AMENDMENT #3

This Amendment is entered into and made effective 1st day of July, 2021 (the "Effective Date") by and between CorVel Enterprise Comp, Inc. ("CorVel") and City of Lakeland (FL) ("Customer").

WHEREAS, CorVel and Customer entered into the Enterprise Comp Services Agreement with an Effective Date of July 1, 2017 as amended (the "Agreement") pursuant to which CorVel agreed to provide Customer with certain third party claims administration and bundled managed care services; and

THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree to acknowledge to the Services, which are not currently stipulated in the Agreement, and to amend Agreement as set forth herein:

- **Amend Section 8A (the "Term") of the Agreement renewing the Agreement for a one (1) year Renewal Term effective July 1, 2021 through June 30, 2022. There shall be no price increase for this Renewal Term. During this Renewal Term the pricing shall remain at same fees.**

- **Amend Section 1 of Exhibit B ("Fees") of the Agreement replacing in its entirety with the attached hereunder Exhibit A to this Amendment.**

- **Amend the Agreement adding new, revised and modified Descriptions of Services (Case Management Services: Care Advocacy Services; Bill Review Services; Clinical/Technical Assessment Services; CERiS Services; Preferred Provider Network Access Services; CareIQ Services; Pharmacy Benefit Management Services; Clearinghouse Agent Payer Services; and Telehealth Services) as defined and attached hereunder as Exhibit B to this Amendment.**

All other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, CorVel and Customer have caused this Amendment to be executed by the persons authorized to act in their respective names.

CORVEL ENTERPRISE COMP, INC.

DocuSigned by:

By: Brandon O'Brien
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Print Name: Brandon O'Brien

Title: CFO

Date Signed: 10/5/2021

CITY OF LAKELAND (FL)

By: Joyce Dias

Print Name: Joyce DIAS

Title: Risk Management + Purch Dir

Date Signed:

EXHIBIT A

1) Fees during Renewal Term effective July 1, 2021:

Workers' Compensation Claims Administration

Description	Pricing
Life of Contract Claims Handling Fee - Per Claim	
Medical-Only	$180.25
Indemnity	$1,339.00
Employer's Liability	$1,339.00

Auto and General Liability Claims Administration

Description	Pricing
Liability Handling Fee - Per Year Up to 25 new GLBI, 210 new GLPD, 20 ALBI and 85 new ALPD Liability Claims per year	$149,000.00
Other Liability Claim type pricing may apply	

Program Management

Description	Pricing
Data Conversion - Per Data Source	Waived
Administration Fee - Per Year	$15,450.00
Implementation Fee - One Time Fee	Waived
CareMC Access - Per Year	Included

Account Management and Technical Support

Description	Pricing
Account Management Staff	Included
Electronic Data Transmission In Standard Formats	
Monthly File	Included
Weekly File	Included
Daily File	Included
Training – Onsite and Online	Included
Technical Support	Included
State EDI Files	Included
Monthly Reporting	Included
Ad hoc Report Programming - Per Hour	$200.00
Communication Materials/Posters	Pass through printing cost
Annual Banking Fees	One account included
Carrier TPA Oversight Fees [1]	Bill from Carrier to Client
[1] Fees charged by the carrier (Oversight fees, Tail Claim transfer / takeover fees, etc.) are the responsibility of the client and will be billed directly to the client by the carrier or by CorVel should CorVel be invoiced for such fees.	

Intake and Immediate Intervention Services

Description	Pricing
Claim Intake – Phone/Fax/Email - Per Intake	$30.60
Claim Intake – Client Entry in CareMC	Waived
Incident Only Reporting - Per Incident	Waived
Advocacy 24/7 - Per Call	$75.00 (post implementation)
Telehealth Services	Fee Schedule or U&C value by

Allocated Expense Fees – Legal Services

Description	Pricing
Subrogation	25% of Recoveries
Legal Bill Auditing [1]	2.5% of gross legal charges reviewed
Indexing and OFAC Compliance - Per Index	$15.00

[1] Fees will never exceed the savings generated

Allocated Expense Fees - Bill Review Services

Description	Pricing
Hospital Bills Bill Review [1,2] + Network Solutions Includes: [2] Clinical Review, Implant Analysis, Line Item Bill Review, Negotiations, PPO Network Access, Substantive Denials, Technical Evaluation	20% of Savings
Non-Hospital Bills Bill Review: Includes Standard Fee Schedule and UCR - Per Bill [1,2] + Network Solutions Includes: [2] Clinical Review, Implant Analysis, Line Item Bill Review, Negotiations, PPO Network Access, Substantive Denials, Technical Evaluation	$6.17 20% of Savings
State EDI, Scanning/OCR, Initial 1099 Provider Notification Letter	Included

[1] Includes bill intake, document imaging, file upload, state EDI's, and initial 1099 provider notification letters.

[2] There is a maximum bill review transaction fee of $15,000.00.

Allocated Expense Fees

Description	Pricing
Telephonic Case Management 1st 30 Days 2nd 30 Days 3rd 30 Days	 $309.00 $216.30 $164.80
Telephonic Case Management (after 90 days), Field Case Management and Return to Work Coordinator - Per Hour [1,2]	$96.82
Vocational Rehabilitation - Per Hour	$100.94
Specialty Services (Catastrophic, Life Care Plan, Medicare Conditional Payments, Medicare Set Asides, Bilingual) - Per Hour	$180.25
Utilization Review - Per Review	$139.05 + Peer Review
Care Advocate/Nurse Triage - Per Claim	Included
PeerWell App Access - Per Claim (One-Time Fee)	$500.00

[1] Fee applies to all States with the exception of premium states (CA, HI, AK, and NY).

[1]Statutory rates supersede if applicable.
Prevailing IRS Mileage Rate applies. Mileage rate is .575 billed at IRS rate.

Pharmacy Solutions

Description	Pricing
Retail Pharmacies	
Brand	AWP -10% + $3.00 dispensing fee
Generic	AWP -35% + $3.00 dispensing fee
Mail Order	
Brand	AWP -13% + $1.50 dispensing fee
Generic	AWP -45% + $1.50 dispensing fee
Clinical Modeling	
Integration of Pharmacy Data	Included
Dynamic Calculation/Display in Care^{MC}	Included
Pharmacy Interventions	
Certified Pharmacy Technician	Included
Rx Nurse	Included
Nurse Management	Case Management hourly rate
Pharmacy Review - Per Review	$375.00
Cognitive Behavioral Therapy - Per Hour	$250.00
Medication Review - Per Hour	$206.00

Specialty Network Services

Description	Pricing
Medical Imaging Services	Varies by State and Diagnostic
Independent Medical Exam	See 2021 IME/Peer Fee Schedule
Physical and Occupational Therapy	Varies by State
Durable Medical Equipment	Varies by State and Equipment
IME Peer Review - Per Hour	See 2021 IME/Peer Fee Schedule
Transportation	Varies by State and Service
Translation	Varies by State and Service Level

Medicare Agent Reporting

Description	Pricing
Set up and engagement	Included
Monthly Maintenance	Included
Quarterly Reporting	Included

The above pricing per claim is based on handling of all claims that occur and are reported during the agreement period. If life of contract pricing is selected, claims will be handled until closed or until the end of the agreement period, whichever comes first. If life of claim pricing is selected, claims will be handled until closed.

Renewal pricing is valid for 5/1/2021 through 6/30/2022. Beginning 7/1/2022 and each year thereafter, all fees outlined on the claims and managed care pricing sheet will be subject to an automatic increase of the greater of CPI or three percent (3.0%).

Any service not identified in this proposal will be provided at a later time.

EXHIBIT B
Case Management Services
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) Case management services are provided to manage a claimant's case in order to identify the most appropriate rehabilitative treatment and/or most cost-effective health care alternatives ("Case Management Services"). Case managers may confer with the adjuster, attending physician, other medical providers, employer(s), attorney(s), the patient and the patient's family.

(b) In certain states if requested by Customer, Case Management Services may include vocational rehabilitation services.

2. DELIVERY OF SERVICES

(a) CorVel shall provide Case Management Services to Customer upon receipt by CorVel of specific requests from Customer as mutually agreed by both parties under the special handling instructions.

(b) Telephonic Case Management: Telephonic case management ("TCM") includes a four-point contact with claimant, employer, claims professional and provider. CorVel case managers ("CMs") do the following: (i) facilitate communication among all appropriate parties regarding the diagnosis, prognosis and treatment plan provided by claimant's treating physician, (ii) channel or direct claimant to a PPO Network provider as appropriate, (iii) monitor and facilitate treatment planning, (iv) coordinate early return to work, and (v) subsequently provide periodic assessments of treatment and return to work plans. CMs may recommend additional services or coordinate claim closure, as appropriate.

(c) Medical/Field Case Management: CorVel's medical/field case management ("MCM") personnel perform field based case management services as directed by the employer and/or Authorized TPA which may include on-site contact with claimant, employer, and provider, as well as telephonic communication with the claims professional. MCM's provide the CM services set forth in Section A above.

(d) Vocational Case Management: Vocational case management services may include the following: (i) coordinating return to work, (ii) providing job analysis, (iii) assisting with job placement, (iv) providing expert testimony, (v) assisting with job development, (vi) providing job analysis of essential and non-essential duties for employers under the American's With Disabilities Act, (vii) providing vocational testimony, (viii) providing advice regarding job seeking skills, and (ix) providing transferable skills analysis.

(e) Utilization Review:

(i) CorVel's utilization management program reviews proposed inpatient hospital admissions and ambulatory care to determine the appropriateness, frequency, length of stay, and setting for such proposed treatment. In addition, CorVel can monitor and assess the appropriate utilization of treatment for all orthopedic and soft tissue injuries requiring ambulatory diagnostics and treatment.

(ii) CorVel nurses make recommendations to the claims adjuster based on nationally accepted medical guidelines, including Optimed Managed Care System, a clinical protocol software; the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers; other nationally accepted treatment practice guidelines, as well as any state mandated treatment guidelines.

(iii) Any nurse recommendations for limitation or denial of care based on lack of medical necessity are reviewed by a CorVel Physician Advisor. The Physician Advisor makes a final recommendation to the claims adjuster to approve or deny. If a final recommendation is made to deny treatment, the treating physician is notified in writing of the decision and the appeals process.

(f) Pre-Hab (*Surgery Preparation*) and Rehabilitation (*Recovery*) Services**:**

CorVel provides Case Management Pre-Hab (*Surgery Preparation*) and Rehabilitation (*Recovery*) Services through a platform provided by CorVel's vendor PeerWell utilizing a smart phone based application (the "Platform") providing injured claimant(s) requiring a digital PreHab (surgery preparation) and Rehab (recovery) program to be used for specific musculoskeletal conditions. Customer's injured claimant will need to have a smartphone, Ipad or tablet to download and accept the app's terms and conditions. Such service shall be used in conjunction with CorVel's telephonic or field case management services. If Customer's injured claimant does not activate the Platform app, there will be no fee billed to Customer. CorVel's Pre-Hab (*Surgery Preparation*) and Rehabilitation (*Recovery*) Services will be made available to injured claimants with an existing claim in conjunction with any medical care, where the injured worker requests such care.

Care Advocacy Services
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) Care Advocate nurse service ("Care Advocate nurse") are provided immediately following the work injury to guide the claimant's injury recovery, up to 30 days following injury. The Care Advocate nurses oversee clinical assessment of the injury severity, validate/secure medical information, act as patient advocates and sets expectations for medical care and return to work. They identify the most appropriate treatment and/or most cost-effective health care alternatives. Care Advocate nurses may confer with the adjuster, attending physician, other medical providers, employer(s), attorney(s), the patient and the patient's family.

2. DELIVERY OF SERVICES

(a) CorVel shall provide Care Advocate Services to Customer upon receipt by CorVel of specific requests from Customer, however unless otherwise agreed to by the parties, those cases that meet the Care Advocate referral criteria as mutually agreed shall be automatically referred to the Care Advocate Service.

(b) Care Advocate nurse service: Care Advocate nurse service includes a four-point contact with claimant, employer, claims professional and provider. CorVel care advocates do the following: (i) facilitate communication among all appropriate parties regarding the diagnosis, prognosis and treatment plan provided by claimant's treating physician, (ii) channel or direct claimant to a PPO Network provider as appropriate, (iii) monitor and facilitate treatment planning, (iv) coordinate early return to work, and (v) subsequently provide periodic assessments of treatment and return to work plans up to 30 days following the work injury. Care Advocates may recommend additional services or coordinate claim closure, as appropriate.

(c) Care Advocate nurses are responsible for completing detailed documentation within CareMC focusing on the claimant's medical condition, treatment plan and return to work status. Documentation includes but is not limited to primary injury diagnosis, comorbidities, treatment plan, medical goals, obstacles to recovery, work status and return to work.

(d) Care Advocate nurses act nurse consultants to the claim team.

(e) Care Advocate nurses act a patient advocates.

(f) Care Advocate nurses assess appropriate medical follow-up, work closely with the claim team to identify potential barriers to recovery that may require further follow-up or additional services and develop medical action plans to ensure timely recovery and restoration of function.

Bill Audit, Review and Payment Services
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) CorVel's proprietary bill review program enables an application of the appropriate Standard Fee Schedules or usual and customary values, includes PPO, Technical and Clinical Review, and CERiS, applied to provider bills.

2. **DEFINITIONS**

Bill (per Bill): Each transaction of a bill is considered a separate per bill count. CorVel is able to logically link transactions across logical sequences, but each is its own bill transaction.

Clean/Prepared Bill: When the provider charges are deemed to be an accurate reflection of the services rendered based on the provider's documentation. Network Solutions savings such as Clinical Review and Technical Evaluation and other review types can be applied first to the bill for the bill to qualify for the Prepared Bill status. Once at the prepared bill state Standard Fee Schedule savings can be applied.

Clinical Review: An additional level of review performed by nurses, system, or coding experts to evaluate appropriateness, relatedness of submitted charges with provided documentation.

Implant Analysis: Review of implant charges submitted to a proprietary pricing database and documentation. Implant Analysis results are included as part of Clinical Review.

Line Item Bill Review (LIBR):

Out of Network Line Item Bill Review:

- Original charge data
- U&C review by zip code
- Fee re-bundling and error removal
- Separation of charges by diagnosis/procedure
- Facility to facility cost comparison
- Individual facility chargemaster analysis and price trending

Fair and Reasonable - Universal Chargemaster: The Universal Chargemaster is a compilation of individual hospital line item descriptions from over 85% of the nation's hospitals. It is a virtual thesaurus of hospital billing terms, codes and abbreviations. Specific, unique line item descriptions are defined by the Universal Chargemaster and appropriately compared to the same service or supply for other hospitals in the same geographical area.

Minimum Transaction Fee (MTF): For each bill transaction if the fees on a bill transaction instance do not meet the minimum transaction fee amount, the difference between the fees and the min transaction fee will be automatically added to the fees.

Negotiations: A one time or ongoing agreement with the provider to accept a specific payment amount.

PPO Network Access: A preferred provider organization (PPO) is a medical care arrangement in which medical professionals and facilities provide services at a negotiated/contracted rate. PPO medical and healthcare providers are called preferred providers.

Provider Sendback: Sendbacks occuring when a bill instance does not have enough supporting information from the provider to be a Prepared Bill. The bill is sent back to the provider requesting further information.

Standard Fee Schedule: Savings defined as the amount reduced from the Prepared Bill status to the jurisdictional state fee schedule amounts when those amounts are expressly assigned a specific value, not through reference methodologies developed by a third party or federal agency.

Substantive Denials: Sendbacks occur when a bill instance does not have enough supporting information from the provider to be a Prepared Bill. The bill is sent back to the provider requesting further information. If the provider does not provide the necessary supporting information after 90 days of the sendback status all bill savings will be considered Substantive Denial Savings and charged accordingly through an automatic bill instance. If the bill is later submitted through another bill instance with further information from the provider, another review will occur which may reverse all or part of the Substantive Denial savings and fees.

Technical Evaluation: Applicable to bills when reimbursement is not fully addressed in the jurisdictional fee schedule. State regulations may require payment to be made in accordance with payment methodologies developed by a third party (typically the Centers for Medicare and Medicaid Services (CMS)), often with exceptions or special exemptions added by the state.

UCR: "UCR" is defined as :

· Usual – A charge is considered "Usual" if it is the fee that most providers in the area charge for the same service.

· Customary – A charge is considered "Customary" if it is within the range of fees that most providers who practice in the area charge.

· Reasonable – A charge is considered "Reasonable" if it is both usual and customary or if it is justified by the Payor because of complexity. Payor, CorVel or its designees use a nationally recognized third party database for UCR charges.

In determining UCR prevailing rates, Payors, CorVel or their designees use either (a) CorVel's Enhanced Bill Review database or other nationally recognized databases to provide benchmarks for hospital charges in a hospital Health Care Provider's geographic area and (b) databases provided by FAIR Health, Inc. or other nationally recognized databases to provide benchmarks for charges by non-hospital Health Care Providers in the applicable geographic area. The UCR prevailing rate is the

80th percentile of the relevant database benchmark for the fees and charges in Provider's geographic area.

2. DELIVERY OF SERVICES

(a) Customer's Obligations

(i) During the term of this Agreement, unless agreed to otherwise by the parties in writing, Customer shall utilize CorVel exclusively (even as to Customer) for audit, review and repricing services for Bills related to workers' compensation, auto liability and general liability claims. A breach of the foregoing obligation shall constitute a material breach under this Agreement. Without limiting any other remedies available under law, a breach of the foregoing obligation with respect to PPO (as defined in Schedule 7) Provider Bills will result in immediate termination of all PPO discounts provided by CorVel.

(b) CorVel's Obligations

(i) CorVel shall provide Bill Review Services described herein to Customer upon receipt of specific requests from Customer. In the absence of instructions from Customer to the contrary, which CorVel must approve, Bill Review Services shall be performed as described herein.

(ii) Bill Review Services shall be completed within a reasonable period of time of CorVel's receipt by CorVel of all necessary billing information from Customer ("Complete Billing Information").

(iii) To facilitate timely processing CorVel shall process (A) each Provider Bill within a reasonable period of time and within industry standards after CorVel's receipt thereof, and (B) batches of Provider Bills on a daily basis or as volume dictates.

(iv) CorVel shall process PPO Provider reimbursements on behalf of Customer industry standards from receipt of the corresponding Bill Review Audit analysis from CorVel.

(v) CorVel will be responsible for monitoring, "flagging" and returning to Customer duplicate copies of a Bill ("Duplicates").

(vi) Any conflicts or complaints from medical providers ("Complaints") concerning Bill Review Services completed by CorVel initially will be handled directly by CorVel. CorVel will provide an initial response to a Complaint and will send a written response to the complainant that summarizes the nature of the Complaint and the steps CorVel has taken to resolve it. Customer may be asked to interject itself into a Complaint between CorVel and a medical provider to resolve the Complaint in a manner acceptable to Customer and as needed by CorVel. Notwithstanding the foregoing, Customer shall retain full responsibility for payment of all benefits and any other expenses or services required to be paid or provided under applicable policies or state and federal workers' compensation laws.

(vii) CorVel agrees to supply Customer in the CorVel's standard format a transmission reflecting the results of the Bill Review Services provided hereunder.

(c) Savings for the Fee schedule or usual and customary service shall be:

(i) for states having a Standard Fee Schedule: (A) the medical provider's original bill amount; less (B) the billed amount resulting from the allowance based on specified conversion factor(s) multiplied by referenced value(s).

(ii) for states not having a state mandated Fee Schedule: (A) the medical provider's original bill amount; less (B) the bill amount resulting from UCR.

(d) Scanning Services

(i) CorVel will provide Scanning Services and, when appropriate, Optical Character Recognition ("OCR") Services. CorVel will timely and within industry standards, scan all bills and attached medical notes delivered to CorVel necessary for providing Bill Review services. Subject to applicable law and obtaining any required authorizations, CorVel also shall provide Scanning Services for additional claim-related documentation.

(ii) All material scanned by CorVel hereunder shall be accessible to Customer through CareMC.

Clinical and Technical Assessment Services
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) Clinical and Technical Assessment Services. CorVel provides this service to evaluate state specific complex rules and verify coding by providers when appropriate and supported by documentation. This can include clinical review to validate coding is correct for all applicable Provider bills, Ambulatory Surgical Center bills, and all Hospital bills (inpatient and outpatient) including:

(i) review and analysis of codes, charges, and billing structure for incorrect coding, incorrect billing, bundling, and up-coding of procedures which affect Standard Fee Schedule values;

(ii) review of bills, records, and documentation by a nurse and/or by a coder;

(iii) separation of charges not related to the compensable injury;

(iv) review and apply complex state specific rules;

(v) application of utilization review determinations and clinical edits;

(vi) diagnostic related group validation (i.e., verification that the diagnostic related group billed is appropriate for the services rendered); and

(vii) cost shifting of revenue and CPT codes.

2. DELIVERY OF SERVICES

(a) CorVel will timely and within industry standards, complete Review Services and return the reviewed Bills to Customer, with any adjustments to identified overcharges.

(b) Savings for the Review Services shall be:

(i) for states having a state mandated Standard Fee Schedule: (A) the bill amount in the Fee Schedule; less (B) the bill amount resulting from the nurse review services.

(ii) for states not having a state mandated Standard Fee Schedule: (A) the medical provider's original bill amount; less (B) the bill amount resulting from the nurse review services.

(iii) for states having a state mandated Standard Fee schedule (A) the medical provider's original bill amount; less (B) the bill amount resulting from technical review services.

(iv) for states not having a state mandated Standard Fee Schedule: (A) the medical provider's original bill amount; less (B) the bill amount resulting from the technical review services.

(c) Customer Responsibilities

(i) Customer shall pay bills reviewed by CorVel in a timely manner in accordance with all state guidelines, and agrees to waive any bill audit and/or other retrospective reviews regarding all bills for which CorVel has secured a reduction from the original billed charges.

(ii) If a medical provider submits an appeal, the bill will be reviewed again and, if any adjustment is

necessary, CorVel will provide that information on the Explanation of Review (EOR).

CERiS
(Hospital Bill Itemization Review Services; Negotiation Services; Implant Cost Review Service)
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) Hospital Line Itemization Review Services. (CERiS) performs its Services on Hospital Bills (inpatient and outpatient) and consist of procurement of actual bill itemization, (i) a line-by-line validation and comparison of the itemization description charges actually billed by a particular hospital to what CMS billing guidelines allow to be separately billed for in order to disallow inappropriate charges, and then will compare the valid itemization descriptions to the average itemization description charges utilized by other hospitals within a pre-designated geographic area, and and (ii) a review of charges that fall outside of any pre-contracted discounts or fee schedules, and generates payment recommendations in accordance with the Customer's "Payors Allowable" language. This service does not itself include negotiation services nor Implant Cost Services.

(b) Negotiation Services. (CERiS) will provide negotiation services with respect to all Hospital Bills (inpatient and outpatient). CorVel will contact the provider for agreement of the negotiated rate. A signed agreement regarding such rates will be maintained by CorVel. CorVel will use its commercially reasonable efforts to enter into an agreement regarding negotiated rates in accordance with a mutually agreed upon schedule.

(c) Implant Cost Review Service. (CERiS) includes Implant Cost Review services with respect to the applicability of the Customer's "Payors Allowable" plan or policy language that specifically addresses implant payments. CorVel will identify and provide the manufacturers implant cost through its proprietary repository of national implant invoice data. CorVel then determines the recommended payment in accordance with the Customer's "Payors Allowable". In the event there is insufficient implant invoice data for the requested implant, CorVel will notify the Customer and CorVel shall not be responsible for any costs, fees, damages or penalties for any such inability of CorVel to produce a cost savings per Customer's request.

2. DELIVERY OF SERVICES

(d) When applicable CorVel will timely within industry standards, complete CERiS Services and return the reviewed Hospital Bills to Customer, together with a written summary of any adjustments to identified overcharges.

(e) Savings for the CERiS Services shall be:

(i) for states having a state mandated Fee Schedule: (A) the bill amount in the Fee Schedule; less (B) the bill amount resulting from CERiS Services.

(ii) for states not having a state mandated Fee Schedule: (A) the medical provider's original bill amount; less (B) the bill amount resulting from the CERiS Services.

(f) Customer Responsibilities

(i) Customer shall pay bills reviewed by CorVel in a timely manner in accordance with all state guidelines, and agrees to waive any bill audit and/or other retrospective reviews regarding all bills for which CorVel has secured a reduction from the original billed charges.

(ii) Customer will identify all bills that are not eligible for Enhanced Bill Review Services due to: (A) compensability; (B) a pre-negotiated rate with Customer or other previously established discount; (C) services that are "review only" due to litigation or other non-payment issues; and (D) duplicate bills.

(g) If a medical provider questions the adjustment and/or balance bills the patient, and the claim payor notifies CorVel of such communication, CorVel will provide documentation of its findings. If the hospital provides corrective or qualifying information sufficient to alter our original adjustments, CorVel will revise its report, advise the claim payor of the new, corrected adjustment. Only in the event of a successful appeal of the reduction of the bill by the medical provider shall Customer be entitled to receive a credit for the portion of the fee previously charged for the amount of the adjustment successfully appealed.

Preferred Provider Network Access Services (PPO)
Terms and Conditions

I. DESCRIPTION OF SERVICES

(a) CorVel's preferred provider organization is a network of hospitals, physicians and other providers ("Participating Providers") that offer services at pre-negotiated Provider rates ("PPO Network"). CorVel also provides state certified preferred provider organization networks in states that maintain such networks.

II. DELIVERY OF SERVICES

(a) CorVel will provide Customer with access to its PPO Network provided it is the exclusive preferred provider organization utilized by Customer. CorVel may at any time and in its sole discretion add and/or terminate any provider to or from the PPO Network.

(b) CorVel will provide Customer with a web-based directory of its PPO Network providers.

(c) Customer agrees that, during the Term of this Agreement Customer will not contract directly or indirectly with Participating Providers made known to Customer under this Agreement.

(d) Customer will make reasonable effort to channel all Covered Persons to the Participating Providers as are allowed under the laws of that service area or state.

CAREIQ Services
Terms and Conditions

I. DESCRIPTION OF SERVICES

CareIQ is CorVel Nationwide Ancillary Benefit Management Program. CareIQ's network is comprised of direct provider contracts, affiliate networks and national vendor agreements. CareIQ is responsible to pay rendering providers timely for covered and approved services performed.

The CareIQ Ancillary Benefit Management Program includes; referral management and coordination, billing and invoicing, credentialed provider network management, and/or clinical oversight of treatment. Services Included; Durable Medical Equipment, Home Healthcare, Transportation, Interpretation, Imaging and Diagnostics, Independent Medical Examinations, Age of Injury Determinations, Physical Therapy, Occupational Therapy, and other Rehabilitation and Ancillary Healthcare services.

II. PAYMENT FOR CAREIQ SERVICES

CorVel shall invoice and bill the CareIQ Services directly to the specific claims file.

CorVel reserves the right to increase and amend the rates set forth herein by notifying Customer of such amendment in writing, and Customer shall, if such amendment is unacceptable, have thirty (30) days from the date said notice is received to reject such amendment by delivery of written notice of rejection to CorVel. If CorVel does not receive such notice of termination within such thirty (30) day period, the amendment to the rates shall be deemed accepted by Customer and this Agreement shall continue in full force and effect, as so amended.

Pharmacy Benefit Program
Terms and Conditions

I. DESCRIPTION OF SERVICES.

(a) CorVel shall be the exclusive provider of a Pharmacy Program inclusive of a PBM and a Provider Network representing Participating Pharmacy Providers that are obligated upon and after identification of a participant within CorVel's PBM to:

i. Accept a contracted rate, and

ii. Apply mandated processes and CorVel's Formulary and Concurrent Drug Utilization Review program at point-of-service before dispensing prescribed medications.

II. DEFINITIONS.

(a) "AWP" shall mean the Average Wholesale Price for a Brand or Generic Drug Product. CorVel bases Customer pricing off of the reported AWP value from Medi-Span and the date of service.

(b) "AWP Discount" shall mean the PBM discounts CorVel applies, per Customer's negotiated rates, to Covered Brand and Generic Drug Products, Compound Drugs and Specialty Meds.

(c) "Brand Drug" shall mean a Covered Drug defined as a brand name drug in PBM proprietary Generic Code Conversion ("GCC") logic.

(d) "Compound Drugs" shall be systematically identified when processing through the PBM via the Formulary. Drug compounding is often regarded as the process of combining, mixing, or altering

ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. Compounded drugs are not FDA-approved.

(e) "Concurrent Drug Utilization Review" ("DUR") shall mean the algorithm systematically applied at a Participating Pharmacy before dispensing that considers the Presenting Drug's safety and efficacy in context with other drugs that have been dispensed. In addition, the algorithm includes applicable protocols and guidelines based on the Presenting Drug and specific claim history, such as the time period from the last fill of the same Drug.

(f) "First Fill" shall mean a prescription filled by a Participating Pharmacy for a limited supply of Covered Drugs for a claim that is not, at the time, eligible. First Fill transactions follow CorVel's First Fill Formulary. The First Fill Formulary is for the immediate treatment of injuries, including common exposure drugs/vaccines. The pharmacy is instructed to fill any formulary prescription written by the treating physician, whether or not the claim is accepted as a workers' compensation claim. Most claims are ultimately accepted.

(g) "Formulary" shall mean CorVel's Workers' Compensation Standard or state specific drug/drug class and brand/generic specific triggers systematically applied at a Participating Pharmacy before dispensing a Presenting Drug that prompts the pharmacy through its adjudication system to either: dispense the Presenting Drug, convert from brand to generic, attain approval to dispense,.

(h) "Generic Drug" shall mean a Covered Drug, whether identified by its chemical, proprietary, or non-proprietary name, that (i) is accepted by the FDA as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient; and (ii) defined as a generic drug in PBM proprietary Generic Code Conversion ("GCC") logic. In the adjudication process, CorVel applies Customer's negotiated Generic Drug discount rate to the AWP value of Covered Generic Drugs.

(i) "GCC" refers to PBM proprietary Generic Code Conversion logic. GCC logic converts Medi-Span codes to the brand and generic codes used for claims adjudication.

(j) "Good Samaritan (Emergency) Fill" shall mean a limited supply of Covered Drugs that are outside of the Formulary and typically dispensed outside of normal business hours (overnight, weekends or holidays) by a Participating Pharmacy without Customer's or CorVel's approval in order to meet, in the pharmacist's professional judgment, an immediate or urgent need. Customer is responsible for payment of drug charges processed through Good Samaritan Fills; CorVel assumes no liability.

(k) "Mail Order Program" or "Home Deliver Program" shall mean the managed program from which Covered Drugs are dispensed and billed through CorVel's PBM. A pharmacy's status as a mail order pharmacy does not indicate participation in the CorVel PBM Mail Order Program. Mail Order participation is limited to designated pharmacies operating within the strict parameters of CorVel's Mail Order Program.

(l) "Multi Source Brand" shall mean a Covered Drug specified as a brand name drug available from more than one manufacturer as determined by CorVel primarily using a combination of data fields provided to CorVel by Medi-Span (or another nationally available reporting source that may be selected by CorVel). Multi Source Brand Drugs are eligible for conversions to Generic Drugs at the Participating Pharmacy.

(m) "Multi Source Generic" shall mean a Covered Drug specified as a multi source generic drug as determined by CorVel primarily using a combination of data fields provided to CorVel by Medi-Span (or another nationally available reporting source that may by selected by CorVel). Generic Drugs in their six month exclusivity period or limited supply drugs may be excluded from Multi Source Generic Drugs.

(n) "PBM" shall mean Pharmacy Benefits Manager. CorVel performs as the PBM on behalf of its Customers.

(o) "Presenting Drug" shall mean the drug ordered by the prescriber and presented on a signed prescription to a Participating Pharmacy and processed through CorVel's PBM.

(p) "Rate application exceptions," per Billing and Payments of Pharmacy Program (below) sections (d) and (e), apply when either State Fee Schedule AWP Values or Customer's Negotiated PBM AWP Discount rates are lower than CorVel's Acquisition Price. CorVel's Acquisition Price reflects CorVel's cost of the Covered Drug plus a processing and management fee.

(q) "Single Source Brand" shall mean a Covered Drug specified as a brand name drug available from only one manufacturer as determined by CorVel primarily using a combination of data fields provided to CorVel by Medi-Span (or another nationally available reporting source that may by selected by CorVel). Single Source Brand Drugs are not eligible for conversions to Generic Drugs.

(r) "Single Source Generic" shall mean a Covered Drug as determined by CorVel that may not have been purchased by pharmacies at standard Multi Source Generic Drug rates because of limited manufacturers, limited supply or exclusivity rights. In the adjudication process, Customer's Brand Drug AWP Discount value may be applied to Single Source Generic Drugs.

(s) "Specialty Medications" shall mean certain pharmaceuticals, biotech or biological drugs, that are Covered Drugs used in the management of chronic or genetic disease, including but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling. In the adjudication process, Customer's Claims Professional's approval is required, and Customer's Brand Drug AWP Discount value and dispensing fee may be applied irrespective of the Presenting Drug's GCC (Generic Code Conversion) status.

III. DELIVERY OF SERVICES.

(a) CorVel shall provide its Pharmacy Program's PBM and Network for the benefit of Customer.

(b) Eligibility, First Fill, Pharmacy Identification (ID) Cards, and Mail Order/Home Delivery.

Pharmacy ID cards contain the necessary data elements to enable a Participating Pharmacy provider to electronically process through and transmit claim data to CorVel's PBM. The electronic transmission that occurs at the point of sale is required for application of Formulary, Concurrent Drug Utilization Review and contractual pricing.

i. Customer agrees to promptly provide CorVel all information needed to produce and distribute Pharmacy ID cards to Eligible Claimants. Subject to applicable law, Customer will instruct Eligible Claimants to use the Pharmacy ID cards at participating network providers in order to facilitate the Pharmacy Program.

ii. Distribution of Pharmacy ID cards does not guarantee that Pharmacy ID cards will be appropriately utilized by Eligible Claimants or Participating Pharmacies; therefore,

Customer understands that claims assigned by Pharmacies to third party billers or paper bills submitted by the Pharmacies are not adjudicated through the prospective PBM.

iii. CorVel, agrees to produce and distribute Pharmacy ID cards to Eligible Claimants upon receipt of all necessary Eligible Claimant information from Customer. CorVel will also send an introduction letter to the Eligible Claimant along with the Pharmacy ID card.

iv. CorVel will provide access for Eligible Claimants to the PBM Mail Order Program. CorVel will work with Customer to establish the parameters of the Mail Order Program and the process which will be utilized to encourage Eligible Claimant use of the Mail Order Program.

(c) CorVel's PBM will present a proprietary or state mandated Formulary to Customer. Upon presentation of identification to a Participating Pharmacy, the Formulary will trigger the Participating Pharmacy's adjudication system to either:

i. Automatically dispense certain medications, or

Obtain Prior Authorization (PA) approval from claims professional to dispense,

(d) CorVel's PBM will implement a Concurrent Drug Utilization Review ("DUR") program on behalf of Customer,. Concurrent DUR includes a review of the drug history at the time the prescription is presented. Absent Customer's directions, DUR shall be performed in accordance with CorVel's PBM's standard service model.

IV. BILLING AND PAYMENTS OF PHARMACY PROGRAM.

(i) Financial obligations of parties.

(i) Customer shall be financially responsible for all drug charges incurred by claimants for dispensed medications processed under CorVel's PBM. CorVel assumes no liability for drug charges with the exceptions noted below in subsection iii.

(ii) If the CorVel claims professional determines, upon receipt of CorVel's PBM invoice, that specific formulary and non-formulary drugs should not have been dispensed, the CorVel claims professional should inform the PBM as soon as possible.

1. The PBM will request a reversal from the Participating Pharmacy. If granted, CorVel will reverse the drug charges, however, if the Pharmacy does not grant the PBM's request, Customer is responsible for payment of the drug charges; CorVel assumes no liability for drug charges with the exceptions noted below in subsection iii.

(iii) Upon receipt of an invoice, CorVel claims professional may timely dispute charges for drugs that were dispensed in error, triggering CorVel's PBM to reverse the drug charges, by notifying CorVel for any of the following reasons:

1. CorVel's PBM and/or the Participating Pharmacy's violation of Formulary or Utilization Review Parameters set forth in Customer's DUR program, or in the Claimant Level Formulary; or

2. Duplicate or inadvertent entries or other clerical mistakes on a PBM invoice.

(ii) Invoicing and Payment.

On a per Covered Drug basis CorVel will apply daily for all drug charges and fees related to the PBM directly to the claim file.

CorVel shall invoice and bill directly all prescription fees to the specific claims file.

CorVel uses Medi-Span as our AWP data source. CorVel's Medi-Span database is updated daily and AWP values are applied on the date of dispense.
In all states with the exception of California, Customer will be billed the lessor of the state fee schedule AWP or the CorVel's negotiated rate.

(iii) Both parties understand that pricing indices historically used (including under this Agreement) for determining the financial components of pharmacy billing rates are outside the control of CorVel and Customer. The parties also understand there are extra-market industry, legal, governmental and regulatory activities which may lead to changes relating to, or elimination of, these pricing indices that could alter the financial positions and expectations of both parties as intended under this Agreement.

Both parties agree that, upon entering into this Agreement and thereafter, their mutual intent has been and is to maintain pricing neutrality as intended and not to benefit one party to the detriment of the other. Accordingly, to preserve this mutual intent, if pricing neutrality does change and CorVel undertakes any or all of the following:

(i) Changes the AWP source, or other source if AWP is not applicable, across its book of business (e.g., from Medi-Span to First Databank); or

(ii) Maintains AWP, or other source if AWP is not applicable, as the pricing index with an appropriate adjustment in the event the AWP, or other, methodology and/or its calculation is changed, whether by the existing or alternative sources; or

(iii) Transitions the pricing index from AWP, our other source if AWP in not applicable, to another index or benchmark (e.g., to Wholesale Acquisition Cost);

Customer's negotiated PBM pricing will be modified as reasonably and equitably necessary to maintain the pricing intent under this Agreement.

Clearinghouse Payer Agent Services Program
Terms and Conditions

1. DESCRIPTION OF SERVICES

(a) Clearinghouse Payer Agent Services: CorVel shall act as Customer's agent under this Agreement. CorVel's clearinghouse receives bills from health care providers in electronic form, verifies the data integrity of the information on the bills, and routes directly to CorVel's Bill Review system for completion of CorVel's Bill Review service. Explanation of Benefit (EOR) information will be transmitted to providers from CorVel in the ANSI 835 format. CorVel will send 835 data to health care providers via it's clearinghouse upon CorVel's completion and approval of all Explanation of Reviews (EOR's) via CorVel's Bill Review service in compliance with the local governing state laws and regulations.

(b) Compliance with applicable law: CorVel shall ensure that Clearinghouse Services are provided in compliance with the applicable laws, statutes, rules and regulations of the state service shall be provided in. Customer agrees to timely provide to CorVel

information and assistance requested by CorVel and reasonably required to ensure such compliance.

2. SETUP AND DELIVERY OF SERVICES

(c) Routing Directly to Bill Review: A test sample of Customer's bills will be pulled from the clearinghouse test system and imported to the bill Review test system. Bill Review results will be output to Customer through the existing format. Routing bills through CorVel's Test bill review system may require three to four weeks. CorVel will make reasonable efforts to begin testing within five business days of the request for services.

3. PRICING STRUCTURE

The cost of Clearinghouse Payer Agent Services is as follows:

- For customers for whom CorVel provides bill review services – No additional charge

TeleHealth Services
Terms and Conditions

CorVel shall provide TeleMedicine visits to Customer's injured employees who opt for such service for as level of care determinations are made through our 24/7 nurse triage hotline. A TeleMedicine visit is a single synchronous virtual consultation through CorVel's third party vendor platform between a Qualified Professional and a claimant ("TeleMedicine").
CorVel's 24/7 triage nurses are trained to provide an initial assessment and will provide immediate referral to medical care when needed. Nurses may refer to TeleMedicine as appropriate (i.e., musculo-skeletal injuries).

- TeleMedicine virtual visits are always an "option" for the injured employee.
- If opted by the injured employee, CorVel connects the injured employee to a physician immediately via a computer, tablet or phone.
- If the injured employee decides that he/she does not want a TeleMedicine visit, CorVel will immediately offer to schedule the injured employee with a traditional, in-person PPO medical provider located at a convenient, clinic-based location.

A TeleMedicine "visit" is defined as "A Consultation Unit" is a single synchronous consultation through the Platform between a Qualified Professional and a patient."