ADRIAMYCIN	DOXORUBICIN HCL FOR INJ 10 MG	21200040102105	-18.0%	$0.00	Y
ADRIAMYCIN INJ 20MG	Antineoplastic Agent	ADRIAMYCIN	DOXORUBICIN HCL FOR INJ 20 MG	21200040102110	-13.5%	$0.00	Y
ADRIAMYCIN INJ 2MG/ML	Antineoplastic Agent	ADRIAMYCIN	DOXORUBICIN HCL INJ 2 MG/ML	21200040102010	-18.0%	$0.00	Y
ADRUCIL INJ 50MG/ML	Antineoplastic Agent	ADRUCIL	FLUOROURACIL INJ 500 MG/10ML (50 MG/ML)	21300030002020	-18.0%	$0.00	Y
AFINITOR TAB 10MG	Antineoplastic Agent	AFINITOR	EVEROLIMUS TAB 10 MG	21532530000330	-13.5%	$0.00	Y
AFINITOR TAB 2.5MG	Antineoplastic Agent	AFINITOR	EVEROLIMUS TAB 2.5 MG	21532530000310	-13.5%	$0.00	Y
AFINITOR TAB 5MG	Antineoplastic Agent	AFINITOR	EVEROLIMUS TAB 5 MG	21532530000320	-13.5%	$0.00	Y
AFINITOR TAB 7.5MG	Antineoplastic Agent	AFINITOR	EVEROLIMUS TAB 7.5 MG	21532530000325	-13.5%	$0.00	Y
ALIMTA INJ 100MG	Antineoplastic Agent	ALIMTA	PEMETREXED DISODIUM FOR IV SOLN 100 MG (BASE EQUIV)	21300053102110	-14.5%	$0.00	Y
ALIMTA INJ 500MG	Antineoplastic Agent	ALIMTA	PEMETREXED DISODIUM FOR IV SOLN 500 MG (BASE EQUIV)	21300053102120	-14.5%	$0.00	Y
ALKERAN INJ 50MG	Antineoplastic Agent	ALKERAN	MELPHALAN HCL FOR INJ 50 MG (BASE EQUIV)	21101040102110	-13.5%	$0.00	Y
ARRANON INJ 5MG/ML	Antineoplastic Agent	ARRANON	NELARABINE IV SOLN 5 MG/ML	21300052002020	-13.5%	$0.00	Y
ARZERRA CON 100/50ML	Antineoplastic Agent	ARZERRA	OFATUMUMAB CONC FOR IV INFUSION 1000 MG/50ML	21353045001350	-12.0%	$0.00	Y
ARZERRA CON 100/5ML	Antineoplastic Agent	ARZERRA	OFATUMUMAB CONC FOR IV INFUSION 100 MG/5ML	21353045001320	-12.0%	$0.00	Y
AVASTIN INJ	Antineoplastic Agent	AVASTIN	BEVACIZUMAB IV SOLN 100 MG/4ML (FOR INFUSION)	21335020002025	-16.0%	$0.00	Y
BEXXAR CON 14MG/ML	Antineoplastic Agent	BEXXAR	TOSITUMOMAB FOR IV INJ CONC 14 MG/ML	21358070001320	-13.5%	$0.00	N
BEXXAR I 131 I INJ 0.51/ML	Antineoplastic Agent	BEXXAR 131 I	IODINE I 131 TOSITUMOMAB INJ 0.51 MCI/ML	21600040002220	-13.5%	$0.00	N
BEXXAR I 131 I INJ 5.6MCI/M	Antineoplastic Agent	BEXXAR 131 I	IODINE I 131 TOSITUMOMAB INJ 5.6 MCI/ML	21600040002240	-13.5%	$0.00	N
BICNU INJ 100MG	Antineoplastic Agent	BICNU	CARMUSTINE FOR INJ 100 MG	21102010002105	-13.5%	$0.00	Y
BLEOMYCIN INJ 15UNIT	Antineoplastic Agent	BLEOMYCIN	BLEOMYCIN SULFATE FOR INJ 15 UNIT	21200010102105	-18.0%	$0.00	Y
BLEOMYCIN INJ 30UNIT	Antineoplastic Agent	BLEOMYCIN	BLEOMYCIN SULFATE FOR INJ 30 UNIT	21200010102115	-18.0%	$0.00	Y
BOSULIF TAB 100MG	Antineoplastic Agent	BOSULIF	BOSUTINIB TAB 100 MG	21534012000320	-6.0%	$0.00	Y
BOSULIF TAB 500MG	Antineoplastic Agent	BOSULIF	BOSUTINIB TAB 500 MG	21534012000340	-6.0%	$0.00	Y
BUSULFEX INJ 6MG/ML	Antineoplastic Agent	BUSULFEX	BUSULFAN INJ 6 MG/ML	21100010002020	-11.5%	$0.00	Y
CAMPATH INJ 30MG/ML	Antineoplastic Agent	CAMPATH	ALEMTUZUMAB IV INJ 30 MG/ML (FOR INFUSION)	21353010002040	-13.5%	$0.00	Y
CAMPTOSAR INJ 100/5ML	Antineoplastic Agent	CAMPTOSAR	IRINOTECAN HCL INJ 100 MG/5ML (20 MG/ML)	21550040102030	-13.5%	$0.00	Y
CAMPTOSAR INJ 300/15ML	Antineoplastic Agent	CAMPTOSAR	IRINOTECAN HCL INJ 300 MG/15ML (20 MG/ML)	21550040102035	-13.5%	$0.00	Y
CAMPTOSAR INJ 40MG/2ML	Antineoplastic Agent	CAMPTOSAR	IRINOTECAN HCL INJ 40 MG/2ML (20 MG/ML)	21550040102025	-13.5%	$0.00	Y
CAPRELSA TAB 100MG	Antineoplastic Agent	CAPRELSA	VANDETANIB TAB 100 MG	21534085000320	-11.0%	$0.00	N
CAPRELSA TAB 300MG	Antineoplastic Agent	CAPRELSA	VANDETANIB TAB 300 MG	21534085000340	-11.0%	$0.00	N
CARBOPLATIN INJ 150/15ML	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV SOLN 150 MG/15ML	21100015002035	-18.0%	$0.00	Y
CARBOPLATIN INJ 150MG	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV FOR INJ 150 MG	21100015002120	-18.0%	$0.00	Y
CARBOPLATIN INJ 450/45ML	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV SOLN 450 MG/45ML	21100015002040	-18.0%	$0.00	Y
CARBOPLATIN INJ 50MG	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV FOR INJ 50 MG	21100015002110	-18.0%	$0.00	Y
CARBOPLATIN INJ 50MG/5ML	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV SOLN 50 MG/5ML	21100015002030	-18.0%	$0.00	Y
CARBOPLATIN INJ 600/60ML	Antineoplastic Agent	CARBOPLATIN	CARBOPLATIN IV SOLN 600 MG/60ML	21100015002045	-18.0%	$0.00	Y
CERUBIDINE INJ 20MG	Antineoplastic Agent	CERUBIDINE	DAUNORUBICIN HCL FOR INJ 20 MG	21200030102105	-13.5%	$0.00	Y
CISPLATIN INJ 100MG	Antineoplastic Agent	CISPLATIN	CISPLATIN INJ 100 MG/100ML (1 MG/ML)	21100020002025	-18.0%	$0.00	Y
CISPLATIN INJ 200MG	Antineoplastic Agent	CISPLATIN	CISPLATIN INJ 200 MG/200ML (1 MG/ML)	21100020002030	-18.0%	$0.00	Y
CISPLATIN INJ 50/50ML	Antineoplastic Agent	CISPLATIN	CISPLATIN INJ 50 MG/50ML (1 MG/ML)	21100020002020	-18.0%	$0.00	Y
CISPLATIN POW	Antineoplastic Agent	CISPLATIN	CISPLATIN (BULK) POWDER	96465858002900	-18.0%	$0.00	N
CLADRIBINE INJ 1MG/ML	Antineoplastic Agent	CLADRIBINE	CLADRIBINE INJ 1 MG/ML	21300007002010	-18.0%	$0.00	Y
CLOLAR INJ 1MG/ML	Antineoplastic Agent	CLOLAR	CLOFARABINE IV SOLN 1 MG/ML	21300008002020	-13.5%	$0.00	Y
COMETRIQ KIT 100MG	Antineoplastic Agent	COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 1 X 20 MG (100 DOSE) KIT	21534013106470	-15.0%	$0.00	N
COMETRIQ KIT 140MG	Antineoplastic Agent	COMETRIQ	CABOZANTINIB S-MAL CAP 1 X 80 MG & 3 X 20 MG (140 DOSE) KIT	21534013106480	-15.0%	$0.00	N
COMETRIQ KIT 60MG	Antineoplastic Agent	COMETRIQ	CABOZANTINIB S-MALATE CAP 3 X 20 MG (60 MG DOSE) KIT	21534013106460	-15.0%	$0.00	N
COSMEGEN INJ 0.5MG	Antineoplastic Agent	COSMEGEN	DACTINOMYCIN FOR INJ 0.5 MG	21200020002105	-13.5%	$0.00	Y
CYCLOPHOSPH INJ 1GM	Antineoplastic Agent	CYCLOPHOSPH	CYCLOPHOSPHAMIDE FOR INJ 1 GM	21101020002125	-18.0%	$0.00	Y
CYCLOPHOSPH INJ 2GM	Antineoplastic Agent	CYCLOPHOSPH	CYCLOPHOSPHAMIDE FOR INJ 2 GM	21101020002130	-18.0%	$0.00	Y
CYCLOPHOSPH INJ 500MG	Antineoplastic Agent	CYCLOPHOSPH	CYCLOPHOSPHAMIDE FOR INJ 500 MG	21101020002120	-18.0%	$0.00	Y
CYCLOPHOSPHA POW	Antineoplastic Agent	CYCLOPHOSPHA	CYCLOPHOSPHAMIDE (BULK) POWDER	96468809802900	-15.0%	$0.00	N
CYCLOPHOSPHA POW USP	Antineoplastic Agent	CYCLOPHOSPHA	CYCLOPHOSPHAMIDE (BULK) POWDER	96468809802900	-15.0%	$0.00	N
CYTARABINE INJ 100MG	Antineoplastic Agent	CYTARABINE	CYTARABINE FOR INJ 100 MG	21300010002105	-18.0%	$0.00	Y
CYTARABINE INJ 100MG/ML	Antineoplastic Agent	CYTARABINE	CYTARABINE INJ 100 MG/ML	21300010002040	-18.0%	$0.00	Y
CYTARABINE INJ 1GM	Antineoplastic Agent	CYTARABINE	CYTARABINE FOR INJ 1 GM	21300010002115	-18.0%	$0.00	Y
CYTARABINE INJ 20MG/ML	Antineoplastic Agent	CYTARABINE	CYTARABINE INJ PF 20 MG/ML	21300010002011	-18.0%	$0.00	Y
CYTARABINE INJ 2GM	Antineoplastic Agent	CYTARABINE	CYTARABINE FOR INJ 2 GM	21300010002120	-18.0%	$0.00	Y
CYTARABINE INJ 500MG	Antineoplastic Agent	CYTARABINE	CYTARABINE FOR INJ 500 MG	21300010002110	-18.0%	$0.00	Y
DACARBAZINE INJ 100MG	Antineoplastic Agent	DACARBAZINE	DACARBAZINE FOR INJ 100 MG	21700020002105	-18.0%	$0.00	Y
DACARBAZINE INJ 200MG	Antineoplastic Agent	DACARBAZINE	DACARBAZINE FOR INJ 200 MG	21700020002110	-18.0%	$0.00	Y

DACOGEN INJ 50MG	Antineoplastic Agent	DACOGEN	DECITABINE FOR INJ 50 MG	21300015002120	-11.5%	$0.00	Y
DACTINOMYCIN INJ 0.5MG	Antineoplastic Agent	DACTINOMYCIN	DACTINOMYCIN FOR INJ 0.5 MG	21200020002105	-18.0%	$0.00	Y
DAUNORUBICIN INJ 20MG	Antineoplastic Agent	DAUNORUBICIN	DAUNORUBICIN HCL FOR INJ 20 MG	21200030102105	-18.0%	$0.00	Y
DAUNORUBICIN INJ 5MG/ML	Antineoplastic Agent	DAUNORUBICIN	DAUNORUBICIN HCL INJ 5 MG/ML (BASE EQUIV)	21200030102210	-18.0%	$0.00	Y
DAUNOXOME INJ 2MG/ML	Antineoplastic Agent	DAUNOXOME	DAUNORUBICIN CITRATE LIPOSOME INJ 2 MG/ML	21200030052210	-13.5%	$0.00	Y
DOCEFREZ INJ 20MG	Antineoplastic Agent	DOCEFREZ	DOCETAXEL FOR INJ 20 MG	21500005002120	-14.5%	$0.00	Y
DOCEFREZ INJ 80MG	Antineoplastic Agent	DOCEFREZ	DOCETAXEL FOR INJ 80 MG	21500005002140	-14.5%	$0.00	Y
DOCETAXEL INJ 160/16ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL SOLN FOR IV INFUSION 160 MG/16ML	21500005002050	-25.0%	$0.00	Y
DOCETAXEL INJ 160/8ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL FOR INJ CONC 160 MG/8ML (20 MG/ML)	21500005001317	-25.0%	$0.00	Y
DOCETAXEL INJ 20/0.5ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL FOR INJ CONC 20 MG/0.5ML (40 MG/ML)	21500005001320	-25.0%	$0.00	Y
DOCETAXEL INJ 20MG/2ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL SOLN FOR IV INFUSION 20 MG/2ML	21500005002030	-25.0%	$0.00	Y
DOCETAXEL INJ 20MG/ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL FOR INJ CONC 20 MG/ML	21500005001310	-25.0%	$0.00	Y
DOCETAXEL INJ 80MG/2ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL FOR INJ CONC 80 MG/2ML (40 MG/ML)	21500005001325	-25.0%	$0.00	Y
DOCETAXEL INJ 80MG/4ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL FOR INJ CONC 80 MG/4ML (20 MG/ML)	21500005001315	-25.0%	$0.00	Y
DOCETAXEL INJ 80MG/8ML	Antineoplastic Agent	DOCETAXEL	DOCETAXEL SOLN FOR IV INFUSION 80 MG/8ML	21500005002040	-25.0%	$0.00	Y
DOXIL INJ 2MG/ML	Antineoplastic Agent	DOXIL	DOXORUBICIN HCL LIPOSOMAL INJ (FOR IV INFUSION) 2 MG/ML	21200040402210	-14.5%	$0.00	Y
DOXORUBICIN INJ 10MG	Antineoplastic Agent	DOXORUBICIN	DOXORUBICIN HCL INJ 2 MG/ML	21200040102010	-18.0%	$0.00	Y
DOXORUBICIN INJ 200MG	Antineoplastic Agent	DOXORUBICIN	DOXORUBICIN HCL INJ 2 MG/ML	21200040102010	-18.0%	$0.00	Y
DOXORUBICIN INJ 2MG/ML	Antineoplastic Agent	DOXORUBICIN	DOXORUBICIN HCL INJ 2 MG/ML	21200040102010	-18.0%	$0.00	Y
DOXORUBICIN INJ 50MG	Antineoplastic Agent	DOXORUBICIN	DOXORUBICIN HCL INJ 2 MG/ML	21200040102010	-18.0%	$0.00	Y
ELIGARD INJ 22.5MG	Antineoplastic Agent	ELIGARD	LEUPROLIDE ACETATE (3 MONTH) FOR SUBCUTANEOUS INJ KIT 22.5MG	21405010156432	-14.5%	$0.00	Y
ELIGARD INJ 30MG	Antineoplastic Agent	ELIGARD	LEUPROLIDE ACETATE (4 MONTH) FOR SUBCUTANEOUS INJ KIT 30 MG	21405010206435	-14.5%	$0.00	Y
ELIGARD INJ 45MG	Antineoplastic Agent	ELIGARD	LEUPROLIDE ACETATE (6 MONTH) FOR SUBCUTANEOUS INJ KIT 45 MG	21405010256445	-14.5%	$0.00	Y
ELIGARD INJ 7.5MG	Antineoplastic Agent	ELIGARD	LEUPROLIDE ACETATE FOR SUBCUTANEOUS INJ KIT 7.5 MG	21405010106415	-14.5%	$0.00	Y
ELLENCE INJ 2MG/ML	Antineoplastic Agent	ELLENCE	EPIRUBICIN HCL INJ 50 MG/25ML (2 MG/ML)	21200042102030	-13.5%	$0.00	Y
ELOXATIN INJ 100MG	Antineoplastic Agent	ELOXATIN	OXALIPLATIN IV SOLN 100 MG/20ML	21100028002030	-19.0%	$0.00	Y
ELOXATIN INJ 200MG	Antineoplastic Agent	ELOXATIN	OXALIPLATIN IV SOLN 200 MG/40ML	21100028002035	-19.0%	$0.00	Y
ELOXATIN INJ 50MG	Antineoplastic Agent	ELOXATIN	OXALIPLATIN IV SOLN 50 MG/10ML	21100028002025	-19.0%	$0.00	Y
ELSPAR INJ 10000UNT	Antineoplastic Agent	ELSPAR	ASPARAGINASE FOR INJ 10000 UNIT	21250010002110	-13.5%	$0.00	Y
EPIRUBICIN INJ 200MG	Antineoplastic Agent	EPIRUBICIN	EPIRUBICIN HCL INJ 200 MG/100ML (2 MG/ML)	21200042102045	-18.0%	$0.00	Y
EPIRUBICIN INJ 50/25ML	Antineoplastic Agent	EPIRUBICIN	EPIRUBICIN HCL INJ 50 MG/25ML (2 MG/ML)	21200042102030	-18.0%	$0.00	Y
EPIRUBICIN INJ 50MG	Antineoplastic Agent	EPIRUBICIN	EPIRUBICIN HCL FOR INJ 50 MG	21200042102140	-1.0%	$0.00	Y
ERBITUX INJ 100MG	Antineoplastic Agent	ERBITUX	CETUXIMAB IV SOLN 100 MG/50ML (2 MG/ML)	21353025002020	-18.0%	$0.00	Y
ERBITUX INJ 200MG	Antineoplastic Agent	ERBITUX	CETUXIMAB IV SOLN 200 MG/100ML (2 MG/ML)	21353025002025	-18.0%	$0.00	Y
ERIVEDGE CAP 150MG	Antineoplastic Agent	ERIVEDGE	VISMODEGIB CAP 150 MG	21370070000120	-13.5%	$0.00	Y
ERWINAZE INJ 10000UNT	Antineoplastic Agent	ERWINAZE	ASPARAGINASE ERWINIA CHRYSANTHEMI FOR INJ 10000 UNIT	21250010402120	-15.0%	$0.00	N
ETOPOPHOS INJ 100MG	Antineoplastic Agent	ETOPOPHOS	ETOPOSIDE PHOSPHATE IV FOR INJ 100 MG	21500010602120	-13.5%	$0.00	Y
ETOPOSIDE INJ 20MG/ML	Antineoplastic Agent	ETOPOSIDE	ETOPOSIDE INJ 20 MG/ML	21500010002020	-18.0%	$0.00	Y
ETOPOSIDE POW	Antineoplastic Agent	ETOPOSIDE	ETOPOSIDE (BULK) POWDER	96508045482900	-15.0%	$0.00	N
FASLODEX INJ 250MG	Antineoplastic Agent	FASLODEX	FULVESTRANT INJ 250 MG/5ML	21403530002024	-14.0%	$0.00	Y
FIRMAGON INJ 120MG	Antineoplastic Agent	FIRMAGON	DEGARELIX ACETATE FOR INJ 120 MG (BASE EQUIV)	21405525102130	-7.5%	$0.00	Y
FIRMAGON INJ 80MG	Antineoplastic Agent	FIRMAGON	DEGARELIX ACETATE FOR INJ 80 MG (BASE EQUIV)	21405525102120	-7.5%	$0.00	Y
FLOXURIDINE INJ 0.5GM	Antineoplastic Agent	FLOXURIDINE	FLOXURIDINE FOR INJ 0.5 GM	21300020002105	-18.0%	$0.00	Y
FLUDARA INJ 50MG	Antineoplastic Agent	FLUDARA	FLUDARABINE PHOSPHATE FOR INJ 50 MG	21300025102120	-13.5%	$0.00	Y
FLUDARABINE INJ 50MG	Antineoplastic Agent	FLUDARABINE	FLUDARABINE PHOSPHATE FOR INJ 50 MG	21300025102120	-25.0%	$0.00	Y
FLUDARABINE INJ 50MG/2ML	Antineoplastic Agent	FLUDARABINE	FLUDARABINE PHOSPHATE INJ 25 MG/ML	21300025102020	-18.0%	$0.00	Y
FLUOROURACIL INJ 1GM/20ML	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL INJ 1 GM/20ML (50 MG/ML)	21300030002025	-18.0%	$0.00	Y
FLUOROURACIL INJ 2.5G/50M	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL INJ 2.5 GM/50ML (50 MG/ML)	21300030002030	-18.0%	$0.00	Y
FLUOROURACIL INJ 500MG/10	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL INJ 500 MG/10ML (50 MG/ML)	21300030002020	-18.0%	$0.00	Y
FLUOROURACIL INJ 50MG/ML	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL INJ 5 GM/100ML (50 MG/ML)	21300030002035	-18.0%	$0.00	Y
FLUOROURACIL INJ 5GM/100M	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL INJ 5 GM/100ML (50 MG/ML)	21300030002035	-18.0%	$0.00	Y
FLUOROURACIL POW	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL (BULK) POWDER	96525463632900	-15.0%	$0.00	N
FLUOROURACIL POW USP	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL (BULK) POWDER	96525463632900	-15.0%	$0.00	N
FLUOROURACIL POW USP/NF	Antineoplastic Agent	FLUOROURACIL	FLUOROURACIL (BULK) POWDER	96525463632900	-15.0%	$0.00	N
FOLOTYN INJ 20MG/ML	Antineoplastic Agent	FOLOTYN	PRALATREXATE IV INJ 20 MG/ML	21300054002020	-18.8%	$0.00	Y
FOLOTYN INJ 40MG/2ML	Antineoplastic Agent	FOLOTYN	PRALATREXATE IV INJ 40 MG/2ML	21300054002025	-18.8%	$0.00	Y
FUDR INJ 0.5GM	Antineoplastic Agent	FUDR	FLOXURIDINE FOR INJ 0.5 GM	21300020002105	-13.5%	$0.00	Y
GEMCITABINE INJ 1GM	Antineoplastic Agent	GEMCITABINE	GEMCITABINE HCL FOR INJ 1 GM	21300034102140	-75.0%	$0.00	Y
GEMCITABINE INJ 200MG	Antineoplastic Agent	GEMCITABINE	GEMCITABINE HCL FOR INJ 200 MG	21300034102110	-75.0%	$0.00	Y
GEMCITABINE INJ 2GM	Antineoplastic Agent	GEMCITABINE	GEMCITABINE HCL FOR INJ 2 GM	21300034102160	-75.0%	$0.00	Y
GEMZAR INJ 1GM	Antineoplastic Agent	GEMZAR	GEMCITABINE HCL FOR INJ 1 GM	21300034102140	-15.5%	$0.00	Y
GEMZAR INJ 200MG	Antineoplastic Agent	GEMZAR	GEMCITABINE HCL FOR INJ 200 MG	21300034102110	-15.5%	$0.00	Y

GLEEVEC TAB 100MG	Antineoplastic Agent	GLEEVEC	IMATINIB MESYLATE TAB 100 MG (BASE EQUIVALENT)	21534035100320	-24.0%	$0.00	Y
GLEEVEC TAB 400MG	Antineoplastic Agent	GLEEVEC	IMATINIB MESYLATE TAB 400 MG (BASE EQUIVALENT)	21534035100340	-24.0%	$0.00	Y
HALAVEN INJ 1MG/2ML	Antineoplastic Agent	HALAVEN	ERIBULIN MESYLATE INJ 1 MG/2ML (0.5 MG/ML)	21500009202020	-15.0%	$0.00	Y
HERCEPTIN INJ 440MG	Antineoplastic Agent	HERCEPTIN	TRASTUZUMAB FOR IV SOLN 440 MG	21353070002120	-16.0%	$0.00	Y
HYCAMTIN CAP 0.25MG	Antineoplastic Agent	HYCAMTIN	TOPOTECAN HCL CAP 0.25 MG (BASE EQUIV)	21550080100120	-14.0%	$0.00	Y
HYCAMTIN CAP 1MG	Antineoplastic Agent	HYCAMTIN	TOPOTECAN HCL CAP 1 MG (BASE EQUIV)	21550080100140	-14.0%	$0.00	Y
HYCAMTIN INJ 4MG	Antineoplastic Agent	HYCAMTIN	TOPOTECAN HCL FOR INJ 4 MG	21550080102120	-14.0%	$0.00	Y
ICLUSIG TAB 15MG	Antineoplastic Agent	ICLUSIG	PONATINIB HCL TAB 15 MG (BASE EQUIV)	21534075100320	-15.0%	$0.00	N
ICLUSIG TAB 45MG	Antineoplastic Agent	ICLUSIG	PONATINIB HCL TAB 45 MG (BASE EQUIV)	21534075100340	-15.0%	$0.00	N
IDAMYCIN PFS INJ 10/10ML	Antineoplastic Agent	IDAMYCIN PFS	IDARUBICIN HCL IV INJ 10 MG/10ML (1 MG/ML)	21200045102030	-13.5%	$0.00	Y
IDAMYCIN PFS INJ 20/20ML	Antineoplastic Agent	IDAMYCIN PFS	IDARUBICIN HCL IV INJ 20 MG/20ML (1 MG/ML)	21200045102035	-13.5%	$0.00	Y
IDAMYCIN PFS INJ 5MG/5ML	Antineoplastic Agent	IDAMYCIN PFS	IDARUBICIN HCL IV INJ 5 MG/5ML (1 MG/ML)	21200045102025	-13.5%	$0.00	Y
IDARUBICIN INJ 10/10ML	Antineoplastic Agent	IDARUBICIN	IDARUBICIN HCL IV INJ 10 MG/10ML (1 MG/ML)	21200045102030	-18.0%	$0.00	Y
IDARUBICIN INJ 20/20ML	Antineoplastic Agent	IDARUBICIN	IDARUBICIN HCL IV INJ 20 MG/20ML (1 MG/ML)	21200045102035	-18.0%	$0.00	Y
IDARUBICIN INJ 5MG/5ML	Antineoplastic Agent	IDARUBICIN	IDARUBICIN HCL IV INJ 5 MG/5ML (1 MG/ML)	21200045102025	-18.0%	$0.00	Y
IFEX INJ 1GM	Antineoplastic Agent	IFEX	IFOSFAMIDE FOR INJ 1 GM	21101025002110	-13.5%	$0.00	Y
IFEX INJ 3GM	Antineoplastic Agent	IFEX	IFOSFAMIDE FOR INJ 3 GM	21101025002130	-13.5%	$0.00	Y
IFOSFAMIDE INJ 1GM	Antineoplastic Agent	IFOSFAMIDE	IFOSFAMIDE FOR INJ 1 GM	21101025002110	-18.0%	$0.00	Y
IFOSFAMIDE INJ 1GM/20ML	Antineoplastic Agent	IFOSFAMIDE	IFOSFAMIDE IV INJ 1 GM/20ML (50 MG/ML)	21101025002025	-17.0%	$0.00	Y
IFOSFAMIDE INJ 3GM	Antineoplastic Agent	IFOSFAMIDE	IFOSFAMIDE FOR INJ 3 GM	21101025002130	-17.0%	$0.00	Y
IFOSFAMIDE INJ 3GM/60ML	Antineoplastic Agent	IFOSFAMIDE	IFOSFAMIDE IV INJ 3 GM/60ML (50 MG/ML)	21101025002030	-17.0%	$0.00	Y
IFOSFAMIDE KIT MESNA	Antineoplastic Agent	IFOSFAMIDE	IFOSFAMIDE & MESNA INJ KIT 1000-1000 MG	21990002405440	-18.0%	$0.00	Y
INLYTA TAB 1MG	Antineoplastic Agent	INLYTA	AXITINIB TAB 1 MG	21534008000320	-13.5%	$0.00	Y
INLYTA TAB 5MG	Antineoplastic Agent	INLYTA	AXITINIB TAB 5 MG	21534008000340	-13.5%	$0.00	Y
IRINOTECAN INJ 100/5ML	Antineoplastic Agent	IRINOTECAN	IRINOTECAN HCL INJ 100 MG/5ML (20 MG/ML)	21550040102030	-82.0%	$0.00	Y
IRINOTECAN INJ 40MG/2ML	Antineoplastic Agent	IRINOTECAN	IRINOTECAN HCL INJ 40 MG/2ML (20 MG/ML)	21550040102025	-82.0%	$0.00	Y
IRINOTECAN INJ 500MG/25	Antineoplastic Agent	IRINOTECAN	IRINOTECAN HCL INJ 500 MG/25ML (20 MG/ML)	21550040102040	-82.0%	$0.00	Y
ISTODAX INJ 10MG	Antineoplastic Agent	ISTODAX	ROMIDEPSIN FOR IV INJ 10 MG	21531560002120	-14.0%	$0.00	Y
IXEMPRA KIT INJ 15MG	Antineoplastic Agent	IXEMPRA KIT	IXABEPILONE FOR IV INFUSION 15 MG	21500011002120	-16.5%	$0.00	Y
IXEMPRA KIT INJ 45MG	Antineoplastic Agent	IXEMPRA KIT	IXABEPILONE FOR IV INFUSION 45 MG	21500011002140	-16.5%	$0.00	Y
JAKAFI TAB 10MG	Antineoplastic Agent	JAKAFI	RUXOLITINIB PHOSPHATE TAB 10 MG (BASE EQUIVALENT)	21537560200320	-16.0%	$0.00	N
JAKAFI TAB 15MG	Antineoplastic Agent	JAKAFI	RUXOLITINIB PHOSPHATE TAB 15 MG (BASE EQUIVALENT)	21537560200325	-16.0%	$0.00	N
JAKAFI TAB 20MG	Antineoplastic Agent	JAKAFI	RUXOLITINIB PHOSPHATE TAB 20 MG (BASE EQUIVALENT)	21537560200330	-16.0%	$0.00	N
JAKAFI TAB 25MG	Antineoplastic Agent	JAKAFI	RUXOLITINIB PHOSPHATE TAB 25 MG (BASE EQUIVALENT)	21537560200335	-16.0%	$0.00	N
JAKAFI TAB 5MG	Antineoplastic Agent	JAKAFI	RUXOLITINIB PHOSPHATE TAB 5 MG (BASE EQUIVALENT)	21537560200310	-16.0%	$0.00	N
JEVTANA INJ 60/1.5ML	Antineoplastic Agent	JEVTANA	CABAZITAXEL INJ 60 MG/1.5ML (FOR IV INFUSION)	21500003002020	-17.0%	$0.00	Y
KADCYLA INJ 100MG	Antineoplastic Agent	KADCYLA	ADO-TRASTUZUMAB EMTANSINE FOR IV SOLN 100 MG	21355070302120	-13.0%	$0.00	Y
KADCYLA INJ 160MG	Antineoplastic Agent	KADCYLA	ADO-TRASTUZUMAB EMTANSINE FOR IV SOLN 160 MG	21355070302130	-13.0%	$0.00	Y
KYPROLIS SOL 60MG	Antineoplastic Agent	KYPROLIS	CARFILZOMIB FOR INJ 60 MG	21536025002120	-18.0%	$0.00	Y
KYTRIL INJ 1MG/ML	Antineoplastic Agent	KYTRIL	GRANISETRON HCL INJ 4 MG/4ML (1 MG/ML)	50250035102015	-13.5%	$0.00	N
LEUPROLIDE INJ 1MG/0.2	Antineoplastic Agent	LEUPROLIDE	LEUPROLIDE ACETATE INJ KIT 5 MG/ML	21405010106407	-35.0%	$0.00	Y
LEUPROLIDE POW ACETATE	Antineoplastic Agent	LEUPROLIDE	LEUPROLIDE ACETATE (BULK) POWDER	96845048502900	-15.0%	$0.00	N
LEUSTATIN INJ 1MG/ML	Antineoplastic Agent	LEUSTATIN	CLADRIBINE INJ 1 MG/ML	21300007002010	-13.5%	$0.00	N
LIPODOX INJ 2MG/ML	Antineoplastic Agent	LIPODOX	DOXORUBICIN HCL LIPOSOMAL INJ (FOR IV INFUSION) 2 MG/ML	21200040402210	-18.0%	$0.00	Y
LIPODOX 50 INJ 2MG/ML	Antineoplastic Agent	LIPODOX 50	DOXORUBICIN HCL LIPOSOMAL INJ (FOR IV INFUSION) 2 MG/ML	21200040402210	-18.0%	$0.00	Y
LUPR DEP-PED INJ 11.25MG	Antineoplastic Agent	LUPR DEP-PED	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 11.25 MG	30080050106430	-14.0%	$0.00	Y
LUPR DEP-PED INJ 15MG	Antineoplastic Agent	LUPR DEP-PED	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 15 MG	30080050106440	-14.0%	$0.00	Y
LUPR DEP-PED INJ 30MG	Antineoplastic Agent	LUPR DEP-PED	LEUPROLIDE ACETATE (3 MONTH) FOR INJ PEDIATRIC KIT 30 MG	30080050156440	-14.0%	$0.00	Y
LUPR DEP-PED INJ 7.5MG	Antineoplastic Agent	LUPR DEP-PED	LEUPROLIDE ACETATE FOR INJ PEDIATRIC KIT 7.5 MG	30080050106420	-14.0%	$0.00	Y
LUPRON DEPOT INJ 11.25MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 11.25 MG	21405010156420	-14.0%	$0.00	Y
LUPRON DEPOT INJ 22.5MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE (3 MONTH) FOR INJ KIT 22.5 MG	21405010156430	-14.0%	$0.00	Y
LUPRON DEPOT INJ 3.75MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE FOR INJ KIT 3.75 MG	21405010106405	-14.0%	$0.00	Y
LUPRON DEPOT INJ 30MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE (4 MONTH) FOR INJ KIT 30 MG	21405010206430	-14.0%	$0.00	Y
LUPRON DEPOT INJ 45MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE (6 MONTH) FOR INJ KIT 45 MG	21405010256450	-14.0%	$0.00	Y
LUPRON DEPOT INJ 7.5MG	Antineoplastic Agent	LUPRON DEPOT	LEUPROLIDE ACETATE FOR INJ KIT 7.5 MG	21405010106410	-14.0%	$0.00	Y
MELPHALAN INJ 50MG	Antineoplastic Agent	MELPHALAN	MELPHALAN HCL FOR INJ 50 MG (BASE EQUIV)	21101040102110	-18.0%	$0.00	Y
MERCAPTOPURI POW	Antineoplastic Agent	MERCAPTOPURI	MERCAPTOPURINE MONOHYDRATE (BULK) POWDER	96665053902900	-15.0%	$0.00	N
MERCAPTOPURI POW MONOHYDR	Antineoplastic Agent	MERCAPTOPURI	MERCAPTOPURINE MONOHYDRATE (BULK) POWDER	96665053902900	-15.0%	$0.00	N
MERCAPTOPURI POW USP	Antineoplastic Agent	MERCAPTOPURI	*BULK CHEMICALS - POWDER**	96900010002900	-15.0%	$0.00	N
MESNEX INJ 1GM	Antineoplastic Agent	MESNEX	MESNA INJ 100 MG/ML	21758050002010	-13.5%	$0.00	Y
MESNEX TAB 400MG	Antineoplastic Agent	MESNEX	MESNA TAB 400 MG	21758050000320	-13.5%	$0.00	Y
MITOMYCIN INJ 20MG	Antineoplastic Agent	MITOMYCIN	MITOMYCIN FOR INJ 20 MG	21200050002110	-18.0%	$0.00	Y

MITOMYCIN INJ 40MG	Antineoplastic Agent	MITOMYCIN	MITOMYCIN FOR INJ 40 MG	21200050002120	-18.0%	$0.00	Y
MITOMYCIN INJ 5MG	Antineoplastic Agent	MITOMYCIN	MITOMYCIN FOR INJ 5 MG	21200050002105	-18.0%	$0.00	Y
MITOMYCIN POW	Antineoplastic Agent	MITOMYCIN	MITOMYCIN (BULK) POWDER	96665860452900	-15.0%	$0.00	N
MITOMYCIN POW USP	Antineoplastic Agent	MITOMYCIN	MITOMYCIN (BULK) POWDER	96665860452900	-15.0%	$0.00	N
MITOMYCIN C POW	Antineoplastic Agent	MITOMYCIN C	MITOMYCIN (BULK) POWDER	96665860452900	-15.0%	$0.00	N
MITOXANTRON INJ 2MG/ML	Antineoplastic Agent	MITOXANTRON	MITOXANTRONE HCL INJ CONC 20 MG/10ML (2 MG/ML)	21200055001320	-18.0%	$0.00	Y
MUSTARGEN INJ 10MG	Antineoplastic Agent	MUSTARGEN	MECHLORETHAMINE HCL FOR INJ 10 MG	21101030102105	-13.5%	$0.00	Y
NAVELBINE INJ 10MG/ML	Antineoplastic Agent	NAVELBINE	VINORELBINE TARTRATE INJ 10 MG/ML	21500050802020	-26.0%	$0.00	Y
NAVELBINE INJ 50MG/5ML	Antineoplastic Agent	NAVELBINE	VINORELBINE TARTRATE INJ 50 MG/5ML (10 MG/ML)	21500050802025	-26.0%	$0.00	Y
NEXAVAR TAB 200MG	Antineoplastic Agent	NEXAVAR	SORAFENIB TOSYLATE TAB 200 MG (BASE EQUIVALENT)	21533050400320	-13.5%	$0.00	Y
NIPENT INJ 10MG	Antineoplastic Agent	NIPENT	PENTOSTATIN FOR INJ 10 MG	21700045002120	-13.5%	$0.00	Y
ONCASPAR INJ 750/ML	Antineoplastic Agent	ONCASPAR	PEGASPARGASE INJ 750 UNIT/ML	21250060002020	-17.0%	$0.00	Y
ONTAK INJ 150/ML	Antineoplastic Agent	ONTAK	DENILEUKIN DIFTITOX IV SOLN 150 MCG/ML	21700024002020	-13.5%	$0.00	Y
OXALIPLATIN INJ 100MG	Antineoplastic Agent	OXALIPLATIN	OXALIPLATIN IV SOLN 100 MG/20ML	21100028002030	-35.0%	$0.00	Y
OXALIPLATIN INJ 50MG	Antineoplastic Agent	OXALIPLATIN	OXALIPLATIN FOR IV INJ 50 MG	21100028002120	-35.0%	$0.00	Y
PACLITAXEL INJ 100MG	Antineoplastic Agent	PACLITAXEL	PACLITAXEL IV CONC 100 MG/16.7ML (6 MG/ML)	21500012001335	-18.0%	$0.00	Y
PACLITAXEL INJ 150/25ML	Antineoplastic Agent	PACLITAXEL	PACLITAXEL IV CONC 150 MG/25ML (6 MG/ML)	21500012001340	-18.0%	$0.00	Y
PACLITAXEL INJ 300/50ML	Antineoplastic Agent	PACLITAXEL	PACLITAXEL IV CONC 300 MG/50ML (6 MG/ML)	21500012001350	-18.0%	$0.00	Y
PACLITAXEL INJ 30MG/5ML	Antineoplastic Agent	PACLITAXEL	PACLITAXEL IV CONC 30 MG/5ML (6 MG/ML)	21500012001325	-18.0%	$0.00	Y
PENTOSTATIN INJ 10MG	Antineoplastic Agent	PENTOSTATIN	PENTOSTATIN FOR INJ 10 MG	21700045002120	-18.0%	$0.00	Y
PERJETA INJ 420/14ML	Antineoplastic Agent	PERJETA	PERTUZUMAB SOLN FOR IV INFUSION 420 MG/14ML (30 MG/ML)	21353054002020	-12.5%	$0.00	Y
PHOTOFRIN INJ 75MG	Antineoplastic Agent	PHOTOFRIN	PORFIMER SODIUM FOR INJ 75 MG	21707070102140	-13.5%	$0.00	N
POMALYST CAP 1MG	Antineoplastic Agent	POMALYST	POMALIDOMIDE CAP 1 MG	21450080000110	-13.0%	$0.00	Y
POMALYST CAP 2MG	Antineoplastic Agent	POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	-13.0%	$0.00	Y
POMALYST CAP 3MG	Antineoplastic Agent	POMALYST	POMALIDOMIDE CAP 3 MG	21450080000120	-13.0%	$0.00	Y
POMALYST CAP 4MG	Antineoplastic Agent	POMALYST	POMALIDOMIDE CAP 4 MG	21450080000125	-13.0%	$0.00	Y
PROLEUKIN INJ 22MU	Antineoplastic Agent	PROLEUKIN	ALDESLEUKIN FOR IV SOLN 22000000 UNIT	21703020002120	-19.0%	$0.00	Y
REVLIMID CAP 10MG	Antineoplastic Agent	REVLIMID	LENALIDOMIDE CAP 10 MG	99394050000130	-13.0%	$0.00	Y
REVLIMID CAP 15MG	Antineoplastic Agent	REVLIMID	LENALIDOMIDE CAP 15 MG	99394050000140	-13.0%	$0.00	Y
REVLIMID CAP 2.5MG	Antineoplastic Agent	REVLIMID	LENALIDOMIDE CAPS 2.5 MG	99394050000110	-13.0%	$0.00	Y
REVLIMID CAP 25MG	Antineoplastic Agent	REVLIMID	LENALIDOMIDE CAP 25 MG	99394050000150	-13.0%	$0.00	Y
REVLIMID CAP 5MG	Antineoplastic Agent	REVLIMID	LENALIDOMIDE CAP 5 MG	99394050000120	-13.0%	$0.00	Y
RITUXAN INJ 100MG	Antineoplastic Agent	RITUXAN	RITUXIMAB FOR IV INJ CONC 10 MG/ML	21353060001310	-16.5%	$0.00	Y
RITUXAN INJ 500MG	Antineoplastic Agent	RITUXAN	RITUXIMAB FOR IV INJ CONC 10 MG/ML	21353060001310	-16.5%	$0.00	Y
SPRYCEL TAB 100MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 100 MG	21534020000360	-14.5%	$0.00	Y
SPRYCEL TAB 140MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 140 MG	21534020000380	-14.5%	$0.00	Y
SPRYCEL TAB 20MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 20 MG	21534020000320	-14.5%	$0.00	Y
SPRYCEL TAB 50MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 50 MG	21534020000340	-14.5%	$0.00	Y
SPRYCEL TAB 70MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 70 MG	21534020000350	-14.5%	$0.00	Y
SPRYCEL TAB 80MG	Antineoplastic Agent	SPRYCEL	DASATINIB TAB 80 MG	21534020000354	-14.5%	$0.00	Y
STIVARGA TAB 40MG	Antineoplastic Agent	STIVARGA	REGORAFENIB TAB 40 MG	21533050000320	-13.5%	$0.00	Y
SUPPRELIN LA KIT 50MG	Antineoplastic Agent	SUPPRELIN LA	HISTRELIN ACETATE (CPP) IMPLANT KIT 50 MG	30080045106450	-16.4%	$0.00	Y
SUTENT CAP 12.5MG	Antineoplastic Agent	SUTENT	SUNITINIB MALATE CAP 12.5 MG (BASE EQUIVALENT)	21533070300120	-16.5%	$0.00	Y
SUTENT CAP 25MG	Antineoplastic Agent	SUTENT	SUNITINIB MALATE CAP 25 MG (BASE EQUIVALENT)	21533070300130	-16.5%	$0.00	Y
SUTENT CAP 50MG	Antineoplastic Agent	SUTENT	SUNITINIB MALATE CAP 50 MG (BASE EQUIVALENT)	21533070300140	-16.5%	$0.00	Y
SYNRIBO INJ 3.5MG	Antineoplastic Agent	SYNRIBO	OMACETAXINE MEPESUCCINATE FOR INJ 3.5 MG	21700040102120	-15.0%	$0.00	Y
TARCEVA TAB 100MG	Antineoplastic Agent	TARCEVA	ERLOTINIB TAB 100 MG	21534025000340	-16.5%	$0.00	Y
TARCEVA TAB 150MG	Antineoplastic Agent	TARCEVA	ERLOTINIB TAB 150 MG	21534025000360	-16.5%	$0.00	Y
TARCEVA TAB 25MG	Antineoplastic Agent	TARCEVA	ERLOTINIB TAB 25 MG	21534025000320	-16.5%	$0.00	Y
TASIGNA CAP 150MG	Antineoplastic Agent	TASIGNA	NILOTINIB CAP 150 MG	21534060000115	-15.0%	$0.00	Y
TASIGNA CAP 200MG	Antineoplastic Agent	TASIGNA	NILOTINIB CAP 200 MG	21534060000120	-13.5%	$0.00	Y
TAXOTERE INJ 20/0.5ML	Antineoplastic Agent	TAXOTERE	DOCETAXEL FOR INJ CONC 20 MG/0.5ML (40 MG/ML)	21500005001320	-15.0%	$0.00	Y
TAXOTERE INJ 20MG/ML	Antineoplastic Agent	TAXOTERE	DOCETAXEL FOR INJ CONC 20 MG/ML	21500005001310	-15.0%	$0.00	Y
TAXOTERE INJ 80MG/2ML	Antineoplastic Agent	TAXOTERE	DOCETAXEL FOR INJ CONC 80 MG/2ML (40 MG/ML)	21500005001325	-15.0%	$0.00	Y
TAXOTERE INJ 80MG/4ML	Antineoplastic Agent	TAXOTERE	DOCETAXEL FOR INJ CONC 80 MG/4ML (20 MG/ML)	21500005001315	-15.0%	$0.00	Y
TEMODAR CAP 100MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 100 MG	21104070000140	-17.0%	$0.00	Y
TEMODAR CAP 140MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 140 MG	21104070000143	-17.0%	$0.00	Y
TEMODAR CAP 180MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 180 MG	21104070000147	-17.0%	$0.00	Y
TEMODAR CAP 20MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 20 MG	21104070000120	-17.0%	$0.00	Y
TEMODAR CAP 250MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 250 MG	21104070000150	-17.0%	$0.00	Y
TEMODAR CAP 5MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE CAP 5 MG	21104070000110	-17.0%	$0.00	Y
TEMODAR INJ 100MG	Antineoplastic Agent	TEMODAR	TEMOZOLOMIDE FOR IV SOLN 100 MG	21104070002120	-17.0%	$0.00	Y

THERACYS INJ	Antineoplastic Agent	THERACYS	BCG LIVE INTRAVESICAL FOR SUSP 81 MG/VIAL	21700013001940	-12.5%	$0.00	Y
THIOTEPA INJ 15MG	Antineoplastic Agent	THIOTEPA	THIOTEPA FOR INJ 15 MG	21100040002105	-13.5%	$0.00	Y
TICE BCG INJ	Antineoplastic Agent	TICE BCG	BCG LIVE INTRAVESICAL FOR SUSP 50 MG	21700013001930	-5.0%	$0.00	Y
TOPOSAR INJ 100/5ML	Antineoplastic Agent	TOPOSAR	ETOPOSIDE INJ 20 MG/ML	21500010002020	-18.0%	$0.00	Y
TOPOSAR INJ 1GM/50ML	Antineoplastic Agent	TOPOSAR	ETOPOSIDE INJ 20 MG/ML	21500010002020	-18.0%	$0.00	Y
TOPOSAR INJ 500/25ML	Antineoplastic Agent	TOPOSAR	ETOPOSIDE INJ 20 MG/ML	21500010002020	-18.0%	$0.00	Y
TOPOTECAN INJ 4MG	Antineoplastic Agent	TOPOTECAN	TOPOTECAN HCL FOR INJ 4 MG	21550080102120	-18.0%	$0.00	Y
TOPOTECAN INJ 4MG/4ML	Antineoplastic Agent	TOPOTECAN	TOPOTECAN HCL INJ 4 MG/4ML (BASE EQUIV) (FOR INFUSION)	21550080102020	-18.0%	$0.00	Y
TORISEL SOL 25MG/ML	Antineoplastic Agent	TORISEL	TEMSIROLIMUS SOLN FOR IV INFUSION 25 MG/ML	21532570002020	-16.5%	$0.00	Y
TREANDA INJ 100MG	Antineoplastic Agent	TREANDA	BENDAMUSTINE HCL FOR IV SOLN 100 MG	21100009102120	-16.5%	$0.00	Y
TREANDA INJ 25MG	Antineoplastic Agent	TREANDA	BENDAMUSTINE HCL FOR IV SOLN 25 MG	21100009102110	-16.5%	$0.00	Y
TRELSTAR DEP INJ 3.75MG	Antineoplastic Agent	TRELSTAR DEP	TRIPTORELIN PAMOATE FOR IM SUSP 3.75 MG	21405050201920	-26.0%	$0.00	Y
TRELSTAR LA INJ 11.25MG	Antineoplastic Agent	TRELSTAR LA	TRIPTORELIN PAMOATE FOR IM SUSP 11.25 MG	21405050201930	-26.0%	$0.00	Y
TRELSTAR MIX INJ 22.5MG	Antineoplastic Agent	TRELSTAR MIX	TRIPTORELIN PAMOATE FOR IM SUSP 22.5 MG	21405050201940	-26.0%	$0.00	Y
TRETINOIN CAP 10MG	Antineoplastic Agent	TRETINOIN	TRETINOIN CAP 10 MG	21708080000110	-18.0%	$0.00	Y
TRISENOX SOL 10MG/10M	Antineoplastic Agent	TRISENOX	ARSENIC TRIOXIDE INJ 10 MG/10ML (1 MG/ML)	21700008102020	-13.5%	$0.00	Y
TYKERB TAB 250MG	Antineoplastic Agent	TYKERB	LAPATINIB DITOSYLATE TAB 250 MG (BASE EQUIV)	21534050100320	-20.0%	$0.00	Y
VANTAS KIT 50MG	Antineoplastic Agent	VANTAS	HISTRELIN ACETATE IMPLANT KIT 50 MG	21405007106450	-15.0%	$0.00	Y
VECTIBIX INJ 100MG	Antineoplastic Agent	VECTIBIX	PANITUMUMAB IV SOLN 100 MG/5ML	21535050002025	-13.5%	$0.00	Y
VECTIBIX INJ 400MG	Antineoplastic Agent	VECTIBIX	PANITUMUMAB IV SOLN 400 MG/20ML	21535050002035	-13.5%	$0.00	Y
VELCADE INJ 3.5MG	Antineoplastic Agent	VELCADE	BORTEZOMIB FOR INJ 3.5 MG	21535015002120	-16.5%	$0.00	Y
VIDAZA INJ 100MG	Antineoplastic Agent	VIDAZA	AZACITIDINE FOR INJ 100 MG	21300003001920	-13.5%	$0.00	Y
VINBLASTINE INJ 10MG	Antineoplastic Agent	VINBLASTINE	VINBLASTINE SULFATE FOR INJ 10 MG	21500030102105	-18.0%	$0.00	Y
VINBLASTINE INJ 1MG/ML	Antineoplastic Agent	VINBLASTINE	VINBLASTINE SULFATE INJ 1 MG/ML	21500030102020	-18.0%	$0.00	Y
VINCASAR PFS INJ 1MG/ML	Antineoplastic Agent	VINCASAR PFS	VINCRISTINE SULFATE IV SOLN 1 MG/ML	21500020102005	-18.0%	$0.00	Y
VINCRISTINE INJ 1MG/ML	Antineoplastic Agent	VINCRISTINE	VINCRISTINE SULFATE IV SOLN 1 MG/ML	21500020102005	-18.0%	$0.00	Y
VINORELBINE INJ 10MG/ML	Antineoplastic Agent	VINORELBINE	VINORELBINE TARTRATE INJ 10 MG/ML	21500050602020	-26.0%	$0.00	Y
VINORELBINE INJ 50MG/5ML	Antineoplastic Agent	VINORELBINE	VINORELBINE TARTRATE INJ 50 MG/5ML (10 MG/ML)	21500050602025	-26.0%	$0.00	Y
VOTRIENT TAB 200MG	Antineoplastic Agent	VOTRIENT	PAZOPANIB HCL TAB 200 MG (BASE EQUIV)	21534070100320	-16.5%	$0.00	Y
VUMON INJ 50MG/5ML	Antineoplastic Agent	VUMON	TENIPOSIDE IV SOLN 10 MG/ML	21500015002020	-13.5%	$0.00	Y
XALKORI CAP 200MG	Antineoplastic Agent	XALKORI	CRIZOTINIB CAP 200 MG	21534015000120	-16.5%	$0.00	N
XALKORI CAP 250MG	Antineoplastic Agent	XALKORI	CRIZOTINIB CAP 250 MG	21534015000125	-16.5%	$0.00	N
XELODA TAB 150MG	Antineoplastic Agent	XELODA	CAPECITABINE TAB 150 MG	21300005000320	-15.0%	$0.00	Y
XELODA TAB 500MG	Antineoplastic Agent	XELODA	CAPECITABINE TAB 500 MG	21300005000350	-15.0%	$0.00	Y
XTANDI CAP 40MG	Antineoplastic Agent	XTANDI	ENZALUTAMIDE CAP 40 MG	21402430000120	-13.5%	$0.00	Y
XYNTHA SOLOF INJ 1000UNIT	Antineoplastic Agent	XYNTHA SOLOF	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 1000 UNIT	85100010266440	-21.5%	$0.00	Y
YERVOY INJ 200MG	Antineoplastic Agent	YERVOY	IPILIMUMAB SOLN FOR IV INFUSION 200 MG/40ML (5 MG/ML)	21353032002040	-17.0%	$0.00	Y
YERVOY INJ 50MG	Antineoplastic Agent	YERVOY	IPILIMUMAB SOLN FOR IV INFUSION 50 MG/10ML (5 MG/ML)	21353032002020	-17.0%	$0.00	Y
ZALTRAP INJ 100/4ML	Antineoplastic Agent	ZALTRAP	ZIV-AFLIBERCEPT IV SOLN 100 MG/4ML (FOR INFUSION)	21335010102020	-13.5%	$0.00	Y
ZALTRAP INJ 200/8ML	Antineoplastic Agent	ZALTRAP	ZIV-AFLIBERCEPT IV SOLN 200 MG/8ML (FOR INFUSION)	21335010102030	-13.5%	$0.00	Y
ZANOSAR INJ 1GM	Antineoplastic Agent	ZANOSAR	STREPTOZOCIN FOR INJ 1 GM	21102030002105	-17.0%	$0.00	Y
ZELBORAF TAB 240MG	Antineoplastic Agent	ZELBORAF	VEMURAFENIB TAB 240 MG (BASE EQUIVALENT)	21532080000320	-13.5%	$0.00	Y
ZEVALIN KIT IN-111	Antineoplastic Agent	ZEVALIN	IBRITUMOMAB TIUXETAN FOR INDIUM-111 (IN-111) KIT 3.2 MG/2ML	21358035206420	-15.0%	$0.00	N
ZEVALIN KIT Y-90	Antineoplastic Agent	ZEVALIN	IBRITUMOMAB TIUXETAN FOR YTTRIUM-90 (Y-90) KIT 3.2 MG/2ML	21358035406420	-15.0%	$0.00	N
ZOLADEX IMP 10.8MG	Antineoplastic Agent	ZOLADEX	GOSERELIN ACETATE IMPLANT 10.8 MG	21405005102330	-20.0%	$0.00	Y
ZOLADEX IMP 3.6MG	Antineoplastic Agent	ZOLADEX	GOSERELIN ACETATE IMPLANT 3.6 MG	21405005102310	-20.0%	$0.00	Y
ZOLINZA CAP 100MG	Antineoplastic Agent	ZOLINZA	VORINOSTAT CAP 100 MG	21531575000120	-16.0%	$0.00	Y
ZYTIGA TAB 250MG	Antineoplastic Agent	ZYTIGA	ABIRATERONE ACETATE TAB 250 MG	21406010200320	-16.5%	$0.00	Y
STELARA INJ 45MG/0.5	Antipsoriatics	STELARA	USTEKINUMAB INJ 45 MG/0.5ML	90250585002020	-17.0%	$0.00	Y
STELARA INJ 90MG/ML	Antipsoriatics	STELARA	USTEKINUMAB INJ 90 MG/ML	90250585002025	-17.0%	$0.00	Y
ABACAVIR TAB 300MG	Antiretroviral Agent	ABACAVIR	ABACAVIR SULFATE TAB 300 MG (BASE EQUIV)	12105005100320	-18.0%	$0.00	Y
APTIVUS CAP 250MG	Antiretroviral Agent	APTIVUS	TIPRANAVIR CAP 250 MG	12104585000120	-12.5%	$0.00	Y
APTIVUS SOL	Antiretroviral Agent	APTIVUS	TIPRANAVIR ORAL SOLN 100 MG/ML	12104585002020	-12.5%	$0.00	Y
ATRIPLA TAB	Antiretroviral Agent	ATRIPLA	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300 MG	12109903300320	-17.5%	$0.00	Y
BARACLUDE SOL .05MG/ML	Antiretroviral Agent	BARACLUDE	ENTECAVIR ORAL SOLN 0.05 MG/ML	12352030002020	-12.5%	$0.00	Y
BARACLUDE TAB 0.5MG	Antiretroviral Agent	BARACLUDE	ENTECAVIR TAB 0.5 MG	12352030000320	-12.5%	$0.00	Y
BARACLUDE TAB 1MG	Antiretroviral Agent	BARACLUDE	ENTECAVIR TAB 1 MG	12352030000330	-12.5%	$0.00	Y
COMBIVIR TAB 150-300	Antiretroviral Agent	COMBIVIR	LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	12109902500320	-14.5%	$0.00	Y
COMPLERA TAB	Antiretroviral Agent	COMPLERA	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DF TAB 200-25-300 MG	12109903400320	-14.5%	$0.00	Y
CRIXIVAN CAP 200MG	Antiretroviral Agent	CRIXIVAN	INDINAVIR SULFATE CAP 200 MG	12104530200120	-10.0%	$0.00	Y
CRIXIVAN CAP 400MG	Antiretroviral Agent	CRIXIVAN	INDINAVIR SULFATE CAP 400 MG	12104530200140	-10.0%	$0.00	Y
DIDANOSINE CAP 125MG	Antiretroviral Agent	DIDANOSINE	DIDANOSINE DELAYED RELEASE CAPSULE 125 MG	12105015005520	-40.0%	$0.00	Y

DIDANOSINE CAP 200MG	Antiretroviral Agent	DIDANOSINE	DIDANOSINE DELAYED RELEASE CAPSULE 200 MG	12105015006528	-40.0%	$0.00	Y
DIDANOSINE CAP 250MG	Antiretroviral Agent	DIDANOSINE	DIDANOSINE DELAYED RELEASE CAPSULE 250 MG	12105015006535	-40.0%	$0.00	Y
DIDANOSINE CAP 400MG	Antiretroviral Agent	DIDANOSINE	DIDANOSINE DELAYED RELEASE CAPSULE 400 MG	12105015006550	-40.0%	$0.00	Y
EDURANT TAB 25MG	Antiretroviral Agent	EDURANT	RILPIVIRINE HCL TAB 25 MG (BASE EQUIVALENT)	12109080100320	-10.0%	$0.00	Y
EMTRIVA CAP 200MG	Antiretroviral Agent	EMTRIVA	EMTRICITABINE CAPS 200 MG	12106030000120	-7.0%	$0.00	Y
EMTRIVA SOL 10MG/ML	Antiretroviral Agent	EMTRIVA	EMTRICITABINE SOLN 10 MG/ML	12106030002010	-7.0%	$0.00	Y
EPIVIR SOL 10MG/ML	Antiretroviral Agent	EPIVIR	LAMIVUDINE ORAL SOLN 10 MG/ML	12106060002020	-5.0%	$0.00	Y
EPIVIR TAB 150MG	Antiretroviral Agent	EPIVIR	LAMIVUDINE TAB 150 MG	12106060000320	-5.0%	$0.00	Y
EPIVIR TAB 300MG	Antiretroviral Agent	EPIVIR	LAMIVUDINE TAB 300 MG	12106060000330	-5.0%	$0.00	Y
EPIVIR HBV SOL 5MG/ML	Antiretroviral Agent	EPIVIR HBV	LAMIVUDINE ORAL SOLN 5 MG/ML	12106080002010	-5.0%	$0.00	Y
EPIVIR HBV TAB 100MG	Antiretroviral Agent	EPIVIR HBV	LAMIVUDINE TAB 100 MG	12106080000315	-5.0%	$0.00	Y
EPZICOM TAB	Antiretroviral Agent	EPZICOM	ABACAVIR SULFATE-LAMIVUDINE TAB 600-300 MG	12109902200340	-13.0%	$0.00	Y
FUZEON INJ 90MG	Antiretroviral Agent	FUZEON	ENFUVIRTIDE FOR INJ 90 MG	12102530002120	-15.5%	$0.00	Y
FUZEON KIT	Antiretroviral Agent	FUZEON	ENFUVIRTIDE FOR INJ KIT 90 MG	12102530006420	-15.5%	$0.00	Y
INTELENCE TAB 100MG	Antiretroviral Agent	INTELENCE	ETRAVIRINE TAB 100 MG	12109035000320	-12.0%	$0.00	Y
INTELENCE TAB 200MG	Antiretroviral Agent	INTELENCE	ETRAVIRINE TAB 200 MG	12109035000340	-12.0%	$0.00	Y
INTELENCE TAB 25MG	Antiretroviral Agent	INTELENCE	ETRAVIRINE TAB 25 MG	12109035000310	-12.0%	$0.00	Y
INVIRASE CAP 200MG	Antiretroviral Agent	INVIRASE	SAQUINAVIR MESYLATE CAP 200 MG	12104580200120	-12.5%	$0.00	Y
INVIRASE TAB 500MG	Antiretroviral Agent	INVIRASE	SAQUINAVIR MESYLATE TAB 500 MG	12104580200320	-12.5%	$0.00	Y
ISENTRESS CHW 100MG	Antiretroviral Agent	ISENTRESS	RALTEGRAVIR POTASSIUM CHEW TAB 100 MG (BASE EQUIV)	12103080100540	-11.5%	$0.00	Y
ISENTRESS CHW 25MG	Antiretroviral Agent	ISENTRESS	RALTEGRAVIR POTASSIUM CHEW TAB 25 MG (BASE EQUIV)	12103080100510	-11.5%	$0.00	Y
ISENTRESS TAB 400MG	Antiretroviral Agent	ISENTRESS	RALTEGRAVIR POTASSIUM TAB 400 MG (BASE EQUIV)	12103080100320	-11.5%	$0.00	Y
KALETRA SOL	Antiretroviral Agent	KALETRA	LOPINAVIR-RITONAVIR SOLN 400-100 MG/5ML (80-20 MG/ML)	12109902552020	-11.0%	$0.00	Y
KALETRA TAB 100-25MG	Antiretroviral Agent	KALETRA	LOPINAVIR-RITONAVIR TAB 100-25 MG	12109902550310	-11.0%	$0.00	Y
KALETRA TAB 200-50MG	Antiretroviral Agent	KALETRA	LOPINAVIR-RITONAVIR TAB 200-50 MG	12109902550320	-11.0%	$0.00	Y
LAMIVUD/ZIDO TAB 150-300	Antiretroviral Agent	LAMIVUD/ZIDO	LAMIVUDINE-ZIDOVUDINE TAB 150-300 MG	12109902500320	-38.0%	$0.00	Y
LAMIVUDINE TAB 150MG	Antiretroviral Agent	LAMIVUDINE	LAMIVUDINE TAB 150 MG	12106060000320	-20.0%	$0.00	Y
LAMIVUDINE TAB 300MG	Antiretroviral Agent	LAMIVUDINE	LAMIVUDINE TAB 300 MG	12106060000330	-20.0%	$0.00	Y
LEXIVA SUS 50MG/ML	Antiretroviral Agent	LEXIVA	FOSAMPRENAVIR CALCIUM SUSP 50 MG/ML (BASE EQUIV)	12104525101620	-12.5%	$0.00	Y
LEXIVA TAB 700MG	Antiretroviral Agent	LEXIVA	FOSAMPRENAVIR CALCIUM TAB 700 MG (BASE EQUIV)	12104525100330	-12.5%	$0.00	Y
NEVIRAPINE SUS 50MG/5ML	Antiretroviral Agent	NEVIRAPINE	NEVIRAPINE SUSP 50 MG/5ML	12109050001820	-85.0%	$0.00	Y
NEVIRAPINE TAB 200MG	Antiretroviral Agent	NEVIRAPINE	NEVIRAPINE TAB 200 MG	12109050000320	-85.0%	$0.00	Y
NORVIR CAP 100MG	Antiretroviral Agent	NORVIR	RITONAVIR CAP 100 MG	12104580000120	-5.0%	$0.00	Y
NORVIR SOL 80MG/ML	Antiretroviral Agent	NORVIR	RITONAVIR ORAL SOLN 80 MG/ML	12104580002020	-5.0%	$0.00	Y
NORVIR TAB 100MG	Antiretroviral Agent	NORVIR	RITONAVIR TAB 100 MG	12104580000320	-5.0%	$0.00	Y
PREZISTA TAB 150MG	Antiretroviral Agent	PREZISTA	DARUNAVIR ETHANOLATE TAB 150 MG (BASE EQUIV)	12104520100315	-13.0%	$0.00	Y
PREZISTA TAB 400MG	Antiretroviral Agent	PREZISTA	DARUNAVIR ETHANOLATE TAB 400 MG (BASE EQUIV)	12104520100330	-13.0%	$0.00	Y
PREZISTA TAB 600MG	Antiretroviral Agent	PREZISTA	DARUNAVIR ETHANOLATE TAB 600 MG (BASE EQUIV)	12104520100340	-13.0%	$0.00	Y
PREZISTA TAB 75MG	Antiretroviral Agent	PREZISTA	DARUNAVIR ETHANOLATE TAB 75 MG (BASE EQUIV)	12104520100310	-13.0%	$0.00	Y
PREZISTA TAB 800MG	Antiretroviral Agent	PREZISTA	DARUNAVIR ETHANOLATE TAB 800 MG (BASE EQUIV)	12104520100350	-13.0%	$0.00	Y
RESCRIPTOR TAB 100 MG	Antiretroviral Agent	RESCRIPTOR	DELAVIRDINE MESYLATE TAB 100 MG	12109020200320	-5.0%	$0.00	Y
RESCRIPTOR TAB 200MG	Antiretroviral Agent	RESCRIPTOR	DELAVIRDINE MESYLATE TAB 200 MG	12109020200330	-5.0%	$0.00	Y
RETROVIR CAP 100MG	Antiretroviral Agent	RETROVIR	ZIDOVUDINE CAP 100 MG	12108085000110	-3.0%	$0.00	Y
RETROVIR INJ 10MG/ML	Antiretroviral Agent	RETROVIR	ZIDOVUDINE IV SOLN 10 MG/ML	12108085002020	-3.0%	$0.00	Y
RETROVIR SYP 50MG/5ML	Antiretroviral Agent	RETROVIR	ZIDOVUDINE SYRUP 10 MG/ML	12108085001210	-3.0%	$0.00	Y
RETROVIR TAB 300MG	Antiretroviral Agent	RETROVIR	ZIDOVUDINE TAB 300 MG	12108085000330	-3.0%	$0.00	Y
REYATAZ CAP 100MG	Antiretroviral Agent	REYATAZ	ATAZANAVIR SULFATE CAP 100 MG (BASE EQUIV)	12104515200120	-13.0%	$0.00	Y
REYATAZ CAP 150MG	Antiretroviral Agent	REYATAZ	ATAZANAVIR SULFATE CAP 150 MG (BASE EQUIV)	12104515200130	-13.0%	$0.00	Y
REYATAZ CAP 200MG	Antiretroviral Agent	REYATAZ	ATAZANAVIR SULFATE CAP 200 MG (BASE EQUIV)	12104515200140	-13.0%	$0.00	Y
REYATAZ CAP 300MG	Antiretroviral Agent	REYATAZ	ATAZANAVIR SULFATE CAP 300 MG (BASE EQUIV)	12104515200150	-13.0%	$0.00	Y
SELZENTRY TAB 150MG	Antiretroviral Agent	SELZENTRY	MARAVIROC TAB 150 MG	12102060000320	-13.5%	$0.00	Y
SELZENTRY TAB 300MG	Antiretroviral Agent	SELZENTRY	MARAVIROC TAB 300 MG	12102060000330	-13.5%	$0.00	Y
STAVUDINE CAP 15MG	Antiretroviral Agent	STAVUDINE	STAVUDINE CAP 15 MG	12108070000115	-38.0%	$0.00	Y
STAVUDINE CAP 20MG	Antiretroviral Agent	STAVUDINE	STAVUDINE CAP 20 MG	12108070000120	-38.0%	$0.00	Y
STAVUDINE CAP 30MG	Antiretroviral Agent	STAVUDINE	STAVUDINE CAP 30 MG	12108070000130	-38.0%	$0.00	Y
STAVUDINE CAP 40MG	Antiretroviral Agent	STAVUDINE	STAVUDINE CAP 40 MG	12108070000140	-38.0%	$0.00	Y
STAVUDINE SOL 1MG/ML	Antiretroviral Agent	STAVUDINE	STAVUDINE FOR ORAL SOLN 1 MG/ML	12108070002120	-38.0%	$0.00	Y
STRIBILD TAB	Antiretroviral Agent	STRIBILD	ELVITEGRAV-COBICIS-EMTRICITAB-TENOFOV TAB 150-150-200-300 MG	12109904300320	-15.5%	$0.00	Y
SUSTIVA CAP 200MG	Antiretroviral Agent	SUSTIVA	EFAVIRENZ CAP 200 MG	12109030000140	-10.0%	$0.00	Y
SUSTIVA CAP 50MG	Antiretroviral Agent	SUSTIVA	EFAVIRENZ CAP 50 MG	12109030000110	-10.0%	$0.00	Y
SUSTIVA TAB 600MG	Antiretroviral Agent	SUSTIVA	EFAVIRENZ TAB 600 MG	12109030000330	-10.0%	$0.00	Y
TRIZIVIR TAB	Antiretroviral Agent	TRIZIVIR	ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE TAB 300-150-300 MG	12109903200320	-14.5%	$0.00	Y

TRUVADA TAB	Antiretroviral Agent	TRUVADA	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300 MG	12109902300320	-13.5%	$0.00	Y
VIDEX SOL 2GM	Antiretroviral Agent	VIDEX	DIDANOSINE FOR SOLN 2 GM	12105015002120	-1.0%	$0.00	Y
VIDEX SOL 4GM	Antiretroviral Agent	VIDEX	DIDANOSINE FOR SOLN 4 GM	12105015002140	-1.0%	$0.00	Y
VIDEX EC CAP 125MG	Antiretroviral Agent	VIDEX EC	DIDANOSINE DELAYED RELEASE CAPSULE 125 MG	12105015006520	-1.0%	$0.00	Y
VIDEX EC CAP 200MG	Antiretroviral Agent	VIDEX EC	DIDANOSINE DELAYED RELEASE CAPSULE 200 MG	12105015006528	-1.0%	$0.00	Y
VIDEX EC CAP 250MG	Antiretroviral Agent	VIDEX EC	DIDANOSINE DELAYED RELEASE CAPSULE 250 MG	12105015006535	-1.0%	$0.00	Y
VIDEX EC CAP 400MG	Antiretroviral Agent	VIDEX EC	DIDANOSINE DELAYED RELEASE CAPSULE 400 MG	12105015006550	-1.0%	$0.00	Y
VIRACEPT TAB 250MG	Antiretroviral Agent	VIRACEPT	NELFINAVIR MESYLATE TAB 250 MG	12104545200320	-12.0%	$0.00	Y
VIRACEPT TAB 625MG	Antiretroviral Agent	VIRACEPT	NELFINAVIR MESYLATE TAB 625 MG	12104545200340	-12.0%	$0.00	Y
VIRAMUNE SUS 50MG/5ML	Antiretroviral Agent	VIRAMUNE	NEVIRAPINE SUSP 50 MG/5ML	12109050001820	-10.0%	$0.00	Y
VIRAMUNE TAB 200MG	Antiretroviral Agent	VIRAMUNE	NEVIRAPINE TAB 200 MG	12109050000320	-10.0%	$0.00	Y
VIRAMUNE XR TAB	Antiretroviral Agent	VIRAMUNE XR	NEVIRAPINE TAB SR 24HR 400 MG	12109050007520	-10.0%	$0.00	Y
VIRAMUNE XR TAB 400MG	Antiretroviral Agent	ZOLEDRONIC	ZOLEDRONIC ACID INJ CONC FOR IV INFUSION 4 MG/5ML	30042090001320	-10.0%	$0.00	Y
VIREAD POW 40MG/GM	Antiretroviral Agent	VIREAD	TENOFOVIR DISOPROXIL FUMARATE ORAL POWDER 40 MG/GM	12108570102920	-17.0%	$0.00	Y
VIREAD TAB 150MG	Antiretroviral Agent	VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 150 MG	12108570100305	-12.0%	$0.00	Y
VIREAD TAB 200MG	Antiretroviral Agent	VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 200 MG	12108570100310	-12.0%	$0.00	Y
VIREAD TAB 250MG	Antiretroviral Agent	VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 250 MG	12108570100315	-12.0%	$0.00	Y
VIREAD TAB 300MG	Antiretroviral Agent	VIREAD	TENOFOVIR DISOPROXIL FUMARATE TAB 300 MG	12108570100320	-12.0%	$0.00	Y
ZERIT CAP 15MG	Antiretroviral Agent	ZERIT	STAVUDINE CAP 15 MG	12108070000115	-7.5%	$0.00	Y
ZERIT CAP 20MG	Antiretroviral Agent	ZERIT	STAVUDINE CAP 20 MG	12108070000120	-7.5%	$0.00	Y
ZERIT CAP 30MG	Antiretroviral Agent	ZERIT	STAVUDINE CAP 30 MG	12108070000130	-7.5%	$0.00	Y
ZERIT CAP 40MG	Antiretroviral Agent	ZERIT	STAVUDINE CAP 40 MG	12108070000140	-7.5%	$0.00	Y
ZERIT SOL 1MG/ML	Antiretroviral Agent	ZERIT	STAVUDINE FOR ORAL SOLN 1 MG/ML	12108070002120	-7.5%	$0.00	Y
ZIAGEN SOL 20MG/ML	Antiretroviral Agent	ZIAGEN	ABACAVIR SULFATE SOLN 20 MG/ML (BASE EQUIV)	12105005102020	-9.0%	$0.00	Y
ZIAGEN TAB 300MG	Antiretroviral Agent	ZIAGEN	ABACAVIR SULFATE TAB 300 MG (BASE EQUIV)	12105005100320	-9.0%	$0.00	Y
ZIDOVUDINE CAP 100MG	Antiretroviral Agent	ZIDOVUDINE	ZIDOVUDINE CAP 100 MG	12108085000110	-35.0%	$0.00	Y
ZIDOVUDINE SYP 50MG/5ML	Antiretroviral Agent	ZIDOVUDINE	ZIDOVUDINE SYRUP 10 MG/ML	12108085001210	-35.0%	$0.00	Y
ZIDOVUDINE TAB 300MG	Antiretroviral Agent	ZIDOVUDINE	ZIDOVUDINE TAB 300 MG	12108085000330	-35.0%	$0.00	Y
ORENCIA INJ 125MG/ML	Antirheumatic	ORENCIA	ABATACEPT SUBCUTANEOUS INJ 125 MG/ML	66400010002020	-15.0%	$0.00	Y
ORENCIA INJ 250MG	Antirheumatic	ORENCIA	ABATACEPT FOR IV SOLN 250 MG	66400010002120	-15.0%	$0.00	Y
XELJANZ TAB 5MG	Antirheumatic	XELJANZ	TOFACITINIB CITRATE TAB 5 MG (BASE EQUIVALENT)	65803065100320	-15.0%	$0.00	Y
HUMIRA KIT 20MG/0.4	Antirheumatic Agent	HUMIRA	ADALIMUMAB INJ KIT 20 MG/0.4ML	66270015006410	-15.0%	$0.00	Y
HUMIRA KIT 40MG/0.8	Antirheumatic Agent	HUMIRA	ADALIMUMAB INJ KIT 40 MG/0.8ML (50 MG/ML)	66270015006420	-15.0%	$0.00	Y
HUMIRA PEN KIT 40MG/0.8	Antirheumatic Agent	HUMIRA PEN	ADALIMUMAB INJ KIT 40 MG/0.8ML (50 MG/ML)	66270015006420	-15.0%	$0.00	Y
HUMIRA PEN KIT CROHNS	Antirheumatic Agent	HUMIRA PEN	ADALIMUMAB INJ KIT 40 MG/0.8ML (50 MG/ML)	66270015006420	-15.0%	$0.00	Y
HUMIRA PEN KIT PSORIASI	Antirheumatic Agent	HUMIRA PEN	ADALIMUMAB INJ KIT 40 MG/0.8ML (50 MG/ML)	66270015006420	-15.0%	$0.00	Y
REMICADE INJ 100MG	Antirheumatic Agent	REMICADE	INFLIXIMAB FOR IV INJ 100 MG	52505040002120	-16.0%	$0.00	Y
COPEGUS TAB 200MG	Antiviral Agent	COPEGUS	RIBAVIRIN TAB 200 MG	12353070000320	-15.0%	$0.00	Y
INCIVEK TAB 375MG	Antiviral Agent	INCIVEK	TELAPREVIR TAB 375 MG	12353085000320	-17.0%	$0.00	Y
INFERGEN INJ 15MCG	Antiviral Agent	INFERGEN	INTERFERON ALFACON-1 INJ 15 MCG/0.5ML	12353040102215	-16.5%	$0.00	Y
INFERGEN INJ 9MCG	Antiviral Agent	INFERGEN	INTERFERON ALFACON-1 INJ 9 MCG/0.3ML	12353040102210	-16.5%	$0.00	Y
PEG-INTRON KIT 120 RP	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 120 MCG/0.5ML	12353060106424	-18.5%	$0.00	Y
PEG-INTRON KIT 120MCG	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 120 MCG/0.5ML	12353060106424	-18.5%	$0.00	Y
PEG-INTRON KIT 150 RP	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 150 MCG/0.5ML	12353060106430	-18.5%	$0.00	Y
PEG-INTRON KIT 150MCG	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 150 MCG/0.5ML	12353060106430	-18.5%	$0.00	Y
PEG-INTRON KIT 50MCG	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 50 MCG/0.5ML	12353060106410	-18.5%	$0.00	Y
PEG-INTRON KIT 50MCG RP	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 50 MCG/0.5ML	12353060106410	-18.5%	$0.00	Y
PEG-INTRON KIT 80MCG	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 80 MCG/0.5ML	12353060106416	-18.5%	$0.00	Y
PEG-INTRON KIT 80MCG RP	Antiviral Agent	PEG-INTRON	PEGINTERFERON ALFA-2B FOR INJ KIT 80 MCG/0.5ML	12353060106416	-18.5%	$0.00	Y
REBETOL CAP 200MG	Antiviral Agent	REBETOL	RIBAVIRIN CAP 200 MG	12353070000120	-13.5%	$0.00	Y
REBETOL SOL 40MG/ML	Antiviral Agent	REBETOL	RIBAVIRIN SOLN 40 MG/ML	12353070002020	-13.5%	$0.00	Y
RIBAPAK MIS 600/DAY	Antiviral Agent	RIBAPAK	RIBAVIRIN TAB 200 MG & RIBAVIRIN TAB 400 MG DOSE PACK	12353070005315	-28.0%	$0.00	Y
RIBAPAK PAK 1000/DAY	Antiviral Agent	RIBAPAK	RIBAVIRIN TAB 400 MG & RIBAVIRIN TAB 600 MG DOSE PACK	12353070005320	-28.0%	$0.00	Y
RIBAPAK PAK 1200/DAY	Antiviral Agent	RIBAPAK	RIBAVIRIN TAB 600 MG	12353070000360	-28.0%	$0.00	Y
RIBAPAK PAK 800/DAY	Antiviral Agent	RIBAPAK	RIBAVIRIN TAB 400 MG	12353070000340	-28.0%	$0.00	Y
RIBASPHERE CAP 200MG	Antiviral Agent	RIBASPHERE	RIBAVIRIN CAP 200 MG	12353070000120	-60.0%	$0.00	Y
RIBASPHERE TAB 200MG	Antiviral Agent	RIBASPHERE	RIBAVIRIN TAB 200 MG	12353070000320	-60.0%	$0.00	Y
RIBASPHERE TAB 400MG	Antiviral Agent	RIBASPHERE	RIBAVIRIN TAB 400 MG	12353070000340	-60.0%	$0.00	Y
RIBASPHERE TAB 600MG	Antiviral Agent	RIBASPHERE	RIBAVIRIN TAB 600 MG	12353070000360	-60.0%	$0.00	Y
RIBATAB PAK 1000/DAY	Antiviral Agent	RIBATAB	RIBAVIRIN TAB 400 MG & RIBAVIRIN TAB 600 MG DOSE PACK	12353070005320	-80.0%	$0.00	Y
RIBATAB TAB 1200/DAY	Antiviral Agent	RIBATAB	RIBAVIRIN TAB 600 MG	12353070000360	-80.0%	$0.00	Y
RIBATAB TAB 800/DAY	Antiviral Agent	RIBATAB	RIBAVIRIN TAB 400 MG	12353070000340	-80.0%	$0.00	Y

RIBAVIRIN CAP 200MG	Antiviral Agent	RIBAVIRIN	RIBAVIRIN CAP 200 MG	12353070000120	-82.0%	$0.00	Y
RIBAVIRIN POW	Antiviral Agent	RIBAVIRIN	RIBAVIRIN (BULK) POWDER	96765806032900	-80.0%	$0.00	N
RIBAVIRIN TAB 200MG	Antiviral Agent	RIBAVIRIN	RIBAVIRIN TAB 200 MG	12353070000320	-82.0%	$0.00	Y
VICTRELIS CAP 200MG	Antiviral Agent	VICTRELIS	BOCEPREVIR CAP 200 MG	12353015000120	-19.5%	$0.00	Y
HEPSERA TAB 10MG	Antivirals	HEPSERA	ADEFOVIR DIPIVOXIL TAB 10 MG	12352015100320	-13.0%	$0.00	Y
KALYDECO TAB 150MG	Antivirals	KALYDECO	IVACAFTOR TAB 150 MG	45302030000320	-17.0%	$0.00	Y
KUVAN TAB 100MG	Antivirals	KUVAN	SAPROPTERIN DIHYDROCHLORIDE SOLUBLE TAB 100 MG	30908565107320	-14.0%	$0.00	Y
PROMACTA TAB 12.5MG	Antivirals	PROMACTA	ELTROMBOPAG OLAMINE TAB 12.5 MG (BASE EQUIV)	82405030100310	-15.5%	$0.00	Y
PROMACTA TAB 25MG	Antivirals	PROMACTA	ELTROMBOPAG OLAMINE TAB 25 MG (BASE EQUIV)	82405030100320	-15.5%	$0.00	Y
PROMACTA TAB 50MG	Antivirals	PROMACTA	ELTROMBOPAG OLAMINE TAB 50 MG (BASE EQUIV)	82405030100330	-15.5%	$0.00	Y
PROMACTA TAB 75MG	Antivirals	PROMACTA	ELTROMBOPAG OLAMINE TAB 75 MG (BASE EQUIV)	82405030100340	-15.5%	$0.00	Y
TYZEKA TAB 600MG	Antivirals	TYZEKA	TELBIVUDINE TAB 600 MG	12352080000330	-11.0%	$0.00	Y
SOLESTA INJ 50-15ML	Assorted Classes	SOLESTA	DEXTRANOMER-SODIUM HYALURONATE INJ GEL 50-15 MG/ML	99379902404020	-14.5%	$0.00	Y
ACTIMMUNE INJ 2MU/0.5	Biologic Response Modifiers	ACTIMMUNE	INTERFERON GAMMA-1B INJ 100 MCG/0.5ML (2000000 UNIT/0.5ML)	21700060702020	-14.0%	$0.00	Y
ADAGEN INJ 250/ML	Biologicals	ADAGEN	PEGADEMASE BOVINE INJ 250 UNIT/ML	20000050002025	-1.0%	$0.00	N
BONIVA INJ 3MG/3ML	Bisphosphonate Derivative	BONIVA	IBANDRONATE SODIUM IV SOLN 3 MG/3ML (BASE EQUIVALENT)	30042048102030	-7.0%	$0.00	Y
ZOMETA INJ 4MG/100	Bisphosphonate Derivative	ZOMETA	ZOLEDRONIC ACID IV SOLN 4 MG/100ML	30042090002016	-11.5%	$0.00	Y
ZOMETA INJ 4MG/5ML	Bisphosphonate Derivative	ZOMETA	ZOLEDRONIC ACID INJ CONC FOR IV INFUSION 4 MG/5ML	30042090001320	-11.5%	$0.00	Y
ARALAST NP INJ 1000MG	Blood Product Derivative	ARALAST NP	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 1000 MG	45100010102120	-16.5%	$0.00	N
ARALAST NP INJ 400MG	Blood Product Derivative	ARALAST NP	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 400 MG	45100010102108	-16.5%	$0.00	N
ARALAST NP INJ 500MG	Blood Product Derivative	ARALAST NP	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 500 MG	45100010102110	-16.5%	$0.00	N
ARALAST NP INJ 800MG	Blood Product Derivative	ARALAST NP	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 800 MG	45100010102118	-16.5%	$0.00	N
BERINERT INJ 500UNIT	Blood Product Derivative	BERINERT	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ KIT 500 UNIT	85802022006420	-23.0%	$0.00	N
BIVIGAM INJ 10%	Blood Product Derivative	BIVIGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 5 GM/50ML	19100020102068	-15.0%	$0.00	Y
CINRYZE SOL 500 UNIT	Blood Product Derivative	CINRYZE	C1 ESTERASE INHIBITOR (HUMAN) FOR IV INJ 500 UNIT	85802022002120	-10.5%	$0.00	N
GLASSIA INJ	Blood Product Derivative	GLASSIA	ALPHA1-PROTEINASE INHIBITOR (HUMAN) INJ 1000 MG/50ML	45100010102020	-18.0%	$0.00	N
MICRHOGAM PL INJ 50MCG	Blood Product Derivative	MICRHOGAM PL	RHO D IMMUNE GLOBULIN (HUMAN) IM INJ 50 MCG	19100050002210	-15.0%	$0.00	Y
OCTAGAM INJ 10GM	Blood Product Derivative	OCTAGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 10 GM/200ML	19100020102042	-15.0%	$0.00	Y
OCTAGAM INJ 1GM	Blood Product Derivative	OCTAGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 1 GM/20ML	19100020102030	-15.0%	$0.00	Y
OCTAGAM INJ 2.5GM	Blood Product Derivative	OCTAGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 2.5 GM/50ML	19100020102034	-15.0%	$0.00	Y
OCTAGAM INJ 25GM	Blood Product Derivative	OCTAGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 25 GM/500ML	19100020102046	-15.0%	$0.00	Y
OCTAGAM INJ 5GM	Blood Product Derivative	OCTAGAM	IMMUNE GLOBULIN (HUMAN) IV SOLN 5 GM/100ML	19100020102038	-15.0%	$0.00	Y
OMONTYS INJ 10MG/ML	Blood Product Derivative	OMONTYS	PEGINESATIDE ACETATE SOLN INJ 10 MG/ML	82401060102050	-15.0%	$0.00	N
OMONTYS INJ 20MG/2ML	Blood Product Derivative	OMONTYS	PEGINESATIDE ACETATE SOLN INJ 20 MG/2ML	82401060102055	-15.0%	$0.00	N
PRIVIGEN INJ 10GRAMS	Blood Product Derivative	PRIVIGEN	IMMUNE GLOBULIN (HUMAN) IV SOLN 10 GM/100ML	19100020102072	-45.0%	$0.00	Y
PRIVIGEN INJ 20GRAMS	Blood Product Derivative	PRIVIGEN	IMMUNE GLOBULIN (HUMAN) IV SOLN 20 GM/200ML	19100020102076	-45.0%	$0.00	Y
PRIVIGEN INJ 5 GRAMS	Blood Product Derivative	PRIVIGEN	IMMUNE GLOBULIN (HUMAN) IV SOLN 5 GM/50ML	19100020102068	-45.0%	$0.00	Y
PROLASTIN INJ 1000MG	Blood Product Derivative	PROLASTIN	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 1000 MG	45100010102120	-16.0%	$0.00	
PROLASTIN INJ 500MG	Blood Product Derivative	PROLASTIN	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 500 MG	45100010102110	-16.0%	$0.00	
PROLASTIN-C INJ 1000MG	Blood Product Derivative	PROLASTIN-C	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 1000 MG	45100010102120	-16.0%	$0.00	N
ZEMAIRA INJ 1000MG	Blood Product Derivative	ZEMAIRA	ALPHA1-PROTEINASE INHIBITOR (HUMAN) FOR IV SOLN 1000 MG	45100010102120	-15.0%	$0.00	N
GAMMAKED INJ 10GM/100	Blood Product Derivative	GAMMAKED	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 10 GM/100ML	19100020302072	-15.0%	$0.00	Y
GAMMAKED INJ 1GM/10ML	Blood Product Derivative	GAMMAKED	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 1 GM/10ML	19100020302060	-15.0%	$0.00	Y
GAMMAKED INJ 2.5GM/25	Blood Product Derivative	GAMMAKED	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 2.5 GM/25ML	19100020302064	-15.0%	$0.00	Y
GAMMAKED INJ 20GM/200	Blood Product Derivative	GAMMAKED	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 20 GM/200ML	19100020302076	-15.0%	$0.00	Y
GAMMAKED INJ 5GM/50ML	Blood Product Derivative	GAMMAKED	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 5 GM/50ML	19100020302068	-15.0%	$0.00	Y
GAMMAPLEX INJ 10GM	Blood Product Derivative	GAMMAPLEX	IMMUNE GLOBULIN (HUMAN) IV SOLN 10 GM/200ML	19100020102042	-38.0%	$0.00	Y
GAMMAPLEX INJ 2.5GM	Blood Product Derivative	GAMMAPLEX	IMMUNE GLOBULIN (HUMAN) IV SOLN 2.5 GM/50ML	19100020102034	-38.0%	$0.00	Y
GAMMAPLEX INJ 5GM	Blood Product Derivative	GAMMAPLEX	IMMUNE GLOBULIN (HUMAN) IV SOLN 5 GM/100ML	19100020102038	-38.0%	$0.00	Y
HIZENTRA INJ 1GM/5ML	Blood Product Derivative	HIZENTRA	IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS INJ 1 GM/5ML	19100020202050	-45.0%	$0.00	N
HIZENTRA INJ 2GM/10ML	Blood Product Derivative	HIZENTRA	IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS INJ 2 GM/10ML	19100020202054	-45.0%	$0.00	N
HIZENTRA INJ 4GM/20ML	Blood Product Derivative	HIZENTRA	IMMUNE GLOBULIN (HUMAN) SUBCUTANEOUS INJ 4 GM/20ML	19100020202058	-45.0%	$0.00	N
DEXRAZOXANE INJ 250MG	Cardioprotectant	DEXRAZOXANE	DEXRAZOXANE FOR INJ 250 MG	21754040002120	-18.0%	$0.00	Y
DEXRAZOXANE INJ 500MG	Cardioprotectant	DEXRAZOXANE	DEXRAZOXANE FOR INJ 500 MG	21754040002140	-18.0%	$0.00	Y
TOTECT INJ 500MG	Cardioprotectant	TOTECT	DEXRAZOXANE FOR INJ 500 MG	21754040002140	-15.0%	$0.00	Y
FLOLAN INJ 0.5MG	Cardiovascular Agent	FLOLAN	EPOPROSTENOL SODIUM FOR INJ 0.5 MG	40170040102110	-4.0%	$0.00	N
FLOLAN INJ 1.5MG	Cardiovascular Agent	FLOLAN	EPOPROSTENOL SODIUM FOR INJ 1.5 MG	40170040102130	-4.0%	$0.00	N
TYVASO SOL 0.6MG/ML	Cardiovascular Agent	TYVASO	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	-13.0%	$0.00	N
TYVASO REFIL SOL 0.6MG/ML	Cardiovascular Agent	TYVASO REFIL	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	-13.0%	$0.00	N
TYVASO START SOL 0.6MG/ML	Cardiovascular Agent	TYVASO START	TREPROSTINIL INHALATION SOLUTION 0.6 MG/ML	40170080002020	-13.0%	$0.00	N
ADCIRCA TAB 20MG	Cardiovascular Agents	ADCIRCA	TADALAFIL TAB 20 MG (PAH)	40143080000320	-15.0%	$0.00	Y
LETAIRIS TAB 10MG	Cardiovascular Agents	LETAIRIS	AMBRISENTAN TAB 10 MG	40160007000320	-16.5%	$0.00	N

LETAIRIS TAB 5MG	Cardiovascular Agents	LETAIRIS	AMBRISENTAN TAB 5 MG	40160007000310	-16.5%	$0.00	N
REMODULIN INJ 10MG/ML	Cardiovascular Agents	REMODULIN	TREPROSTINIL SODIUM INJ 10 MG/ML (BASE EQUIV)	40170080102040	-17.0%	$0.00	N
REMODULIN INJ 1MG/ML	Cardiovascular Agents	REMODULIN	TREPROSTINIL SODIUM INJ 1 MG/ML (BASE EQUIV)	40170080102010	-17.0%	$0.00	N
REMODULIN INJ 2.5MG/ML	Cardiovascular Agents	REMODULIN	TREPROSTINIL SODIUM INJ 2.5 MG/ML (BASE EQUIV)	40170080102020	-17.0%	$0.00	N
REMODULIN INJ 5MG/ML	Cardiovascular Agents	REMODULIN	TREPROSTINIL SODIUM INJ 5 MG/ML (BASE EQUIV)	40170080102030	-17.0%	$0.00	N
REVATIO INJ	Cardiovascular Agents	REVATIO	SILDENAFIL CITRATE IV SOLN 10 MG/12.5ML (BASE EQUIVALENT)	40143060102020	-10.0%	$0.00	Y
REVATIO TAB 20MG	Cardiovascular Agents	REVATIO	SILDENAFIL CITRATE TAB 20 MG	40143060100320	-16.0%	$0.00	Y
VENTAVIS SOL 10MCG/ML	Cardiovascular Agents	VENTAVIS	ILOPROST INHALATION SOLUTION 10 MCG/ML	40170060002020	-13.0%	$0.00	N
VENTAVIS SOL 20MCG/ML	Cardiovascular Agents	VENTAVIS	ILOPROST INHALATION SOLUTION 20 MCG/ML	40170060002040	-13.0%	$0.00	N
PROVENGE INJ	Cellular Immunotherapy	PROVENGE	SIPULEUCEL-T SUSPENSION FOR IV INFUSION	21651070001800	-15.0%	$0.00	N
XENAZINE TAB 12.5MG	Central Monoamine-Depleting Agent	XENAZINE	TETRABENAZINE TAB 12.5 MG	62380070000310	-17.0%	$0.00	N
XENAZINE TAB 25MG	Central Monoamine-Depleting Agent	XENAZINE	TETRABENAZINE TAB 25 MG	62380070000320	-17.0%	$0.00	N
XYREM SOL 500MG/ML	Central Nervous System Depressant	XYREM	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	62450060202020	-8.0%	$0.00	N
FERRIPROX TAB 500MG	Chelating Agent	FERRIPROX	DEFERIPRONE TAB 500 MG	93100028000320	-15.0%	$0.00	N
AMIFOSTINE INJ 500MG	Chemoprotective Agent	AMIFOSTINE	AMIFOSTINE CRYSTALLINE FOR INJ 500 MG	21758010102120	-18.0%	$0.00	Y
ETHYOL INJ 500MG	Chemotherapy Agents	ETHYOL	AMIFOSTINE CRYSTALLINE FOR INJ 500 MG	21758010102120	-13.5%	$0.00	Y
ZINECARD INJ 250MG	Chemotherapy Agents	ZINECARD	DEXRAZOXANE FOR INJ 250 MG	21754040002120	-13.5%	$0.00	Y
ZINECARD INJ 500MG	Chemotherapy Agents	ZINECARD	DEXRAZOXANE FOR INJ 500 MG	21754040002140	-13.5%	$0.00	Y
IMPLANON IMP 68MG	Contraceptive	IMPLANON	ETONOGESTREL SUBDERMAL IMPLANT 68 MG	25300005002320	-11.0%	$0.00	N
MIRENA IUD SYSTEM	Contraceptive	MIRENA	LEVONORGESTREL RELEASING IUD 20 MCG/24HR (52 MG TOTAL)	25200050005320	-13.0%	$0.00	N
NEXPLANON IMP 68MG	Contraceptive	NEXPLANON	ETONOGESTREL SUBDERMAL IMPLANT 68 MG	25300005002320	-11.0%	$0.00	N
BOTOX COSMET INJ 100UNIT	Dermatologicals	BOTOX COSMET	ONABOTULINUMTOXINA (COSMETIC) FOR INJ 100 UNIT	90890020002120	-9.5%	$0.00	Y
BOTOX COSMET INJ 50UNIT	Dermatologicals	BOTOX COSMET	ONABOTULINUMTOXINA (COSMETIC) FOR INJ 50 UNIT	90890020002110	-9.5%	$0.00	Y
QUTENZA KIT 8% 1-PCH	Dermatologicals	QUTENZA	CAPSAICIN PATCH 8% & CLEANSING GEL KIT	90850025306420	-11.0%	$0.00	Y
QUTENZA KIT 8% 2-PCH	Dermatologicals	QUTENZA	CAPSAICIN PATCH 8% & CLEANSING GEL KIT	90850025306420	-11.0%	$0.00	Y
EXJADE TAB 125MG	Detoxification Agent	EXJADE	DEFERASIROX TAB FOR ORAL SUSP 125 MG	93100025007320	-13.5%	$0.00	Y
EXJADE TAB 250MG	Detoxification Agent	EXJADE	DEFERASIROX TAB FOR ORAL SUSP 250 MG	93100025007330	-13.5%	$0.00	Y
EXJADE TAB 500MG	Detoxification Agent	EXJADE	DEFERASIROX TAB FOR ORAL SUSP 500 MG	93100025007340	-13.5%	$0.00	Y
ACTHREL INJ 100MCG	Diagnostic Agent	ACTHREL	CORTICORELIN OVINE TRIFLUTATE FOR IV INJ 100 MCG	94200036202120	-15.0%	$0.00	N
THYROGEN INJ 1.1MG	Diagnostic Agents	THYROGEN	THYROTROPIN ALFA FOR INJ 1.1 MG	94200090102120	-8.5%	$0.00	Y
ACTHAR HP INJ 80UNIT	Endocrine & Metabolic Agent	ACTHAR HP	CORTICOTROPIN INJ GEL 80 UNIT/ML	30300010004010	-17.0%	$0.00	Y
AREDIA INJ 30MG	Endocrine & Metabolic Agent	AREDIA	PAMIDRONATE DISODIUM FOR INJ 30 MG	30942060102120	-13.5%	$0.00	Y
CHOR GONADOT INJ 10000UNT	Endocrine & Metabolic Agent	CHOR GONADOT	CHORIONIC GONADOTROPIN FOR INJ 10000 UNIT	30062020002140	-18.0%	$0.00	Y
CHORIONIC POW GONADOTR	Endocrine & Metabolic Agent	CHORIONIC	CHORIONIC GONADOTROPIN (BULK) POWDER	96465650402900	-15.0%	$0.00	N
FOLLISTIM AQ INJ 150UNIT	Endocrine & Metabolic Agent	FOLLISTIM AQ	FOLLITROPIN BETA INJ 150 UNIT/0.5ML	30062030102005	-15.1%	$0.00	Y
FOLLISTIM AQ INJ 300UNIT	Endocrine & Metabolic Agent	FOLLISTIM AQ	FOLLITROPIN BETA INJ 300 UNIT/0.36ML	30062030102020	-15.1%	$0.00	Y
FOLLISTIM AQ INJ 600UNIT	Endocrine & Metabolic Agent	FOLLISTIM AQ	FOLLITROPIN BETA INJ 600 UNIT/0.72ML	30062030102030	-15.1%	$0.00	Y
FOLLISTIM AQ INJ 75UNIT	Endocrine & Metabolic Agent	FOLLISTIM AQ	FOLLITROPIN BETA INJ 75 UNIT/0.5ML	30062030102003	-15.1%	$0.00	Y
FOLLISTIM AQ INJ 900UNIT	Endocrine & Metabolic Agent	FOLLISTIM AQ	FOLLITROPIN BETA INJ 900 UNIT/1.08ML	30062030102040	-15.1%	$0.00	Y
FOLLISTIM PEN	Endocrine & Metabolic Agent	FOLLISTIM PEN	FOLLISTIM PEN FOR RXSOL MAIL SERVICE	00000000000077	-15.1%	$0.00	
GONAL-F INJ 1050UNIT	Endocrine & Metabolic Agent	GONAL-F	FOLLITROPIN ALFA FOR INJ 1050 UNIT	30062030052150	-16.0%	$0.00	Y
GONAL-F INJ 450UNIT	Endocrine & Metabolic Agent	GONAL-F	FOLLITROPIN ALFA FOR INJ 450 UNIT	30062030052140	-16.0%	$0.00	Y
GONAL-F RFF INJ 300	Endocrine & Metabolic Agent	GONAL-F RFF	FOLLITROPIN ALFA INJ 300 UNIT/0.5ML	30062030052020	-16.0%	$0.00	Y
GONAL-F RFF INJ 450	Endocrine & Metabolic Agent	GONAL-F RFF	FOLLITROPIN ALFA INJ 450 UNIT/0.75ML	30062030052025	-16.0%	$0.00	Y
GONAL-F RFF INJ 75UNIT	Endocrine & Metabolic Agent	GONAL-F RFF	FOLLITROPIN ALFA FOR INJ 75 UNIT	30062030052115	-16.0%	$0.00	Y
GONAL-F RFF INJ 900	Endocrine & Metabolic Agent	GONAL-F RFF	FOLLITROPIN ALFA INJ 900 UNIT/1.5ML	30062030052040	-16.0%	$0.00	Y
OCTREOTIDE INJ 1000MCG	Endocrine & Metabolic Agent	OCTREOTIDE	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	-25.0%	$0.00	Y
OCTREOTIDE INJ 100MCG	Endocrine & Metabolic Agent	OCTREOTIDE	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	-25.0%	$0.00	Y
OCTREOTIDE INJ 200MCG	Endocrine & Metabolic Agent	OCTREOTIDE	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	-25.0%	$0.00	Y
OCTREOTIDE INJ 500MCG	Endocrine & Metabolic Agent	OCTREOTIDE	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	-25.0%	$0.00	Y
OCTREOTIDE INJ 50MCG/ML	Endocrine & Metabolic Agent	OCTREOTIDE	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	-25.0%	$0.00	Y
OVIDREL INJ	Endocrine & Metabolic Agent	OVIDREL	CHORIOGONADOTROPIN ALFA INJ 250 MCG/0.5ML	30062022052220	-1.0%	$0.00	Y
PREGNYL INJ 10000UNT	Endocrine & Metabolic Agent	PREGNYL	CHORIONIC GONADOTROPIN FOR INJ 10000 UNIT	30062020002140	-18.0%	$0.00	Y
REPRONEX INJ 75UNIT	Endocrine & Metabolic Agent	REPRONEX	MENOTROPINS FOR INJ 75 UNIT	30062050002155	-15.1%	$0.00	Y
ZEMPLAR CAP 1MCG	Endocrine & Metabolic Agent	ZEMPLAR	PARICALCITOL CAP 1 MCG	30905070000110	-8.0%	$0.00	Y
ZEMPLAR CAP 2MCG	Endocrine & Metabolic Agent	ZEMPLAR	PARICALCITOL CAP 2 MCG	30905070000120	-8.0%	$0.00	Y
ZEMPLAR CAP 4MCG	Endocrine & Metabolic Agent	ZEMPLAR	PARICALCITOL CAP 4 MCG	30905070000140	-8.0%	$0.00	Y
ZEMPLAR INJ 2MCG/ML	Endocrine & Metabolic Agent	ZEMPLAR	PARICALCITOL IV SOLN 2 MCG/ML	30905070002010	-13.5%	$0.00	Y
ZEMPLAR INJ 5MCG/ML	Endocrine & Metabolic Agent	ZEMPLAR	PARICALCITOL IV SOLN 5 MCG/ML	30905070002020	-13.5%	$0.00	Y
ALDURAZYME INJ 2.9MG/5M	Endocrine & Metabolic Agents	ALDURAZYME	LARONIDASE SOLN FOR IV INFUSION 2.9 MG/5ML	30906550002020	-14.6%	$0.00	Y
BRAVELLE INJ 75UNIT	Endocrine & Metabolic Agents	BRAVELLE	UROFOLLITROPIN PURIFIED FOR INJ 75 UNIT	30062090102112	-15.5%	$0.00	Y
CETROTIDE KIT 0.25MG	Endocrine & Metabolic Agents	CETROTIDE	CETRORELIX ACETATE FOR INJ KIT 0.25 MG	30090025106420	-11.5%	$0.00	Y

CETROTIDE KIT 3MG	Endocrine & Metabolic Agents	CETROTIDE	CETRORELIX ACETATE FOR INJ KIT 3 MG	30090025106440	-11.5%	$0.00	Y
ELAPRASE INJ 6MG/3ML	Endocrine & Metabolic Agents	ELAPRASE	IDURSULFASE SOLN FOR IV INFUSION 6 MG/3ML (2 MG/ML)	30906850002020	-13.5%	$0.00	Y
FABRAZYME INJ 35MG	Endocrine & Metabolic Agents	FABRAZYME	AGALSIDASE BETA FOR IV SOLN 35 MG	30903610102120	-15.5%	$0.00	Y
FABRAZYME INJ 5MG	Endocrine & Metabolic Agents	FABRAZYME	AGALSIDASE BETA FOR IV SOLN 5 MG	30903610102110	-15.5%	$0.00	Y
GANIRELIX AC INJ	Endocrine & Metabolic Agents	GANIRELIX AC	GANIRELIX ACETATE INJ 250 MCG/0.5ML	30090040102020	-16.0%	$0.00	Y
MENOPUR INJ 75UNIT	Endocrine & Metabolic Agents	MENOPUR	MENOTROPINS FOR SUBCUTANEOUS INJ 75 UNIT	30062050002175	-15.0%	$0.00	Y
MYOZYME INJ 50MG	Endocrine & Metabolic Agents	MYOZYME	ALGLUCOSIDASE ALFA FOR IV SOLN 50 MG	30907715002120	-14.5%	$0.00	Y
NAGLAZYME INJ 1MG/ML	Endocrine & Metabolic Agents	NAGLAZYME	GALSULFASE SOLN FOR IV INFUSION 1 MG/ML	30907535002020	-13.5%	$0.00	Y
NOVAREL INJ 10000UNT	Endocrine & Metabolic Agents	NOVAREL	CHORIONIC GONADOTROPIN FOR INJ 10000 UNIT	30062020002140	-18.0%	$0.00	Y
ORFADIN CAP 10MG	Endocrine & Metabolic Agents	ORFADIN	NITISINONE CAP 10 MG	30904045000130	-1.0%	$0.00	N
ORFADIN CAP 2MG	Endocrine & Metabolic Agents	ORFADIN	NITISINONE CAP 2 MG	30904045000110	-1.0%	$0.00	N
ORFADIN CAP 5MG	Endocrine & Metabolic Agents	ORFADIN	NITISINONE CAP 5 MG	30904045000120	-1.0%	$0.00	N
PAMIDRONATE INJ 30/10ML	Endocrine & Metabolic Agents	PAMIDRONATE	PAMIDRONATE DISODIUM IV SOLN 3 MG/ML	30042060102006	-18.0%	$0.00	Y
PAMIDRONATE INJ 30MG	Endocrine & Metabolic Agents	PAMIDRONATE	PAMIDRONATE DISODIUM FOR INJ 30 MG	30042060102120	-18.0%	$0.00	Y
PAMIDRONATE INJ 6MG/ML	Endocrine & Metabolic Agents	PAMIDRONATE	PAMIDRONATE DISODIUM IV SOLN 6 MG/ML	30042060102009	-18.0%	$0.00	Y
PAMIDRONATE INJ 90/10ML	Endocrine & Metabolic Agents	PAMIDRONATE	PAMIDRONATE DISODIUM IV SOLN 9 MG/ML	30042060102012	-18.0%	$0.00	Y
PAMIDRONATE INJ 90MG	Endocrine & Metabolic Agents	PAMIDRONATE	PAMIDRONATE DISODIUM FOR INJ 90 MG	30042060102140	-18.0%	$0.00	Y
PROLIA SOL 60MG/ML	Endocrine & Metabolic Agents	PROLIA	DENOSUMAB INJ 60 MG/ML	30044530002020	-10.5%	$0.00	Y
RECLAST INJ 5/100ML	Endocrine & Metabolic Agents	RECLAST	ZOLEDRONIC ACID IV SOLN 5 MG/100ML	30042090002020	-12.5%	$0.00	Y
SAMSCA TAB 15MG	Endocrine & Metabolic Agents	SAMSCA	TOLVAPTAN TAB 15 MG	30454060000320	-17.0%	$0.00	Y
SAMSCA TAB 30MG	Endocrine & Metabolic Agents	SAMSCA	TOLVAPTAN TAB 30 MG	30454060000330	-17.0%	$0.00	Y
SENSIPAR TAB 30MG	Endocrine & Metabolic Agents	SENSIPAR	CINACALCET HCL TAB 30 MG (BASE EQUIV)	30905225100320	-12.0%	$0.00	Y
SENSIPAR TAB 60MG	Endocrine & Metabolic Agents	SENSIPAR	CINACALCET HCL TAB 60 MG (BASE EQUIV)	30905225100330	-12.0%	$0.00	Y
SENSIPAR TAB 90MG	Endocrine & Metabolic Agents	SENSIPAR	CINACALCET HCL TAB 90 MG (BASE EQUIV)	30905225100340	-12.0%	$0.00	Y
SOMATULINE INJ 120/.5ML	Endocrine & Metabolic Agents	SOMATULINE	LANREOTIDE ACETATE EXTENDED RELEASE INJ 120 MG/0.5ML	30170050102040	-19.5%	$0.00	Y
SOMATULINE INJ 60/0.2ML	Endocrine & Metabolic Agents	SOMATULINE	LANREOTIDE ACETATE EXTENDED RELEASE INJ 60 MG/0.2ML	30170050102025	-19.5%	$0.00	Y
SOMATULINE INJ 90/0.3ML	Endocrine & Metabolic Agents	SOMATULINE	LANREOTIDE ACETATE EXTENDED RELEASE INJ 90 MG/0.3ML	30170050102030	-19.5%	$0.00	Y
SOMAVERT INJ 10MG	Endocrine & Metabolic Agents	SOMAVERT	PEGVISOMANT FOR INJ 10 MG (AS PROTEIN)	30180060002120	-17.5%	$0.00	Y
SOMAVERT INJ 15MG	Endocrine & Metabolic Agents	SOMAVERT	PEGVISOMANT FOR INJ 15 MG (AS PROTEIN)	30180060002130	-17.5%	$0.00	Y
SOMAVERT INJ 20MG	Endocrine & Metabolic Agents	SOMAVERT	PEGVISOMANT FOR INJ 20 MG (AS PROTEIN)	30180060002140	-17.5%	$0.00	Y
XGEVA INJ	Endocrine & Metabolic Agents	XGEVA	DENOSUMAB INJ 120 MG/1.7ML	30044530002030	-12.0%	$0.00	Y
ELELYSO INJ 200UNIT	Enzyme	ELELYSO	TALIGLUCERASE ALFA FOR INJ 200 UNIT	82700080102120	-16.5%	$0.00	N
XIAFLEX INJ 0.9MG	Enzymes	XIAFLEX	COLLAGENASE CLOSTRIDIUM HISTOLYTICUM FOR INJ 0.9 MG	99350035002120	-11.5%	$0.00	Y
ARIXTRA SOL 10/0.8	Factor Xa Inhibitor	ARIXTRA	FONDAPARINUX SODIUM INJ 10 MG/0.8ML	83103030102045	-15.5%	$0.00	N
ARIXTRA SOL 2.5/0.5	Factor Xa Inhibitor	ARIXTRA	FONDAPARINUX SODIUM INJ 2.5 MG/0.5ML	83103030102020	-15.5%	$0.00	N
ARIXTRA SOL 5.0/0.4	Factor Xa Inhibitor	ARIXTRA	FONDAPARINUX SODIUM INJ 5 MG/0.4ML	83103030102035	-16.5%	$0.00	N
ARIXTRA SOL 7.5/0.6	Factor Xa Inhibitor	ARIXTRA	FONDAPARINUX SODIUM INJ 7.5 MG/0.6ML	83103030102040	-15.5%	$0.00	N
FONDAPARINUX SOL 10/0.8	Factor Xa Inhibitor	FONDAPARINUX	FONDAPARINUX SODIUM INJ 10 MG/0.8ML	83103030102045	-30.0%	$0.00	N
FONDAPARINUX SOL 2.5/0.5	Factor Xa Inhibitor	FONDAPARINUX	FONDAPARINUX SODIUM INJ 2.5 MG/0.5ML	83103030102020	-30.0%	$0.00	N
FONDAPARINUX SOL 5.0/0.4	Factor Xa Inhibitor	FONDAPARINUX	FONDAPARINUX SODIUM INJ 5 MG/0.4ML	83103030102035	-30.0%	$0.00	N
FONDAPARINUX SOL 7.5/0.6	Factor Xa Inhibitor	FONDAPARINUX	FONDAPARINUX SODIUM INJ 7.5 MG/0.6ML	83103030102040	-30.0%	$0.00	N
SUCRAID SOL 8500/ML	Gastrointestinal	SUCRAID	SACROSIDASE SOLN 8500 UNIT/ML	51200080002030	-15.0%	$0.00	Y
ALOXI INJ 0.25MG/5	Gastrointestinal Agents	ALOXI	PALONOSETRON HCL IV SOLN 0.25 MG/5ML (BASE EQUIVALENT)	50250070102020	-12.0%	$0.00	Y
CIMZIA KIT	Gastrointestinal Agents	CIMZIA	CERTOLIZUMAB PEGOL FOR INJ KIT 2 X 200 MG	52505020106420	-15.0%	$0.00	Y
CIMZIA KIT 200MG/ML	Gastrointestinal Agents	CIMZIA	CERTOLIZUMAB PEGOL INJ KIT 2 X 200 MG/ML	52505020106440	-15.0%	$0.00	Y
CIMZIA KIT STARTER	Gastrointestinal Agents	CIMZIA	CERTOLIZUMAB PEGOL INJ KIT 6 X 200 MG/ML	52505020106460	-15.0%	$0.00	Y
RELISTOR INJ 12/0.6ML	Gastrointestinal Agents	RELISTOR	METHYLNALTREXONE BROMIDE INJ 12 MG/0.6ML (20 MG/ML)	52580050102020	-11.5%	$0.00	Y
RELISTOR INJ 8/0.4ML	Gastrointestinal Agents	RELISTOR	METHYLNALTREXONE BROMIDE INJ 8 MG/0.4ML (20 MG/ML)	52580050102015	-11.5%	$0.00	Y
RELISTOR KIT 12/0.6ML	Gastrointestinal Agents	RELISTOR	METHYLNALTREXONE BROMIDE INJ KIT 12 MG/0.6ML	52580050106420	-11.5%	$0.00	Y
SEROSTIM INJ 6MG	Growth Hormone	SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 6 MG	30100020102125	-18.0%	$0.00	Y
ACTIVASE INJ 100MG	Hematological Agent	ACTIVASE	ALTEPLASE FOR INJ 100 MG	85601010002120	-13.5%	$0.00	Y
ACTIVASE INJ 50MG	Hematological Agent	ACTIVASE	ALTEPLASE FOR INJ 50 MG	85601010002110	-13.5%	$0.00	Y
ADVATE INJ 1000UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 1000 UNIT	85100010252140	-40.5%	$0.00	Y
ADVATE INJ 1500UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 1500 UNIT	85100010252150	-40.5%	$0.00	Y
ADVATE INJ 2000UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 2000 UNIT	85100010252170	-40.5%	$0.00	Y
ADVATE INJ 250UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 250 UNIT	85100010252120	-40.5%	$0.00	Y
ADVATE INJ 3000UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 3000 UNIT	85100010252180	-40.5%	$0.00	Y
ADVATE INJ 4000UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 4000 UNIT	85100010252185	-40.5%	$0.00	Y
ADVATE INJ 500UNIT	Hematological Agents	ADVATE	ANTIHEMOPHILIC FACTOR RAHF-PFM FOR INJ 500 UNIT	85100010252130	-40.5%	$0.00	Y
BENEFIX INJ 1000UNIT	Hematological Agents	BENEFIX	COAGULATION FACTOR IX (RECOMBINANT) FOR INJ 1000 UNIT	85100028202140	-16.5%	$0.00	Y
BENEFIX INJ 2000UNIT	Hematological Agents	BENEFIX	COAGULATION FACTOR IX (RECOMBINANT) FOR INJ 2000 UNIT	85100028202150	-16.5%	$0.00	Y
BENEFIX INJ 250UNIT	Hematological Agents	BENEFIX	COAGULATION FACTOR IX (RECOMBINANT) FOR INJ 250 UNIT	85100028202120	-16.5%	$0.00	Y

BENEFIX INJ 3000UNIT	Hematological Agents	BENEFIX	COAGULATION FACTOR IX (RECOMBINANT) FOR INJ 3000 UNIT	85100028202160	-16.5%	$0.00	Y
BENEFIX INJ 500UNIT	Hematological Agents	BENEFIX	COAGULATION FACTOR IX (RECOMBINANT) FOR INJ 500 UNIT	85100028202130	-16.5%	$0.00	Y
ENOXAPARIN INJ 100MG/ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 100 MG/ML	83101020102016	-18.0%	$0.00	N
ENOXAPARIN INJ 120/0.8	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 120 MG/0.8ML	83101020102018	-18.0%	$0.00	N
ENOXAPARIN INJ 150MG/ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 150 MG/ML	83101020102020	-18.0%	$0.00	N
ENOXAPARIN INJ 30/0.3ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 30 MG/0.3ML	83101020102012	-18.0%	$0.00	N
ENOXAPARIN INJ 300/3ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	-18.0%	$0.00	N
ENOXAPARIN INJ 40/0.4ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 40 MG/0.4ML	83101020102013	-18.0%	$0.00	N
ENOXAPARIN INJ 60/0.6ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 60 MG/0.6ML	83101020102014	-18.0%	$0.00	N
ENOXAPARIN INJ 80/0.8ML	Hematological Agents	ENOXAPARIN	ENOXAPARIN SODIUM INJ 80 MG/0.8ML	83101020102015	-18.0%	$0.00	N
FEIBA NF INJ	Hematological Agents	FEIBA NF	"ANTIINHIBITOR COAGULANT COMPLEX FOR INJ""	85100020002100	-33.0%	$0.00	Y
FEIBA VH INJ IMMUNO	Hematological Agents	FEIBA VH	"ANTIINHIBITOR COAGULANT COMPLEX FOR INJ""	85100020002100	-33.0%	$0.00	Y
FIRAZYR INJ 30MG/3ML	Hematological Agents	FIRAZYR	ICATIBANT ACETATE INJ 30 MG/3ML (BASE EQUIVALENT)	85820040102020	-13.5%	$0.00	Y
KALBITOR INJ 10MG/ML	Hematological Agents	KALBITOR	ECALLANTIDE INJ 10 MG/ML	85840030002020	-13.0%	$0.00	N
LOVENOX INJ 100MG/ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 100 MG/ML	83101020102016	-18.0%	$0.00	N
LOVENOX INJ 120/0.8	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 120 MG/0.8ML	83101020102018	-18.0%	$0.00	N
LOVENOX INJ 150MG/ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 150 MG/ML	83101020102020	-18.0%	$0.00	N
LOVENOX INJ 30/0.3ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 30 MG/0.3ML	83101020102012	-18.0%	$0.00	N
LOVENOX INJ 300/3ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 300 MG/3ML	83101020102050	-18.0%	$0.00	N
LOVENOX INJ 40/0.4ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 40 MG/0.4ML	83101020102013	-18.0%	$0.00	N
LOVENOX INJ 60/0.6ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 60 MG/0.6ML	83101020102014	-18.0%	$0.00	N
LOVENOX INJ 80/0.8ML	Hematological Agents	LOVENOX	ENOXAPARIN SODIUM INJ 80 MG/0.8ML	83101020102015	-18.0%	$0.00	N
MONONINE INJ 1000UNIT	Hematological Agents	MONONINE	COAGULATION FACTOR IX FOR INJ 1000 UNIT	85100028002160	-30.5%	$0.00	Y
MONONINE INJ 250UNIT	Hematological Agents	MONONINE	COAGULATION FACTOR IX FOR INJ 250 UNIT	85100028002160	-30.5%	$0.00	Y
MONONINE INJ 500UNIT	Hematological Agents	MONONINE	COAGULATION FACTOR IX FOR INJ 500 UNIT	85100028002170	-30.5%	$0.00	Y
RECOMBINATE INJ	Hematological Agents	RECOMBINATE	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ 1801-2400 UNIT	85100010202155	-39.5%	$0.00	Y
RECOMBINATE INJ 220-400	Hematological Agents	RECOMBINATE	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ 220-400 UNIT	85100010202115	-39.5%	$0.00	Y
RECOMBINATE INJ 401-800	Hematological Agents	RECOMBINATE	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ 401-800 UNIT	85100010202125	-39.5%	$0.00	Y
RECOMBINATE INJ 801-1240	Hematological Agents	RECOMBINATE	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ 801-1240 UNIT	85100010202135	-39.5%	$0.00	Y
RIASTAP SOL 1GM	Hematological Agents	RIASTAP	FIBRINOGEN CONC (HUMAN) INJ APPROXIMATELY 1 GM (900-1300 MG)	85100035002120	-26.0%	$0.00	Y
WILATE INJ	Hematological Agents	WILATE	ANTIHEMOPHILIC FACTOR/VWF (HUMAN) FOR INJ 500-500 UNIT	85100015102129	-26.0%	$0.00	Y
XYNTHA INJ 1000UNIT	Hematological Agents	XYNTHA	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 1000 UNIT	85100010266440	-21.5%	$0.00	Y
XYNTHA INJ 2000UNIT	Hematological Agents	XYNTHA	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 2000 UNIT	85100010266460	-21.5%	$0.00	Y
XYNTHA INJ 250UNIT	Hematological Agents	XYNTHA	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 250 UNIT	85100010266420	-21.5%	$0.00	Y
XYNTHA INJ 500UNIT	Hematological Agents	XYNTHA	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 500 UNIT	85100010266430	-21.5%	$0.00	Y
XYNTHA SOLOF INJ 2000UNIT	Hematological Agents	XYNTHA SOLOF	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 2000 UNIT	85100010266460	-21.5%	$0.00	Y
XYNTHA SOLOF INJ 3000UNIT	Hematological Agents	XYNTHA SOLOF	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 3000 UNIT	85100010266470	-21.5%	$0.00	Y
XYNTHA SOLOF INJ 500UNIT	Hematological Agents	XYNTHA SOLOF	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 500 UNIT	85100010266430	-21.5%	$0.00	Y
XYNTHA SOLOF KIT 250UNIT	Hematological Agents	XYNTHA SOLOF	ANTIHEMOPHILIC FACTOR RECOMBINANT PAF FOR INJ KIT 250 UNIT	85100010266420	-21.5%	$0.00	Y
VPRIV INJ 400UNIT	Hematopoietic Agent	VPRIV	VELAGLUCERASE ALFA FOR INJ 400 UNIT	82700065102120	-14.0%	$0.00	Y
ARANESP INJ 100MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 100 MCG/0.5ML	82401015112043	-17.5%	$0.00	Y
ARANESP INJ 150MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 150 MCG/0.3ML	82401015112048	-17.5%	$0.00	Y
ARANESP INJ 200MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 200 MCG/0.4ML	82401015112054	-17.5%	$0.00	Y
ARANESP INJ 25MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 25 MCG/0.42ML	82401015112014	-17.5%	$0.00	Y
ARANESP INJ 300MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 300 MCG/0.6ML	82401015112064	-17.5%	$0.00	Y
ARANESP INJ 40MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 40 MCG/0.4ML	82401015112024	-17.5%	$0.00	Y
ARANESP INJ 500MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 500 MCG/ML	82401015112075	-17.5%	$0.00	Y
ARANESP INJ 60MCG	Hematopoietic Agent	ARANESP	DARBEPOETIN ALFA-POLYSORBATE 80 SOLN INJ 60 MCG/0.3ML	82401015112034	-17.5%	$0.00	Y
EPOGEN INJ 10000/ML	Hematopoietic Agent	EPOGEN	EPOETIN ALFA INJ 10000 UNIT/ML	82401020002040	-10.0%	$0.00	Y
EPOGEN INJ 2000/ML	Hematopoietic Agent	EPOGEN	EPOETIN ALFA INJ 2000 UNIT/ML	82401020002010	-10.0%	$0.00	Y
EPOGEN INJ 20000/ML	Hematopoietic Agent	EPOGEN	EPOETIN ALFA INJ 20000 UNIT/ML	82401020002050	-10.0%	$0.00	Y
EPOGEN INJ 3000/ML	Hematopoietic Agent	EPOGEN	EPOETIN ALFA INJ 3000 UNIT/ML	82401020002015	-10.0%	$0.00	Y
EPOGEN INJ 4000/ML	Hematopoietic Agent	EPOGEN	EPOETIN ALFA INJ 4000 UNIT/ML	82401020002020	-10.0%	$0.00	Y
LEUKINE INJ 250MCG	Hematopoietic Agent	LEUKINE	SARGRAMOSTIM LYOPHILIZED FOR INJ 250 MCG	82402050002120	-15.5%	$0.00	Y
LEUKINE INJ 500 MCG	Hematopoietic Agent	LEUKINE	SARGRAMOSTIM INJ 500 MCG/ML	82402050002025	-15.5%	$0.00	Y
MOZOBIL INJ	Hematopoietic Agent	MOZOBIL	PLERIXAFOR SUBCUTANEOUS INJ 24 MG/1.2ML (20 MG/ML)	82502060002020	-16.1%	$0.00	Y
NEULASTA INJ 6MG/0.6M	Hematopoietic Agent	NEULASTA	PEGFILGRASTIM INJ 6 MG/0.6ML	82401570002020	-16.5%	$0.00	Y
NEUMEGA INJ 5MG	Hematopoietic Agent	NEUMEGA	OPRELVEKIN FOR INJ 5 MG	82403060002120	-15.0%	$0.00	Y
NEUPOGEN INJ 300/0.5	Hematopoietic Agent	NEUPOGEN	FILGRASTIM INJ 300 MCG/0.5ML (600 MCG/ML)	82401520002016	-15.5%	$0.00	Y
NEUPOGEN INJ 300MCG	Hematopoietic Agent	NEUPOGEN	FILGRASTIM INJ 300 MCG/ML	82401520002010	-15.5%	$0.00	Y
NEUPOGEN INJ 480/0.8	Hematopoietic Agent	NEUPOGEN	FILGRASTIM INJ 480 MCG/0.8ML (600 MCG/ML)	82401520002018	-15.5%	$0.00	Y
NEUPOGEN INJ 480MCG	Hematopoietic Agent	NEUPOGEN	FILGRASTIM INJ 480 MCG/1.6ML (300 MCG/ML)	82401520002012	-15.5%	$0.00	Y

NPLATE INJ 250MCG	Hematopoietic Agent	NPLATE	ROMIPLOSTIM FOR INJ 250 MCG	824050600002120	-13.0%	$0.00	Y
NPLATE INJ 500MCG	Hematopoietic Agent	NPLATE	ROMIPLOSTIM FOR INJ 500 MCG	824050600002130	-13.0%	$0.00	Y
PROCRIT INJ 10000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 10000 UNIT/ML	824010200002040	-13.0%	$0.00	Y
PROCRIT INJ 2000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 2000 UNIT/ML	824010200002010	-13.0%	$0.00	Y
PROCRIT INJ 20000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 20000 UNIT/ML	824010200002050	-13.0%	$0.00	Y
PROCRIT INJ 3000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 3000 UNIT/ML	824010200002015	-13.0%	$0.00	Y
PROCRIT INJ 4000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 4000 UNIT/ML	824010200002020	-13.0%	$0.00	Y
PROCRIT INJ 40000/ML	Hematopoietic Agent	PROCRIT	EPOETIN ALFA INJ 40000 UNIT/ML	824010200002060	-13.0%	$0.00	Y
CEREZYME INJ 200UNIT	Hematopoietic Agents	CEREZYME	IMIGLUCERASE FOR INJ 200 UNIT	827000500002110	-16.5%	$0.00	Y
CEREZYME INJ 400UNIT	Hematopoietic Agents	CEREZYME	IMIGLUCERASE FOR INJ 400 UNIT	827000500002120	-16.5%	$0.00	Y
ZAVESCA CAP 100MG	Hematopoietic Agents	ZAVESCA	MIGLUSTAT CAP 100 MG	827000700000120	-13.5%	$0.00	N
ALPHANATE INJ VWF/HUM	Hemostatics	ALPHANATE	ANTIHEMOPHILIC FACTOR/VWF (HUMAN) FOR INJ 500 UNIT	851000151021700	-43.0%	$0.00	Y
ALPHANINE SD INJ 1000UNIT	Hemostatics	ALPHANINE SD	COAGULATION FACTOR IX FOR INJ 1000 UNIT	851000280021800	-13.8%	$0.00	Y
ALPHANINE SD INJ 1500UNIT	Hemostatics	ALPHANINE SD	COAGULATION FACTOR IX FOR INJ 1500 UNIT	851000280021850	-13.8%	$0.00	Y
ALPHANINE SD INJ 500UNIT	Hemostatics	ALPHANINE SD	COAGULATION FACTOR IX FOR INJ 500 UNIT	851000280021700	-13.8%	$0.00	Y
BEBULIN INJ 200-1200	Hemostatics	BEBULIN	FACTOR IX COMPLEX FOR INJ 200-1200 UNIT	851000300021500	-26.0%	$0.00	Y
BEBULIN VH INJ 200-1200	Hemostatics	BEBULIN VH	FACTOR IX COMPLEX FOR INJ 200-1200 UNIT	851000300021500	-26.0%	$0.00	Y
CYKLOKAPRON INJ 100MG/ML	Hemostatics	CYKLOKAPRON	TRANEXAMIC ACID INJ 100 MG/ML	841000400020100	-16.0%	$0.00	Y
HELIXATE FS INJ 1000UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 1000 UNIT	851000102064400	-46.5%	$0.00	Y
HELIXATE FS INJ 2000UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 2000 UNIT	851000102064500	-46.5%	$0.00	Y
HELIXATE FS INJ 250UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 250 UNIT	851000102064200	-46.5%	$0.00	Y
HELIXATE FS INJ 3000UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 3000 UNIT	851000102064600	-46.5%	$0.00	Y
HELIXATE FS INJ 500UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 500 UNIT	851000102064300	-46.5%	$0.00	Y
HELIXATE FS SOL 1000UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 1000 UNIT	851000102064400	-46.5%	$0.00	Y
HELIXATE FS SOL 250UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 250 UNIT	851000102064200	-46.5%	$0.00	Y
HELIXATE FS SOL 500UNIT	Hemostatics	HELIXATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 500 UNIT	851000102064300	-46.5%	$0.00	Y
HEMOFIL M INJ 220-400	Hemostatics	HEMOFIL M	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 220-400 UNIT	851000100021090	-46.5%	$0.00	Y
HEMOFIL M INJ 401-800	Hemostatics	HEMOFIL M	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 401-800 UNIT	851000100021250	-46.5%	$0.00	Y
HEMOFIL M SOL 501-2000	Hemostatics	HEMOFIL M	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 1501-2000 UNIT	851000100021700	-46.5%	$0.00	Y
HEMOFIL M SOL 801-1500	Hemostatics	HEMOFIL M	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 801-1500 UNIT	851000100021600	-46.5%	$0.00	Y
HUMATE-P INJ 600UNIT	Hemostatics	HUMATE-P	ANTIHEMOPHILIC FACTOR/VWF (HUMAN) FOR INJ 250-600 UNIT	851000151021220	-41.0%	$0.00	Y
HUMATE-P SOL 1200UNIT	Hemostatics	HUMATE-P	ANTIHEMOPHILIC FACTOR/VWF (HUMAN) FOR INJ 500-1200 UNIT	851000151021320	-41.0%	$0.00	Y
HUMATE-P SOL 2400UNIT	Hemostatics	HUMATE-P	ANTIHEMOPHILIC FACTOR/VWF (HUMAN) FOR INJ 1000-2400 UNIT	851000151021440	-41.0%	$0.00	Y
KOATE-DVI INJ 1000UNIT	Hemostatics	KOATE-DVI	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 1000 UNIT	851000100021400	-1.0%	$0.00	Y
KOATE-DVI INJ 250UNIT	Hemostatics	KOATE-DVI	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 250 UNIT	851000100021100	-1.0%	$0.00	Y
KOATE-DVI INJ 500UNIT	Hemostatics	KOATE-DVI	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ 500 UNIT	851000100021300	-1.0%	$0.00	Y
KOGENATE FS INJ 1000/BS	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 1000 UNIT	851000102064400	-46.5%	$0.00	Y
KOGENATE FS INJ 1000UNIT	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 1000 UNIT	851000102064400	-46.5%	$0.00	Y
KOGENATE FS INJ 2000/BS	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 2000 UNIT	851000102064500	-46.5%	$0.00	Y
KOGENATE FS INJ 2000UNIT	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 2000 UNIT	851000102064500	-46.5%	$0.00	Y
KOGENATE FS INJ 250/BS	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 250 UNIT	851000102064200	-46.5%	$0.00	Y
KOGENATE FS INJ 250UNIT	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 250 UNIT	851000102064200	-46.5%	$0.00	Y
KOGENATE FS INJ 3000/BS	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 3000 UNIT	851000102064600	-46.5%	$0.00	Y
KOGENATE FS INJ 3000UNIT	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 3000 UNIT	851000102064600	-46.5%	$0.00	Y
KOGENATE FS INJ 500/BS	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 500 UNIT	851000102064300	-46.5%	$0.00	Y
KOGENATE FS INJ 500UNIT	Hemostatics	KOGENATE FS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 500 UNIT	851000102064300	-46.5%	$0.00	Y
MONOCLATE-P INJ 1000UNIT	Hemostatics	MONOCLATE-P	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ KIT 1000 UNIT	851000100064600	-26.0%	$0.00	Y
MONOCLATE-P INJ 1500UNIT	Hemostatics	MONOCLATE-P	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ KIT 1500 UNIT	851000100064750	-26.0%	$0.00	Y
MONOCLATE-P INJ 250UNIT	Hemostatics	MONOCLATE-P	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ KIT 250 UNIT	851000100064100	-26.0%	$0.00	Y
MONOCLATE-P INJ 500UNIT	Hemostatics	MONOCLATE-P	ANTIHEMOPHILIC FACTOR (HUMAN) FOR INJ KIT 500 UNIT	851000100064300	-26.0%	$0.00	Y
NOVOSEVEN RT INJ 1MG	Hemostatics	NOVOSEVEN RT	COAGULATION FACTOR VIIA (RECOMB) FOR INJ 1 MG (1000 MCG)	851000262021170	-31.5%	$0.00	Y
NOVOSEVEN RT INJ 2MG	Hemostatics	NOVOSEVEN RT	COAGULATION FACTOR VIIA (RECOMB) FOR INJ 2 MG (2000 MCG)	851000262021260	-31.5%	$0.00	Y
NOVOSEVEN RT INJ 5MG	Hemostatics	NOVOSEVEN RT	COAGULATION FACTOR VIIA (RECOMB) FOR INJ 5 MG (5000 MCG)	851000262021450	-31.5%	$0.00	Y
NOVOSEVEN RT INJ 8MG	Hemostatics	NOVOSEVEN RT	COAGULATION FACTOR VIIA (RECOMB) FOR INJ 8 MG (8000 MCG)	851000262021600	-31.5%	$0.00	Y
PROFILNINE INJ 1000UNIT	Hemostatics	PROFILNINE	FACTOR IX COMPLEX FOR INJ 1000 UNIT	851000300021100	-26.0%	$0.00	Y
PROFILNINE INJ 1500UNIT	Hemostatics	PROFILNINE	FACTOR IX COMPLEX FOR INJ 1500 UNIT	851000300021150	-26.0%	$0.00	Y
PROFILNINE INJ 500UNIT	Hemostatics	PROFILNINE	FACTOR IX COMPLEX FOR INJ 500 UNIT	851000300021050	-26.0%	$0.00	Y
REFACTO INJ 500UNIT	Hemostatics	REFACTO	ANTIHEMOPHILIC FACTOR (RECOMBINANT) FOR INJ KIT 500 UNIT	851000102064300	-46.5%	$0.00	Y
TRANEXAMIC INJ ACID	Hemostatics	TRANEXAMIC	TRANEXAMIC ACID INJ 100 MG/ML	841000400020100	-16.0%	$0.00	Y
CARIMUNE NF INJ 12GM	Immunizing Agent	CARIMUNE NF	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 12 GM	191000201021350	-36.0%	$0.00	Y
CARIMUNE NF INJ 3GM	Immunizing Agent	CARIMUNE NF	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 3 GM	191000201021170	-36.0%	$0.00	Y
CARIMUNE NF INJ 6GM	Immunizing Agent	CARIMUNE NF	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 6 GM	191000201021250	-36.0%	$0.00	Y

CYTOGAM INJ	Immunizing Agent	CYTOGAM	CYTOMEGALOVIRUS IMMUNE GLOBULIN (HUMAN) IV INJ	19100005002200	-25.0%	$0.00	Y
FLEBOGAMMA INJ 10%	Immunizing Agent	FLEBOGAMMA	IMMUNE GLOBULIN (HUMAN) IV SOLN 20 GM/200ML	19100020102076	-24.0%	$0.00	Y
FLEBOGAMMA INJ 5%	Immunizing Agent	FLEBOGAMMA	IMMUNE GLOBULIN (HUMAN) IV SOLN 0.5 GM/10ML	19100020102020	-24.0%	$0.00	Y
FLEBOGAMMA INJ DIF 5%	Immunizing Agent	FLEBOGAMMA	IMMUNE GLOBULIN (HUMAN) IV SOLN 20 GM/400ML	19100020102044	-24.0%	$0.00	Y
GAMASTAN S/D INJ	Immunizing Agent	GAMASTAN S/D	IMMUNE GLOBULIN (HUMAN) INJ	19100020002200	-12.5%	$0.00	Y
GAMMAGARD INJ 10GM/100	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 10 GM/100ML	19100020302072	-43.0%	$0.00	Y
GAMMAGARD INJ 1GM/10ML	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 1 GM/10ML	19100020302060	-43.0%	$0.00	Y
GAMMAGARD INJ 2.5GM/25	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 2.5 GM/25ML	19100020302064	-43.0%	$0.00	Y
GAMMAGARD INJ 20GM/200	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 20 GM/200ML	19100020302076	-43.0%	$0.00	Y
GAMMAGARD INJ 30GM/300	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 30 GM/300ML	19100020302080	-43.0%	$0.00	Y
GAMMAGARD INJ 5GM/50ML	Immunizing Agent	GAMMAGARD	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 5 GM/50ML	19100020302068	-43.0%	$0.00	Y
GAMMAGARD SD INJ 10GM HU	Immunizing Agent	GAMMAGARD SD	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 10 GM	19100020102130	-55.0%	$0.00	Y
GAMMAGARD SD INJ 2.5GM HU	Immunizing Agent	GAMMAGARD SD	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 2.5 GM	19100020102115	-55.0%	$0.00	Y
GAMMAGARD SD INJ 5GM HU	Immunizing Agent	GAMMAGARD SD	IMMUNE GLOBULIN (HUMAN) IV FOR SOLN 5 GM	19100020102120	-55.0%	$0.00	Y
GAMUNEX INJ 10%	Immunizing Agent	GAMUNEX	IMMUNE GLOBULIN (HUMAN) IV SOLN 20 GM/200ML	19100020102076	-30.0%	$0.00	
GAMUNEX-C INJ 10GM/100	Immunizing Agent	GAMUNEX-C	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 10 GM/100ML	19100020302072	-33.0%	$0.00	Y
GAMUNEX-C INJ 1GM/10ML	Immunizing Agent	GAMUNEX-C	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 1 GM/10ML	19100020302060	-33.0%	$0.00	Y
GAMUNEX-C INJ 2.5GM/25	Immunizing Agent	GAMUNEX-C	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 2.5 GM/25ML	19100020302064	-33.0%	$0.00	Y
GAMUNEX-C INJ 20GM/200	Immunizing Agent	GAMUNEX-C	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 20 GM/200ML	19100020302076	-33.0%	$0.00	Y
GAMUNEX-C INJ 5GM/50ML	Immunizing Agent	GAMUNEX-C	IMMUNE GLOBULIN (HUMAN) IV OR SUBCUTANEOUS SOLN 5 GM/50ML	19100020302068	-33.0%	$0.00	Y
IMOGAM RABIE INJ 150/ML	Immunizing Agent	IMOGAM RABIE	RABIES IMMUNE GLOBULIN (HUMAN) INJ 150 UNIT/ML	19100045002205	-12.5%	$0.00	Y
RHOGAM PLUS INJ 300MCG	Immunizing Agent	RHOGAM PLUS	RHO D IMMUNE GLOBULIN (HUMAN) IM INJ 300 MCG	19100050002220	-1.0%	$0.00	Y
RHOPHYLAC INJ 1500/2ML	Immunizing Agent	RHOPHYLAC	RHO D IMMUNE GLOBULIN (HUMAN) INJ 1500 UNT/2ML (300 MCG/2ML)	19100050002015	-13.5%	$0.00	Y
SOLIRIS INJ 10MG/ML	Immunizing Agent	SOLIRIS	ECULIZUMAB IV SOLN 10 MG/ML (FOR INFUSION)	85800050002020	-13.5%	$0.00	Y
SYNAGIS INJ 100MG/ML	Immunizing Agent	SYNAGIS	PALIVIZUMAB IM SOLN 100 MG/ML	19502060002020	-13.5%	$0.00	Y
SYNAGIS INJ 50MG	Immunizing Agent	SYNAGIS	PALIVIZUMAB IM SOLN 50 MG/0.5ML	19502060002015	-13.5%	$0.00	Y
WINRHO SDF INJ 15000UNT	Immunizing Agent	WINRHO SDF	RHO D IMMUNE GLOBULIN (HUMAN) INJ 15000 UNIT/13ML	19100050002065	-26.0%	$0.00	Y
WINRHO SDF INJ 1500UNIT	Immunizing Agent	WINRHO SDF	RHO D IMMUNE GLOBULIN (HUMAN) INJ 1500 UNIT/1.3ML	19100050002060	-26.0%	$0.00	Y
WINRHO SDF INJ 2500UNIT	Immunizing Agent	WINRHO SDF	RHO D IMMUNE GLOBULIN (HUMAN) INJ 2500 UNIT/2.2ML	19100050002050	-26.0%	$0.00	Y
WINRHO SDF INJ 5000UNIT	Immunizing Agent	WINRHO SDF	RHO D IMMUNE GLOBULIN (HUMAN) INJ 5000 UNIT/4.4ML	19100050002055	-26.0%	$0.00	Y
BENLYSTA INJ 120MG	Immunizing Agents	BENLYSTA	BELIMUMAB FOR IV SOLN 120 MG	99422015002120	-14.5%	$0.00	Y
BENLYSTA INJ 400MG	Immunizing Agents	BENLYSTA	BELIMUMAB FOR IV SOLN 400 MG	99422015002140	-14.5%	$0.00	Y
HYPERRAB S/D INJ 150/ML	Immunizing Agents	HYPERRAB S/D	RABIES IMMUNE GLOBULIN (HUMAN) INJ 150 UNIT/ML	19100045002205	-15.0%	$0.00	Y
ACTEMRA INJ 200/10ML	Immunologic Agents	ACTEMRA	TOCILIZUMAB IV INJ 200 MG/10ML	66500070002035	-13.0%	$0.00	Y
ACTEMRA INJ 400/20ML	Immunologic Agents	ACTEMRA	TOCILIZUMAB IV INJ 400 MG/20ML	66500070002040	-13.0%	$0.00	Y
ACTEMRA INJ 80MG/4ML	Immunologic Agents	ACTEMRA	TOCILIZUMAB IV INJ 80 MG/4ML	66500070002030	-13.0%	$0.00	Y
ARCALYST INJ 220MG	Immunologic Agents	ARCALYST	RILONACEPT FOR INJ 220 MG	65450060002120	-16.5%	$0.00	N
ENBREL INJ 25/0.5ML	Immunologic Agents	ENBREL	ETANERCEPT SUBCUTANEOUS INJ 25 MG/0.5ML	66290030002025	-15.0%	$0.00	Y
ENBREL INJ 25MG	Immunologic Agents	ENBREL	ETANERCEPT FOR SUBCUTANEOUS INJ KIT 25 MG	66290030006420	-15.0%	$0.00	Y
ENBREL INJ 50MG/ML	Immunologic Agents	ENBREL	ETANERCEPT SUBCUTANEOUS INJ 50 MG/ML	66290030002020	-15.0%	$0.00	Y
ENBREL SRCLK INJ 50MG/ML	Immunologic Agents	ENBREL SRCLK	ETANERCEPT SUBCUTANEOUS INJ 50 MG/ML	66290030002020	-15.0%	$0.00	Y
KINERET INJ	Immunologic Agents	KINERET	ANAKINRA SUBCUTANEOUS INJ 100 MG/0.67ML	66280010002020	-15.0%	$0.00	Y
SIMPONI INJ 50MG	Immunologic Agents	SIMPONI	GOLIMUMAB SUBCUTANEOUS INJ 50 MG/0.5ML	66270040002020	-15.0%	$0.00	Y
ATGAM INJ 250MG	Immunosuppressive Agent	ATGAM	LYMPHOCYTE IMMUNE GLOBULIN ANTI-THYMOCYTE G INJ 50 MG/ML(EQ)	99402540102220	-14.5%	$0.00	Y
CELLCEPT CAP 250MG	Immunosuppressive Agent	CELLCEPT	MYCOPHENOLATE MOFETIL CAP 250 MG	99403030100120	-13.0%	$0.00	Y
CELLCEPT SUS 200MG/ML	Immunosuppressive Agent	CELLCEPT	MYCOPHENOLATE MOFETIL FOR ORAL SUSP 200 MG/ML	99403030101920	-13.0%	$0.00	Y
CELLCEPT TAB 500MG	Immunosuppressive Agent	CELLCEPT	MYCOPHENOLATE MOFETIL TAB 500 MG	99403030100330	-13.0%	$0.00	Y
CELLCEPT IV INJ 500MG	Immunosuppressive Agent	CELLCEPT IV	MYCOPHENOLATE MOFETIL HCL FOR IV SOLN 500 MG (BASE EQUIV)	99403030202120	-13.0%	$0.00	Y
CYCLOSPORINE CAP 100MG	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE CAP 100 MG	99402020000140	-32.0%	$0.00	Y
CYCLOSPORINE CAP 100MG MD	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE MODIFIED CAP 100 MG	99402020300150	-32.0%	$0.00	Y
CYCLOSPORINE CAP 25MG	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE CAP 25 MG	99402020000110	-32.0%	$0.00	Y
CYCLOSPORINE CAP 25MG MOD	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE MODIFIED CAP 25 MG	99402020300120	-32.0%	$0.00	Y
CYCLOSPORINE CAP 50MG MOD	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE MODIFIED CAP 50 MG	99402020300130	-32.0%	$0.00	Y
CYCLOSPORINE INJ 50MG/ML	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE IV SOLN 50 MG/ML	99402020002005	-32.0%	$0.00	Y
CYCLOSPORINE SOL 100MG/ML	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE ORAL SOLN 100 MG/ML	99402020002010	-32.0%	$0.00	Y
CYCLOSPORINE SOL MODIFIED	Immunosuppressive Agent	CYCLOSPORINE	CYCLOSPORINE MODIFIED ORAL SOLN 100 MG/ML	99402020302020	-32.0%	$0.00	Y
GENGRAF CAP 100MG	Immunosuppressive Agent	GENGRAF	CYCLOSPORINE MODIFIED CAP 100 MG	99402020300150	-18.0%	$0.00	Y
GENGRAF CAP 25MG	Immunosuppressive Agent	GENGRAF	CYCLOSPORINE MODIFIED CAP 25 MG	99402020300120	-18.0%	$0.00	Y
GENGRAF SOL 100MG/ML	Immunosuppressive Agent	GENGRAF	CYCLOSPORINE MODIFIED ORAL SOLN 100 MG/ML	99402020302020	-18.0%	$0.00	Y
HECORIA CAP 0.5MG	Immunosuppressive Agent	HECORIA	TACROLIMUS CAP 0.5 MG	99404080000105	-18.0%	$0.00	Y
HECORIA CAP 1MG	Immunosuppressive Agent	HECORIA	TACROLIMUS CAP 1 MG	99404080000110	-18.0%	$0.00	Y
HECORIA CAP 5MG	Immunosuppressive Agent	HECORIA	TACROLIMUS CAP 5 MG	99404080000120	-18.0%	$0.00	Y

MYCOPHENOLAT CAP 250MG	Immunosuppressive Agent	MYCOPHENOLAT	MYCOPHENOLATE MOFETIL CAP 250 MG	99403030100120	-84.0%	$0.00	Y
MYCOPHENOLAT TAB 500MG	Immunosuppressive Agent	MYCOPHENOLAT	MYCOPHENOLATE MOFETIL TAB 500 MG	99403030100330	-84.0%	$0.00	Y
MYFORTIC TAB 180MG	Immunosuppressive Agent	MYFORTIC	MYCOPHENOLATE SODIUM TAB DR 180 MG (MYCOPHENOLIC ACID EQUIV)	99403030300620	-10.0%	$0.00	Y
MYFORTIC TAB 360MG	Immunosuppressive Agent	MYFORTIC	MYCOPHENOLATE SODIUM TAB DR 360 MG (MYCOPHENOLIC ACID EQUIV)	99403030300630	-10.0%	$0.00	Y
NEORAL CAP 100MG	Immunosuppressive Agent	NEORAL	CYCLOSPORINE MODIFIED CAP 100 MG	99402020300150	-3.0%	$0.00	Y
NEORAL CAP 25MG	Immunosuppressive Agent	NEORAL	CYCLOSPORINE MODIFIED CAP 25 MG	99402020300120	-3.0%	$0.00	Y
NEORAL SOL 100MG/ML	Immunosuppressive Agent	NEORAL	CYCLOSPORINE MODIFIED ORAL SOLN 100 MG/ML	99402020302020	-3.0%	$0.00	Y
NULOJIX INJ 250MG	Immunosuppressive Agent	NULOJIX	BELATACEPT FOR IV INFUSION 250 MG	99408020002120	-14.5%	$0.00	Y
PROGRAF CAP 0.5MG	Immunosuppressive Agent	PROGRAF	TACROLIMUS CAP 0.5 MG	99404080000105	-15.0%	$0.00	Y
PROGRAF CAP 1MG	Immunosuppressive Agent	PROGRAF	TACROLIMUS CAP 1 MG	99404080000110	-15.0%	$0.00	Y
PROGRAF CAP 5MG	Immunosuppressive Agent	PROGRAF	TACROLIMUS CAP 5 MG	99404080000120	-15.0%	$0.00	Y
PROGRAF INJ 5MG/ML	Immunosuppressive Agent	PROGRAF	TACROLIMUS INJ 5 MG/ML	99404080002010	-9.0%	$0.00	Y
RAPAMUNE SOL 1MG/ML	Immunosuppressive Agent	RAPAMUNE	SIROLIMUS ORAL SOLN 1 MG/ML	99404070002020	-11.0%	$0.00	Y
RAPAMUNE TAB 0.5MG	Immunosuppressive Agent	RAPAMUNE	SIROLIMUS TAB 0.5 MG	99404070000310	-11.0%	$0.00	Y
RAPAMUNE TAB 1MG	Immunosuppressive Agent	RAPAMUNE	SIROLIMUS TAB 1 MG	99404070000320	-11.0%	$0.00	Y
RAPAMUNE TAB 2MG	Immunosuppressive Agent	RAPAMUNE	SIROLIMUS TAB 2 MG	99404070000330	-11.0%	$0.00	Y
SANDIMMUNE CAP 100MG	Immunosuppressive Agent	SANDIMMUNE	CYCLOSPORINE CAP 100 MG	99402020000140	-5.5%	$0.00	Y
SANDIMMUNE CAP 25MG	Immunosuppressive Agent	SANDIMMUNE	CYCLOSPORINE CAP 25 MG	99402020000110	-5.5%	$0.00	Y
SANDIMMUNE INJ 50MG/ML	Immunosuppressive Agent	SANDIMMUNE	CYCLOSPORINE IV SOLN 50 MG/ML	99402020002005	-5.5%	$0.00	Y
SANDIMMUNE SOL 100MG/ML	Immunosuppressive Agent	SANDIMMUNE	CYCLOSPORINE ORAL SOLN 100 MG/ML	99402020002010	-5.5%	$0.00	Y
TACROLIMUS CAP 0.5MG	Immunosuppressive Agent	TACROLIMUS	TACROLIMUS CAP 0.5 MG	99404080000105	-50.0%	$0.00	Y
TACROLIMUS CAP 1MG	Immunosuppressive Agent	TACROLIMUS	TACROLIMUS CAP 1 MG	99404080000110	-50.0%	$0.00	Y
TACROLIMUS CAP 5MG	Immunosuppressive Agent	TACROLIMUS	TACROLIMUS CAP 5 MG	99404080000120	-50.0%	$0.00	Y
TACROLIMUS POW	Immunosuppressive Agent	TACROLIMUS	TACROLIMUS (BULK) POWDER	96804209002900	-15.0%	$0.00	
TACROLIMUS POW MONOHYD	Immunosuppressive Agent	TACROLIMUS	TACROLIMUS (BULK) POWDER	96804209002900	-15.0%	$0.00	N
ZORTRESS TAB 0.25MG	Immunosuppressive Agent	ZORTRESS	EVEROLIMUS TAB 0.25 MG	99404035000320	-14.0%	$0.00	Y
ZORTRESS TAB 0.5MG	Immunosuppressive Agent	ZORTRESS	EVEROLIMUS TAB 0.5 MG	99404035000325	-14.0%	$0.00	Y
ZORTRESS TAB 0.75MG	Immunosuppressive Agent	ZORTRESS	EVEROLIMUS TAB 0.75 MG	99404035000330	-14.0%	$0.00	Y
MAKENA INJ 250MG/ML	Infertility	MAKENA	HYDROXYPROGESTERONE CAPROATE IM IN OIL 250 MG/ML	26000010101710	-12.0%	$0.00	Y
ALFERON N INJ 5MU/ML	Interferon	ALFERON N	INTERFERON ALFA-N3 INJ 5000000 UNIT/ML	21700060302020	-18.0%	$0.00	Y
AVONEX KIT 30MCG	Interferon	AVONEX	INTERFERON BETA-1A FOR IM INJ KIT 30MCG (33MCG(6.6 MU)/VIAL)	62403060456420	-17.0%	$0.00	Y
AVONEX PEN KIT 30MCG	Interferon	AVONEX PEN	INTERFERON BETA-1A IM INJ KIT 30 MCG/0.5ML	62403060456430	-17.0%	$0.00	Y
AVONEX PREFL KIT 30MCG	Interferon	AVONEX PREFL	INTERFERON BETA-1A IM INJ KIT 30 MCG/0.5ML	62403060456430	-17.0%	$0.00	Y
INTRON-A INJ 10MU	Interferon	INTRON-A	INTERFERON ALFA-2B FOR INJ 10000000 UNIT	21700060202130	-15.0%	$0.00	Y
INTRON-A INJ 18MU	Interferon	INTRON-A	INTERFERON ALFA-2B INJ 60000000 UNIT/ML	21700060202022	-15.0%	$0.00	Y
INTRON-A INJ 25MU	Interferon	INTRON-A	INTERFERON ALFA-2B INJ 10000000 UNIT/ML	21700060202030	-15.0%	$0.00	Y
INTRON-A INJ 50MU	Interferon	INTRON-A	INTERFERON ALFA-2B FOR INJ 50000000 UNIT	21700060202160	-15.0%	$0.00	Y
PEGASYS INJ	Interferon	PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/0.5ML	12353060052040	-13.5%	$0.00	Y
PEGASYS INJ 180MCG/M	Interferon	PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/ML	12353060052020	-13.5%	$0.00	Y
PEGASYS INJ PROCLICK	Interferon	PEGASYS	PEGINTERFERON ALFA-2A INJ 180 MCG/0.5ML	12353060052040	-13.5%	$0.00	Y
PEGASYS KIT	Interferon	PEGASYS	PEGINTERFERON ALFA-2A INJ KIT 180 MCG/0.5ML	12353060056440	-13.5%	$0.00	Y
SYLATRON KIT 296MCG	Interferon	SYLATRON	PEGINTERFERON ALFA-2B FOR INJ KIT 296 MCG	21700075206410	-18.0%	$0.00	Y
SYLATRON KIT 444MCG	Interferon	SYLATRON	PEGINTERFERON ALFA-2B FOR INJ KIT 444 MCG	21700075206420	-18.0%	$0.00	Y
SYLATRON KIT 888MCG	Interferon	SYLATRON	PEGINTERFERON ALFA-2B FOR INJ KIT 888 MCG	21700075206430	-18.0%	$0.00	Y
CARBAGLU TAB 200MG	Metabolic Alkalosis Agent	CARBAGLU	CARGLUMIC ACID TAB 200 MG	30908230000320	-10.5%	$0.00	N
HYPERTET S/D INJ 250/ML	Misc	HYPERTET S/D	TETANUS IMMUNE GLOBULIN (HUMAN) INJ 250 UNIT/ML	19100060002205	-15.0%	$0.00	Y
ONFI TAB 10MG	Misc.	ONFI	CLOBAZAM TAB 10 MG	72100007000310	-7.3%	$0.00	Y
ONFI TAB 20MG	Misc.	ONFI	CLOBAZAM TAB 20 MG	72100007000320	-7.3%	$0.00	Y
ONFI TAB 5MG	Misc.	ONFI	CLOBAZAM TAB 5 MG	72100007000305	-7.3%	$0.00	Y
TRACLEER TAB 125MG	Misc. Vasodilatin	TRACLEER	BOSENTAN TAB 125 MG	40160015000330	-13.0%	$0.00	Y
TRACLEER TAB 62.5MG	Misc. Vasodilatin	TRACLEER	BOSENTAN TAB 62.5 MG	40160015000320	-13.0%	$0.00	Y
EUFLEXXA INJ 10MG/ML	Neuromuscular Agents	EUFLEXXA	SODIUM HYALURONATE INTRA-ARTICULAR INJ 20 MG/2ML	75800070102024	-12.0%	$0.00	Y
APOKYN INJ	Neuromuscular Agent	APOKYN	APOMORPHINE HYDROCHLORIDE INJ 10 MG/ML	73203010102020	-14.0%	$0.00	Y
APOKYN INJ 10MG/ML	Neuromuscular Agent	APOKYN	APOMORPHINE HYDROCHLORIDE INJ 10 MG/ML	73203010102020	-14.0%	$0.00	Y
HYALGAN INJ 20MG/2ML	Neuromuscular Agent	HYALGAN	SODIUM HYALURONATE INTRA-ARTICULAR INJ 20 MG/2ML	75800070102024	-18.0%	$0.00	Y
BOTOX INJ 100UNIT	Neuromuscular Agents	BOTOX	ONABOTULINUMTOXINA FOR INJ 100 UNIT	74400020052120	-9.5%	$0.00	Y
BOTOX INJ 200UNIT	Neuromuscular Agents	BOTOX	ONABOTULINUMTOXINA FOR INJ 200 UNIT	74400020052140	-9.5%	$0.00	Y
DYSPORT INJ 300UNIT	Neuromuscular Agents	DYSPORT	ABOBOTULINUMTOXINA FOR INJ 300 UNIT	74400020032115	-8.0%	$0.00	Y
DYSPORT INJ 500UNIT	Neuromuscular Agents	DYSPORT	ABOBOTULINUMTOXINA FOR INJ 500 UNIT	74400020032120	-8.0%	$0.00	Y
MYOBLOC INJ 10000/2	Neuromuscular Agents	MYOBLOC	RIMABOTULINUMTOXINB INJ 10000 UNIT/2ML	74400020102022	-13.0%	$0.00	Y
MYOBLOC INJ 2500/0.5	Neuromuscular Agents	MYOBLOC	RIMABOTULINUMTOXINB INJ 2500 UNIT/0.5ML	74400020102018	-13.0%	$0.00	Y
MYOBLOC INJ 5000/ML	Neuromuscular Agents	MYOBLOC	RIMABOTULINUMTOXINB INJ 5000 UNIT/ML	74400020102020	-13.0%	$0.00	Y

ORTHOVISC INJ 15MG/ML	Neuromuscular Agents	ORTHOVISC	HYALURONAN INTRA-ARTICULAR INJ 15 MG/ML	75800060002020	-13.0%	$0.00	Y
SUPARTZ INJ 25/2.5ML	Neuromuscular Agents	SUPARTZ	SODIUM HYALURONATE INTRA-ARTICULAR INJ 25 MG/2.5ML	75800070102026	-27.0%	$0.00	Y
SYNVISC ONE INJ 8MG/ML	Neuromuscular Agents	SYNVISC ONE	HYLAN INTRA-ARTICULAR INJ 8 MG/ML	75800040002220	-13.5%	$0.00	Y
XEOMIN INJ 100UNIT	Neuromuscular Agents	XEOMIN	INCOBOTULINUMTOXINA FOR INJ 100 UNIT	74400020202130	-9.5%	$0.00	Y
XEOMIN INJ 50 UNIT	Neuromuscular Agents	XEOMIN	INCOBOTULINUMTOXINA FOR INJ 50 UNIT	74400020202120	-9.5%	$0.00	Y
JETREA INJ 2.5MG/ML	Ophthalmic Agent	JETREA	OCRIPLASMIN INTRAVITREAL INJ 0.5 MG/0.2ML (2.5 MG/ML)	86801060002020	-15.0%	$0.00	N
LUCENTIS SOL 0.3MG	Ophthalmic Agent	LUCENTIS	RANIBIZUMAB INTRAVITREAL INJ 0.3 MG/0.05ML (6 MG/ML)	86655060002012	-13.5%	$0.00	Y
LUCENTIS SOL 0.5MG	Ophthalmic Agent	LUCENTIS	RANIBIZUMAB INTRAVITREAL INJ 0.5 MG/0.05ML (10 MG/ML)	86655060002020	-13.5%	$0.00	Y
EYLEA INJ 2/0.05ML	Ophthalmic Agents	EYLEA	AFLIBERCEPT INTRAVITREAL INJ 2 MG/0.05ML (40 MG/ML)	86655010002020	-11.0%	$0.00	Y
MACUGEN INJ	Ophthalmic Agents	MACUGEN	PEGAPTANIB SODIUM INTRAVITREOUS INJ 0.3 MG/90 MICROLITER	86655050302020	-13.5%	$0.00	Y
OZURDEX IMP 0.7MG	Ophthalmic Agents	OZURDEX	DEXAMETHASONE INTRAVITREAL IMPLANT 0.7 MG	86300010002320	-12.5%	$0.00	Y
VISUDYNE INJ 15MG	Ophthalmic Agents	VISUDYNE	VERTEPORFIN FOR IV SOLN 15 MG (2 MG/ML)	86700065002120	-11.0%	$0.00	Y
SANDOSTATIN INJ 1000MCG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE INJ 1000 MCG/ML (1 MG/ML)	30170070102030	-15.0%	$0.00	Y
SANDOSTATIN INJ 100MCG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE INJ 100 MCG/ML (0.1 MG/ML)	30170070102010	-15.0%	$0.00	Y
SANDOSTATIN INJ 200MCG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE INJ 200 MCG/ML (0.2 MG/ML)	30170070102015	-15.0%	$0.00	Y
SANDOSTATIN INJ 500MCG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE INJ 500 MCG/ML (0.5 MG/ML)	30170070102020	-15.0%	$0.00	Y
SANDOSTATIN INJ 50MCG/ML	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE INJ 50 MCG/ML (0.05 MG/ML)	30170070102005	-15.0%	$0.00	Y
SANDOSTATIN KIT LAR 10MG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE FOR IM INJ KIT 10 MG	30170070106410	-15.0%	$0.00	Y
SANDOSTATIN KIT LAR 20MG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE FOR IM INJ KIT 20 MG	30170070106420	-15.0%	$0.00	Y
SANDOSTATIN KIT LAR 30MG	Other Misc. Therapeutic Agent	SANDOSTATIN	OCTREOTIDE ACETATE FOR IM INJ KIT 30 MG	30170070106430	-15.0%	$0.00	Y
FORTEO SOL 600/2.4	Parathyroid	FORTEO	TERIPARATIDE (RECOMBINANT) INJ 600 MCG/2.4ML	30044070002020	-14.0%	$0.00	Y
FORTEO STARTER KIT	Parathyroid	FORTEO STARTE	FORTEO PATIENT STARTER KIT FOR RXSOL MAIL SERVICE	00000000000022	-14.0%	$0.00	
MIACALCIN INJ 200/ML	Parathyroid	MIACALCIN	CALCITONIN (SALMON) INJ 200 UNIT/ML	30043020002020	-7.0%	$0.00	Y
SILDENAFIL TAB 20MG	Phosphodiesterase-5 Enzyme Inhibitor	SILDENAFIL	SILDENAFIL CITRATE TAB 20 MG	40143060100320	-93.0%	$0.00	Y
EPOPROSTENOL INJ 0.5MG	Prostacyclin	EPOPROSTENOL	EPOPROSTENOL SODIUM FOR INJ 0.5 MG	40170040102110	-10.0%	$0.00	N
EPOPROSTENOL INJ 1.5MG	Prostacyclin	EPOPROSTENOL	EPOPROSTENOL SODIUM FOR INJ 1.5 MG	40170040102130	-10.0%	$0.00	N
VELETRI INJ 0.5MG	Prostacyclin	VELETRI	EPOPROSTENOL SODIUM FOR INJ 0.5 MG	40170040102110	-10.0%	$0.00	N
VELETRI INJ 1.5MG	Prostacyclin	VELETRI	EPOPROSTENOL SODIUM FOR INJ 1.5 MG	40170040102130	-10.0%	$0.00	N
AMPYRA TAB 10MG	Psychotherapeutic & Neurological Agent	AMPYRA	DALFAMPRIDINE TAB SR 12HR 10 MG	62406030007420	-10.0%	$0.00	N
BETASERON INJ 0.3MG	Psychotherapeutic & Neurological Agent	BETASERON	INTERFERON BETA-1B FOR INJ 0.3 MG	62403060502120	-10.0%	$0.00	Y
COPAXONE KIT 20MG/ML	Psychotherapeutic & Neurological Agent	COPAXONE	GLATIRAMER ACETATE INJ KIT 20 MG/ML	62400030106420	-17.0%	$0.00	Y
EXTAVIA INJ 0.3MG	Psychotherapeutic & Neurological Agent	EXTAVIA	INTERFERON BETA-1B FOR INJ 0.3 MG	62403060502120	-16.0%	$0.00	Y
GILENYA CAP 0.5MG	Psychotherapeutic & Neurological Agent	GILENYA	FINGOLIMOD HCL CAP 0.5 MG (BASE EQUIV)	62407025100120	-16.0%	$0.00	Y
REBIF INJ 22/0.5	Psychotherapeutic & Neurological Agent	REBIF	INTERFERON BETA-1A INJ 22 MCG/0.5ML (12MU/ML) (44 MCG/ML)	62403060452020	-17.5%	$0.00	Y
REBIF INJ 44/0.5	Psychotherapeutic & Neurological Agent	REBIF	INTERFERON BETA-1A INJ 44 MCG/0.5ML (24MU/ML) (88 MCG/ML)	62403060452040	-18.5%	$0.00	Y
REBIF REBIDO INJ 22/0.5	Psychotherapeutic & Neurological Agent	REBIF REBIDO	INTERFERON BETA-1A INJ 22 MCG/0.5ML (12MU/ML) (44 MCG/ML)	62403060452020	-18.5%	$0.00	Y
REBIF REBIDO INJ 44/0.5	Psychotherapeutic & Neurological Agent	REBIF REBIDO	INTERFERON BETA-1A INJ 44 MCG/0.5ML (24MU/ML) (88 MCG/ML)	62403060452040	-18.5%	$0.00	Y
REBIF REBIDO SOL TITRATN	Psychotherapeutic & Neurological Agent	REBIF REBIDO	INTERFERON BETA-1A INJ 8.8 MCG/0.2ML & 6 X 22 MCG/0.5ML	62403060452050	-18.5%	$0.00	Y
REBIF TITRTN SOL PACK	Psychotherapeutic & Neurological Agent	REBIF TITRTN	INTERFERON BETA-1A INJ 8.8 MCG/0.2ML & 6 X 22 MCG/0.5ML	62403060452050	-18.5%	$0.00	Y
TYSABRI INJ	Psychotherapeutic & Neurological Agent	TYSABRI	NATALIZUMAB FOR IV INJ CONC 300 MG/15ML	62405050001320	-15.0%	$0.00	Y
AUBAGIO TAB 14MG	Pyrimidine Synthesis Inhibitor	AUBAGIO	TERIFLUNOMIDE TAB 14 MG	62404070000330	-12.5%	$0.00	Y
AUBAGIO TAB 7MG	Pyrimidine Synthesis Inhibitor	AUBAGIO	TERIFLUNOMIDE TAB 7 MG	62404070000320	-12.5%	$0.00	Y
AMYVID INJ	Radiopharmaceutical	AMYVID	FLORBETAPIR F 18 IV SOLN 500-1900 MBQ/ML (13.5-51 MCI/ML)	94352530002020	-15.0%	$0.00	N
PULMOZYME SOL 1MG/ML	Respiratory Agents	PULMOZYME	DORNASE ALFA INHAL SOLN 1 MG/ML	45304020002010	-18.0%	$0.00	Y
HYPERRHO S/D INJ 300MCG	Serums	HYPERRHO S/D	RHO D IMMUNE GLOBULIN (HUMAN) IM INJ 300 MCG	19100050002220	-15.0%	$0.00	Y
HYPERRHO S/D INJ 50MCG	Serums	HYPERRHO S/D	RHO D IMMUNE GLOBULIN (HUMAN) IM INJ 50 MCG	19100050002210	-15.0%	$0.00	Y
GABLOFEN INJ 10000/20	Skeletal Muscle Relaxant	GABLOFEN	BACLOFEN INTRATHECAL INJ 10000 MCG/20ML (500 MCG/ML)	75100010002032	-15.0%	$0.00	N
GABLOFEN INJ 20000/20	Skeletal Muscle Relaxant	GABLOFEN	BACLOFEN INTRATHECAL INJ 20000 MCG/20ML (1000 MCG/ML)	75100010002040	-15.0%	$0.00	N
GABLOFEN INJ 40000/20	Skeletal Muscle Relaxant	GABLOFEN	BACLOFEN INTRATHECAL INJ 40000 MCG/20ML (2000 MCG/ML)	75100010002048	-15.0%	$0.00	N
GABLOFEN INJ 50MCG/ML	Skeletal Muscle Relaxant	GABLOFEN	BACLOFEN INTRATHECAL INJ 50 MCG/ML	75100010002022	-15.0%	$0.00	N
LIORESAL INT INJ 0.05MG/1	Skeletal Muscle Relaxant	LIORESAL INT	BACLOFEN INTRATHECAL INJ 0.05 MG/ML (50 MCG/ML)	75100010002020	-16.0%	$0.00	N
LIORESAL INT INJ 10MG/20	Skeletal Muscle Relaxant	LIORESAL INT	BACLOFEN INTRATHECAL INJ 10 MG/20ML (500 MCG/ML)	75100010002034	-16.0%	$0.00	N
LIORESAL INT INJ 10MG/5ML	Skeletal Muscle Relaxant	LIORESAL INT	BACLOFEN INTRATHECAL INJ 10 MG/5ML (2000 MCG/ML)	75100010002046	-16.0%	$0.00	N
LIORESAL INT INJ 40MG/20	Skeletal Muscle Relaxant	LIORESAL INT	BACLOFEN INTRATHECAL INJ 40 MG/20ML (2000 MCG/ML)	75100010002050	-16.0%	$0.00	N
EGRIFTA INJ 1MG	Somatotropin Agonists	EGRIFTA	TESAMORELIN ACETATE FOR INJ 1 MG (BASE EQUIV)	30150085102120	-18.0%	$0.00	Y
EGRIFTA SOL 2MG	Somatotropin Agonists	EGRIFTA	TESAMORELIN ACETATE FOR INJ 2 MG (BASE EQUIV)	30150085102130	-18.0%	$0.00	Y
GENOTROPIN INJ 0.2MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 0.2 MG	30100020002166	-13.0%	$0.00	Y
GENOTROPIN INJ 0.4MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 0.4 MG	30100020002168	-13.0%	$0.00	Y
GENOTROPIN INJ 0.6MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 0.6 MG	30100020002170	-13.0%	$0.00	Y
GENOTROPIN INJ 0.8MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 0.8 MG	30100020002172	-13.0%	$0.00	Y
GENOTROPIN INJ 1.2MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 1.2 MG	30100020002176	-13.0%	$0.00	Y
GENOTROPIN INJ 1.4MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 1.4 MG	30100020002178	-13.0%	$0.00	Y

GENOTROPIN INJ 1.6MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 1.6 MG	30100020002180	-13.0%	$0.00	Y
GENOTROPIN INJ 1.8MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 1.8 MG	30100020002182	-13.0%	$0.00	Y
GENOTROPIN INJ 12MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 12 MG (13.8 MG OVERFILL)	30100020002134	-13.0%	$0.00	Y
GENOTROPIN INJ 1MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 1 MG	30100020002174	-13.0%	$0.00	Y
GENOTROPIN INJ 2MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR INJ 2 MG	30100020002184	-13.0%	$0.00	Y
GENOTROPIN INJ 5MG	Somatotropin Agonists	GENOTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	-13.0%	$0.00	Y
HUMATROPE INJ 12MG	Somatotropin Agonists	HUMATROPE	SOMATROPIN FOR INJ 12 MG (36 UNIT)	30100020002132	-16.5%	$0.00	Y
HUMATROPE INJ 24MG	Somatotropin Agonists	HUMATROPE	SOMATROPIN FOR INJ 24 MG	30100020002150	-16.5%	$0.00	Y
HUMATROPE INJ 5MG	Somatotropin Agonists	HUMATROPE	SOMATROPIN FOR INJ 5 MG	30100020002120	-16.5%	$0.00	Y
HUMATROPE INJ 6MG	Somatotropin Agonists	HUMATROPE	SOMATROPIN FOR INJ 6 MG (18 UNIT)	30100020002125	-16.5%	$0.00	Y
INCRELEX INJ 40MG/4ML	Somatotropin Agonists	INCRELEX	MECASERMIN INJ 40 MG/4ML (10 MG/ML)	30160045002020	-13.5%	$0.00	Y
NORDITROPIN INJ 10/1.5ML	Somatotropin Agonists	NORDITROPIN	SOMATROPIN INJ 10 MG/1.5ML	30100020002058	-15.0%	$0.00	Y
NORDITROPIN INJ 15/1.5ML	Somatotropin Agonists	NORDITROPIN	SOMATROPIN INJ 15 MG/1.5ML	30100020002062	-15.0%	$0.00	Y
NORDITROPIN INJ 30/3ML	Somatotropin Agonists	NORDITROPIN	SOMATROPIN INJ 30 MG/3ML	30100020002066	-15.0%	$0.00	Y
NORDITROPIN INJ 5/1.5ML	Somatotropin Agonists	NORDITROPIN	SOMATROPIN INJ 5 MG/1.5ML	30100020002050	-15.0%	$0.00	Y
NUTROPIN INJ 10MG	Somatotropin Agonists	NUTROPIN	SOMATROPIN FOR INJ 10 MG	30100020002140	-11.5%	$0.00	Y
NUTROPIN INJ 5MG	Somatotropin Agonists	NUTROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	-11.5%	$0.00	Y
NUTROPIN AQ INJ 10MG/2ML	Somatotropin Agonists	NUTROPIN AQ	SOMATROPIN INJ 10 MG/2ML	30100020002020	-11.5%	$0.00	Y
NUTROPIN AQ INJ 20MG/2ML	Somatotropin Agonists	NUTROPIN AQ	SOMATROPIN INJ 20 MG/2ML	30100020002064	-11.5%	$0.00	Y
NUTROPIN AQ INJ NUSPIN 5	Somatotropin Agonists	NUTROPIN AQ	SOMATROPIN INJ 5 MG/2ML	30100020002016	-11.5%	$0.00	Y
NUTROPIN AQ PEN 20 KIT	Somatotropin Agonists	NUTROPIN AQ P	+STERILE TOWEL DRAPES 18X2 FOR RXSOL MAIL SERVICE	00000000000103	-11.5%	$0.00	
NUTROPIN AQ PEN KIT	Somatotropin Agonists	NUTROPIN AQ P	GROWTH HORMONE PEN KITS FOR RXSOL MAIL SERVICE	00000000000014	-11.5%	$0.00	Y
OMNITROPE INJ 10/1.5ML	Somatotropin Agonists	OMNITROPE	SOMATROPIN INJ 10 MG/1.5ML	30100020002056	-13.0%	$0.00	Y
OMNITROPE INJ 5.8MG	Somatotropin Agonists	OMNITROPE	SOMATROPIN FOR INJ 5.8 MG	30100020002123	-13.0%	$0.00	Y
OMNITROPE INJ 5/1.5ML	Somatotropin Agonists	OMNITROPE	SOMATROPIN INJ 5 MG/1.5ML	30100020002050	-13.0%	$0.00	Y
SAIZEN INJ 5MG	Somatotropin Agonists	SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 5 MG	30100020102120	-16.5%	$0.00	Y
SAIZEN INJ 8.8MG	Somatotropin Agonists	SAIZEN	SOMATROPIN (NON-REFRIGERATED) FOR INJ 8.8 MG	30100020102130	-16.5%	$0.00	Y
SEROSTIM INJ 4MG	Somatotropin Agonists	SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 4 MG	30100020102118	-18.0%	$0.00	Y
SEROSTIM INJ 5MG	Somatotropin Agonists	SEROSTIM	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 5 MG	30100020102121	-18.0%	$0.00	Y
TEV-TROPIN INJ 5MG	Somatotropin Agonists	TEV-TROPIN	SOMATROPIN FOR SUBCUTANEOUS INJ 5 MG	30100020002121	-17.0%	$0.00	Y
ZORBTIVE INJ 8.8MG	Somatotropin Agonists	ZORBTIVE	SOMATROPIN (NON-REFRIGERATED) FOR SUBCUTANEOUS INJ 8.8 MG	30100020102132	-16.5%	$0.00	Y
CATHFLO ACTI INJ VASE	Thrombolytic Agent	CATHFLO ACTI	ALTEPLASE FOR INJ 2 MG	85601010002102	-4.5%	$0.00	N

Price Summary

OPTUMRx™

Confidential and Proprietary

The following administrative fees and rates are exclusive to City of Cincinnati. Rates and fees are effective upon the implementation of services; this offer expires in 90 days.

Retiree Drug Subsidy - Enhanced Services

Subsidy Services
• Interim Reporting
  • Download Covered Retiree List for eligible members from RDS*
  • Create cost summary reports based on drug utilization of members listed in Covered Retiree List as per RDS submission requirements and guidelines
  • Storage and archival of backup data per RDS guidelines for audit purposes
• Reconciliation
  • Create final cost summary data for the reconciliation plan year
  • Provide back up claims and rebate data, if requested by client
  • Support B/D drug methodology, as per RDS guidelines
  • Provide calculations for ACA (Actual Cost Adjustment) using rebates
  • Storage and archival of backup data per RDS guidelines for audit purposes
  • Coordination of individual retiree cost:
  If our services are used, the client has to provide us with claim data and rebate information from the previous vendor. A separate one time charge of $5,000 is associated with it.
• Audit
  • Provide backup data - claims, rebates, and drug lists
  • Provide documentation to support methodology (Part B vs. Part D) used for calculating final cost data
  • Additional services required will be negotiable
• Transmission
  • Upload cost reports to RDS**
	$0.60 per Paid Claim in addition to Administrative Fee

Account Setup for groups with fewer than 500 RDS Members	$5,000
Creditable Coverage Determination	$500 to $1,500
Additional Subsidy Related Services	$500 per hour - as negotiated
Actuarial Certification & Attestation	$1,500 to $3,500

Notes

* Client must designate OptumRx as a designee

** Client must designate OptumRx as a designee or cost reporter

EXHIBIT D

BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum ("Addendum") is effective as of January 1, 2014, and is incorporated into and made part of the Prescription Drug Benefit Administration Agreement ("Agreement") by and between **OptumRx, Inc.** ("Business Associate") and **City of Cincinnati** ("Covered Entity") (each a "Party" and collectively the "Parties").

The Parties hereby agree as follows:

1. DEFINITIONS

1.1 Unless otherwise specified in this Addendum, all capitalized terms used in this Addendum not otherwise defined have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended and supplemented by HITECH, as each is amended from time to time. (collectively, "HIPAA") Capitalized terms used in this Addendum that are not otherwise defined in this Addendum and that are defined in the Agreement shall have the respective meanings assigned to them in the Agreement.

1.2 "Affiliate", for purposes of this Addendum, means any entity that is a subsidiary of UnitedHealth Group.

1.3 "Breach" means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exclusions set forth, in 45 C.F.R. § 164.402.

1.4 "Breach Rule" means the federal breach regulations, as amended from time to time, issued pursuant to HIPAA and codified at 45 C.F.R. Part 164 (Subpart D).

1.5 "Compliance Date" means the later of September 23, 2013 or the effective date of the Agreement.

1.6 "Electronic Protected Health Information" ("ePHI") means PHI that is transmitted or maintained in Electronic Media.

1.7 "HITECH" means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, 42 U.S.C. §§ 17921-17954, and all associated existing and future implementing regulations, when and as each is effective.

1.8 "PHI" means Protected Health Information, as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received, maintained, created or transmitted on behalf of, Covered Entity by Business Associate in performance of the Services.

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

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

1.10 "Services" means, to the extent and only to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI, the services provided by Business Associate to Covered Entity under the Agreement, including those set forth in this Addendum in Sections 4.3 through 4.7, as amended by written agreement of the Parties from time to time.

2. **RESPONSIBILITIES OF BUSINESS ASSOCIATE**

With regard to its use and/or disclosure of PHI, Business Associate agrees to:

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

2.2 implement and use appropriate administrative, physical and technical safeguards and, as of the Compliance Date comply with applicable Security Rule requirements with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by this Addendum.

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

2.4 with respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or more of its obligations under this Addendum, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach and for providing all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity. Business Associate shall provide these notifications in accordance with the notification requirements set forth in the Breach Rule, and shall pay for the reasonable and actual costs associated with those notifications. In the event of a Breach, without unreasonable delay, and in any event no later than sixty (60) calendar days after Discovery, Business Associate shall provide Covered Entity with written notification in accordance with 45 C.F.R. § 164.410 that includes a description of the Breach, a list of Individuals (unless Covered Entity is a plan sponsor ineligible to receive PHI) and, in the event the delegation set forth above has been triggered, a copy of the template notification letter to be sent to Individuals.

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

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

2.7 document, and within thirty (30) days after receiving a written request from Covered Entity, make available to Covered Entity, information necessary for Covered Entity to make an accounting of disclosures of PHI about an Individual, in accordance with 45 C.F.R. § 164.528.

2.8 provide access, within twenty days (20) days after receiving a written request from Covered Entity to PHI in a Designated Record Set about an Individual, to Covered Entity, sufficient to allow Covered Entity to comply with the requirements of 45 C.F.R. § 164.524.

2.9 to the extent that the PHI in Business Associate's possession constitutes a Designated Record Set, make available, within thirty (30) days after a written request by Covered Entity, PHI

for amendment and incorporate any amendments to the PHI as requested by Covered Entity, all in accordance with 45 C.F.R. § 164.526.

3. **RESPONSIBILITIES OF COVERED ENTITY**

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

3.1 shall identify the records it furnishes to Business Associate it considers to be PHI for purposes of this Addendum.

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

3.3 in the event that the Covered Entity honors a request to restrict the use or disclosure of PHI pursuant to 45 C.F.R. § 164.522(a) or makes revisions to its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520 that increase the limitations on uses or disclosures of PHI or agrees to a request by an Individual for confidential communications under 45 C.F.R. § 164.522(b), Covered Entity agrees not to provide Business Associate any PHI that is subject to any of those restrictions or limitations to the extent any may limit Business Associate's ability to use and/or disclose PHI as permitted or required under this Addendum unless Covered Entity notifies Business Associate of the restriction or limitation and Business Associate agrees to honor the restriction or limitation. In addition, if those limitations or revisions materially increase Business Associate's cost of providing services under the Agreement, including this Addendum, Covered Entity shall reimburse Business Associate for such increase in cost.

3.4 shall be responsible for using administrative, physical and technical safeguards at all times to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate pursuant to the Agreement, including this Addendum, in accordance with the standards and requirements of HIPAA, before and during the transmission of such PHI to Business Associate.

3.5 shall obtain any consent or authorization that may be required by applicable federal or state laws and regulations prior to furnishing Business Associate the PHI for use and disclosure in accordance with this Addendum.

3.6 represents that is has ensured, and has received certification from Plan Sponsor, that Plan Sponsor has taken the appropriate steps in accordance with 45 C.F.R. § 164.504(f) and 45 C.F.R. § 164.314(b) to enable Business Associate on behalf of Covered Entity to disclose PHI to Plan Sponsor, including but not limited to amending its plan documents to incorporate, and agreeing to, the requirements set forth in 45 C.F.R. § 164.504(f)(2) and 45 C.F.R. § 164.314(b). Covered Entity shall ensure that only employees authorized under 45 C.F.R. §164.504(f) shall have access to the PHI disclosed by Business Associate to Plan Sponsor.

4. **PERMITTED USES AND DISCLOSURES OF PHI**

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

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

4.2 use and disclose PHI for proper management and administration of Business Associate. In addition, to carry out the legal responsibilities of Business Associate, provided that the disclosures are Required by Law or any third party to which Business Associate discloses PHI for

those purposes provides written assurances in advance that: (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law; and (ii) the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

4.3 De-identify any and all PHI received or created by Business Associate under this Addendum, which De-identified information shall not be subject to this Addendum and may be used and disclosed on Business Associate's own behalf, all in accordance with the De-identification requirements of the Privacy Rule;

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

4.5 identify Research projects conducted by Business Associate, its Affiliates or third parties for which PHI may be relevant; obtain on behalf of Covered Entity documentation of individual authorizations or an Institutional Review Board or privacy board waiver that meets the requirements of 45 C.F.R. § 164.512(i)(1) (each an "Authorization" or "Waiver") related to such projects; provide Covered Entity with copies of such Authorizations or Waivers, subject to confidentiality obligations ("Required Documentation"); and disclose PHI for such Research provided that Business Associate does not receive Covered Entity's disapproval in writing within ten (10) days of Covered Entity's receipt of Required Documentation.

4.6 make PHI available for reviews preparatory to Research and obtain and maintain written representations in accord with 45 C.F.R. § 164.512(i)(1)(ii) that the requested PHI is sought solely as necessary to prepare a Research protocol or for similar purposes preparatory to Research, that the PHI is necessary for the Research, and that no PHI will be removed in the course of the review.

4.7 use the PHI to create a Limited Data Set ("LDS") in compliance with 45 C.F.R. § 164.514(e).

4.8 use and disclose the LDS referenced in Section 4.7 solely for Research or Public Health purposes; provided that, Business Associate shall (i) not use or further disclose the information other than as permitted by this Section 4.8 or as otherwise Required by Law; (ii) use appropriate safeguards to prevent use or disclosure of the information other than as provided for by this Section 4.8; (iii) report to Covered Entity any use or disclosure of the information not provided for by this Section 4.8 of which Business Associate becomes aware; (iv) ensure that any agents to whom Business Associate provides the LDS agree to the same restrictions and conditions that apply to Business Associate with respect to such information; and (v) not identify the information or contact the Individuals.

4.9 use and disclose PHI for Covered Entity's health care operations purposes in accordance with the Privacy Rule, including (a) conducting quality assessment and improvement activities with respect to the Benefit Plan services provided by Covered Entity through Business Associate; (b) conducting evaluations of Benefit Plan performance; (c) business planning and development; (d) conducting, on behalf of Covered Entity, population-based activities relating to improving the health of Members of Covered Entity's Benefit Plan and reducing their healthcare costs; (e) contacting Members of Covered Entity's Benefit Plan, on behalf of Covered Entity, with health education information and information about prescription drugs, treatment alternatives, and related functions; and (f) communicating with Members of Covered Entity's Benefit Plan, on behalf of Covered Entity, to describe health-related products or services (or payment for such products or services) provided by or included in Covered Entity's Benefit Plan through Business Associate's services, including communications about pharmacies participating in the Plan's network, replacement of or enhancement to the Plan, and health-related products or services available only to Members that add value to, but are not part of the Benefit Plan. Covered Entity

and Business Associate agree that these communications with Members constitute health care operations conducted on behalf of the Covered Entity.

5. TERMINATION AND COOPERATION

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

5.2 Effect of Termination or Expiration. Within sixty (60) days after the expiration or termination for any reason of the Agreement and/or this Addendum, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in possession of Business Associate's subcontractors. In the event that Business Associate determines that return or destruction of the PHI is not feasible, Business Associate shall notify Covered Entity in writing and may retain the PHI subject to this Section 5.2. Under any circumstances, Business Associate shall extend any and all protections, limitations and restrictions contained in this Addendum to Business Associate's use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this Addendum, and shall limit any further uses and/or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

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

6. MISCELLANEOUS

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

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

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

6.4 Independent Contractor. Business Associate and Covered Entity are and shall remain independent contractors throughout the term. Nothing in this Addendum or otherwise in the Agreement shall be construed to constitute Business Associate and Covered Entity as partners, joint venturers, agents or anything other than independent contractors.

6.5 Notices. All notices given in connection with this Addendum shall be made in accordance with the applicable provisions of the Agreement. In addition, Covered Entity hereby directs Business Associate to send a copy of any notice or other communication given by Business Associate in connection with this Addendum to the following address (and/or, at Business Associate's discretion, provide verbal notice to the following telephone number) and/or to such other address(es) (or telephone number(s)) as Covered Entity may in the future designate in writing by proper notice. If such address(es) (or telephone number(s)) belongs to a third party, Covered Entity hereby acknowledges and agrees that Business Associate may rely on the direction in this section as being permissible under HIPAA and HITECH, and any other then-

effective laws or regulations relating to the use and/or disclosure of PHI, by virtue of a valid business associate relationship having been established between Covered Entity and such third party.

ADDRESS:	City of Cincinnati 805 Central Avenue Cincinnati, OH 45202
PHONE NUMBER:	513-352-2551

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK. SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, each of Covered Entity and Business Associate has executed in its name and on its behalf this Addendum effective as of the date first written above.

COVERED ENTITY
City of Cincinnati

By: _____

Name: David L. Holmes

Title: Asst Cm

Date: 12/31/13

BUSINESS ASSOCIATE
OptumRx, Inc.

By: _____

Name: Wayne Miller

Title: SVP, Client Services

Date: 12.30.13

RECOMMENDED BY:

_____
Karen Alder, Risk Manager

APPROVED AS TO FORM

_____
Assistant City Solicitor

EXHIBIT E

PERFORMANCE GUARANTEES

Service and Performance Guarantees

OptumRx™ is pleased to place an aggregate total of $140,000 at risk annually for City of Cincinnati, of which $56,000 will be applied to all implementation activities and $84,000 will be applied to ongoing service standards in Contract Year 1. In subsequent contract years, 100% of all performance guarantee penalties will be applied to ongoing service standards.

Penalties will be assessed annually based upon aggregate annual average results. Penalty amounts per standards will be mutually agreed upon. Guarantees are to be monitored internally and reported quarterly.

Network Pharmacy Compliance					
Pharmacy Network Access	95% of members will have access to 1 pharmacy in 5 miles on average.	(Metric is Client-Specific)	$4,800	$8,000	$8,000

Retail Paper Claims Processing Time					
Retail Paper Claims Processing Time	97% of paper claims reimbursed or responded to within 10 business days of receipt. All paper claims reimbursed or responded to within an average of 10 business days of receipt.	Percent of paper claims reimbursed or responded to that do not require intervention (clean claims). A minimum of 100 paper claims per year is required to qualify for this guarantee. (Metric is Client-Specific)	$4,800	$8,000	$8,000
Mail Order Claims Processing Time					

Mail Pharmacy Clean Turnaround	95% of clean prescription orders will be shipped within an average of 2.0 business days	Measured in whole business days from the date a prescription order is received by Administrator (either via mail, phone, fax, or Internet) to the date the prescription order is shipped. Calculated by taking the total number of whole days to ship divided the total number of prescription orders. (Metric is Client-Specific)	$4,800	$8,000	$8,000

Mail Pharmacy Intervention Prescription Turnaround	100% of prescription orders requiring intervention (Problem) will be shipped within an average of 5.0 business days.	Measured in whole business days from the date a prescription order is received by Administrator (either via mail, phone, fax, or Internet) to the date the prescription order is shipped. Calculated by taking the total number of whole days to ship divided the total number of prescription orders. Contact with prescriber or customer not achieved as a result of unresponsiveness for an intervention prescription order will be excluded from calculation. (Metric is Client-Specific)	$4,800	$8,000	$8,000

Mail Pharmacy Dispensing Accuracy	99.99% of mail pharmacy and specialty pharmacy prescriptions dispensed accurately with no errors.	Dispensing Accuracy Rate means (i) the number of all mail order prescriptions dispensed in a contract quarter less the number of those prescriptions dispensed in such contract quarter which are reported and verified as having been dispensed with the incorrect drug, strength, form, patient name, directions, packing non-conformance, or address causing medication to be delivered incorrectly divided by (ii) the number of all mail order prescriptions dispensed in such contract quarter. (Metric is total book of business driven)	$4,800	$8,000	$8,000
Retail and Mail Claims Processing Accuracy					

Claims Paid without Error	≥99.9%	Percent of all claims audited and found to be without error of any form, divided by all claims audited. Based on Administrator's internal quality review. (Metric is total book of business driven)	$4,800	$8,000	$8,000

Customer Service					
Average Speed of Answer	30 seconds or less	The amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative. Includes calls routed to IVR. (Metric is Client-Specific)	$6,000	$10,000	$10,000

Percent of Calls Abandoned	≤3%	Percentage of calls abandoned by the caller before call is answered by a Customer Service Representative. Calculated as the number of calls that are not answered, divided by the number of calls received. Includes calls routed to IVR and calls abandoned within the first 15 seconds. (Metric is Client-Specific)	$6,000	$10,000	$10,000
First Call Resolution	95% of calls resolved during initial call.	Calculated as the total calls to Administrator minus total number of unresolved calls, divided by the total number of calls received. Excludes calls routed to IVR. (Metric is total book of business driven)	$4,800	$8,000	$8,000

Written Inquiry Response Time	97% of written inquiries received via e-mail will be responded to by e-mail within 5 business days. All written inquiries will be responded to within an average of 10 business days.	Member inquiries received via designated e-mail box. Response time for all written inquiries will be based on the number of calendar days subtracting the date received by Administrator from the date the response was sent. (Metric is Client-Specific)	$4,800	$8,000	$8,000
Member Satisfaction Survey	"Overall Member Satisfaction" survey results of "Satisfied" and "Very Satisfied" for 90% of respondents.	Member satisfaction results will be measured by the responses to Administrator's Voice of the Customer satisfaction survey. (Metric is total book of business driven)	$4,800	$8,000	$8,000
Account Management					
Satisfaction with Account Management	"Overall Client Satisfaction" survey results of "Satisfied" and "Very Satisfied" will be 7 or better on a 10 point scale Client must participate in the survey to qualify for this guarantee.	Satisfaction results will be measured by the response to Administrator's annual satisfaction survey. (Metric is Client-Specific)	$4,800	$8,000	$8,000

Plan Management Meetings	Administrator will provide attendance by plan representatives trained on Client's plan benefits at 100% of meetings scheduled by Client, for 100% of the meeting's duration, including all Wellness and Benefit Fairs, and Client-sponsored open enrollment meetings.	(Metric is Client-Specific)	$4,800	$8,000	$8,000

Administration					
Electronic Eligibility Load -Standard	Electronic Eligibility maintenance files submitted to Administrator will be loaded within an average of 24 hours.	Assumes complete and accurate information is received. This applies to maintenance loads only, not initial eligibility setup. Assumes use of an electronic interchange and Administrator's standard file format. (Metric is Client-Specific)	$4,800	$8,000	$8,000

Standard Financial and Clinical Reporting	45 days after the end of the quarter.	Measured as the time from the last day of the end of a reporting cycle to the day standard reports are sent. Ad hoc/custom reporting requests are excluded from this standard. (Metric is Client-Specific)	$4,800	$8,000	$8,000
Ongoing Plan Design Set up –New Benefits or Updates	Within 7 business days.	Measured by Administrator's ability to implement and test new or revised plan design changes after receipt of signed documentation of new plan design. Any change considered rush or non-standard will be determined based upon a mutually agreed upon timeframe and excluded from this guarantee. (Metric is Client-Specific)	$4,800	$8,000	$8,000

Annual Benefit Plan Review	Maintain a documented quality control and pre-implementation document and provide it to Client for review and approval at least 15 days prior to implementation of any benefit or program change	Administrator will conduct an annual benefit plan review by mid-November to coincide with Client's plan implementation of benefit plan modifications. If such reviews identify any systems set in error by Administrator, then Administrator will reconcile such errors on a dollar for dollar basis, and shall pay Client's penalty amount at risk (Metric is Client-Specific)	$4,800	$8,000	$8,000

New Client Implementation					
Implementation Client Satisfaction	"Post Implementation" survey results of all implementation categories will be an average rating of 7 or better based on a 10 point scale.	"Post Implementation" survey results from all contacts who participate in implementation activity. (Metric is Client-Specific)	$8,000	N/A	N/A

Implementation Manager	Administrator will assign an implementation manager suitable to Client that will be mutually agreed upon between Client and Administrator	(Metric is Client-Specific)	$8,000	N/A	N/A
Implementation Tasks	No later than 120 days prior to the effective date, tasks with deliverable dates, necessary to effectively install the program by the effective date, will be clearly defined by the Administrator and presented to Client.	(Metric is Client-Specific)	$8,000	N/A	N/A

Benefit Set Up	Upon receipt of final sign-off from Client of plan parameters, Administrator will load, fully test, and release the plan benefit coding information for production within 6 weeks of Client's final sign off.	Plan parameters shall include, but not be limited to member cost share (e.g. integrated deductible, copayments, maximums, etc.), plan limitations (e.g. days supply, refills allowed, refill-too-soon, etc.), and compensable medications (e.g. covered drugs, exclusions, etc.) Assuming Client follows a 120 day implementation timeline for complex requirements and provided Administrator has the opportunity to review and mutually agree upon the request. (Metric is Client-Specific)	$8,000	N/A	N/A

ID Card Production & Mailing	Accurate ID cards will be mailed at least 10 days prior to the effective date.	Assuming receipt of clean and accurate eligibility files from Client 30 business days prior to the effective date. (Metric is Client-Specific)	$8,000	N/A	N/A
Pre-Implementation Audit	Administrator will fully support auditor requests for pre-implementation audit and will schedule on-site portion of audit at least 15 days prior to the effective date.	Provided the audit is conducted at least 6 weeks after Client's final sign-off. (Metric is Client-Specific)	$8,000	N/A	N/A

Contracting	A written redline response of the contract will be sent back to Client within 10 business days after receipt of a redline from Client. Administrator will have 10 business days to provide a written responsive redline to each redline received from Client from the time Administrator receives all the necessary information from Client or Aon Hewitt in order to complete the written responsive redline to the time Administrator transmits the responsive redline to Client or Aon Hewitt.	The Contracting guarantee will take effect on the contract effective date. Administrator shall not be deemed to have failed to meet this requirement to the extent and proportion that such failure is due to circumstances caused by Client, Aon Hewitt or other third party and/or is otherwise not within Administrator's reasonable control. (Metric is Client-Specific)	$8,000	N/A	N/A

EXHIBIT FIVE

CAVANAUGH MACDONALD

ANALYSIS OF PROJECTED COST IMPACTS OF SETTLEMENT PROVISIONS

city of CINCINNATI RETIREMENT

Projected Cost Impact of Items Included in the Settlement Agreement

The City of Cincinnati and various plaintiff groups representing certain active and retired members of the Cincinnati Retirement System (CRS) have agreed on a list of items that would affect the provision of retiree health care and pension benefits. These items are listed below along with the effect of each item on the actuarial accrued liabilities of the Retiree Health Care and Pension Trusts. The impact on the funding ratios are also shown and reflect projected results as of the 12/31/2013 valuation.

Present Value of Future Benefits (PVFB): Value on a given date of the future payments expected to be paid to current retirees and current active members who are expected to become eligible for future retiree health care or pension benefits discounted to reflect the expected effects of the time value of money and probabilities of payment.

Actuarial Accrued Liability (AAL): The portion of the present value of future benefits that is expected to be paid in the future for current retirees, and a portion for current active members that is attributable to past service. The AAL does not include liabilities for projected future accruals.

Actuarial Value of Assets (AVA): The actuarial value of assets recognizes a portion of the difference between the market value of assets and the expected market value of assets, based on the assumed valuation rate of return. The amount recognized each year is 20% of the difference between market value and expected market value. Under this method, all investment gains and losses associated with a given year are recognized after five years. In addition, the actuarial value of assets cannot be less than 80% or more than 120% of the market value of assets.

Funding Ratio: The funding ratio is simply the AVA divided by either the AAL or the PVFB. The difference between the AAL and PVFB is the portion of liabilities allocated to the future service of active members funded via future normal cost contributions.

Retiree Health Care ($ in millions)			
	Increase/(Decrease) in AAL		
	Actives	Retirees	Total
EGWP	($19.5)	($58.3)	($77.8)
MERP	($3.5)	($2.9)	($6.4)
New Eligibility	($15.2)	$0	($15.2)
Medical Plan/New Retirees	($11.2)	$0	($11.2)
Total*	**($45.9)**	**($61.2)**	**($107.1)**

* Value of Plan changes are not additive of individual plan changes.
** Assumes no change to any underlying assumptions from the 12/31/2013 valuation, including, but not limited to, discount rate, retiree health care benefit utilization, and pension benefit eligibility.

Retiree Health Care		
	Funding Ratio as of 12/31/13	
	PVFB	AVA
Baseline as of 12/31/13	100.1%	109.1%
EGWP	114.5%	124.8%
MERP	101.3%	110.2%
New Eligibility	103.8%	111.8%
Medical Plan/New Retirees	102.3%	111.1%
Combined Changes w/No Asset Transfer*	**122.8%**	**131.9%**
Combined Changes w/Asset Transfer Out of $215 Million 7/2016	**90.0%**	**96.6%**

* Value of Plan changes are not additive of individual plan changes.
** Assumes no change to any underlying assumptions from the 12/31/2013 valuation, including, but not limited to, discount rate, retiree health care benefit utilization, and pension benefit eligibility.

If all actuarial assumptions were realized, the projection results estimate a PVFB funding ratio of 86% in 2043 with an asset reduction of $215 million in mid-2016 and if the plan was closed to new hires effective 1/1/2016. The future funding projections for Retiree Health Care will be highly sensitive to deviations from the actuarial assumptions such as medical inflation trends and investment returns. This sensitivity can be addressed through the development of a Retiree Health Care Funding & Benefits Policy.

Pension ($ in millions)			
	Increase/(Decrease) in AAL		
	Actives	Retirees	Total
Change to 3% Simple COLA	$25.2	($55.6)	($30.4)
3 Year COLA Suspension with one-time payment for Retiree Class in 2018 of 3% capped at $1,000	($20.0)	($100.3)	($120.3)
Retirement Eligibility Changes	$43.9	$0	$43.9
Increased Benefit Multiplier	$5.3	$0	$5.3
Total*	**$48.1**	**($135.9)**	**($87.8)**

* Value of Plan changes are not additive of individual plan changes.

Pension	
	AAL Funding Ratio as of 12/31/13
Baseline as of 12/31/13	63.2%
Change to 3% Simple COLA	64.1%
3 Year COLA Suspension with one-time payment for Retiree Class in 2018 of 3% capped at $1,000	66.8%
Retirement Eligibility Changes	62.0%
Increased Benefit Multiplier	63.1%
Combined Changes Before Asset Transfer*	**65.8%**
Combined Changes With Asset Transfer of $215 Million 7/1/2016 and Lump Sum ERIP Payment of $39.1 Million**	**77.5%**

* Value of Plan changes are not additive of individual plan changes.

** Though the figures show the impact of the asset transfers (ERIP payment & $215 million) as of the 12/31/2013 valuation, the true impact would be reflected on the 2015 and 2016 valuation results.

On a forward looking basis, and assuming all of the assumptions occur as expected, the Pension funding ratio is projected to reach 100% by 2043. This is due to the following three reasons:

1. As of the 12/31/2013 valuation, there are investment gains for actuarial smoothing still to be recognized.
2. The lower cost benefit structure of newer members will allow a greater portion of the fixed employer contribution rate to be applied towards paying down the unfunded actuarial liability in future years
3. The fixed employer contribution rate of 16.25% is higher than the projected annual required contribution in later years.

It is important to recognize that these figures and projections are based on many actuarial assumptions. They are likely to vary in future years to the extent that CRS actual experience varies from the expected actuarial assumptions.

The figures above were developed by the actuarial firm, Cavanaugh Macdonald. The firm is retained by the Cincinnati Board of Trustees.

EXHIBIT SIX

PROPOSED PRELIMINARY APPROVAL ORDER

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

NICK SUNYAK, *et al.,*	:	Case Nos.: 1:11-CV-445 and 1:12-cv-329
vs.	:	Judge Michael R. Barrett
CITY OF CINCINNATI, *et al,*	:	
(City of Cincinnati Pension Litigation)	:	**[PROPOSED] ORDER GRANTING PRELIMINARY APPROVAL OF CLASS ACTION SETTLEMENT**

WHEREAS, Current Employees Plaintiffs Nick Sunyak, Jeffery Harmon, Jill Allgeyer, Kim Kappel, Waleia Jackson, Finley Jones and Richard Ganulin, and Retiree Plaintiffs Thomas A. Gamel, Sr., Paul Smith, Mark K. Jones, Dennis Davis, Ely Ryder, and Ann DeGroot (collectively the "Named Plaintiffs"), individually and on behalf of two proposed Classes, and Defendants the City of Cincinnati, the Mayor of Cincinnati, the City Manager, the Vice-Mayor, the City Council Members, the Cincinnati Retirement System ("CRS"), and the appointed Board of Trustees of the CRS ("Board") have entered into a Collaborative Settlement Agreement (the "Agreement") intended to resolve certain litigation, including litigation pending in this Court; and

WHEREAS, the Settlement Agreement, together with supporting materials, sets forth the terms and conditions for the proposed settlement;

WHEREAS, the Court has before it the Parties' Motion for Preliminary Approval of Settlement and Memorandum in Support of Motion for Preliminary Approval of Settlement, together with the Agreement and related materials; and

WHEREAS, the Court is satisfied that the terms and conditions set forth in the Agreement and exhibits attached thereto were the result of good faith, arm's length settlement negotiations between competent and experienced counsel for both Named Plaintiffs and Defendants.

IT IS HEREBY ORDERED this _____ day of _____, 2015, as follows:

1. The terms of the Agreement including all exhibits are hereby conditionally approved, subject to further consideration thereof at the Fairness Hearing provided for below.

2. The Agreement is adopted by the Court and made part of this Order as if set out in full herein.

3. The Agreement and the terms contained therein are hereby preliminarily approved as fair, reasonable, adequate, and in the best interests of the Current Employees Class and the Retirees Class.

4. The Court approves the proposed Notice Program set forth in Section 38 of the Agreement. The Notice Program is reasonably calculated to apprise Class Members of their right to object, constitutes due, adequate, and sufficient notice to all persons entitled to receive notice, is the best notice practicable under the circumstances, and meets all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law. Subject to amendment if the need arises, the Notice Program shall be initiated within thirty (30) days of this Preliminary Approval Order and executed as set forth in the Settlement Agreement.

5. Pursuant to Federal Rule of Civil Procedure 23(a), (b)(1) and (b)(2), and for purposes of settlement only, the Court makes the following preliminary findings of fact and

conclusions of law:

a. The Current Employees Class and the Retirees Class (as defined, respectively, in the Agreement) are sufficiently definite and identifiable;

b. The Current Employees Class and the Retirees Class are so numerous that joinder of all Members is impracticable;

c. There are questions of law and/or fact common within the Current Employees Class including but not limited to: (1) whether the Current Employees Class was fully vested in their CRS benefits on July 1, 2011; (2) whether Defendants improperly revoked and/ or impaired the Current Employees Class' vested CRS benefits when it enforced Ordinance No. 84-2011; (3) whether Defendants impaired contractual rights of the Current Employees Class when they enforced Ordinance No. 84-2011; (4) whether Defendants are estopped from enforcing Ordinance No. 84-2011 so as to prevent the revocation and/or impairment of the contractual rights of the Current Employees Class; and (5) whether Defendants' enforcement of Ordinance No. 84-2011 operated as an unconstitutional taking of the vested property interest of the Current Employees Class.

d. There are questions of law and/or fact common within the Retirees Class including but not limited to: (1) whether Defendants' offer of retirement benefits to the Retirees Class created a fundamental property right, giving each of them a vested right in those retirement benefits which cannot be reduced, impaired, revoked, or eliminated; (2) whether Defendants' actions as explained in the Retirees Class Complaint constitute an unlawful taking of the Retirees Class Members' property rights in violation of the United States Constitution and/or the Ohio Constitution; (3) whether the Defendants have a contractual obligation to provide the Retirees Class with certain retirement benefits,

which cannot now or afterwards be reduced, impaired, revoked, or eliminated; (4) whether the unilateral reduction, impairment, revocation, and/or elimination of the Retirees Class Members' retirement benefits constitutes a breach of the Defendants' fiduciary duty; and (5) whether the Defendants are estopped from reducing, impairing, revoking, or eliminating the retirement benefits owed to the Retirees Class;

e. The Current Employees Plaintiffs' claims are typical of the claims of the Members of the Current Employees Class as all subgroups were represented and no conflict exists between or among the subgroups, and the Retiree Plaintiffs' claims are typical of the claims of the Members of the Retirees Class;

f. Current Employees Plaintiffs and the Current Employees Class Counsel have and will fairly and adequately represent and protect the interests of the Current Employees Class, and the Retiree Plaintiffs and the Retirees Class Counsel have and will fairly and adequately represent and protect the interests of the Retirees Class;

g. Current Employees Plaintiffs' interests do not conflict with the interests of the Current Employees Class in the maintenance of this action and this Settlement, and the Retiree Plaintiffs' interests do not conflict with the interests of the Retirees Class in the maintenance of this action and this Settlement;

h. The questions of law and/or fact common to the Current Employees Class and those common to the Retirees Class predominate over the questions affecting only individual members of those Classes;

j. Certification of the Current Employees Class and the Retirees Class is appropriate because prosecuting separate actions by individual Members of these Classes would create a risk of inconsistent and varying adjudications with respect to individual

Members of the Classes that would establish incompatible standards of conduct for the Defendants;

k. Certification of the Current Employees Class and the Retirees Class is appropriate because adjudications with respect to individual Members of the Classes, as a practical matter, would be dispositive of the interests of the other Members not parties thereto and would substantially impair or impede their ability to protect their interests; and

l. Certification of the Current Employees Class and the Retirees Class is appropriate because the Defendants have acted or refused to act on grounds that apply generally to the Classes, so that final injunctive relief or corresponding declaratory relief as agreed to by the Parties is appropriate respecting the Classes as a whole.

6. Pursuant to Fed. R. Civ. P. 23 and for purposes of Settlement, the Court appoints the Named Plaintiffs as Class Representatives and conditionally certifies the following Classes:

> Current Employees Class: All individuals (and/or their Dependents or Surviving Beneficiaries) who participated in the Cincinnati Retirement System with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011, and who are Members of "Group C," "Group D," "Group E," or "Group F" as these terms are defined by Cincinnati Municipal Code § 203-1-Ml (b), (c), (d), and (e).[1]

> Retirees Class: All individuals (and/or their Dependents or Surviving Beneficiaries) formerly employed by the City of Cincinnati, the University of Cincinnati, the University Hospital f/k/a General Hospital and Hamilton County, who retired on or before July 1, 2011 and have received retirement benefits from the City of Cincinnati and their Dependents and/or their Surviving Beneficiaries who are entitled to those benefits.

7. Pursuant to Fed. R. Civ. P. 23(g) the Court appoints Marc D. Mezibov, Robert D. Klausner, Jeffrey S. Goldenberg, and Christian A. Jenkins as Class Counsel for the Current

[1] The Current Employees Class also includes City of Cincinnati employees who had at least five years of creditable service prior to July 1, 2011 and who retired after July 1, 2011, as well as veterans who purchase service credit sufficient to satisfy the five years of service requirement prior to July 1, 2011.

Employees Class and Robert A. Pitcairn, Jr., James F. McCarthy, III, Peter O'Shea, and the law firm of Katz, Teller, Brant & Hild as Class Counsel for the Retirees Class. Class Counsel shall submit their applications for attorney fees and expenses no later than twenty-one (21) days prior to the date for Class Members to submit objections.

8. The City is authorized to retain Class Action Administration, Inc. as the Settlement Administrator to perform all functions and duties assigned to the Settlement Administrator in the Agreement, the cost of which shall be reimbursed by Defendant City of Cincinnati.

9. The Court directs the parties and Class Action Administration, Inc. to implement the Notice Program and to disseminate and/or publish the Notice referenced in Section 38 of the Agreement in accordance with this Order and the Agreement.

10. Any Class Member who wishes to object to the fairness, reasonableness, or adequacy of the Agreement, or to the request for attorneys' fees and expense reimbursement, must file with the Clerk of the Court and serve on designated Counsel, within 60 days of the Notice Date, a written statement of the objection as well as the specific reason(s), if any, for the objection, including any legal support the Class Member wishes to bring to the Court's attention and any evidence the Class Member wishes to introduce in support of the objection. Class Members may so object either on their own or through an attorney hired at their own expense.

Any attorney hired by a Class Member at that Class Member's expense for the purpose of objecting to the fairness, reasonableness, or adequacy of the Agreement, to any terms of the proposed Settlement, or to proposed attorneys' fees and expenses shall file with the Court and deliver to designated Counsel a Notice of Appearance no later than 60 days from the Notice Date.

Additionally, Class Members and/or their attorneys intending to make an appearance at the Fairness Hearing must by no later than 14 days prior to the Fairness Hearing:

a. File a notice of intention to appear, with the Clerk of the Court, that contains the Class Member's and/or their attorney's name, address, and telephone number, as well as a description of all evidence the Class Member and/or Class Member's attorney will seek to introduce at the Fairness Hearing, including all documents to be introduced and witnesses to be called; and

b. Serve a copy of such notice of intention to appear on counsel for the Parties as described in the Notice.

Any Class Member who files and serves a written objection in accordance with the procedure set forth above and in the Section 39 of the Settlement Agreement may appear at the Fairness Hearing to object to any aspect of the fairness, reasonableness, or adequacy of the Settlement. Class Members and/or their attorneys who do not timely comply with the procedures set forth above shall not be heard at the Fairness Hearing and waive any objection to the Settlement Agreement.

11. The Fairness Hearing shall take place on _____, 2015 at _____ in Courtroom _____, 100 East Fifth Street, Cincinnati, Ohio 45202. At the Fairness Hearing the Parties will request that the Court, among other things, (a) approve the Agreement as final, fair, reasonable, adequate, and binding on all Class Members; (b) direct the Parties and their Counsel to implement and consummate the Agreement according to its terms and to direct the Parties to comply with the Consent Decree for the full term of its 30-year duration; (c) certify the Current Employees Class and Retirees Class pursuant to Federal Rules of Civil Procedure 23(b)(1) and (b)(2); (d) finally approve the Current Employees Plaintiffs and Retirees Plaintiffs as

representatives of their respective Class; (e) finally approve and appoint Current Employees Class Counsel and Retirees Class Counsel to represent their respective Class; (f) determine and approve the payment of reasonable attorneys' fees and expense reimbursements for Class Counsel; (g) order the Settlement Administrator to process all payments due to Class Members under the Agreement; and (h) order that the claims at issue in this litigation are fully and finally resolved as of the date of Finality, as defined in the Agreement, and that Current Employees Plaintiffs, the Current Employees Class, the Retirees Plaintiffs, and the Retirees Class are forever barred and enjoined from filing, commencing, prosecuting, intervening in, participating in (as Class Members or otherwise), or receiving any benefits or other relief from, any other lawsuit, arbitration, or administrative, regulatory, or other proceeding or order in any jurisdiction based on the claims at issue in this litigation, except as set forth in the Re-Opener provisions in the Agreement and Consent Decree.

IT IS SO ORDERED.

Dated: _____

_____
The Honorable Michael Barrett
United States District Judge

5579117.2

KTBH: 4822-9768-6819, v. 2

EXHIBIT SEVEN

PROPOSED ORDER GRANTING FINAL APPROVAL

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

NICK SUNYAK, *et al.,*	:	Case Nos.: 1:11-cv-445 and 1:12-cv-329
vs.	:	Judge Michael R. Barrett
CITY OF CINCINNATI, *et al,*	:	**[PROPOSED] ORDER GRANTING FINAL APPROVAL OF CLASS ACTION SETTLEMENT**
(City of Cincinnati Pension Litigation)	:	

WHEREAS, this Court granted Preliminary Approval of the Class Action Settlement ("Settlement") of these Actions on _____, 2015 (Doc. #__).

WHEREAS, the Current Employees Plaintiffs (Nick Sunyak, Jeffery Harmon, Jill Allgeyer, Kim Kappel, Waleia Jackson, Richard Ganulin, and Finley Jones), the Retiree Plaintiffs (Thomas A. Gamel, Sr., Paul Smith, Mark K. Jones, Dennis Davis, Ely Ryder, and Ann DeGroot), the American Federation of State and Municipal Employees Ohio Council No. 8 ("AFSCME"), and the Defendants (The City of Cincinnati, Mayor John Cranley, City Manager Harry Black, Vice-Mayor David Mann, Cincinnati City Council Members, the Cincinnati Retirement System, and the Board of Trustees of the Cincinnati Retirement System, (collectively, the "Parties") have filed a motion seeking final approval of this Settlement ("Motion") (Doc. #__);

WHEREAS, the Parties appeared with their attorneys of record at a Fairness Hearing on _____, 2015 after all members of the Classes were given an opportunity to be heard in accordance with the Court's Preliminary Approval Order, and the Court has given due consideration to the Parties' Collaborative Settlement Agreement, including all attached exhibits and related materials, the Parties' Motion for Final Approval, including the attached

Memorandum and all other papers filed in support, all objections to the Settlement, the complete record in this litigation, the information and arguments presented at the _____, 2015 Fairness Hearing, and all other materials relevant to this matter including the Declaration of the Settlement Administrator on Implementation and Adequacy of Settlement Notice Program as well as the Declaration of _____ (insert name of actuarial expert) concerning the impact and benefits of this Settlement on the Cincinnati Retirement System ("CRS") and the members of the Classes;

WHEREAS, the Court recognizes that the Parties have litigated complex questions about the management of the CRS – and the respective rights of plan participants – for nearly five years, including issues related to benefits levels, eligibility requirements, healthcare packages, and funding mechanisms, and that while some of these lawsuits have been subject to conclusive appellate rulings, many pertinent legal and factual questions remain; and

WHEREAS, the Court is satisfied that the terms and conditions set forth in the Collaborative Settlement Agreement and related Consent Decree were the result of good faith, arm's length settlement negotiations between competent and experienced counsel for the Current Employees Plaintiffs, the Current Employees Class, the Retiree Plaintiffs, the Retirees Class, and Defendants;

NOW, THEREFORE, IT IS ORDERED THAT:

1. This Order approves, adopts, and incorporates by reference in their entirety the Collaborative Settlement Agreement and the Consent Decree which are attached hereto as Exhibits 1 and 2 respectively. The Collaborative Settlement Agreement and the Consent Decree are made part of this Order as if set out in full herein and shall be fully enforceable by this Court. Accordingly, the Parties are ordered to implement and comply with all the terms of the

Collaborative Settlement Agreement and the Consent Decree.

2. For purposes of this litigation, the Court has subject matter and personal jurisdiction over the Parties, including all Class Members, and has the power and authority to approve the Collaborative Settlement Agreement and Consent Decree, including all Exhibits thereto.

3. Pursuant to Federal Rules of Civil Procedure 23(a), 23(b)(1), and 23(b)(2), the Court confirms its previous certification, and for purposes of effectuating the Settlement, grants final approval to the following two Classes:

> Current Employees Class: All individuals (and/or their Dependents or Surviving Beneficiaries) who participated in the Cincinnati Retirement System with at least five years of creditable service and who were actively employed or otherwise qualified for benefits on July 1, 2011, and who are Members of "Group C," "Group D," "Group E," or "Group F" as these terms are defined by Cincinnati Municipal Code § 203-1-Ml (b), (c), (d), and (e).[1]
>
> Retirees Class: All individuals (and/or their Dependents or Surviving Beneficiaries) formerly employed by the City of Cincinnati, the University of Cincinnati, the University Hospital f/k/a General Hospital and Hamilton County, who retired on or before July 1, 2011 and have received retirement benefits from the City of Cincinnati and their Dependents and/or their Surviving Beneficiaries who are entitled to those benefits.

4. Pursuant to Federal Rule of Civil Procedure 23(a), (b)(1), and (b)(2), and for purposes of settlement only, the Court makes the following findings of fact and conclusions of law:

a. The Current Employees Class and the Retirees Class are sufficiently definite and identifiable;

b. The Current Employees Class and the Retirees Class are so numerous that joinder of all members is impracticable;

[1] The Current Employees Class also includes City of Cincinnati employees who had at least five years of creditable service prior to July 1, 2011 and who retired after July 1, 2011, as well as veterans who purchase service credit sufficient to satisfy the five years of service requirement prior to July 1, 2011.

c. There are questions of law and/or fact common within the Current Employees Class including but not limited to: (1) whether the members of the Current Employees Class were fully vested in their CRS benefits on July 1, 2011; (2) whether Defendants improperly revoked and/ or impaired Current Employees Class Members' vested CRS benefits when they enforced Ordinance No. 84-2011; (3) whether Defendants impaired contractual rights of the Current Employees Class when they enforced Ordinance No. 84-2011; (4) whether Defendants are estopped from enforcing Ordinance No. 84-2011 so as to revoke and/or impair the employment agreement with Current Employees Class Members; and (5) whether Defendants' enforcement of Ordinance No. 84-2011 operated as an unconstitutional taking of the vested property interest of Current Employees Class Members;

d. There are questions of law and/or fact common within the Retirees Class including but not limited to: (1) whether Defendants' offer of retirement benefits to the Retirees Class Members created a fundamental property right, giving each of them a vested right in those retirement benefits which cannot be reduced, impaired, revoked, or eliminated; (2) whether Defendants' actions as explained in the Retirees Class Complaint constitute an unlawful taking of the Retirees Class Members' property rights in violation of the United States Constitution and/or the Ohio Constitution; (3) whether the Defendants have a contractual obligation to provide the Retirees Class Members with certain retirement benefits, which cannot now or afterwards be reduced, impaired, revoked, or eliminated; (4) whether the unilateral reduction, impairment, revocation, and/or elimination of the Retirees Class Members' retirement benefits constitutes a breach of the Defendants' fiduciary duty; and (5) whether the Defendants are estopped

from reducing, impairing, revoking, or eliminating the retirement benefits owed to the Retirees Class;

e. The Current Employees Plaintiffs' claims are typical of the claims of the Members of the Current Employees Class as all subgroups were represented and no conflict exists between or among the subgroups, and the Retirees Plaintiffs' claims are typical of the claims of the Members of the Retirees Class;

f. Current Employees Plaintiffs and the Current Employees Class Counsel have and will fairly and adequately represent and protect the interests of the Current Employees Class, and the Retiree Plaintiffs and the Retirees Class Counsel have and will fairly and adequately represent and protect the interests of the Retirees Class;

g. Current Employees Plaintiffs' interests do not conflict with the interests of the Current Employees Class in the maintenance of this action and this Settlement, and the Retiree Plaintiffs' interests do not conflict with the interests of the Retirees Class in the maintenance of this action and this Settlement;

h. Certification of the Current Employees Class and the Retirees Class is appropriate because prosecuting separate actions by individual members of these Classes would create a risk of inconsistent and varying adjudications with respect to individual members of the Classes that would establish incompatible standards of conduct for the Defendants;

i. Certification of the Current Employees Class and the Retirees Class is appropriate because adjudications with respect to individual members of the Classes, as a practical matter, would be dispositive of the interests of the other Members not parties thereto and would substantially impair or impede their ability to protect their interests;

and

j. Certification of the Current Employees Class and the Retirees Class is appropriate because the Defendants have acted or refused to act on grounds that apply generally to the Classes, so that final injunctive relief or corresponding declaratory relief as agreed to by the Parties is appropriate respecting the Classes as a whole.

5. The Collaborative Settlement Agreement, the Consent Decree, and the terms contained therein are hereby finally approved as fair, reasonable, adequate, in the best interests of the Current Employees Class and the Retirees Class, and in compliance with all applicable requirements of the Federal Rules of Civil Procedure, the Class Action Fairness Act, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable law.

6. Pursuant to Rule 23(g), the following are hereby finally designated and approved as Current Employees Class Counsel: (1) Christian A. Jenkins, Esq., Minnillo & Jenkins, Co. LPA, 2712 Observatory Avenue, Cincinnati, Ohio 45208; (2) Marc D. Mezibov, Esq., Law Office of Marc Mezibov, 401 E. Court Street, Suite 600, Cincinnati, OH 45202; (3) Jeffrey S. Goldenberg, Esq., Goldenberg Schneider, LPA, One West Fourth Street, 18th Floor, Cincinnati, Ohio 45202; and (4) Robert D. Klausner, Esq., Klausner, Kaufman, Jensen & Levinson, 10059 Northwest 1st Court, Plantation, FL 33324. The Court's designation and approval of Current Employees Class Counsel is based upon: (1) the work they have done to identify and investigate the claims in this litigation; (2) their experience handling class actions and other complex litigation, including employee benefits litigation; (3) their knowledge of the applicable law and their familiarity with the complexities of this type of pension benefits litigation; and (4) the resources they committed and are willing to continue to commit to this litigation and the

implementation of the Consent Decree going forward.

7. Robert A. Pitcairn, Esq., James F. McCarthy, III, Esq., and Peter O'Shea, Esq. of the law firm of Katz Teller Brant & Hild, 255 East Fifth Street, Suite 2400, Cincinnati, Ohio, 45202 are hereby finally designated and approved as Retirees Class Counsel pursuant to Rule 23(g). The Court's designation and approval of Retirees Class Counsel is based upon: (1) the work performed to identify and investigate the claims in this litigation; (2) their experience handling class actions and other complex litigation, including employee benefits litigation; (3) their knowledge of the applicable law and their familiarity with the complexities of this type of pension benefits litigation; and (4) the resources they committed and are willing to continue to commit to this litigation and the implementation of the Consent Decree going forward.

8. Nick Sunyak, Jeffery Harmon, Jill Allgeyer, Kim Kappel, Waleia Jackson, Richard Ganulin, and Finley Jones are designated and granted final approval as the Current Employees Class Representatives. Jill Allgeyer is designated and granted final approval as the Sub-Class C representative. Kim Kappel, Waleia Jackson, and Richard Ganulin are designated and granted final approval as the Sub-Class D representatives. Finley Jones is designated and granted final approval as the Sub-Class E representative. Jeffrey Harmon and Nick Sunyak are designated and granted final approval as the Sub-Class F representatives.

9. Thomas A. Gamel, Sr., Paul Smith, Mark K. Jones, Dennis Davis, Ely Ryder, and Ann DeGroot are finally designated and approved as the Retirees Class Representatives.

10. The Parties have provided direct mail notice to the Classes in a manner consistent with the Order Granting Motion for Preliminary Approval of Class Action Settlement. The Notice Plan, as implemented, satisfied the requirements of due process and was the best notice practicable under the circumstances. The Notice Plan was reasonably calculated, under the

circumstances, to apprise Class Members of the terms of the proposed Settlement, their right to object or exclude themselves from the proposed Settlement, and their right to appear at the Fairness Hearing. Further, the notice was reasonable and constituted due, adequate, and sufficient notice to all persons entitled to receive notice. Also, Defendants, through Class Action Administration, Inc., notified the appropriate federal official (the Attorney General of the United States) and the appropriate State of Ohio officials (the Auditor of the State of Ohio and the Attorney General of the State of Ohio) pursuant to the Class Action Fairness Act of 2005 ("CAFA"), 28 U.S.C. § 1715. Accordingly, the Defendants' notification complies fully with its obligations under CAFA, and the notice met all applicable requirements under the Federal Rules of Civil Procedure, the United States Constitution (including the Due Process Clause), the Rules of the Court, and any other applicable rule or law.

11. Class Action Administration, Inc. ("Settlement Administrator") was retained to disseminate the Notice Plan in accordance with the terms of the Collaborative Settlement Agreement and the Court's Order Granting Motion for Preliminary Approval of Class Action Settlement. It is apparent from the Declaration of _____ that the Notice Plan was properly implemented and was effective.

12. The Court has determined that notice and full opportunity has been given to the Classes to object to the terms of the Settlement. The Court also has determined that notice and full opportunity has been given to the Classes to object to Current Employees Class Counsel's and Retirees Class Counsel's request for attorneys' fees and expenses. The Court has considered all of the objections to the Settlement that were submitted by members of the Classes as well as Class Counsel and Defendants' responses to those objections, and has determined as follows:

a. the Current Employees Plaintiffs, the Retiree Plaintiffs, the Current

Employees Class, and the Retirees Class face significant risks if this litigation were to proceed, including the real possibility of losing this litigation;

b. the possibility of a greater ultimate recovery is highly speculative and any such recovery would only occur after considerable delay, if at all;

c. the terms of the Collaborative Settlement Agreement and Consent Decree provide substantial and meaningful benefits to the Classes;

d. the Collaborative Settlement Agreement and Consent Decree are the product of vigorous, highly-contested litigation that included meaningful investigation into the facts and the law underlying the claims at issue;

e. the Settlement occurred after the litigation was substantially developed, including the exchange of voluminous actuarial data and other information during the mediation process and due diligence following the execution of the Memorandum of Understanding on December 31, 2014;

f. the Settlement negotiations were extensive, arms-length, and under the direction of the Court through a collaborative and agreed-to process that occurred without any collusion;

g. the reaction by the Classes has been overwhelmingly in favor of the Settlement; and

h. experienced Class Counsel support the Settlement.

13. Accordingly, having considered the foregoing, the costs and risks and delays of continued litigation versus the benefits provided by the Settlement, and based on this Court's knowledge of the Actions, the Court finds and concludes that the Settlement is in the best interests of the Classes and is fair, reasonable, and adequate to all members of the Classes.

14. This Settlement, including the terms of the Collaborative Settlement Agreement and Consent Decree, is accordingly granted final approval and is confirmed as fair, reasonable, adequate, and binding upon all members of the Classes.

15. The Parties are hereby directed to proceed with and complete the implementation of the Settlement. Therefore, the Court hereby orders and directs the Parties and their counsel to proceed with and complete the implementation and consummation of this Collaborative Settlement Agreement and Consent Decree according to its terms and provisions.

16. The Court enters judgment in accordance with the Collaborative Settlement Agreement and further declares the Collaborative Settlement Agreement binding on all the Parties.

17. Except as provided in the Collaborative Settlement Agreement and Consent Decree, all Parties are barred, estopped, and enjoined from asserting claims or interests arising under or out of, in connection with, or in any way relating to the claims set forth in the Litigation as defined in the Collaborative Settlement Agreement ("Barred Claims").

18. AFSCME warrants and acknowledges that it will dismiss with prejudice *State ex rel. Council 8 AFSCME, et al. v. City of Cincinnati, et al.*, Case No. A 1 104791, within 10 days of Finality as defined in the Collaborative Settlement Agreement pursuant, and to the terms of the separate settlement agreement entered into between AFSCME and the Defendants.

19. All Parties are bound by this Order Granting Final Approval, the Collaborative Settlement Agreement, and the Consent Decree. The Court declares that the Collaborative Settlement Agreement and related Consent Decree are incorporated into this Order Granting Final Approval, each of which shall be binding on all Parties. Further, the Collaborative Settlement Agreement, the Consent Decree, and this Order shall be preclusive for the 30 years

following the Effective Date, as defined in the Collaborative Settlement Agreement, in all other pending and future lawsuits or other proceedings relating to the Barred Claims in these Actions.

20. Consistent with the above paragraph, the Court also orders that the Barred Claims are fully and finally resolved as of the date of Finality, as defined in the Collaborative Settlement Agreement, and that the City, CRS and related City Defendants are forever discharged and released from the Barred Claims and that the Current Employees Plaintiffs, the Retiree Plaintiffs, and the members of the Classes are permanently barred and enjoined from filing, commencing, prosecuting, intervening in, participating in (as Class Members or otherwise), or receiving any benefits or other relief from, any other lawsuit, arbitration, or administrative, regulatory, or other proceeding or order in any jurisdiction based on the Barred Claims, except as set forth in the Re-Opener provisions in the Collaborative Settlement Agreement and Consent Decree.

21. The Court, having considered the request of Current Employees Class Counsel for an award of attorneys' fees and reimbursement of expenses, hereby grants the request and awards Current Employees Class Counsel attorneys' fees in the sum of $_____ which amount the Court concludes is fair and reasonable in light of the estimated $_____ valuation of the benefits to the Current Employees Class resulting from this Settlement. The Court also approves and grants Current Employees Class Counsels' request for expense reimbursement in the amount of $_____ for their reasonable expenses incurred in prosecuting this action and in implementing this Settlement. The fees shall be paid be paid by _____.

22. The Court, having considered the request of Retirees Class Counsel for an award of attorneys' fees and reimbursement of expenses, hereby grants the request and awards Retirees Class Counsel attorney's fees in the sum of $_____ which amount the Court concludes is

fair and reasonable. The Court also approves and grants Retirees Class Counsels' request for expense reimbursement in the amount of $_____ for their reasonable expenses incurred in prosecuting this action and in implementing this Settlement. The fees shall be paid by _____.

23. Without affecting the finality of this Final Order for purposes of appeal, if any, the Court retains continuing and exclusive jurisdiction over the Parties for thirty years following the Effective Date as to all matters relating to the administration, consummation, enforcement, and interpretation of the Collaborative Settlement Agreement, the Consent Decree, and this Order Granting Final Approval, and for any other necessary purpose related thereto, including the entry of any additional orders as may be necessary and appropriate.

IT IS SO ORDERED.

DATED: _____, 2015

_____
The Honorable Michael R. Barrett
United States District Judge

5615638.2

KTBH: 4829-0350-1603, v. 2

EXHIBIT EIGHT

CURRENT CRS

"POINT SYSTEM"

CINCINNATI RETIREMENT SYSTEM

2015 Retiree Healthcare Point System Matrix for Members Hired On or After January 9,1997

Full Years of Membership Service + Full Years of Age at Termination = Points

Percent of Monthly Healthcare Premium Categories

Tier of Coverage	90 + Points	80-89 Points	70-79 Points	60-69 Points	< 60 Points
	5%	25%	50%	75%	75%
Retiree only - Medicare Eligible	$23.73	$118.66	$237.33	$355.99	$355.99
Retiree only - Non Medicare	$47.05	$235.25	$470.50	$705.74	$705.74
Retiree & Spouse - Medicare Eligible	$46.23	$231.14	$462.29	$693.43	Not Available
Retiree & Spouse - 1 Medicare	$69.55	$347.73	$695.45	$1,043.18	Not Available
Retiree & Spouse - Non Medicare	$92.86	$464.31	$928.62	$1,392.92	Not Available
Retiree & Child(ren) - Medicare Eligible	$37.68	$188.41	$376.83	$565.24	Not Available
Retiree & Child(ren) - Non Medicare	$61.00	$305.00	$610.00	$914.99	Not Available
Retiree & Spouse & Child(ren) - Medicare Eligible	$65.04	$325.18	$650.37	$975.55	Not Available
Retiree & Spouse & Child(ren) -1 Medicare Eligible	$88.35	$441.77	$883.53	$1,325.30	Not Available
Retiree & Spouse & Child(ren) -Non Medicare	$111.67	$558.35	$1,116.70	$1,675.05	Not Available