MEMORANDUM

February 23, 2022

TO: Mayor John P. Kahl and Members of the City Council

FROM: Scott A. Brunton, City Attorney

SUBJECT: Resolution Approving Third Party Administrator Contract and Pharmacy Benefit Manager Contract Extension for the City's Group Health Insurance Plan

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DISCUSSION:

The Third-Party Administrator contract with Consociate for the City's self-funded Group Health Care Plan will expire at the end of the current fiscal year on April 30, 2022. As a result, the City's Insurance & Benefits Committee has recently reviewed this contract and met with Consociate representatives regarding renewal of their contract. Because Consociate has continued to provide excellent service as the Third-Party Administrator for the City's Health Care Plan at a fair cost, the Committee has negotiated a new five-year contract with Consociate for these necessary Third-Party Administrator services.

Accordingly, the Committee is again recommending entering into a new five-year contract with Consociate for these services for the City's Health Care Plan. The Committee has further found that Consociate continues to assist the Committee in its efforts to diligently control the overall costs of the Plan.

Additionally, back in April 2021, the City approved the transition of the administration of the prescription drug benefits portion of the Plan to ExpressScripts through the pharmacy benefits optimizer and coordinator RxBenefits. This transition was made on August 1, 2021, under the terms of the Client Agreement between the City, RxBenefits, and Consociate. As a part of entering into this new five-year contract with Consociate, the Committee has also recommended a one-year extension of the Client Agreement with Consociate and RxBenefits for the administration of the prescription drug benefits portion of the Plan.

The Resolution approves a new five-year contract with Consociate for the Third-Party Administrator services for the City's Group Health Care Plan and approves a one-year extension of the Client Agreement for the administration of the prescription drug benefits portion of the City's Plan.

RECOMMENDATION:

The Insurance & Benefits Committee recommends that the Council pass this Resolution.

RESOLUTION NO. 2122-115

East Peoria, Illinois
____________________, 2022

RESOLUTION BY COMMISSIONER __________________________________

RESOLUTION REGARDING THE THIRD-PARTY ADMINISTRATOR AND PHARMACY BENEFITS MANAGER FOR THE CITY'S GROUP HEALTH INSURANCE PLAN

WHEREAS, the City of East Peoria maintains a self-insured group health care plan ("Plan") for the benefit of its employees and retirees, and the City's Insurance and Benefits Committee oversees the Plan; and

WHEREAS, as part of the contract renewal process related to the Plan, the Insurance and Benefits Committee reviewed the service received from Consociate Inc. for the Plan's third-party administrator services for administration of benefits under the Plan, determining that the service from Consociate Inc. has been excellent and that Consociate Inc. has assisted the Plan with controlling Plan costs; and

WHEREAS, based upon a strong track record of service from Consociate Inc., the City's Insurance and Benefits Committee unanimously recommends that the City enter into a new five-year contract with Consociate Inc., attached as "Exhibit 1" (the "TPA Contract"), for the claims administration and related services for the City's Plan; and

WHEREAS, in April 2021, the City entered into a short-term contract effective on August 1, 2021, with RxBenefits Inc. for the transition of the administration of the Plan's prescription drug benefits to ExpressScripts whereby RxBenefits acts as a pharmacy benefits optimizer and coordinator for the City's Plan in relation to the Plan's prescription drug benefits; and

WHEREAS, as a means to implement this transition to RxBenefits Inc. and ExpressScripts for the administration of the Plan's prescription drug benefits, the City entered into a Client Agreement with RxBenefits and Consociate Inc. with an effective date of August 1, 2021 (the "PBM Client Agreement); and

WHEREAS, in conjunction with approval of the TPA Contract with Consociate as provided herein, the Insurance and Benefits Committee also recommends a one-year rollover extension of the PBM Client Agreement;

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF EAST PEORIA, TAZEWELL COUNTY, ILLINOIS, THAT:

Section 1. The City adopts the recommendation made by the Insurance and Benefits Committee, as set forth above, thereby approving the TPA Contract with Consociate Inc., attached as "Exhibit 1", which will be effective from May 1, 2022, through April 30, 2027.

Section 2. The City further adopts the recommendation made by the Insurance and Benefits Committee for the one-year rollover extension of the PBM Client Agreement, as set forth above.

Section 3. The Mayor and City Clerk are hereby authorized and directed to execute the five-year TPA Contract with Consociate Inc., attached as "Exhibit 1", together with such changes therein to the TPA Contract as the Mayor in his discretion may deem appropriate; provided, however that such agreement shall not be binding upon the City until an executed original thereof has been delivered to the respective service provider. Furthermore, the Mayor and City Clerk are further authorized to execute any required and necessary agreements or documentation ancillary to fulfilling the terms and intent of the attached TPA Contract with Consociate Inc.

APPROVED:

____
Mayor

ATTEST:

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City Clerk

EXHIBIT 1

Third-Party Administrative Services Agreement with Consociate, LLC

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement and accompanying exhibits and appendices which are attached hereto and incorporated herein (collectively referred to as the "Agreement") is made and entered into this 1st day of May, 2022 (the "Effective Date"), by and between City of East Peoria, a municipality, duly organized and existing under the laws of the state of Illinois with its principal place of business at 401 West Washington Street, East Peoria, Illinois (hereinafter referred to as the "Plan Sponsor") and Consociate, Inc., a corporation duly organized and existing under the laws of the state of Illinois with its principal place of business at Decatur, Illinois (hereinafter referred to as the "Claims Administrator").

WHEREAS, it is agreed that during the five-year term of this Agreement, this Agreement will automatically renew each year unless modified, amended or terminated herein as outlined hereafter;

WHEREAS, the Plan Sponsor is a municipality that sponsors a self-funded employee welfare benefit plan (the "Plan");

WHEREAS, the Plan Sponsor desires to make available a program of health care benefits under the Plan and fund said Plan from the general assets of the employer or from a separate trust, funded through salary reductions and/or other plan or employer assets;

WHEREAS, the Plan Sponsor wishes to contract with an independent third-party to perform certain services with respect to the Plan as enumerated below;

WHEREAS, the Claims Administrator desires to contract with the Plan Sponsor to perform certain services with respect to the Plan as enumerated below;

WHEREAS, the parties intend that the Claims Administrator shall not be deemed a "fiduciary" of the Plan and Claims Administrator shall have no discretionary authority or final determinative capability with regard to benefit determinations; and

THEREFORE, in consideration of the promises and mutual covenants contained herein, the Plan Sponsor and the Claims Administrator enter into this Agreement for administrative services for the Plan.

ARTICLE I. DEFINITIONS

For purposes of this Agreement, the following words and phrases have the meanings set forth below, unless the context clearly indicates otherwise and wherever appropriate, the singular includes the plural and the plural includes the singular.

1.1 Adjudicate means, with respect to all claims submitted to the Plan, process (electronically or manually) and pay, deny or pend for additional information.

1.2 Claim means a request by a Claimant for payment or reimbursement for Covered Services from the Plan.

1.3 Claimant means any person or entity submitting expenses for payment or reimbursement from the Plan.

1.4 Claims Payment Account means an account established by and owned by the Plan Sponsor for payment or reimbursement for Covered Services, which Account shall be an asset of the Plan Sponsor.

1.5 Claims Runout means Claims that are incurred but unreported and/or unpaid as of the effective date of termination of this Agreement.

1.6 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

1.7 Covered Services means the care, treatments, services, supplies, or amounts described in the Plan Document as eligible for payment or reimbursement from the Plan.

1.8 Employer means Plan Sponsor (unless otherwise stated), and any successor organization, subsidiary, or affiliate of such Employer that assumes the obligations of the Employer, the Plan, and this Agreement.

1.9 Health Care Providers means physicians, dentists, hospitals, or other medical practitioners or medical care facilities that are duly licensed and authorized to receive payment or reimbursement for Covered Services provided under the terms of the Plan.

1.10 Paid Claims means claims for benefits solely funded by the Plan Sponsor and submitted for processing to the Claims Administrator and for which payment has been issued to the Claimant or assignee.

1.11 Plan means the self-funded employee welfare benefit plan, which is the subject of this Agreement and which the Plan Sponsor has established and maintains pursuant to the applicable Plan Document.

1.12 Plan Administrator means the person or organization responsible for the functions and management of the Plan. The Plan Administrator may employ persons or firms to process

claims and perform other Plan-connected services. If a Plan Administrator is not appointed in the Plan Document, then the Plan Administrator is the Plan Sponsor.

1.13 Plan Document means the instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of Covered Services, as may be amended from time to time.

1.14 Plan Participant is any employee or retiree of Employer eligible for enrollment, and his or her covered dependents, who are properly enrolled in and entitled to benefits from the Plan. Persons eligible for enrollment are those who meet the Plan's eligibility requirements.

1.15 Plan Sponsor means the organization, person, or entity identified as the Plan Sponsor in the introduction to this Agreement. This term also includes the Plan Sponsor's designee, unless otherwise indicated.

1.16 Plan Year means the period of time specified as such in the Plan Document.

1.17 Utilization Management means the review and evaluation of medical necessity and appropriateness of the use of health care services, procedures or facilities utilized by a Covered Person under the terms of the Plan, as well as any other services that a vendor of Utilization Management services defines as falling within the scope of this term, upon and after execution of an agreement between the Plan and such Utilization Management vendor.

ARTICLE II. PURPOSE OF AGREEMENT AND RELATIONSHIP OF PARTIES

2.1 The purpose of this Agreement is to state the terms and conditions by which the Claims Administrator will provide administrative services to the Plan Sponsor as it relates to administration of the Plan(s).

2.2 The parties acknowledge that:

(a) This is a contract for administrative services only as specifically set forth herein.

(b) The Claims Administrator shall not be obligated to disburse more in payment under this Agreement than the Plan Sponsor shall have made available in the Claims Payment Account.

(c) This Agreement shall not be deemed to be a contract of insurance under any laws or regulations. The Claims Administrator does not insure, guarantee or underwrite liability. The Claims Administrator has no responsibility, and the Plan Sponsor has total responsibility, for payment of claims arising under the Plan and all expenses incidental to the Plan.

(d) The Plan Sponsor acknowledges and agrees that the Claims Administrator will not be deemed to be a legal or tax advisor as a result of the performance of any of its duties

under this Agreement, including but not limited to claims processing, COBRA or HIPAA administration, or payment or calculation of any applicable taxes, fees, or other assessments. The Claims Administrator makes no representation concerning federal, state, or local laws, rules or regulations applicable to the Plan. The Plan Sponsor must seek its own counsel for legal advice and guidance.

(e) Except as specifically set forth herein, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives and successors; provided, however, neither party may assign this Agreement or any or all of its rights or obligations hereunder (except by operation of law) without the prior written consent of the other, which consent may not be unreasonably withheld.

(f) The work to be performed by the Claims Administrator under this Agreement may, at its discretion, be performed directly by it or wholly or in part through a subsidiary or affiliate of the Claims Administrator or under an agreement with an organization, agent, advisor, or other person of its choosing. Unless the Plan Sponsor objects to the entity chosen, the Claims Administrator may delegate certain portions of its work under this Agreement to any other entity. The Plan Sponsor retains final authority to decide whether said organization, agent, advisor, or other person may be retained or utilized.

(g) The Claims Administrator represents that it is duly licensed as a claims administrator to the extent required under applicable law and agrees to maintain such licensure at all times while this Agreement is in effect.

(h) The Claims Administrator will possess, at all times while this Agreement is in effect, an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its clients.

(i) The Claims Administrator agrees to comply with any applicable state or federal statutes or regulations regarding its operations.

ARTICLE III. RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR

The Claims Administrator will provide the following administrative services for the Plan on behalf of the Plan Sponsor:

3.1 Administer the enrollment of eligible individuals and termination of Plan Participants as directed by the Plan Sponsor, subject to the provisions of this Agreement.

3.2 Maintain Plan records based on eligibility information submitted by the Plan Sponsor as to the dates on which a Plan Participant’s coverage commences and terminates.

3.3 Maintain Plan records of Plan coverage applicable to each Plan Participant based on information submitted by the Plan Sponsor.

3.4 Maintain Plan records regarding payments of Claims, denials of Claims, and Claims pending.

3.5 Adjudicate Claims incurred by Plan Participants according to the terms of the Plan Document and this Agreement. These Claims will be adjudicated in accordance with accepted industry practices and the Claims Administrator will use an industry-recognized method of determining usual, customary, and reasonable charges, if and as applicable.

3.6 Process with due diligence and according to the terms and conditions of the Plan Document all Claims, requests, information, and other responsibilities consistent with this Agreement as outlined herein, including COBRA and HIPAA administration, as outlined in Appendix A, Exhibit IX.

3.7 Unless otherwise stated, adjudicate Claims incurred by Plan Participants according to the terms of the Plan Document as construed by the Plan Sponsor or Plan Administrator. The Claims Administrator shall adhere to the administrative guidelines and standard provisions as set forth in the Plan Document and as established by the Plan Sponsor, unless instructed differently by the Plan Sponsor. Any such instructions given by the Plan Sponsor must be communicated to the Claims Administrator in writing.

3.8 Unless otherwise stated, claims will be adjudicated in accordance with agreed-upon parameters, set forth within the terms of the applicable Plan Document, including – if applicable – the determination of usual, customary, and reasonable charges.

3.9 The Claims Administrator reserves the right to charge an additional administration fee for adjudicating Plan provisions requiring special claims handling or considerable manual intervention. The Claims Administrator reserves the right to acknowledge or decide, as set forth above, the validity of a Claim or the need for additional information within any time period specified by applicable laws or agreements. If additional information is needed, the Claims Administrator will send through the U.S. Mail to the appropriate persons (with a copy to the Plan Participant) an Explanation of Benefits denying the claim pending receipt of requested information. The fact that a written request for additional information has been made will be shown on the Explanation of Benefits form. When all necessary documents and Claim form information have been received, and if the Claim has been approved, a Claim check or draft shall be remitted on the next dispersal date after funding by the Plan Sponsor and Plan Participants shall be notified in writing through the U. S. Mail of ineligible Claims received, indicating the specific Plan provisions attributable to the declination of the Claims pursuant to the written Claims review and appeal procedure in the Plan.

3.10 The Claims Administrator reserves the right to increase the fees outlined within this Agreement in the event that the Plan Sponsor materially alters the Plan Document during the term of this Agreement. A material alteration is one that amends the Plan Document in such a way that it requires the Claims Administrator to expend additional resources to properly perform its functions under this Agreement. Such increased fee must be agreed

upon in writing by both parties; either party reserves the right to terminate this Agreement in accordance with Article VII if the parties cannot agree on an increased fee.

3.11 Provide third-party recovery services, including subrogation and reimbursement, as described within the Plan Document. The Claims Administrator shall perform the necessary services with respect to obtaining recoveries, including, but not limited to, identifying claims, sending questionnaires, providing and receiving documentation, as applicable. The Claims Administrator has the discretion to utilize the services of a third-party in connection with such matters. Plan Sponsor acknowledges that waiver or reduction of a recovery may be necessary as a result of the particular facts or law applicable to the recovery. The Claims Administrator shall refer requests for negotiation or waiver of a claim to the Plan Sponsor for final determination. The Claims Administrator reserves the right to retain a nominal percentage of the net recovery to the Plan Sponsor to compensate the Claims Administrator for increased administrative fees associated with ensuring recoveries.

3.12 Expedite Claim Review and Resolution. Unless otherwise stated, the Claims Administrator will refer any doubtful or disputed claims to the Plan Sponsor for a final decision. In the event that the Claims Administrator makes an initial determination that a claim is not eligible for payment under the Plan, and the claimant (or authorized representative or beneficiary) requests a review of such determination, the Claims Administrator shall refer such request to the Plan Sponsor together with the relevant records in the possession of the Claims Administrator. The Plan Sponsor shall then make a full and fair review of the claim denial as required by law and shall notify the claimant in writing of its decision on review in accordance with the time limits and other requirements of applicable law. The Plan Sponsor acknowledges that the Claims Administrator does not represent or warrant that all determinations made by the Claims Administrator will be accurate, and the Plan Sponsor expressly reserves for itself the ultimate authority as to claims determinations.

3.13 Notify the Plan Participant if any benefits are denied for services submitted on a Claim form. After receiving a notice of denial, a Plan Participant may appeal to the Claims Administrator in accordance with the provisions of the Plan Document. The Plan Participant may also ask the Claims Administrator to provide the Plan Participant with any records that would aid the Plan Participant in an appeal. The Claims Administrator will review the denial in accordance with the terms of the Plan Document and render a decision. Should the Plan Participant further appeal a decision via an appeal to the Plan Sponsor, the Claims Administrator shall assist the Plan Sponsor by providing to the Plan Sponsor the information necessary properly conduct its review.

3.14 In processing Claims in accordance with the Plan Document, the Claims Administrator shall provide notice in writing when a Claim for benefits has been denied, setting forth the reasons for the denial, the right to a full and fair review of the denial under the terms of the Plan Document and applicable law, and otherwise satisfying applicable regulatory requirements governing notice of a denied Claim.

3.15 Process, issue, and distribute Claims checks or drafts that the Claims Administrator determines may be due in accordance with the terms of the Plan Document to Plan Participants, Health Care Providers, or others as may be applicable.

3.16 In the event that the Claims Administrator pays a Claim in good faith but in error, the Claims Administrator shall make good faith attempts to recover any overpayments. If the Claims Administrator is unable to recover the overpayment, the claim may be referred to a collection agency or other organization at the request and expense of the Plan Sponsor. In no event may the Plan Sponsor hold the Claims Administrator liable for reimbursement of overpayments made in error but in good faith by the Claims Administrator, unless specified elsewhere in this Agreement.

3.17 If the Plan Sponsor is exempt from the requirement to provide women with no-cost access to contraception, and has accurately completed the EBSA Form 700 and submitted a copy to the Claims Administrator, the Claims Administrator shall keep a record of the form on file for the tenure of this Agreement. If the Plan Sponsor validly completes and submits such form to the Claims Administrator, the Claims Administrator shall ensure that the contraception that the Plan Sponsor is exempted from providing is nonetheless provided to Plan Participants, and the Claims Administrator will not increase the fees charged to the Plan Sponsor in connection with providing such contraception. If the Plan Sponsor is not eligible to self-certify for an exemption to the provision of contraception, the Claims Administrator has no obligation to ensure that the relevant contraception is provided.

3.18 Unless otherwise stated, investigate claims when appropriate. This includes, but is not limited to, referring claims to professional consultants at the expense of the Plan. In addition, the Claims Administrator may obtain, to the extent permitted by law, from any provider or from hospitals in which a provider's care is provided, such information and records relating to a Plan Participant as the Claims Administrator may require to properly adjudicate a Claim. The Plan Sponsor or its designee shall have the final authority to authorize or disallow benefit payments.

3.19 In accordance with the terms of the Plan Document, coordinate benefit coverage when benefits are being provided under two (2) or more group benefit plans or group health care programs as described in the Plan Document.

3.20 Execute the Plan's responsibility, on the Plan's behalf, to return funds to the excess loss carrier if and when reimbursement of funds is received by Claims Administrator and/or the Plan, via subrogation, reimbursement, or other claims recovery; after the excess loss carrier has reimbursed the Plan and in accordance with agreement(s) between the Plan and the approved excess loss carrier, if applicable.

3.21 Load eligibility data within 72 business hours of receipt. The Claims Administrator will accept emergency additions and/or terminations from the Plan Sponsor on an as-needed basis. The Claims Administrator shall not pay claims for any person unless included on the eligibility file or as advised by the Plan Sponsor. If applicable, all payments for services performed by a Preferred Provider Organization will be made directly to the provider. With

regard to services performed by an out-of-Network provider, as defined in the applicable Policy or network agreement, when filing proof of loss, the Plan Participant may request in writing that the payment be made to the provider pursuant to an assignment of benefits. In the event there is not an assignment of benefits, all other payments shall be payable to the Plan Participant, or to the estate, except that if the person is a minor or otherwise not competent to give a valid release, payment may be made payable to his parent, guardian or other person as specified by a valid court order.

3.22 Document claim payments made to providers and submit the required applicable tax form for the purpose of reporting to the Internal Revenue Service.

3.23 Furnish to any provider or any Plan Participant, on request, a Claim form to make a claim for payment for services under the Plan.

3.24 When applicable, utilize the Health Plan Identifier assigned to the Plan Sponsor in standard transactions, including any required by applicable federal law or regulations.

3.25 The Claims Administrator will notify the Plan Sponsor of the amount required to be prospectively deposited to the Claims Payment Account to pay the Claims liability as these Claims are paid weekly. The Claims Administrator will notify the Plan Sponsor of the amount required to be prospectively deposited to the Claims Payment Account to pay the Claims liability as these Claims occur as outlined above.

3.26 Respond to Claims inquiries by a Plan Participant, the estate of a Plan Participant, an authorized member of a Plan Participant's family unit, or an authorized Health Care Provider in accordance with the requirements of Article VIII and the Business Associate Agreement that is incorporated herein as Appendix C.

3.27 Maintain all patient information and other protected or individually identifiable health or health care information in the strictest confidence in accordance with applicable state and federal laws and any and all regulations issued thereunder, and in accordance with Article VIII and the Business Associate Agreement that is incorporated herein as Appendix C.

3.28 If applicable, capture and provide data for IRS Form 5500 filings to the Plan Sponsor.

3.29 Provide the Plan Sponsor with check register on a weekly basis. Such reports shall be in an electronic format (Excel) and in a PDF format upon request.

3.30 The Claims Administrator shall issue identification cards to each individual who enrolls in the Plan, unless otherwise agreed upon by the Claims Administrator and the Claims Administrator. Such identification cards shall be for the administration of Plan Participants' health care benefits under the Plan only and may state that the Claims Administrator assumes no financial risk with respect to Claims.

3.31 Utilization Management Services. As outlined in Appendix D, Exhibit IV, the Plan Sponsor will select a vendor to provide Utilization Management services for the Plan. The Claims

Administrator will provide information as necessary to the Utilization Management vendor in order to perform Utilization Management services as agreed to by the Plan Sponsor. The Plan Sponsor will ensure that the Utilization Management vendor it selects will provide to the Claims Administrator, or the Plan Sponsor will provide to Claims Administrator, a copy of the applicable agreement between the Utilization Management vendor and the Plan Sponsor, including but not limited to an explicit list of all services to be provided by the Utilization Management vendor to the Plan Sponsor.

3.32 Maintain a Claim file on every Claim reported to it by Plan Participants. Such files and all Plan-related information shall be made available to the Plan Sponsor for consultation, review, and audit upon reasonable notice and request, during regular business hours on business days and at the office of the Claims Administrator. Any such audit will be at the sole expense of the Plan Sponsor.

3.33 Upon termination of this Agreement, all Claim files, reports, magnetic tapes, and Plan-related documentation will be remitted to the Plan Sponsor. Until that time, such records will be maintained at the principal administrative office of the Claims Administrator or its secure storage facilities for at least 7 years following the termination of a Plan Year. At the end of the 7-year period or termination of this Agreement, if earlier, the Claims Administrator shall notify the Plan Sponsor that these records will be destroyed unless the Plan Sponsor requests, in writing, that all or some of the records be forwarded to the Plan Sponsor.

3.34 Refer any doubtful or disputed Claims to the Plan Sponsor for a final decision.

3.35 Summary of Benefits and Coverage (SBC) preparation. In accordance with PPACA, the Plan Sponsor is required to provide Plan Participants with a Summary of Benefits and Coverage. The Plan Sponsor may elect to have the Claims Administrator provide SBC preparation services. The SBC will be drafted in accordance with the PPACA-mandated form and regulations. If SBC preparation is elected, the Claims Administrator requires 90 days' notice of Plan changes 90 days prior to the applicable plan year.

3.36 The Claims Administrator, per the IL Public Act 102-0630 ("Consumer Coverage Disclosure Act"), will provide the Plan Sponsor a written list of the covered benefits included in the group health insurance coverage in a format that easily compares those covered benefits with the essential health insurance benefits required of individual health insurance coverage regulated by the State of Illinois.

ARTICLE IV. RESPONSIBILITIES OF THE PLAN SPONSOR

The Plan Sponsor will:

4.1 Maintain current and accurate Plan eligibility and coverage records, verify Plan Participant eligibility, and submit this information every month to the Claims Administrator. This information shall be provided in a format reasonably acceptable to the Claims Administrator and include the following for each Plan Participant: name, address, Social

Security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan. The Plan Sponsor assumes the responsibility for the erroneous disbursement of benefits by the Claims Administrator in the event of error or neglect on the Plan Sponsor's part of providing eligibility and coverage information to the Claims Administrator, including, but not limited to, failure to give timely notification of ineligibility of a former Plan Participant. Eligibility information may be communicated via electronic eligibility file, transmitted to the Claims Administrator by the Plan Sponsor.

4.2 Unless otherwise stated, the Plan Sponsor acknowledges that it serves as Plan Administrator and fiduciary, and shall have discretionary authority and control over the management of the Plan, and sole discretionary authority and responsibility for the administration of the Plan. The Claims Administrator does not serve either as Plan Administrator or as a Named Fiduciary of the Plan. All functions, duties and responsibilities of the Claims Administrator are governed exclusively by this Agreement and the Plan Document. The Plan Sponsor will resolve all Plan ambiguities and disputes relating to the Plan eligibility of a Plan Participant, Plan coverage, denial of Claims, or any other Plan interpretation questions. The Claims Administrator will administer and adjudicate Claims in accordance with the terms of the Plan Document but will have no discretionary authority to interpret the Plan Document. If adjudication of a Claim requires interpretation of ambiguous Plan language, and the Plan Sponsor has not previously indicated to the Claims Administrator the proper interpretation of the language, then the Plan Sponsor will be responsible for resolving the ambiguity or any other dispute. In any event, the Plan Sponsor's decision as to any Claim (whether or not it involves a Plan ambiguity or other dispute) shall be final and binding.

4.3 Conduct and control all enrollment meetings, maintenance of enrollment records, and distribution of enrollment materials. Pertinent enrollment information will be sent to the Claims Administrator as agreed to by and between the parties.

4.4 Fund the Claims Payment Account and grant the Claims Administrator drafting authority with respect to such Account. The Claims Administrator shall notify the Plan Sponsor of the amount necessary to pay Claims adjudicated from the previous week and the Plan Sponsor will deposit amounts necessary to pay such claims within 7 business days or as agreed upon by and between the parties of such notification by the Claims Administrator. The Claims Payment Account shall be set up by the Plan Sponsor who shall execute and deliver to the Claims Administrator, and a depository selected by the Plan Sponsor, any and all documents necessary to empower the Claims Administrator or its vendor to act as signatory on such account.

4.5 Not require the Claims Administrator, under any circumstances, to issue payment for Claims, excess loss premiums, or any other costs arising out of the subject matter of this Agreement, unless the Plan Sponsor has previously deposited sufficient funds to cover such payment.

4.6 Provide the Claims Administrator with written notice of any and all revisions or changes to the Plan Document, as agreed to by the parties.

4.7 Provide and timely distribute all notices and information required to be given to Plan Participants, maintain and operate the Plan in accordance with applicable law, maintain all recordkeeping, and file all forms relative thereto pursuant to any federal, state, or local law, unless this Agreement specifically assigns such duties to the Claims Administrator.

4.8 Pay any and all taxes, surcharges, licenses, and fees levied by any local, state, or federal authority in connection with the Plan.

4.9 Comply with all applicable law and any agreements to which the Plan Sponsor is a party or to which the Claims Administrator is a party on behalf of the Plan Sponsor.

4.10 Warrant and represent that the only entities that participate, or will participate, in the Plan are in the Plan Sponsor's controlled group of corporations.

4.11 Review the statement for the fees charged by the Claims Administrator as applicable, which has been prepared in accordance with the Fee Schedule and which is attached hereto and incorporated herein and marked as Appendix A.

4.12 Maintain excess loss insurance with a carrier approved by the Claims Administrator, which approval shall not be unreasonably withheld, and notify the Claims Administrator of any termination, expiration, lapse, or modification of this insurance, if applicable within 10 business days of such event. Plan Sponsor may not hold the Claims Administrator responsible in the event of any denial, reduction, or other decision made by the applicable excess loss carrier, regardless of whether such carrier was placed or recommended by the Claims Administrator, and regardless of reason for such denial, reduction, or decision.

4.13 If the Plan Sponsor is eligible to self-certify an exemption from contraceptive coverage with EBSA Form 700, the Plan Sponsor shall accurately complete such form and submit a copy to the Claims Administrator, and the Plan Sponsor shall retain a copy of such form for the tenure of this Agreement.

4.14 Maintain any fidelity bond or other insurance as may be required by state or federal law for the protection of the Plan and Plan Participants, if applicable.

4.15 Not hold the Claims Administrator responsible if the Plan is deemed noncompliant with PPACA or regulations promulgated thereunder as the result of the particular benefits offered within the Plan.

4.16 Not copy, sell, transfer, or otherwise use the language in this Agreement to create other documents or for any purposes except those in furtherance of the purposes of this Agreement.

ARTICLE V. CLAIMS AUDIT

5.1 At the Plan Sponsor's expense, the Plan Sponsor shall have the right to audit any Claims paid by the Claims Administrator on behalf of the Plan Sponsor on the premises of the Claims Administrator, during regular business hours. The Claims Administrator reserves the right to charge a reasonable fee to the Plan Sponsor for expenditure of time by the any employees of the Claims Administrator in completing any audits.

5.2 Any errors identified and/or amounts identified as owed to the Plan Sponsor as the result of the audit shall be subject to review and approval by the Claims Administrator prior to any reimbursements to the Plan Sponsor. Overpayments shall be credited to the Claims Payment Account.

5.3 Any and all Claims records or other information reviewed by the Plan Sponsor or any third-party auditor shall be treated as confidential and shall be used strictly within the parameters of the audit. The Plan Sponsor and any third-party auditor shall agree to jointly and severally indemnify and hold the Claims Administrator harmless from any action, cost, expense or liability, including reasonable attorneys' fees, which may arise out of the disclosure of any confidential information obtained through such audit and shall execute an agreement to this effect prior to conducting such audit. This indemnity shall survive termination of this Agreement.

ARTICLE VI. PROPRIETARY INFORMATION

6.1 The Claims Administrator agrees to treat all proprietary information concerning the Plan Sponsor's operations and the Plan as confidential.

6.2 The Claims Administrator owns and shall own all rights, title and interest in and to the systems, procedures, methodologies and practices used by it in connection with the Claims processing, Claims payment and utilization monitoring functions of the Plan, together with any applicable provider network, the negotiated fees, terms and discounts with providers, Claims processing, Claims history and utilization data and information (collectively, the "Claims Administrator Proprietary Information"), all of which is proprietary, confidential, and a trade secret of the Claims Administrator. The Plan Sponsor shall have no right, title or interest in or to the Claims Administrator Proprietary Information. The Plan Sponsor agrees to treat all Claims Administrator Proprietary Information in a confidential manner.

6.3 The Plan owns all rights, title, and interest in and to the underlying Plan data and records of claims of all Plan Participants and Beneficiaries (the "Plan Data"). The Claims Administrator shall have access to and shall maintain all Plan Data while this Agreement is in effect and during any period of Claims Runout. The Claims Administrator shall retain such Plan Data until the Claims Administrator receives a request from the Plan Sponsor for transmittal, or for a period of Seven (7) Years after the date of termination, whichever occurs first. The Plan Sponsor, and the Plan itself, shall have access to all Plan Data and a copy of all Plan Data in a form and format that is mutually agreed upon by the Claims

Administrator and the Plan Sponsor, and it shall be delivered to the Plan at no cost, no more than once per year and once upon termination of this Agreement.

6.4 Neither party shall disclose proprietary information to any other entity without the prior written consent of the party that holds the right, title and interest in the information. Nothing in this Article shall prohibit the disclosure of any information required by law, but in the event of any such disclosure, the disclosing party shall immediately notify the other party in writing, describing the circumstances of and extent of the disclosure. This provision shall survive termination of this Agreement.

ARTICLE VII. TERMINATION AND MODIFICATION OF AGREEMENT

7.1 At any time during the effective term of this Agreement, either the Plan Sponsor or the Claims Administrator may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the Plan Sponsor and the Claims Administrator. However, in the event of a material alteration to the Plan Document, as provided in Article III, a reasonable fee increase may be effected immediately and without written agreement.

7.2 This Agreement may be terminated by either the Plan Sponsor or the Claims Administrator at any time, either upon giving 90 days advance written notice to the other party unless both parties agree to waive such advance notice, or with no notice, as stated below. At the option of the party initiating the termination, the other party may be permitted a cure period (of a length determined by the party initiating the termination) to cure any default.

7.3 The Claims Administrator may, at its option, terminate this Agreement upon the occurrence of any one or more of the following events on 60 days advance written notice to the Plan Sponsor:

(a) The Plan Sponsor fails to fund the Claims Payment Account;

(b) A temporary or permanent receiver is appointed by any court for all or substantially all of the Plan Sponsor's assets, the Plan Sponsor makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Plan Sponsor and it is not dismissed within 120 days of such filing;

(c) The Plan Sponsor fails to pay administration fees or other fees for the services performed by the Claims Administrator in accordance with this Agreement and Appendix A;

(d) The Plan Sponsor engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the Claims Administrator is in violation of any federal, state, or other government statute, rule, or regulation;

(e) The Plan Sponsor, through its acts, practices, or operations, exposes the Claims Administrator to any existing or potential investigation or litigation; or

(f) The Plan Sponsor permits its excess loss insurance to lapse, whether by failure to pay premiums or otherwise.

7.4 The Plan Sponsor may, at its option, terminate this Agreement upon the occurrence of any one or more of the following events on 60 days advance written notice to the Claims Administrator:

(a) A temporary or permanent receiver is appointed by any court for all or substantially all of the assets of the Claims Administrator, the Claims Administrator makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Claims Administrator and it is not dismissed within 120 days of such filing;

(b) The Claims Administrator engages in any unethical business practice or conducts itself in a manner that the Plan Sponsor reasonably determines to be in violation of any federal, state, or other government statute, rule, or regulation;

(c) The Claims Administrator, through its acts, practices or operations, exposes the Plan Sponsor to any existing or potential investigation or litigation; or

ARTICLE VIII. CLAIMS RUNOUT

8.1 If applicable and as agreed to by and between the parties, the Claims Administrator shall pay the Claims Runout for 90 days following the date of termination of this Agreement (the “Runout Period”). Following termination of this Agreement, the terms of this Agreement shall continue to apply with respect to the processing and payment of such Claims Runout and the any fees due to the Claims Administrator (see Appendix A), including the indemnification provision and the Business Associate Agreement (Appendix C). The Claims Administrator shall forward any claims received after the Runout Period to the Plan Sponsor or other person or entity designated by the Plan Sponsor; however, the Claims Administrator shall not be obligated to continue forwarding claims more than 90 days after the end of the Runout Period.

8.2 If applicable, and as agreed to by and between the parties, upon termination of this Agreement, fees due to the Claims Administrator applicable to the Claims Runout shall include 3 months of fees. This fee must be paid prior to the commencement of the Runoff Period. Any additional services requested by the Plan Sponsor and not specifically addressed in this Agreement will be billed as follows: Monthly. Any other fees incurred by the Claims Administrator on behalf of the Plan Sponsor will be billed directly to the Plan Sponsor for payment or paid out of the claims account.

ARTICLE IX. HIPAA

9.1 The Plan Sponsor agrees that the Plan will be in compliance with all requirements involving the use or disclosure of protected health information as provided for in 45 C.F.R. Part 164. The duties and responsibilities of the Claims Administrator in connection with the requirements imposed by HIPAA and regulations promulgated thereunder will be set forth in the Business Associate Agreement entered into between the Parties to this Agreement.

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

ARTICLE X. MISCELLANEOUS

10.1 This Agreement, together with all addenda, exhibits, and appendices supersedes any and all prior representations, conditions, warranties, understandings, proposals, or other agreements between the Plan Sponsor and the Claims Administrator hereto, oral or written, in relation to the services and systems of the Claims Administrator, which are rendered or are to be rendered in connection with its assistance to the Plan Sponsor in the administration of the Plan. This Agreement, together with all addenda, exhibits, and appendices, constitutes the entire Administrative Services Agreement of whatsoever kind or nature existing between the parties.

10.2 The Claims Administrator reserves the right to engage the services of subcontractors in its performance of any services performed hereunder.

10.3 This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument.

10.4 Neither party may assign any of its rights or obligations under this Agreement without the written consent of the other party.

10.5 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.

10.6 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.

10.7 Exclusivity. The Plan Sponsor warrants that the Claims Administrator will exclusively handle these matters for the Plan Sponsor during the pendency of this Agreement.

10.8 Governing Law. This Agreement is entered into and governed by and construed in accordance with the laws of the state of Illinois without regard to any applicable conflicting choice of law provisions.

10.9 Severability. All provisions of this Agreement are severable, and the unenforceability or invalidity of any of the provisions shall not affect the validity or enforceability of the remaining provisions. The remaining provisions will be construed in such a manner as to carry out the full intention of the parties. Section titles or references used in this Agreement shall not have substantive meaning or content and are not a part of this Agreement.

10.10 Force Majeure. Neither party will be liable for any failure or delay in performance of its obligations hereunder by reason of any event or circumstance beyond its reasonable control, including but not limited to acts of God, war, riot, strike, labor disturbance, fire explosion, telephone network failure(s), flood or shortage or failure of suppliers. If any delay in performance under this section continues for more than 30 consecutive days, the unaffected party will have the right to terminate this agreement with 30 days prior written notice to the affected party, unless the affected party is able to remedy its circumstances within the 30-day notice period.

10.11 Indemnification. In addition to the terms already set forth, each party agrees to indemnify and hold harmless the other party against all claims, demands, costs, expenses (including reasonable attorneys' fees), liabilities, and losses arising under this Agreement where such claims, demands, costs, expenses, liabilities, and losses are caused by acts or omissions of the indemnifying party.

(a) The Claims Administrator will indemnify, defend, and hold the Plan Sponsor and its respective directors, officers and employees harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, court costs and attorney's fees, that the Plan Sponsor may suffer or incur as a result of any dishonest, fraudulent, grossly negligent, or criminal act or omission of the Claims Administrator or its employees, or by a breach of confidentiality or right of privacy of any Plan Participant by the Claims Administrator except for acts taken at the specific direction of the Plan Sponsor. Should the Claims Administrator be called upon to indemnify the Plan Sponsor, it may at its discretion choose to handle any defense efforts necessary to counter claims against the Claims Administrator and/or the Plan Sponsor which would give rise to, and necessitate, said indemnification. The Claims Administrator shall be entitled to rely, without investigation or inquiry, upon any written communication(s) of the Plan Sponsor or agents of the Plan Sponsor. This indemnity does not extend to any acts or omissions other than those enumerated in this paragraph. This indemnity shall survive termination of this Agreement. The remedy for payments made in error will be to seek recovery from the Plan Participant or the provider of services.

(b) The Plan Sponsor will indemnify, defend, and hold the Claims Administrator and its respective directors, officers and employees harmless from and against any and all

claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, court costs and attorney's fees, that the Claims Administrator may suffer or incur as a result of any dishonest, fraudulent, grossly negligent, or criminal act or omission of the Plan Sponsor or its employees, or by the Plan Sponsor's breach of confidentiality or right of privacy of any Plan Participant except for acts taken at the specific direction of the Claims Administrator. Should the Plan Sponsor be called upon to indemnify the Claims Administrator, it may at its discretion choose to handle any defense efforts necessary to counter claims against the Claims Administrator and/or the Plan Sponsor which would give rise to, and necessitate, said indemnification. The Plan Sponsor shall be entitled to rely, without investigation or inquiry, upon any written communication(s) of the Claims Administrator or agents of the Claims Administrator. This indemnity does not extend to any acts or omissions other than those enumerated in this paragraph. This indemnity shall survive termination of this Agreement.

(c) The Claims Administrator will not be liable for any damages, assessments, or other contractual or other issues arising between the Plan sponsor and any vendor of the Plan Sponsor, even in the event the Claims Administrator has suggested, introduced, or otherwise endorsed the particular vendor. Contracting with vendors and ensuring that such contracts are adhered to is ultimately the responsibility of the Plan Sponsor.

10.12 Damages. In no event shall the Claims Administrator be liable for special or consequential damages, even if the Claims Administrator was advised of, or has agreed to, the possibility of such damages. This provision is controlling over any conflicting language in any agreement between Plan Sponsor and the Claims Administrator.

10.13 Survival. The Parties agree that Articles 3, 4, 5 and 10 shall survive termination of this Agreement.

10.14 Integration. The parties acknowledge that they have read this Agreement in its entirety and understand and agree to be bound by its terms and conditions. This Agreement constitutes a complete and exclusive statement of the understanding between the parties with respect to its subject matter. This Agreement supersedes and overrides any and all other prior communications and agreements between the parties, whether written or oral. Any prior agreements, promises, negotiations or representations related to the subject matter not expressly set forth in this Agreement are of no force and effect. This Agreement is intended to work in concert with a Business Associate Agreement entered into by the parties to this Agreement.

10.15 Third-Party Beneficiaries. The Claims Administrator and the Plan Sponsor specifically acknowledge and agree that no parties shall be third-party beneficiaries under this Agreement. The parties further agree that nothing under this Agreement shall impose upon the Claims Administrator any obligation to any other party including, but not limited to, beneficiaries under the Plan or covered employees or their assignees.

10.16 Intellectual Property. Plan Sponsor may not reuse, redistribute, or otherwise claim the language contained within this Agreement as its own intellectual property. Plan Sponsor may not use this Agreement for any purpose other than that for which it is specifically designed.

10.17 Authority. Each party represents and warrants to the other that the signatory identified beneath its name below has the authority to execute this Agreement on its behalf. The parties, intending to be legally bound, have executed and delivered this Agreement as of the date set forth.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective May 1, 2022**.**

Consociate, Inc.

BY: ___________________________

NAME: Terry Lovekamp

TITLE: Chief Financial Officer

DATE: _________________________

City of East Peoria

BY: _____________________________

NAME: John P. Kahl
TITLE: Mayor

ATTEST:

BY: _____________________________

NAME: Morgan R. Cadwalader
TITLE: City Clerk

DATE: ___________________________

AFFILIATES, AGENTS AND/OR SUBSIDIARIES OF PLAN SPONSOR SUBJECT TO THIS AGREEMENT: None

APPENDIX A – FEES & SERVICES

Any Claims Administrator service(s) selected by Plan Sponsor (below), not described in the Administrative Services Agreement, effective as of May 1, 2022. Appendixes and and/or Exhibits attached thereto, heretofore collectively referred to as the "Agreement", shall be accompanied by a description of the service, as well as terms and limitations applicable to the service(s). Any such description, manual, or terms applicable to service(s) purchased (below) will be deemed to be part of the Agreement. See the Agreement for additional details.

Payment for Claims Administrator services shall be due upon the first day of each month. Late payments will incur additional interest of 5% each 30 days.

Disputes regarding fees, deadlines, and penalties will be resolved in accordance with the terms of the Administrative Services Agreement.

In addition to the fees identified below, Claims Administrator may be entitled to reasonable commissions and fees from certain other companies as such commissions and fees may be earned in the ordinary course of business in arm's length transactions. Claims Administrator may contract with PBMs or other vendors to provide certain services to Plan Sponsor and its health plan. Claims Administrator may receive administrative fees (such as prescription drug rebates) from such vendor. With respect to all compensation Claims Administrator actually receives as a result of the Agreement, Claims Administrator will disclose such amounts to Client annually, upon request, to the extent required to assist Client in filing its IRS Form 5500.

Fees shown are Per Employee Per Month unless otherwise noted.

Claims administration for medical, dental, vision, Rx, Medicare (5-year rate guarantee)	\$17.56 (Year 1 - 5.1.22-4.30.23) \$18.14 (Year 2 - 5.1.23-4.30.24) \$18.74 (Year 3 - 5.1.24-4.30.25) \$19.36 (Year 4 - 5.1.25-4.30.26) \$20.00 (Year 5 - 5.1.26-4.30.27)
COBRA administration	Included in claims administration
HIPAA administration	Included in claims administration
Managed Care – Precedence (including UR, precertification, case management	\$10.88
Flexible Spending Account (FSA) administration	\$5.50 PPPM
Importing Rx data from the Pharmacy Benefit Manager, reformatting the Rx and our medical, and then exporting to Wellness Vendor	No Fee

Transmitting eligibility information to vendors (PBM, UR, Wellness, etc.)	No Fee
Additional Fees	
Initial set-up fees	N/A
Run-in claims processing	No Fee
In-Network or OON Claims Repricing fees	20-30% of Savings (based on vendor)
Subrogation fees (PHIA Group)	25% of Recovery
Fraud, Waste and Abuse Audits	30% of Savings
Communications costs (enrollment kits, ID cards etc.)	Initial ID Cards Included, $2.00 per reissued set Special Communications - at cost
Statistical reports	No Fee
Special/non-standard reports	$125.00/Hour
Medical conversion fee	N/A
Legal service fees	N/A – No legal services provided
Actuarial fees	OPTIONAL ONLY Outsourced ($1,000 set up, $500.00/month) (IBNR calculated by Lewis & Ellis Actuary Firm)
Web Access (set-up and monthly charge)	No Fee
Reinsurance administration A.J. Gallagher/Consociate Health	$14.43
Commission or Broker Acquisition fees – A.J. Gallagher	$1.00
Access Fees	
UnityPoint Health Plus	$0.00
PHCS (wrap)	30% of savings
BJC COE (Optional)	$3.50 PEPM
IL Public Act 102-0630 fees	$750.00 annually (Year 1)
Subsequent years, when applicable, if there have been plan changes or changes to IPA.	$250.00 annually

Consociate Health can only make multi-year rate agreements in regard to our own administrative service fees. Fees charged by our vendor partners are subject to change at the discretion of these vendors and/or their separate client service agreements.

APPENDIX B – DISCLOSURE FORM

Claims Administrator: Consociate, Inc.

The Claims Administrator listed above will contract Related Services Agreements in conjunction with the sale of the group policy(ies) you have selected to purchase. This arrangement does not limit your Agent and/or Claims Administrator from marketing for other insurance companies or organizations.

The Agent and/or Claims Administrator may be entitled to commissions and/or marketing allowances on such contracts, expressed as a percentage of gross annual premium and/or a flat dollar amount, as follows:

AGENT:
A.J. Gallagher
Reinsurance Administration
$7.22 PEPM

CLAIMS ADMINISTRATOR:
Consociate Health
Reinsurance Administration
$7.22 PEPM

A.J. Gallagher
Broker Commission
$1.00 PEPM

The undersigned acknowledges receipt of the various proposals and the statement prior to any purchase and approves this transaction on behalf of the Plan without receiving, either directly or indirectly, any personal compensation in connection with the purchase of policies under the Plan.

____

On behalf of Claims Administrator

NAME: Terry Lovekamp

TITLE: Chief Financial Officer

DATE: ________________________

APPENDIX C - BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement**,** is entered into as of May 1, 2022, by and between City of East Peoria Health Plan *(*the "Plan" or "Covered Entity"); and Consociate, Inc. (the "Business Associate").

WITNESSETH:

WHEREAS, the Covered Entity previously has entered into an agreement (the "Agreement") with the Business Associate, whereby the Business Associate has agreed to provide certain services to the Plan;

WHEREAS, to provide such services to the Plan, the Business Associate must have access to certain protected health information ("Protected Health Information" or "PHI"), as defined in the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") and amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the final regulations to such Acts promulgated in January 2013;

WHEREAS, to comply with the requirements of the Privacy Standards, the Covered Entity must enter into this Business Associate Agreement with the Business Associate.

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

I. Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the Privacy Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Secretary, Subcontractor, and Use. If other terms are used, but not otherwise defined under this Business Associate Agreement, such terms shall then have the same meaning as those terms in the Privacy Rule.

(a) ***Business Associate***. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

(b) ***Covered Electronic Transactions.*** "Covered Electronic Transactions" shall have the meaning given the term "transaction"" in 45 CFR §160.103.

(c) ***Covered Entity.*** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103.

(d) ***Electronic Protected Health Information.*** "Electronic Protected Health Information" shall have the same meaning as the term "electronic protected health information" in 45 CFR §160.103.

(e) ***Genetic Information***. "Genetic Information" shall have the same meaning as the term "genetic information" in 45 CFR §160.103.

(f) ***HIPAA Rules.*** "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(g) ***Individual.*** "Individual" shall have the same meaning as the term "individual" in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).

(h) ***Privacy Rule.*** "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A and E.

(i) ***Protected Health Information (PHI).*** "Protected Health Information (PHI)" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of a Covered Entity pursuant to this Agreement.

(j) ***Required By Law.*** "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR §164.103.

(k) ***Secretary.*** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

(l) ***Standards for Electronic Transactions Rule.*** "Standards for Electronic Transactions Rule" means the final regulations issued by HHS concerning standard transactions and code sets under the Administration Simplification provisions of HIPAA, 45 CFR Part 160 and Part 162.

(m) ***Security Incident.*** "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR §164.304.

(n) ***Security Rule.*** "Security Rule" shall mean the Security Standards and Implementation Specifications at 45 CFR Part 160 and Part 164, subpart C.

(o) ***Subcontractor.*** "Subcontractor" shall have the same meaning as the term subcontractor in 45 CFR §160.103.

(p) ***Transaction.*** "Transaction" shall have the meaning given the term "transaction" in 45 CFR §160.103

(q) ***Unsecured Protected Health Information.*** "Unsecured Protected Health Information" shall have the meaning given the term "unsecured protected health information" in 45 CFR §164.402.

II. Safeguarding Privacy and Security of Protected Health Information

(a) ***Permitted Uses and Disclosures.*** The Business Associate is permitted to use and disclose Protected Health Information that it creates or receives on the Covered Entity's behalf or receives from the Covered Entity (or another business associate of the Covered Entity) and to request Protected Health Information on the Covered Entity's behalf (collectively, "Covered Entity's Protected Health Information") only:

(i) Functions and Activities on the **Covered Entity's Behalf.** To perform those services referred in the attached services agreement.

(ii) Business Associate's Operations. For the Business Associate's proper management and administration or to carry out the Business Associate's legal responsibilities, provided that, with respect to disclosure of the Covered Entity's Protected Health Information, either:

(A) The disclosure is Required by Law; or

(B) The Business Associate obtains reasonable assurance from any person or entity to which the Business Associate will disclose the Covered Entity's Protected Health Information that the person or entity will:

(1) Hold the Covered Entity's Protected Health Information in confidence and use or further disclose the Covered Entity's Protected Health Information only for the purpose for which the Business Associate disclosed the Covered Entity's Protected Health Information to the person or entity or as Required by Law; and

(2) Promptly notify the Business Associate (who will in turn notify the Covered Entity in accordance with the breach notification provisions) of any instance of which the person or entity becomes aware in which the confidentiality of the Covered Entity's Protected Health Information was breached.

(C) To de-identify the information in accordance with 45 CFR 164.514(a) – (c) as necessary to perform those services required under the Agreement.

(iii) Minimum Necessary. The Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of the Covered Entity's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that the Business Associate will not be obligated to comply with this minimum-

necessary limitation if neither the Business Associate nor the Covered Entity is required to limit its use, disclosure or request to the minimum necessary. The Business Associate and the Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HITECH Act.

(b) ***Prohibition on Unauthorized Use or Disclosure.*** The Business Associate will neither use nor disclose the Covered Entity's Protected Health Information, except as permitted or required by this Agreement or in writing by the Covered Entity or as Required by Law. This Agreement does not authorize the Business Associate to use or disclose the Covered Entity's Protected Health Information in a manner that will violate Subpart E of 45 CFR Part 164 if done by the Covered Entity.

(c) ***Information Safeguards.***

(i) Privacy of the **Covered Entity's Protected Health Information.** The Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of the Covered Entity's Protected Health Information. The safeguards must reasonably protect the Covered Entity's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made to a use or disclosure otherwise permitted by this Agreement.

(ii) Security of the **Covered Entity's Electronic Protected Health Information.** The Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Business Associate creates, receives, maintains, or transmits on the Covered Entity's behalf as required by the Security Rule. The Business Associate will comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information to prevent use or disclosure of protected health information other than as provided for by the Agreement.

(iii) No Transfer of PHI Outside United States. The Business Associate will not transfer Protected Health Information outside the United States without the prior written consent of the Covered Entity. In this context, a "transfer" outside the United States occurs if Business Associate's workforce members, agents, or subcontractors physically located outside the United States are able to access, use, or disclose Protected Health Information.

(iv) Policies and Procedures. The Business Associate shall maintain written policies and procedures, conduct a risk analysis, and train and discipline of its workforce.

(d) ***Subcontractors and Agents.*** In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, the Business Associate will ensure that any of its Subcontractors and agents that create, receive, maintain, or transmit Protected Health Information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.,

(e) ***Prohibition on Sale of Records.*** As of the effective date specified by HHS in final regulations to be issued on this topic, the Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an individual unless the Covered Entity or Business Associate obtained from the individual, in accordance with 45 CFR §164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that individual, except as otherwise allowed under the HITECH Act.

(f) Prohibition on Use or Disclosure of Genetic Information. The Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of the HIPAA rules.

(g) ***Penalties For Noncompliance.*** The Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the privacy rule and security rule, under the HIPAA Rules, as amended by the HITECH Act.

III. Compliance with Electronic Transactions Rule

If the Business Associate conducts in whole or part Electronic Transactions on behalf of the Covered Entity for which HHS has established standards, the Business Associate will comply, and will require any Subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule. The Business Associate shall also comply with the National Provider Identifier requirements, if and to the extent applicable.

IV. Obligations of the Covered Entity

The Covered Entity shall notify the Business Associate of:

(a) Any limitation(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information;

(b) Any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information; and

(c) Any restriction to the use or disclosure of Protected Health Information that the Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.

V. Permissible Requests by the Covered Entity

The Covered Entity shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by the Covered Entity.

VI. Individual Rights

(a) ***Access.*** The Business Associate will, within twenty-five (25) calendar days following the Covered Entity's request, make available to the Covered Entity or, at the Covered Entity's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies of the Covered Entity's Protected Health Information about the individual that is in the Business Associate's custody or control, so that the Covered Entity may meet its access obligations under 45 CFR §164.524. Effective as of the date specified by HHS, if the Protected Health Information is held electronically in a designated record Set in the Business Associate's custody or control, the Business Associate will provide an electronic copy in the form and format specified by the Covered Entity if it is readily producible in such form. The Business Associate will provide an electronic copy in the form and format specified by the Covered Entity if it is readily producible in such format; if it is not readily producible in such format, the Business Associate will work with the Covered Entity to determine an alternative forma and format as specified by the Covered Entity to meet its electronic access obligations under 45 CFR 164.524.

(b) ***Amendment.*** The Business Associate will, upon receipt of written notice from the Covered Entity, promptly amend or permit the Covered Entity access to amend any portion of the Covered Entity's Protected Health Information in a designated record set as directed or agreed to by the Covered Entity, so that the Covered Entity may meet its amendment obligations under 45 CFR §164.526.

(c) ***Disclosure Accounting.*** The Business Associate will maintain and make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy the Covered Entity's obligations under 45 CFR §164.528.

(i) Disclosures Subject to Accounting. The Business Associate will record the information specified below ("Disclosure Information") for each disclosure of the Covered Entity's Protected Health Information, not excepted from disclosure accounting as specified below, that the Business Associate makes to the Covered Entity or to a third party.

(ii) Disclosures Not Subject to Accounting. The Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of the Covered Entity's Protected Health Information if the Covered Entity need not account for such disclosures under the HIPAA Rules.

(iii)Disclosure Information. With respect to any disclosure by the Business Associate of the Covered Entity's Protected Health Information that is not excepted from disclosure accounting under the HIPAA Rules, the Business Associate will record the following Disclosure Information as applicable to the type of accountable disclosure made:

(A) Disclosure Information Generally. Except for repetitive disclosures of the Covered Entity's Protected Health Information as specified below, the Disclosure Information that the Business Associate must record for each accountable disclosure is (1) the disclosure date, (2) the name and (if known) address of the entity to which the Business Associate made the disclosure, (3) a brief description of the Covered Entity's Protected Health

Information disclosed, and (4) a brief statement of the purpose of the disclosure.

(B) Disclosure Information for Repetitive Disclosures. For repetitive disclosures of the Covered Entity's Protected Health Information that the Business Associate makes for a single purpose to the same person or entity (including the Covered Entity), the Disclosure Information that the Business Associate must record is either the Disclosure Information specified above for each accountable disclosure, or (1) the Disclosure Information specified above for the first of the repetitive accountable disclosures; (2) the frequency, periodicity, or number of the repetitive accountable disclosures; and (3) the date of the last of the repetitive accountable disclosures.

(iv) Availability of Disclosure Information. The Business Associate will maintain the Disclosure Information for at least 6 years following the date of the accountable disclosure to which the Disclosure Information relates (3 years for disclosures related to an Electronic Health Record, starting with the date specified by HHS). The Business Associate will make the Disclosure Information available to the Covered Entity within fifty (50) calendar days following the Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting. Effective as of the date specified by HHS, with respect to disclosures related to an Electronic Health Record, the Business Associate shall provide the accounting directly to an individual making such a disclosure request, if a direct response is requested by the individual. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

(d) ***Restriction Agreements and Confidential Communications.*** The Covered Entity shall notify the Business Associate of any limitations in the notice of privacy practices of the Covered Entity under 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information. The Business Associate will comply with any agreement that the Covered Entity makes that either (i) restricts use or disclosure of the Covered Entity's Protected Health Information pursuant to 45 CFR §164.522(a), or (ii) requires confidential communication about the Covered Entity's Protected Health Information pursuant to 45 CFR §164.522(b), provided that the Covered Entity notifies the Business Associate in writing of the restriction or confidential communication obligations that the Business Associate must follow. The Covered Entity will promptly notify the Business Associate in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct the Business Associate whether any of the Covered Entity's Protected Health Information will remain subject to the terms of the restriction agreement. Effective February 17, 2010 (or such other date specified as the effective date by HHS), the Business Associate will comply with any restriction request if: (i) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (ii) the Protected Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

VII. Breaches and Security Incidents

(a) ***Reporting.***

(i) Impermissible Use or Disclosure. The Business Associate will report to Covered Entity any use or disclosure of Protected Health Information not permitted by this Agreement not more than fifty (50) calendar days after Business Associate becomes aware of such non-permitted use or disclosure.

(ii) Privacy or Security Breach. The Business Associate will report to the Covered Entity any use or disclosure of the Covere**d** Entity's Protected Health Information not permitted by this Agreement of which it becomes aware, including breaches of Unsecured Protected Health Information as required by 45 CFR 164.40 and any Security Incident of which it becomes aware. The Business Associate will make the report to the Covered Entity's Privacy Official not more than fifty (50) calendar days after the Business Associate becomes aware of such non-permitted use or disclosure. If a delay is requested by a law-enforcement official in accordance with 45 CFR §164.412, the Business Associate may delay notifying the Covered Entity for the applicable time period. The Business Associate's report will at least:

(A) Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of the Breach;

(B) Identify the Covered Entity's Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, social security number, date of birth, home address, account number or other information were involved) on an individual basis;

(C) Identify who made the non-permitted use or disclosure and who received the non-permitted use or disclosure;

(D) Identify what corrective or investigational action the Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

(E) Identify what steps the individuals who were subject to a Breach should take to protect themselves; and

(F) Provide such other information, including a written report and risk assessment under 45 CFR 164.402, as the Covered Entity may reasonably request.

(iii) Security Incidents. The Business Associate will report to The Covered Entity any Security Incident of which the Business Associate becomes aware. The Business Associate will make this report once per month, except if any such Security Incident resulted in a disclosure not permitted by this Agreement or Breach of Unsecured Protected Health

Information, Business Associate will make the report in accordance with the provisions set forth above.

(b) Mitigation. The Business Associate shall mitigate, to the extent practicable, any harmful effect known to the Business Associate resulting from a use or disclosure in violation of this Agreement.

VIII. Term and Termination

(a) ***Term.*** The term of this Agreement shall be effective as of as of the date specified above, and shall terminate when all Protected Health Information provided by the Covered Entity to the Business Associate, or created or received by the Business Associate on behalf of the Covered Entity, is destroyed or returned to the Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this section.

(b) ***Right to Terminate for Cause.*** The Covered Entity may terminate this Agreement if it determines, in its sole discretion, that the Business Associate has breached a material provision of this Agreement, and upon written notice to the Business Associate of the breach, the Business Associate fails to cure the breach within thirty (30) calendar days after receipt of the notice. Any such termination will be effective immediately or at such other date specified in the Covered Entity's notice of termination.

(c) ***Treatment of Protected Health Information on Termination.***

(i) Return or Destruction of Covered Entity's Protected Health Information as Feasible.

Upon termination or other conclusion of this Agreement, the Business Associate will, if feasible, return to the Covered Entity or destroy all of the Covered Entity's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of the Covered Entity's Protected Health Information. This provision shall apply to Protected Health Information that is in the possession of Subcontractors or agents of the Business Associate. Further, the Business Associate shall require any such Subcontractor or agent to certify to the Business Associate that it returned to the Business Associate (so that the Business Associate may return it to the Covered Entity) or destroyed all such information which could be returned or destroyed. The Business Associate will complete these obligations as promptly as possible, but not later than thirty (30) calendar days following the effective date of the termination or other conclusion of this Agreement.

(ii) Procedure When Return or Destruction Is Not Feasible. The Business Associate will identify any of the Covered Entity's Protected Health Information, including any that the Business Associate has disclosed to subcontractors or agents as permitted under this Agreement, that cannot feasibly be returned to the Covered Entity or destroyed and explain why return or destruction is infeasible. The Business Associate will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. The Business Associate will complete these obligations as promptly as

possible, but not later than thirty (30) calendar days following the effective date of the termination or other conclusion of this Agreement.

(iii)Continuing Privacy and Security Obligation. The Business Associate's obligation to protect the privacy and safeguard the security of the Covered Entity's Protected Health Information as specified in this Agreement will be continuous and survive termination or other conclusion of this Agreement.

IX. Miscellaneous Provisions

(a) ***Definitions.*** All terms that are used but not otherwise defined in this Agreement shall have the meaning specified under HIPAA, including its statute, regulations and other official government guidance.

(b) ***Inspection of Internal Practices, Books, and Records.*** The Business Associate will make its internal practices, books, and records relating to its use and disclosure of the Covered Entity's Protected Health Information available to the Covered Entity and to HHS to determine compliance with the HIPAA Rules.

(c) ***Amendment to Agreement.*** This Amendment may be amended only by a written instrument signed by the parties. In case of a change in applicable law, the parties agree to negotiate in good faith to adopt such amendments as are necessary to comply with the change in law.

(d) ***No Third-Party Beneficiaries.*** Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.

(e) ***Regulatory References.*** A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.

(f) ***Survival.*** The respective rights and obligations of the Business Associate under Section IX(f) of this Agreement shall survive the termination of this Agreement.

(g) ***Interpretation*****.** Any ambiguity in this Agreement shall be resolved to permit the Covered Entity to comply with the HIPAA Rules.

(h) ***Notices*****.** All notices hereunder shall be in writing and delivered by hand, by certified mail, return receipt requested or by overnight delivery. Notices shall be directed to the parties at their respective addresses set forth in the first paragraph of this Business Associate Agreement or below their signature, as appropriate, or at such other addresses as the parties may from time to time designate in writing.

(i) ***Entire Agreement; Modification*****.** This Business Associate Agreement represents the entire agreement between the Business Associate and the Covered Entity relating to the subject matter hereof. No provision of this Business Associate Agreement may be modified, except in writing, signed by the parties.

(j) ***Indemnification.*** Each Party agrees to indemnify, defend and hold harmless each other Party, its affiliates and each of their respective directors, officers, employees, agents or assigns from and against any and all actions, causes of actions, claims, suits and demands whatever, and from all damages, liabilities, costs, charges, debts and expenses whatever (including reasonable attorneys' fees and expenses related to any litigation or other defense of any claims), which may be asserted or for which they may now or hereafter become subject arising in connection with (i) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the Party to the Agreement and (ii) any claims, demands, awards, judgments, actions, and proceedings made by any person or organization arising out of any way connected with the Party's performance.

(k) ***Assistance in Litigation or Administrative Proceedings.*** The Business Associate shall make itself, and any subcontractors, employees or agents assisting the Business Associate in the performance of its obligations under this Agreement, available to the Covered Entity, at no cost to the Covered Entity, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers, or employees based upon a claimed violation of HIPAA, the HIPAA regulations, or other laws relating to security and privacy, except where the Business Associate or its subcontractors, employees, or agents are named as an adverse party.

(l) ***Binding Effect.*** This Business Associate Agreement shall be binding upon the parties hereto and their successors and assigns.

(m) Governing Law, Jurisdiction, and Venue. This Agreement shall be governed by the law of Illinois, except to the extent preempted by federal law.

(n) Severability. The invalidity or unenforceability of any provisions of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, which shall remain in full force and effect.

(o) Construction and Interpretation. The section headings contained in this Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this Agreement. This Agreement has been negotiated by the parties at arm's-length and each of them has had an opportunity to modify the language of the Agreement. Accordingly, the Agreement shall be treated as having been drafted equally by the parties, and the language shall be construed as a whole and according to its fair meaning. Any presumption or principle that the language is to be construed against any party shall not apply. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

In Witness Whereof, the parties hereto have caused this Agreement to be executed as of the date first above written.

BUSINESS ASSOCIATE:	**COVERED ENTITY:**
Consociate, Inc.	City of East Peoria Health Plan
By: ______________________________	By: __________________________________
Name: Terry Lovekamp	Name: John P. Kahl
Title: Chief Financial Officer	Title: Mayor
Date: ____ ________________________	Date: _________________________________

APPENDIX D – SERVICE EXHIBITS

The Administrative Services Agreement, Appendixes, and Exhibits set forth below, effective as of May 1, 2022, (the "Effective Date"), are attached hereto, incorporated herein, and collectively referred to as the "Agreement."

The Agreement set forth in the Administrative Services Agreement, the terms and general provisions guiding the delivery of services by the Claims Administrator to the Plan Sponsor, in Articles I – X.

In addition to Articles I through X of the Administrative Services Agreement, the following Exhibits for specific services are selected by the parties to the Agreement to be part of the Agreement, and are outlined below.

Fees applicable to the Agreement are set forth in Appendix A – Fees and Services, which is attached hereto and incorporated herein.

Exhibit I	Eligibility, Enrollment, Data Exchange and Billing
Exhibit II	Customized Web Portal
Exhibit III	PPO Access and Administration
Exhibit IV	Utilization Review
Exhibit V	Cost Reduction and Savings Programs
Exhibit VI	Subrogation
Exhibit VII	Pharmacy Benefit Management
Exhibit VIII	Stop-Loss Negotiation & Administration
Exhibit IX	Consumer Benefit Account Administration
Exhibit X	COBRA/HIPAA Administration
Exhibit XI	Run-In Administration
Exhibit XII	Run-Out Administration
Exhibit XIII	Plan Document/Summary Plan Description
Exhibit XIV	Network Prompt Payment Hold Harmless

These Exhibits and fee schedules applicable to selected services set forth herein are effective as of the Effective Date.

EXHIBIT I – ELIGIBILITY, ENROLLMENT, DATA EXCHANGE AND BILLING

1.1 Claims Administrator will provide demographic information (as described in Article III) and if applicable, current benefit elections, based upon timely receipt of such information from the Plan Sponsor. Participant and benefit information, whether electronic or hard copy, must be in a format that is reasonably acceptable to the Claims Administrator.

1.2 Maintain Eligibility Records. Claims Administrator shall maintain Plan records based upon eligibility information submitted by the Plan Sponsor in an electronic or printed format and any changes in the manner described in Article III. Claims Administrator also shall maintain Plan records based on eligibility information submitted by the Plan Sponsor as to the dates on which a Plan Participant's coverage commences and terminates.

1.3 Plan records shall be maintained in accordance with generally accepted standards of insurance bookkeeping. The Commissioner of the Department of Insurance shall be entitled to inspect all books and records of the Claims Administrator for the purpose of examinations and audits.

1.4 If Claims Administrator is to maintain eligibility with respect to Retirees, all authority to convey, extend, except or terminate eligibility for retiree benefits is expressly reserved by the Plan Sponsor.

1.5 Premium Only Plan Administration. Claims Administrator shall monitor enrollments and plan elections that confirm Plan Sponsors Plan Participants may pay for employee paid group insurance premiums to be paid with pre-tax dollars.

1.6 Eligibility Based upon Birthdate. Claims Administrator shall monitor birth dates of all retirees and dependents and shall alert Plan Sponsor, and all related agents and vendors, 4 weeks in advance of coverage changes mandated by age.

1.7 Data File Exchange. Claims Administrator will exchange file formats and data files with third parties at Plan Sponsors request. Such exchanges may occur during Open Enrollment, or on a periodic or recurring basis throughout the Plan Year.

1.8 Consolidated Billing. Claims Administrator will present all benefit bills to Plan Sponsor in a single monthly statement, accompanied by a detailed list bill. Upon remittance by Plan Sponsor, Claims Administrator will be responsible for payments to carriers and other vendors, and will resolve credits, corrections, additions, terminations, and notifications with each carrier and vendor partner. Claims Administrator also will be responsible for exchanging file formats and updating carrier and other vendors' eligibility.

1.9 Consolidated Billing will be provided for the following benefits, as directed by the Plan Sponsor:

- ☐ Medical Plans including Rx

1.10 Retiree Billing. Claims Administrator shall make payments or issue bills and process manual payments for all retiree benefits monthly. Claims Administrator shall post payments, issue late notices, lapse notices, and termination notices where applicable. Claims Administrator shall remit funding received to Plan Sponsor, carriers, and other vendor partners as agreed to by and between the parties.

EXHIBIT II – CUSTOMIZED WEB PORTAL

2.1 The Customized Web Portal enables Plan Sponsor to access data, and provides enrollment, administration and reporting services, as well as customized health and wellness coaching services.

2.2 Plan Sponsor will be provided with a manual describing how the Web Portal functions, what its capabilities are, how it is utilized, and who they may contact for use support.

2.3 Plan Sponsor will have access to web-based tools, allow plan members to check status of claims, request identification cards, add/remove dependents, review balances (where applicable), access comprehensive plan performance metrics and participate in wellness programs.

2.4 Various levels of access and information will be developed, with authorization to access different levels set by the Plan Sponsor. Plan Sponsor will be responsible for submitting customization requests, and providing a list of who or whom is to be provided which level of access. Access to be provided only to those as authorized by completion of separate web access agreement.

EXHIBIT III – PPO ACCESS AND ADMINISTRATION

3.1 Preferred Provider Organizations (PPO). Coordinate Preferred Provider Organization (PPO) services for the Plan Sponsor. A separate fee will be charged for this service. The separate fee for PPO services will be payable by the Plan Sponsor to the Claims Administrator. The Claims Administrator will submit payment on behalf of the Plan Sponsor to the vendor.

3.2 Service Area Access. Claims Administrator will provide Plan Sponsor with access to the network for Covered Services rendered in the Service Area ("Service Area Access"). Each Benefit Plan that selects the network for the Service Area shall utilize the network as its primary network.

3.3 Repricing Services. Claims Administrator will provide Plan Sponsor with repricing services as set forth under separate cover and incorporated herein.

3.4 Out of Area Access. Claims Administrator will provide Plan Sponsor with access to the network for Covered Services rendered outside the Covered Person's primary network service area.

3.5 Financial Responsibility of Payment to Providers. Plan Sponsor shall fund claims payable for the provision of medical services on behalf of Covered Individuals that portion of the contracted rate that exceeds the Copayment, Coinsurance and Deductible amounts specified in the applicable benefit Plan and which is not otherwise excluded or limited by such Benefit Plan.

3.6 Decline to Access. Claims Administrator acknowledges that Plan Sponsor may choose to not access the network in a given instance and instead process the clams as "out of network" and in accordance with the terms of the applicable Benefit Plan. Claims Administrator shall not be financially responsible for payment of these claims.

3.7 Plan Sponsor shall be deemed to be the payer for network agreement purposes and will be responsible for abiding by the terms of the applicable network agreement(s). Payment, and costs incurred by virtue of provider services, dispute resolution, and conflicts due to network agreements shall be borne solely by the Plan Sponsor.

3.8 If Plan Sponsor chooses not to access a Network Agreement at any time, and compensates a provider utilizing a non-network rate, the Plan Sponsor shall be solely responsible for fees and costs arising from that decision. Claims Administrator will never be called upon to advance its own funds towards the payment of any provider.

EXHIBIT IV – UTILIZATION MANAGEMENT SERVICES

4.1 The Claims Administrator will provide information as necessary to the Utilization Management vendor, as selected by the Plan Sponsor, in order to perform Utilization Management services as agreed to by the Plan Sponsor. The Plan Sponsor will ensure that the Utilization Management vendor it selects will provide to the Claims Administrator, or the Plan Sponsor will provide to Claims Administrator, a copy of the applicable agreement between the Utilization Management vendor and the Plan Sponsor, including but not limited to an explicit list of all services to be provided by the Utilization Management vendor to the Plan Sponsor.

4.2 The Plan Sponsor's selected vendor shall provide Utilization Management services for the Plan, potentially including (i) provision of the notification process for inpatient admissions, outpatient surgeries, outpatient psychiatric day treatment and/or chemical dependency and other treatments or procedures provided for under the terms of the Plan Documents, (ii) pre-admission review, outpatient surgical review, outpatient psychiatric day treatment and/or chemical dependency center review and discharge planning, (iii) medical and large case management for catastrophic illness or injury; (iv) disease management for asthma, diabetes, depression, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease; (v) maternity management; (vi) comprehensive physician review of clinical records for denials or appealed notifications as necessary; (vii) and pharmaceutical physician peer review as necessary. The Disease/Maternity Management Program will provide services for (i) identifying employees with disease or condition subject to management; (ii) identifying medical practices that research shows to be most effective; (iii) supporting adherence to those practices by providing treatment guidelines to medical providers, reviewing employees' compliance with the guidelines, and assisting physicians to monitor their patients who are employees; (iv) educating employees on self-management and adherence to treatment plans; (v) collecting and analyzing the process and outcome measures; and other services as outlined in the Plan Document.

4.3 A separate fee will be charged for this service. The separate fee for Utilization Management Services will be payable by the Plan Sponsor to the Claims Administrator. The Claims Administrator will submit payment on behalf of the Plan Sponsor to the vendor.

EXHIBIT V – COST REDUCTION AND SAVINGS PROGRAMS

5.1 Cost Reduction and Savings Program. Cost Reduction and Savings Program. Coordinate inpatient and outpatient hospital and professional fee negotiation services for the Plan Sponsor. A separate fee will be charged for this service. The separate fee for fee negotiation services will be payable by the Plan Sponsor to the Claims Administrator.

5.2 Claims Administrator will review with the Plan all cost containment options and will, in writing, agree upon which services Plan Sponsor desires to utilize;

5.3 Claims Administrator will, when it becomes aware of additional cost containment services, advise the Plan of these opportunities and the associated costs involved in writing;

5.4 If Plan elects to utilize any of the services outlined herein, Claims Administrator shall not be liable for any violation of the terms of use.

EXHIBIT VI – SUBROGATION

6.1 The Plan Sponsor and Claims Administrator hereby agree that Claims Administrator will perform certain services in connection with the Plan regarding subrogation and reimbursement rights of the Plan for the fees stated herein.

6.2. Claims Administrator shall provide recovery services for subrogation/reimbursement of Claims paid by the Plan.

6.3 Subrogation services shall include direct recovery on behalf of the Plan against third parties and reimbursement services shall include recovery of Plan funds from those Covered Persons who have recovered damages from third parties; (including identification of potential subrogation and reimbursement claims, follow up questionnaires to Covered Persons and Health Care Providers, provision of a copy of subrogation forms signed by the Employee to the Plan Sponsor, provision of updated reviews of subrogation efforts, additional research as necessary, notification to Health Care Providers, Covered Persons, and their authorized representatives, settlement of claims with prior authorization from the Plan Sponsor, and other acts necessary to effectuate recovery of Plan funds).

6.4 The Plan Sponsor shall pay direct costs incurred by the Claims Administrator if written approval is given in advance by Plan Sponsor for subrogation and reimbursement services, including, but not limited to costs of consultants, outside legal counsel, and other professionals.

6.5 If necessary to retain outside legal counsel for recovery of Plan funds, the Plan Sponsor shall have sole discretion to select and retain legal counsel.

6.6. Plan Sponsor and Claims Administrator acknowledge that negotiation or waiver of a subrogation/reimbursement claim may be necessary as a result of state or federal law or the specific facts and circumstances of the disputed Claim. The Claims Administrator shall refer any requests for negotiation or waiver of a claim to the Plan Sponsor for final settlement.

EXHIBIT VII – PHARMACY BENEFIT MANAGEMENT

7.1 Pharmacy Benefit Management. Claims Administrator will trade eligibility with the pharmacy vendor partner and will import detailed pharmacy claim data. Claims Administrator will analyze pharmacy expenditures and offer care management and cost containment ideas for the benefit of Plan Sponsor and Plan Participants. It will further coordinate Prescription Benefit Management (PBM) services as needed.

7.2 Identification Cards. Claims Administrator will provide one ID Card per Employee and an additional card for family coverage upon enrollment as part of its Pharmacy Benefit Management services. An additional fee will apply if the Claims Administrator is required to mail the cards to individual employees' homes or an alternative address. Replacement cards will be issued as necessitated by coverage changes or Employee needs.

EXHIBIT VIII – STOP-LOSS NEGOTIATION & ADMINISTRATION

8.1 Broker or Claim Administrator (as selected by The Plan Sponsor) will procure excess loss or stop loss (specific and aggregate) insurance proposals and policies for the Plan Sponsors consideration and selection, which excess loss or stop loss insurance will be an asset of the Plan Sponsor and not of the Plan (if applicable).

8.2 On behalf of the Plan, the Claims Administrator will file in a timely manner any Claims for benefits under the excess loss policies, and notify the excess loss insurance company of any potential large Claims which may become a Claim under the excess loss coverage.

8.3 On behalf of the Plan Sponsor, the Claims Administrator will promptly pay any premium and other notices received from the excess loss insurance company concerning the policy.

8.4 To the extent specified below, the Claims Administrator shall provide the services for, and shall assist the Plan Sponsor in the analysis of their stop-loss coverage, if any, as follows:

(a) Annually market the coverages Plan Sponsor requests to a select number of insurance and reinsurance carriers in order to obtain alternate quotes for comparison, unless Broker has been selected by Plan Sponsor to provide this service.

(b) Prepare and deliver renewal proposal prior to renewal date unless Broker has been selected by Plan Sponsor to provide this service.

(c) Provide supporting claims documentation to support renewal action.

(d) Interpret and analyze claim information in order to make suggestions for possible plan design changes.

(e) Upon renewal, complete all applications, forms and amendments for Plan Sponsor signature.

(f) Communicate renewal decisions to internal departments within Claims Administrator and to all appropriate carrier(s) and/or vendor(s).

EXHIBIT IX – CONSUMER BENEFIT ACCOUNT ADMINISTRATION

9.1 Claims Administrator Responsibilities (in addition to Article III).

(a) Examine each claim for benefits under the Cafeteria Plan, take reasonable steps to verify its validity, compute the amount payable (if any) and either disburse the benefit due under the Cafeteria Plan, or deny the claim.

(b) Administer consumer benefit accounts subject to the provisions and conditions set forth below:

(1) Claims Administrator will deposit funds received from the Plan Sponsor into a designated escrow account as requested from time to time by Claims Administrator, to be used in the disbursement of benefit payments to participants. Payment of claims by Claims Administrator is hereby authorized and will be made from the Claims Administrator's escrow account.

(2) Claims Administrator will rely on one or more of the following in processing claims made under the Cafeteria Plan: IRS Code, Sections 105, 106, and 125; the Cafeteria Plan Document; the Summary Plan Description; the Administrative Agreement; standard practices of the life and health insurance industry; and any other laws, regulations or ruling(s) relating to Cafeteria Plan matters.

(c) Determine if the Cafeteria Plan meets the nondiscrimination requirement(s) imposed by law, including but not limited to, requirements under Code Section 125 or under Code Sections 105, 106 or 129, and in doing so may rely solely upon information provided by the Plan Sponsor in Discrimination Testing Worksheets.

9.2 General Provisions.

(a) The legal and tax status of the Cafeteria Plan under applicable law, including compliance with Sections 105, 106, 125 of the Code is a matter for determination by the Plan Sponsor and not by Claims Administrator, which is not responsible therefore. Claims Administrator is neither the Cafeteria Plan Administrator nor a named Fiduciary of the Plan as these terms are defined in ERISA or other applicable law.

(b) If ERISA or other applicable law requires that the Cafeteria Plan be audited annually by an independent, qualified public accountant, the Plan Sponsor is responsible for arranging for and paying the cost of the audit.

(c) If the Plan Sponsor or the Cafeteria Plan is investigated or audited by any state or federal governmental agency, Claims Administrator will fully cooperate with such

agency’s reasonable and lawful request for information. Any and all costs to Claims Administrator of such investigation or audit will be borne by the Plan Sponsor.

EXHIBIT X – COBRA/HIPAA ADMINISTRATION

10.1 Claims Administrator's Responsibilities (in addition to Article III). To the extent specified below, Claims Administrator shall provide the services for, and shall assist the COBRA Sponsor in the administration of COBRA Continuation Coverage and HIPAA, as follows:

(a) To mail to Qualified Beneficiaries at the time Claims Administrator is notified of a Qualifying Event, an election form for COBRA Continuation Coverage.

(b) To provide Qualified Beneficiaries, who elect COBRA Continuation Coverage, appropriate claims, supplies and instruction for the filing of claims.

(c) Obtain and forward to the COBRA Sponsor all monthly remittances.

(c) To notify Qualified Beneficiaries that their coverage is in a state of lapse or has terminated due to failure to pay premium.

(e) To notify Qualified Beneficiaries of the changes in Plan benefits or cost related to COBRA Continuation Coverage.

(f) To notify individuals when they have lost coverage by forwarding HIPAA Certifications of Creditable Coverage.

(g) Claims Administrator is authorized to do all acts it deems necessary or convenient to carry out the terms and purposes of this Agreement.

10.2 Plan Sponsor/COBRA Sponsors Responsibilities (in addition to Article IV). The parties hereto agree that the effective performance of all obligations hereunder by Claims Administrator will require that the COBRA Sponsor furnish to Claims Administrator certain timely reports and information which Claims Administrator Sponsor agrees to so provide as follows:

(a) COBRA Sponsor shall provide written notice to Claims Administrator of the occurrence of a Qualifying Event with respect to any Covered Person, including:

(1) The name of the Covered Person;

(2) The unique identifier of the Covered Person;

(3) The date of birth of the Covered Person;

(4) The date of the Qualifying Event; and

(5) The date a qualified beneficiary has been determined (under Title 11 or XVI of the Social Security Act) to be disabled at the time of the qualifying event or is no longer disabled.

(6) The current address of the Covered Person in order for Claims Administrator to mail COBRA Continuation Coverage information. (Subsequent notification of address changes is the responsibility of the Qualified Beneficiary). Such notice shall be delivered to both the Plan Administrator and Claims Administrator within the time required by COBRA.

(7) COBRA Sponsor shall also provide such additional information or documentation which, in the opinion of Claims Administrator is necessary in order for Claims Administrator to perform its services under this Agreement. Claims Administrator shall not be responsible for delay in the performance of its services caused by the failure of the COBRA Sponsor to promptly furnish any and all required information.

(8) The COBRA sponsor shall notify Claims Administrator of any inquiries by Covered Persons pertaining to the COBRA Continuation Coverage. The COBRA Sponsor shall comply with COBRA and all other applicable Federal, State and local laws and regulations in connection with the COBRA Continuation Coverage.

10.3 Indemnification. Claims Administrator, in performing its obligations under this Agreement, is acting only as an independent contractor for the COBRA Sponsor. For the purposes of COBRA and any applicable state legislation of a similar nature, the COBRA Sponsor shall be deemed to be the administrator of the Plan.

The Claims Administrator is not, nor shall it be deemed to be, the Plan Administrator or Plan Sponsor. Claims Administrator has no discretionary authority or control with respect to the Plan or the COBRA Continuation Coverage and is not a fiduciary of the Plan, it being understood that Claims Administrator’s services hereunder are purely administrative functions within the framework of policies, interpretations, rules, practices and procedures set down by the COBRA Sponsor.

It is understood that the legal and tax status of the Plan and the COBRA requirements under applicable law are matters for determination by the COBRA Sponsor and that Claims Administrator has given COBRA Sponsor no advice with respect to the legal and tax status of the Plan or compliance with COBRA and bears no responsibility therefore.

EXHIBIT XI – RUN-IN ADMINISTRATION

11.1 Run-In Claims. Claims Administrator agrees to assume responsibility for administering claims incurred prior to the effective date, for the period May 1, 2021, through April 30, 2022 at no fee.

11.2 Other Agreement Terms. All of the other terms of this Administrative Services Administrative Services Agreement will apply to these pre-effective date services.

EXHIBIT XII – RUN-OUT ADMINISTRATION

12.1 Run-Out Claims. Upon termination of the Administrative Services Agreement, Claims Administrator will have no obligation to process claims receive ten (10) days prior to the Termination Date, or after the Termination Date. The Plan Sponsor may request the Claims Administrator, and the Claims Administrator may agree, to process claims incurred prior to the Termination Date, but received within ten (10) days of termination of after, for a period of time. The time period during which the Claims Administrator will process such claims shall be agreed to by both parties, but shall be no less than ninety (90) days. The fee is the current in force fee, payable for three months. After three months, the fee is $15 per processed claim.

12.2 Agreement Breach. Claims Administrator will not provide claim processing services after termination of the Agreement if the Agreement was terminated because Plan Sponsor failed to pay Claims Administrator fees due or Plan Sponsor did not provide required funding or, at Claims Administrator's option, when there is termination for any other reason under the Agreement.

12.3 Other Agreement Terms. All of the other terms of this Administrative Services Agreement will apply to these post-termination services as though the Agreement continued to be in effect.

EXHIBIT XIII – PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

13.1 Prepare a draft Plan Document and Summary Plan Description for review and final Approval. Claims Administrator or its designee, shall, at Plan's request, prepare and maintain a specimen Plan Document and Summary Plan Description, or prepare Plan Amendments if necessary, in a format acceptable to Plan and subject to final approval by Plan and Plan's legal counsel.

13.2 Draft will include a corresponding questionnaire / checklist to be used by whomever seeks to complete / customize a plan document template for use by a benefit plan, whose answers shall be used to populate the said plan document.

13.3 Prepare Plan Document amendments for review and final approval by Plan Sponsor.

13.4 Disperse them in accordance with the Plan Sponsors practice(s) and applicable law; Claims Administrator, or its designee, will furnish a master Summary Plan Description to the Plan Sponsor, either electronically or in printed form pursuant to Plan's direction.

EXHIBIT XIV – NETWORK PROMPT PAYMENT HOLD HARMLESS

WHEREAS, Claims Administrator on behalf of Plan Sponsor entered or may enter into agreements with Healthcare Networks and/or Preferred Provider Organization Networks (the "Networks"), which enable Plan Sponsors' plans and/or participants to receive contracted rates for medical services from Preferred Providers that are less than the Preferred Providers' normal billed charges for such medical services;

WHEREAS, the Networks have entered into contracts with the Preferred Providers (generally, "Hospital Services Agreements") that set forth the contract rates for the medical services provided for Plan participants that are less than the Preferred Providers' normal billed charges;

WHEREAS, some or all of the Hospital Services Agreements may contain contractual provisions that require the Plan to pay the contract rate amount due on or before the 30th day (or 45th, as applicable)] after a clean claim is received by the Administrator (the "Prompt Payment Deadline");

WHEREAS, some or all of the Hospital Services Agreements further provide that, if the contract rate amount is not paid on or before the Prompt Payment Deadline, then the Plan may owe the Preferred Provider the normal billed charges for such medical services, which in all cases is substantially greater than the contract rate; and

THEREFORE, with respect to such Preferred Providers, Plan Sponsor agrees as follows:

Plan Sponsor authorizes Claims Administrator to enter into agreements with Networks that adopt, assume or otherwise make Plan Sponsor a party to, or bound by, the terms of the Hospital Services Agreements, including, but not limited to, the Prompt Payment Deadline, if any.

Plan Sponsor understands that paying for medical services on or before the Prompt Payment Deadline may result in the Plan paying for medical services that are not "covered services" as that term is defined in the Plan, in order to avoid prompt payment penalties.

To the extent that the Plan fails or refuses to pay for Covered Services prior to the Prompt Payment Deadline and the Preferred Provider seeks the difference between the contract amount and normal billed charges, Plan Sponsor will indemnify and hold Claims Administrator harmless from any and all indirect, special, consequential, penalty or incidental damages in connection with or arising out of the Plan's failure and/or refusal to pay for such Covered Services prior to the Prompt Payment Deadline, including, but not limited to, any and all liabilities, obligations, costs, claims, judgments, attorney fees, and attachments related to same.

To the extent that the Benefits Program pays for services that are not Covered Services in order to meet the Prompt Payment Deadline, it shall be Plan Sponsor's sole responsibility to recoup the payment and/or obtain a refund of the payment from the Preferred Provider. Plan Sponsor expressly assumes the risk and acknowledges that, in order to meet the Prompt Payment Deadlines, if any, Plan Sponsor may pay for medical services that are not Covered Services and may be required to seek reimbursement of the amounts paid to the Preferred Providers. Plan Sponsor will indemnify and hold Claims Administrator harmless from any and all indirect, special,

consequential, penalty or incidental damages in connection with or arising out of the Plan's payment for services that ultimately determined not to be Covered Services, including, but not limited to, any and all costs of collection, liabilities, obligations, costs, claims, judgments, attorney fees, and attachments related to same.

Consociate, Inc.	**City of East Peoria**
By: ______________________________	By: ______________________________
Name: Terry Lovekamp	Name: John P. Kahl
Title: Chief Financial Officer	Title: Mayor
Date: _____________________________	Date: _____________________________