AMENDMENT NO. 2
INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT NO. 18-704

This **AMENDMENT NO. 2** is entered into by and between the **Incorporated County of Los Alamos**, an incorporated county of the State of New Mexico ("County"), and **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association** ("Contractor" or "BCBSNM"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Plans, ("Association"), permitting BCBSNM to use the Blue Cross and Blue Shield Service Marks in the State of New Mexico, and that BCBSNM is not contracting as the agent of the Association, to be effective for all purposes, January 1, 2020.

WHEREAS, County and Contractor entered into Services Agreement No. AGR18-704 dated January 1, 2018 and Amendment No. AGR18-704-A1 dated January 1,2019 (as amended, the "Agreement") for Medical Insurance Benefits for Los Alamos County Employees; and

WHEREAS, parts of this Agreement are up for renewal, and rate negotiations with Contractor as allowed for annually under the original terms and conditions of the agreement; and

WHEREAS, the County Council approved this Amendment at a public meeting held on October 29, 2019; and

WHEREAS, both parties wish to renew the term of this Agreement;

NOW, THEREFORE, for good and valuable consideration, County and Contractor agree as follows:

I. To delete **SECTION A. SERVICES** in its entirety and replace it with the following:

SECTION A. SERVICES:

Contractor shall provide County with Administrative Services for Group Medical Insurance Benefits pursuant to the terms of the Administrative Services Agreement ("ASA"), including all Exhibits and Addenda attached thereto and the Sample Benefits Booklet. The final Benefits Booklet shall be provided by the Contractor within 60 days of the effective date of this Services Agreement. The ASA for Calendar Years 2018 and 2019 (Exhibit "A"), Sample Benefits Booklet (Exhibit "B"), and the ASA for Calendar Year 2020 ("Exhibit C") are attached hereto and incorporated herein for all purposes. Contractor is responsible for providing services and benefit determinations under Exhibits A, B. and C above.

II. To delete **SECTION B. TERM** in its entirety and replace it with the following:

SECTION B. TERM:

1. The term of this Agreement, for Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2020, unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to four (4) consecutive one-year periods, unless sooner terminated, as provided therein.

2. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2018 and shall continue through December 31, 2018, unless sooner terminated, as provided herein.

3. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 11 of the ASA), shall commence January 1, 2019 and shall continue through December 31, 2019 unless sooner terminated, as provided herein.

4. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 16 of the ASA), shall commence January 1, 2020 and shall continue through December 31, 2020 unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to four (4) consecutive one-year periods, unless sooner terminated, as provided therein.

III. To delete **SECTION C. COMPENSATION** in its entirety and replace it with the following:

SECTION C. COMPENSATION:

1. **Amount of Compensation**. County shall pay the following compensation for performance of the Services, not to include any subsequent renewal periods, as follows:
   a. Administrative Services provided between January 1, 2018 and December 31, 2019, in the amount of FOUR HUNDRED NINE THOUSAND DOLLARS ($409,000.00);
   b. Administrative Services provided between January 1, 2020 and December 31, 2020, in the amount of ONE HUNDRED EIGHTY THOUSAND DOLLARS ($180,000.00);
   c. Stop Loss Insurance coverage for January 1, 2018 through December 31, 2018, in the amount of SEVEN HUNDRED THOUSAND DOLLARS ($700,000.00);
   d. Stop Loss Insurance coverage for January 1, 2019 through December 31, 2019, in the amount of SEVEN HUNDRED TWENTY-ONE THOUSAND DOLLARS ($721,000.00);
   e. Stop Loss Insurance coverage for January 1, 2020 through December 31, 2020, in the amount of EIGHT HUNDRED ONE THOUSAND DOLLARS ($801,000.00);

f. Total compensation for performance of Services between January 1, 2018 and December 31, 2020 shall not exceed TWO MILLION EIGHT HUNDRED ELEVEN THOUSAND DOLLARS ($2,811,000.00), which amount shall include applicable New Mexico gross receipts taxes ("NMGRT").

g. For any subsequent renewal periods set forth in Section B, "Term," above, compensation will be strictly based upon rate negotiations with Contractor and Council approval of said negotiations;

2. **Invoices.** Contractor shall submit weekly invoices to County's Human Resources Division showing claims paid for covered employees, as well as monthly invoices for administrative services, showing amount of compensation due, amount of any NMGRT, and total amount payable. Payment of undisputed amounts shall be due and payable ten (10) calendar days after County's receipt of the invoice.

Except as expressly modified by this Amendment, the terms and conditions of the Agreement remain unchanged and in effect.

IN WITNESS WHEREOF, the parties have executed this Amendment No. 2 on the date(s) set forth opposite the signatures of their authorized representatives to be effective for all purposes on the date first written above.

ATTEST

_____
NAOMI D. MAESTAS
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

BY: _____
HARRY BURGESS **DATE**
COUNTY MANAGER

Approved as to form:

_____
J. ALVIN LEAPHART
COUNTY ATTORNEY

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY, AN INDEPENDENT LICENSEE OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

BY: _____
NAME: _____ **DATE**
TITLE: _____

BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2020.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number: 251305

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**INCORPORATED COUNTY OF LOS ALAMOS**
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

ATTACHMENT C

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This Administrative Services Agreement ("ASA") made as of the Effective Date specified on page one (1) of this Agreement, by and between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (“Claim Administrator”), and Employer specified on page one (1) of this Agreement (“Employer”), for Employer Group Number(s) set forth on page one (1) of this Agreement, WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of the Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a separate self-insured group health plan component as defined by Section 160.103 of HIPAA ("the Plan"); and

WHEREAS, Employer on behalf of the Plan has executed an ASO BPA and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA, Service Agreement AGR18-704, this Agreement and all Exhibits and Addenda described in Section 1, below, collectively referred to hereinafter as the “Agreement”, unless specified otherwise; and

WHEREAS, Employer on behalf of the Plan desires to retain Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, the parties agree that it is desirable to set forth more fully the obligations, duties, rights and liabilities of Claim Administrator and Employer, as sponsor of the Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: DEFINITIONS, EXHIBITS AND ADDENDA

Capitalized terms used in this Agreement shall have the meanings set forth in Section 24 **"DEFINITIONS"**, unless otherwise provided in the Agreement. All Exhibits and addenda attached hereto and referenced herein are hereby adopted and incorporated by reference as if set out in full in the body of this Agreement.

SECTION 2: APPOINTMENT AND SERVICES

2.1 ***Appointment.*** Employer hereby retains and appoints Claim Administrator to provide Services as hereinafter defined in connection with the administration of the Plan.

2.2 ***Administrative Services.*** Claim Administrator will perform the Services set forth in Exhibit 1 **"CLAIM ADMINISTRATOR SERVICES"**. Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, or any of its subsidiaries or affiliates, including any successor corporation(s), whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 3: RESPONSIBILITIES OF EMPLOYER AND CLAIM ADMINISTRATOR

3.1 ***Employer responsibilities.***

Employer retains full and final authority and responsibility for the Plan, payment of claims under the Plan, determinations of eligibility under the Plan, and its operation; notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed. The Parties acknowledge and agree Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

a. Employer's Direction As To Benefit Design. Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in an automated benefit summary or similar documentation. Employer agrees that Claim Administrator shall process claims in accordance with the automated benefits summary. Employer agrees Claim Administrator may rely on the most current version of the automated benefit summary as the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

b. Eligibility. Employer shall determine eligibility for coverage under the Plan. Employer is responsible for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination. Any clerical errors with respect to eligibility will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected according to Claim Administrator's reasonable administrative practices including, but not limited to, those related to Timely notification of a change in a Covered Person's status.

c. Notices To Covered Persons. Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 8, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 2 (Sections 10 and after) to Covered Persons.

3.2 ***Claim Administrator responsibility.*** Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or through Claim Administrator. The Claims Administrator agrees to undertake reasonable efforts to advise the Employer when it knows the Employer's Plan, as administered by the Claims Administrator, may fail to comply with federal, state or local laws as may apply to the Plan. The Employer however shall retain the ultimate responsibility for Plan compliance and to make any determination relative to Plan compliance except as specifically set forth herein. Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement.

3.3 ***Litigation.*** Each party shall, to the extent practical, advise the other party of any legal actions against it or the other party that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either party under the Plan and this Agreement. The Employer shall undertake the defense of any such claim or such action only to the extent that it alleges breach or wrongdoing, action or failure to act on the part of the Employer. The Claim Administrator shall, with respect to claims or allegations of its breach or wrongdoing or action or failure to act, employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement. The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. For purposes of this Section, Claim Administrator's "cooperation" includes, but is not limited to, providing reasonable levels of documentation and affidavits, when necessary, but only to the extent (i) Employer is entitled to such information under this Agreement, (ii) Employer would be entitled to the information in litigation, including but not limited to information directly relevant to such action, (iii) such information is not otherwise subject to restrictions on disclosures, including but not limited to privilege or

contractual restrictions, and (iv) such documentation is within Claim Administrator's possession in the ordinary course of business. Some defense support, such as from an external reviewer, may require an additional fee.

3.4 ***Claim overpayments.*** Employer acknowledges that unintentional administrative errors may occur. When Claim Administrator becomes aware of a Claim overpayment to a Provider or Covered Person, Claim Administrator will follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will Claim Administrator be required to reimburse the Plan, except for when negligence that is outside reasonable care undertaken in the ordinary course of business or intentional misconduct by Claim Administrator caused the Overpayment.

For purposes of this Section 3.4, an "Overpayment" is defined as a payment to a Provider or a Covered Person which was more than it should have been, or a payment that was made in error.

Recovery Process. Claim Administrator, on behalf of Employer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Sections (a) – (e) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

(a) Reductions From Future Payments to Network Providers. Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) if the Provider is a Network Provider, from Other Plans, up to an amount equal to the Overpayment (collectively, "Off-Set").

(b) Cross-Plan Offsets for Network Providers. Claim Administrator has the right to reduce Another Plan's payment to a Network Provider by the amount necessary to recover the Plan's Overpayment to the same Network Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Network Provider by the amount necessary to recover Another Plan's Overpayment to the same Network Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

(c) Division of Recovery for Multiple Plans. If Claim Administrator has made Overpayments to a Network Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively, against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount, which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 3.

(d) Employer Authorization for Offsets and Cross-Plan Offsets. Employer authorizes and directs Claim Administrator to perform Offsets and Cross-Plan Offsets. Cross-Plan Offsets will be carried out consistent with the terms of the Provider contract. Notwithstanding the foregoing, Employer acknowledges and agrees that claims processed through Inter-Plan arrangements with other Blue Cross and/or Blue Shield licensees operate under rules and procedures issued by the Association, and the recovery policies and procedures of each Blue Cross and/or Blue Shield independent licensee may apply.

(e) No Independent Right of Recovery. Subject to the exception(s) set forth in this Section 3.4, Employer agrees that Claim Administrator will recover Overpayments in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan.

3.5 ***Required Plan information.*** Employer shall furnish on a Timely basis to Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by Claim Administrator for the performance of its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

It is Employer's obligation to Timely notify Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by Employer to Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by Claim Administrator to effect such changes. It is also Employer's obligation to obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Agreement.

3.6 ***Grandfathered Health Plans.*** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations.

3.7 ***Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans.*** If Claim Administrator provides Services for excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

3.8 [Intentionally Omitted]

3.9 ***Summary of Benefits and Coverage ("SBC").*** Unless otherwise provided in the applicable ASO BPA, Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

3.10 ***Massachusetts Health Care Reform Act.*** The Massachusetts Health Care Reform Act requires certain employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through Employer's Plan(s) and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements. If elected on the applicable ASO BPA, Claim Administrator will provide such written statements and electronic reporting, based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3.11 ***Use and disclosure of Covered Persons' information.*** The Parties acknowledge and agree that they have entered into a Business Associate Agreement ("BAA") as required by HIPAA. Although the BAA was executed to comply with HIPAA, the Parties agree the BAA will govern any personally identifiable information ("PII"),

including Protected Health Information ("PHI"), Claim Administrator may collect or receive. While Claim Administrator does not anticipate receiving or collecting PII about Covered Persons that is not PHI, Claim Administrator agrees to protect and secure any PII of Covered Persons according to the terms and requirements of the BAA, except as otherwise provided in this Agreement.

3.12 ***Electronic exchange of information.*** In the event Employer and Claim Administrator exchange various data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data and other information to Employer in the electronic format mutually agreed to by the parties. In the event Employer is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, Claim Administrator is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 4: THIRD PARTY DATA RELEASE

4.1 ***Types of data.*** In the event Employer directs Claim Administrator to provide data directly to its third party consultant and/or vendor (the "Employer's Vendor"), and Claim Administrator agrees in its sole discretion, then Employer acknowledges and agrees, and will cause Employer's Vendor to acknowledge and agree:

- **a.** That the requested documents, records and other information (for purposes of this Section 4, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.
- **b**. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 4, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.
- **c.** To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.
- **d.** To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
- **e.** To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.
- **f.** To return or destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed 60 days thereafter.
- **g.** To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed and consistent with the Inter-Plan provisions of this Agreement.
- **h.** To not sell, re-sell or lease the Information.

4.2 ***Third party obligations.*** Employer's Vendor(s) shall execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator.

4.3 ***Employer obligations.*** Employer shall:

- **a.** Provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose or exchange data. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the Business Associate Agreement between Claim Administrator and Employer.
- **b.** Provide Claim Administrator in writing, the appropriate authorization and specific directions with respect to the release, disclosure or exchange of data with Employer's Vendor(s) identified under 4.3.a. If Employer's Vendor(s) perform services that involve the use, access or disclosure of Protected Health

Information as defined by HIPAA, the information required in this Section will be documented in the Business Associate Agreement between Claim Administrator and Employer.

c. Recognize that Claim Administrator will not be responsible for claims or damages for personal injury or property to the extent that they result in or arise from claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought against Claim Administrator in connection with any claim based upon Claim Administrator's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Employer Vendor(s) of any information and/or documentation or breach by Employer's Vendor(s) of any obligation described in this Agreement, only if such directed disclosure was consistent with Employer's directions. The Parties specifically recognize that the liability of the County of Los Alamos shall be subject in all cases to immunities and limitations of the New Mexico Tort Claims Act (Act), Section 41-4-1 et seq., NMSA 1978, as amended. Claim Administrator recognizes that the Act prohibits Employer from indemnifying Claim Administrator. In lieu of defense by Employer, Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Claim Administrator.

SECTION 5: CLAIMS/INQUIRIES

5.1 ***Claim Administrator's responsibilities.*** As provided in this Agreement, Claim Administrator will receive eligibility information, review and process properly filed Claims, respond to Covered Person's inquiries and conduct Claim reviews and appeals; however, Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish the terms and conditions of the Plan.

5.2 ***Internal Claim Administrator reviews and final internal appeal determinations.*** On occasion Claim Administrator may deny all or part of submitted Claims. Upon request of the Covered Person or the Covered Person's authorized representative, Claim Administrator will provide a review of any adverse determination of a Claim or any adverse determination of a pre-service Claim when the Covered Person would have an adverse financial impact for failing to pre-authorize the service. Certain Claims, pre-service requests for review, appeals or inquiries where there is a question as to eligibility, rescission or clarity of Employer's Plan language will be referred to Employer for review and final determination. In addition, Claim Administrator may provide other types of reviews related to the Plan.

5.3 ***External Review Coordination*.** Claim Administrator may coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 1, "CLAIMS ADMINISTRATOR SERVICES", and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

SECTION 6: INDEMNIFICATION

6.1 The parties acknowledge and agree that (a) Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder, and (b) Employer retains the ultimate responsibility for claims under or related to the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by Claim Administrator.

6.2 Claim Administrator hereby agrees to indemnify and hold harmless Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) which have been adjudged to be (i) negligent and outside reasonable care undertaken in the ordinary course of business, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

SECTION 7: AUDIT RIGHTS

7.1 ***Employer audits Claim Administrator.***

a. During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's approval which shall not be unreasonably withheld) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments and to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. The audit must be free of bias, influence or conflict of interest. Contingency fee-based audits are deemed to have an inherent conflict of interest and will not be supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, after reasonable review of such errors, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for any reasonable personnel time in excess of eighty (80) person-hours required to support audits conducted during the term of this Agreement. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information.

b. If Employer is required to conduct an audit outside of the audit period note in paragraph a. above by a state or federal government agency, Claim Administrator will allow such audit as required by state or federal government agency or regulation.

7.2 ***Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least ninety (90) days prior written notice to Employer, conduct reasonable audits of Employer's membership records with respect to eligibility. Claims Administrator acknowledges Employer has the final authority to determine Covered Persons' eligibility in accordance with section 5.1 above.

SECTION 8: TERM AND TERMINATION OF AGREEMENT

8.1 **Term.** The term of this Agreement, for Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2020, unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to four (4) consecutive one-year periods, unless sooner terminated, as provided therein.

The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2020 and shall continue through December 31, 2020, unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to five (5) consecutive one-year periods, unless sooner terminated, as provided therein.

8.2 ***Termination.*** Subject to the terms identified in this Agreement may be terminated as follows:

a. Employer may terminate this Agreement with or without cause upon thirty (30) days prior written notice to Claim Administrator. Upon such termination, Claim Administrator shall be paid for Services actually completed to the satisfaction of Employer at the rate set out in Section C of the Service Agreement. Claim Administrator shall render a final report of the Services performed to the date of termination and shall turn over to Employer originals of all materials prepared pursuant to this Agreement.

b. By both parties on any date mutually agreed to in writing; or

c. By either party, in the event of conduct by the other party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 16 below; or

d. By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon the Employer's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to Employer as provided in Section 7.1 of Exhibit 2 "FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES" of this Agreement.

e. This Agreement shall terminate without further action by Employer on the first day of any County fiscal year for which funds to pay compensation hereunder are not appropriated by the County Council. Employer shall make reasonable efforts to give Claim Administrator at least ninety (90) days advance notice that funds have not been and are not expected to be appropriated for that purpose. Upon such termination, Claim Administrator shall be paid for Services actually completed to the satisfaction of Claim Administrator at the rate set out in Section C of the Service Agreement.

f. No such termination will take place without a reasonable attempt to contact the Employer pursuant to Section 16 herein. and allow the Employer to make corrective action. No termination will occur without written notification indicated in Section 8.2, above.

8.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 8, Employer agrees to notify all Covered Employees. The parties agree that Employer will give such notice because Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 9: RELATIONSHIP OF PARTIES

9.1 ***Regarding the parties.*** Claim Administrator is an independent contractor with respect to Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever.

9.2 ***Regarding non–parties.*** It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents.

9.3 ***Exclusivity.*** Employer agrees not to perform or engage any other party to perform the same services as Claim Administrator's Services while this Agreement is in effect, unless Employer terminates this Agreement pursuant to its terms.

9.4 ***Assignment.*** Except as otherwise permitted by Section 2 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both parties. Any such attempted assignment in the absence of the prior written consent of the parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates or successors to the parties to the Agreement.

SECTION 10: NON ERISA GOVERNMENT REGULATIONS

10.1 ***In relation to the Plan.*** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of Employer, Employer agrees that Claim Administrator

does not and will not accept any allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator except as set forth in this Agreement. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

10.2 ***In relation to the Plan Administrator/Named Fiduciary(ies).*** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator or of the Plan, except as set forth in this Agreement.

10.3 ***Claim Administrator's limited fiduciary responsibility.*** Although Employer is exempt from ERISA, Employer hereby delegates to Claim Administrator the discretionary authority to administer claims in accordance with the terms of Employer's self-funded health care benefit plan and to make initial claim determinations concerning the availability of Plan benefits and final internal review and benefit determinations for appealed Claims. Claim Administrator hereby acknowledges and agrees that it shall act as a limited fiduciary to the Plan solely with respect to its performance of such claims processing and payment services and Employer acknowledges and agrees that Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, Employer acknowledges and agrees that Claim Administrator shall have no discretionary authority under its agreement with Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by Employer, Employer's other vendors and Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contractors and subcontractors of any type. Employer further agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan participants or beneficiaries as a fiduciary or otherwise with respect to any litigation, including litigation by participants or beneficiaries for benefits under the Plan, except as may be required under Claim Administrator's indemnification obligations under this Agreement or its obligations to act as a fiduciary in its claims processing and payment services function as herein set forth or as may specifically be provided for elsewhere in this Agreement.

SECTION 11: PROPRIETARY MATERIALS

11.1 ***Business Confidential Information and Proprietary Marks.*** The parties acknowledge that Claim Administrator has developed acquired or owns certain Business Confidential Information. "Business Confidential Information" includes, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. "Business Confidential Information" also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence. Employer shall not use or disclose Business Confidential Information to any third party without prior written consent of Claim Administrator.

Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that Claim Administrator may include Employer in its list of clients.

The parties agree that Business Confidential Information, as defined herein, may also include information acquired from other Blue Cross and Blue Shield licensees through Inter-Plan arrangements.

Employer agrees to promptly provide written notice to Claim Administrator if Employer believes it is required by law, court action or order or other legal process, to disclose BCI, , to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator in its sole discretion has the opportunity to take whatever legal actions Claim Administrator determines are necessary. Employer will at all times remain liable for maintaining the

confidentiality of this Business Confidential Information and shall ensure that any affiliated entities or third-party representatives to whom Business Confidential Information is disclosed, are bound in writing not to further disclose Business Confidential Information without the prior written consent of Claim Administrator, unless required by law. If further disclosure is required by law and known by Employer, Employer will promptly provide written notice to Claim Administrator, so that Claim Administrator may similarly have the opportunity to take whatever legal actions Claim Administrator determines are necessary.

11.2 ***Claim Administrator/Association ownership.*** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association. Employer agrees not to contest (i) the Blue Cross and Blue Shield Association's ownership of, or the license granted by the Blue Cross and Blue Shield Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

11.3 ***Infringement.*** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Blue Cross and Blue Shield Association and utilized by Claim Administrator under a license with the Blue Cross and Blue Shield Association.

11.4 Employer is a governmental entity and subject to certain public disclosure laws including, but not limited to, the New Mexico Inspection of Public Records Act, Sections 14-2-2, et seq., NMSA 1979. The Parties intend to preserve, and prevent waiver of all rights and privileges that protect against disclosure or inspection of otherwise public records or of attorney work product and attorney-client communications. This Agreement is not intended to create privileged status for documents or information where it would not otherwise exist, or to obstruct legitimate discovery. Nothing in this Agreement is intended to diminish or expand the application of any applicable disclosure or inspection laws. The Parties shall execute the Non-Disclosure Agreement attached hereto as Exhibit "IV", the terms and conditions of which shall govern the disclosure of information, including information deemed or identified by Claim Administrator to be confidential.

11.5 ***Disclosures in Account Contracts***. Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Claim Administrator to use the Blue Cross and Blue Shield Service Mark, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

11.6 ***Administrative Services Only, Network Only.*** Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to claims liability; and disclose the nature of the services and/or network access Claim Administrator is providing. Such disclosures must be made to Employer, Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and explanation of benefits documentation.

SECTION 12: ELECTRONIC DOCUMENTS

Employer's consent/responsibilities. Employer consents that any documents exchanged between the parties that describe the benefits under, or the administration of, the Plan (including but not limited to benefit booklets) may be in the format of an electronic file or access to an electronic file. Employer further acknowledges and agrees that if Claim Administrator provides Employer, at Employer's request, an electronic file that describes the benefits under, or the administration of, the Plan, Employer will provide Covered Persons access, via the intranet, internet, or otherwise, to only the most current version of that electronic file. Employer also acknowledges and agrees that, in all instances, Claim Administrator may rely on the fact that the most current version of the electronic file Claim Administrator provides to Employer is the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict between such electronic file and any other

electronic or paper file. Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from Employer's use or posting of the electronic file on the intranet and/or internet.

SECTION 13: RECORDS

All Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator are and shall remain the property of Employer upon termination of this Agreement. Claim Administrator shall return a copy of such property upon request in a form as agreed upon by the parties with the cost of preparing such property for transmittal to be borne by Employer. All such Claim records shall be retained by Claim Administrator until Claim Administrator receives a request from Employer for transmittal or for a period of eleven (11) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 14: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of New Mexico without regard to any state choice–of–law statutes, and any applicable federal law. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Los Alamos, New Mexico**.** Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services in accordance with section 15.3 below.

SECTION 15: ENTIRE AGREEMENT

15.1 ***Definition.*** Service Agreement AGR18-704 and this Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement, and any written amendments made pursuant to Section 15.3 (Amending) of this Agreement, shall prevail in the event of a conflict with any Prior Communications that either party or a third party asserts to be a component of the Agreement between the parties.

15.2 ***Components.*** The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - ASO BPA
- **d.** Exhibit 4 - Pharmacy Benefit Management (PBM) Addendum
- **e.** Exhibit 5 - Performance Guarantee (PG) Addendum
- **f.** Exhibit 6 - Stop Loss Agreement
- **g**. Exhibit 7 - Business Associate Agreement ("BAA")

15.3 ***Amending.*** This Agreement shall be amended by mutual written agreement of the parties. Any amendments required by law, regulation or order ("Law"), or by Claim Administrator or the Blue Cross and Blue Shield Association if the change(s) relates to Section 16 herein and/or conditions of Claim Administrator's license agreement with the Blue Cross and Blue Shield Association. may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the parties shall then engage in good faith negotiations to amend the amendment, to the extent reasonably possible. If the parties cannot agree on terms of the amendment in a satisfactory manner, either party shall be allowed to proceed to a mutually agreed upon dispute resolution process or other remedy provided by law.

SECTION 16: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (pursuant to Section 19 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified party the opportunity to make the necessary modifications within the agreed upon term.

SECTION 17: LIMITATIONS; LIMITATION OF LIABILITY

No action or dispute shall be brought to recover under this Agreement after the expiration of six (6) years from the date the cause of action accrued.

As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in connection with this Agreement shall be limited to the Employer's actual, direct damages, not to exceed the total fees set forth in Exhibit "A.". The foregoing limitation of liability shall not apply to claims that arise out of Claim Administrator's gross negligence, fraud, criminal actions, willful, reckless or wanton misconduct or Claim Administrator's bad faith conduct.

SECTION 18: RESERVED

SECTION 19: NOTICES

All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

SECTION 20: SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL

Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

Any delay or inconsistency by either party in the enforcement of any part of this Agreement shall not constitute a waiver by that party of any rights with respect to the enforcement of any part of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

Neither party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, terrorism, cybersecurity crimes or restraints of government.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 3.3 "Responsibilities of Employer and Claim Administrator: Litigation"; Section 4 "Third Party Data Release"; Section 6 "Indemnification" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); Section 11 "Proprietary Materials"; Section 13 "Records"; Section 17 "Limitation; Limitation of Liability"; and Section 8 of Exhibit 2 "Financial Obligation Upon Agreement Termination".

SECTION 21: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the "Permitted Purposes" as defined herein). For purposes of this paragraph, "Permitted Purposes" means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and performance, including, but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, a "limited data set" has the meaning set forth in HIPAA and "de-identified" means both member de-identification (as defined by HIPAA) and Employer de-identification (unless the work is being done in connection with Employer's Plan). Solely for the Permitted Purposes, Claim Administrator may release, or authorize the release of, a limited data set or de-identified data to a third party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for access to such data. Nothing in the paragraph is intended to expand or limit the terms and conditions of the Business Associate Agreement with respect to the permitted use or disclosure of PHI (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to Claim Administrator-assigned Employer Group and Identification number.

SECTION 22: THIRD PARTY RECOVERY VENDORS AND OUTSIDE ATTORNEYS

To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies prior to Claim Payments. Third parties' fees associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third party recovery identification and collection will be paid by Employer, in an amount not to exceed 25% of any recovered amount made by Claim Administrator and identified by Third Party Recovery Vendor or, no more than 35% of any recovered amount made by Claim Administrator's third party law firm, as identified in Exhibit 4 ASO BPA, and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

SECTION 23: NOTICE OF ANNUAL MEETING

Employer is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of Members of said Company, consistent with HCSC bylaws. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Section, the term "Member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan.

From time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 24: DEFINITIONS

24.1 "Accountable Care Organization" means a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

24.2 "Administrative Charge" means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

24.3 "Allowable Charge" means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. ***For Medical Network Providers -*** The Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

b. ***For Medical Providers other than Medical Network Providers ("Non-Contracting Providers") -*** The Allowable Charge will be the lesser of: **(i)** the Provider's billed charges, or; **(ii)** Claim Administrator's Non-Contracting Allowable Charge. Except as otherwise provided in this Section, the Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will be reimbursed at Claim Administrator's default percent of billed charges. Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event Claim Administrator does not have any claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

In the event the Non-Contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's Non-Contracting Allowable Charge for a particular service, the Covered Person may call the customer service number shown on the back of the Covered Person's Identification Card.

Notwithstanding anything to the contrary in the Group Health Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be consistent with the In-Network benefit level for Covered Services provided, the amount the Provider has agreed to accept as payment for Covered Services in accordance with a single case agreement, or 100% of billed charges, whichever is less.

Each of these amounts is calculated excluding any Network or Contracting Provider (Copayment) (or) (Coinsurance) imposed with respect to the Covered Person.

c. When Covered Services are received outside the state of New Mexico from a Provider who does not have a written agreement with Blue Cross and Blue Shield of New Mexico or with the local Blue Cross and Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

d. ***For Prescription Drug Benefits,*** the Allowable Charge is determined as follows:

(i) Participating Pharmacy, Employer – For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Charge, for purposes of calculating the Employer Payment, shall be the cost mutually agreed upon by the Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference.

(ii) Participating Pharmacy, Covered Person – For Participating Prescription Drug Providers, the Allowable Charge, for purposes of calculating the Covered Persons' required deductible and Coinsurance for Covered Services received from a Participating Prescription Drug Provider, is the cost agreed to by the Participating Prescription Drug Provider and Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, as applicable.

(iii) Out-of-Network Pharmacy – For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered, the Allowable Charge for purposes of calculating both the Employer Payment and the Covered Persons' required deductible and Coinsurance shall be the lesser of the charge which the particular Out-of-Network Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus 25% unless otherwise agreed upon by Claim Administrator and Employer.

e. ***For Covered Dental Services,*** if dental benefits coverage is elected on the most current ASO BPA, the Allowable Charge is determined in accordance with the type of dental benefits coverage elected:

(i) Participating Dentist – the amount the Dentist has agreed to accept as full payment for Covered Services.

(ii) Out-of-Network Dentist – Please refer to Plan Summary/Summary Plan Description for criteria used to establish the Out-of-Network Allowable Charge.

24.4 "Alternative Provider Compensation Arrangements" means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.5 "Alternative Provider Compensation Arrangement Payments" means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Homes payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 15.4 of Exhibit 2.

If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 24.5, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for Expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 15.4 of Exhibit 2. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Members, unless an alternate calculation method is used (in the same manner as described in Section 15.4 of Exhibit 2. Expected Payment may vary from Member to Member. For the purposes of this Section 24.5, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons.

Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by the Employer's Covered Persons per month.

Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable Expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM

or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

24.6 "Blue Cross Blue Shield Global Core Access Vendor Fees" means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

24.7 "Care Coordination" means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

24.8 "Care Coordinator" means an individual within a Provider organization who facilitates Care Coordination for patients.

24.9 "Care Coordinator Fee" means a fixed amount paid by a BlueCross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

24.10 "Claim" means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

24.11 "Claim Charge" means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction**.**

24.12 "Claim Payment" means Claim Administrator's payments under this Agreement based on the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Charge**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.13 "Coinsurance" means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

24.14 "Copayment" means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

24.15 "Covered Employee" shall have the same meaning as defined in Employer's Plan to the extent consistent with the ASO BPA.

24.16 "Covered Person" shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

24.17 "Covered Service" means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

24.18 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

24.19 "Fee Schedule" means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2.

24.20 "Fee Schedule Period" means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

24.21 "Global Payment/Total Cost of Care" means a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as Outpatient, Physician, ancillary, Hospital services, and prescription drugs.

24.22 "HIPAA" means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

24.23 "Hospital" means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

24.24 "Host Blue" means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

24.25 "Inpatient" means the Covered Person is a registered bed patient and treated as such in a health care facility.

24.26 "Negotiated Arrangement" means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

24.27 "Network" means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

24.28 "Non-Participating Healthcare Provider" means a healthcare Provider that does not have a contractual agreement with a Host Blue.

24.29 "Outpatient" means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

24.30 "Participating Healthcare Provider" means a healthcare Provider that has a contractual agreement with a Host Blue.

24.31 "Patient-Centered Medical Home" means a model of care in which each patient has an ongoing relationship with a Primary Care Physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

24.32 "Physician" means a physician duly licensed to practice medicine in all of its branches.

24.33 "Plan" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

24.34 "Primary Care Physician" means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

24.35 "Provider" means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services.

24.36 "Provider Incentive" means an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to, any measures or initiatives related to a particular population of Covered Persons.

24.37 "Services" means the services listed in Exhibit 1.

24.38 "Shared Savings" means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

24.39 "Supplemental Charge" means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any

customized reports, forms or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

24.40 "Surcharges" means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

24.41 "Timely" means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within ten (10) calendar days of notification to Employer by Claim Administrator, monthly fees (e.g. administrative) are due by the fifteenth (15th) of the month with a thirty-one (31) day grace period; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

c. With respect to all Plan information due Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

24.42 "Value-Based Program" means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions, including determination of pre-service or prior authorization of services. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care Providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care Providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer from listing below:

  a. ***Enrollment Materials.*** Implementation materials to be provided by Claim Administrator's Marketing Administration Division during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Provision of identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit Plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to a toll–free customer service telephone number.

  e. ***Medical Prior Authorization Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require prior authorization, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical prior authorization helpline for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

- **EXTERNAL REVIEW COORDINATION (if applicable)**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator's coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan's determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting processes at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service (IRS) 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND STATISTICAL**

  Determination of Claims projections and pricing of administrative services and stop–loss coverage.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 3.

- **EMPLOYER PORTAL (currently called BLUE ACCESS® FOR EMPLOYERS)**

  Provide Employer with an on-line resource that allows employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called BLUE ACCESS® FOR MEMBERS)**

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying claims status, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers including, if also applicable, Primary Care Physicians within the designated service area.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current ASO BPA)***

  Provide a program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by Employer and agreed to by Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING (*If elected on the most current ASO BPA)***

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING (RBP) (*If elected on the most current ASO BPA)***

Assist Employer with establishing a maximum coverage amount for specified imaging, inpatient, and outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT *(if elected on the most current ASO BPA)***
  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app or similar technology), where available.
- **SUMMARY OF BENEFITS AND COVERAGE (SBC) *(if elected on the most current ASO BPA)***
  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.
- **MSP INFORMATION REPORTING**
  Pursuant to Exhibit 2, Section 17 entitled "MEDICARE SECONDARY PAYER INFORMATION REPORTING", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.
- **UNCASHED FUNDS**
  Regarding outstanding funds that are or become "stale" (over 365 days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible, escheat such funds to state of payee's last known address on behalf of Employer, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.
- **ADDITIONAL SERVICES NOT SPECIFIED**
  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge in accordance with Los Alamos County Procurement Code.
- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**
  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations.
- **HEALTH ADVOCACY SOLUTIONS (*If elected on the most current ASO BPA*)**
  Provide a program that may include Holistic Health Management, Member Rewards, utilization management, access to clinical and non-clinical Health Advocates, or such other features as determined by Employer and agreed to by Claim Administrator.
- **WELLBEING MANAGEMENT**
  (IF ELECTED ON THE MOST CURRENT BPA). Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator.
- **DISABLED DEPENDENT VERIFICATION**
  Determine the disabled status of any dependent children of Covered Persons, for purposes of administering the Group's age limit for eligibility. Determination will be made based on Claim Administrator's review of clinical information received by Claim Administrator from the Covered Person or the dependent's medical provider(s).

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Exhibit. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA and the PBM Exhibit; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Exhibit; or iii) the date the Agreement is terminated (or in the case of the PBM Exhibit, the date such Exhibit is terminated).

Inter-Plan Arrangement Fees:

i. **BlueCard® Program/Network access fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable;

ii. **Negotiated Arrangement/Custom fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s);

iii. **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**Such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or $2,000 per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 24 AGREEMENT DEFINITIONS of the Agreement.

2.1 "Employer Payment" means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 "Employer Payment Method" means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 "Employer Payment Period" means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 "Medicare Secondary Payer ("MSP")" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 17 of this Exhibit titled "MEDICARE SECONDARY PAYER INFORMATION REPORTING.")

2.5 "Run–Off Claim" means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 "Run–Off Period" means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 "Termination Administrative Charge" means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the Agreement or partial termination of Covered Employees, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** Employer will pay service charges to Claim Administrator, in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining service charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing service charges.*** Such service charges shall be subject to change by Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that ninety (90) days prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- 10% from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, producer/broker fees, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service charges upon termination.*** In the event the Agreement is terminated in accordance with the "TERM AND TERMINATION" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

3.5 ***Additional service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to Employer and/or any other fees for services mutually agreed upon by the parties in writing.

3.6 ***Effect of Plan enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

4.3 ***Covered Person's certain liability.*** Under certain circumstances, if Claim Administrator pays the healthcare Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period**.**

5.2 ***Confirmation or notification of amount due and payment due date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

- **a.** ***If Employer Payment Method is by check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If Employer Payment Method is other than check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties, of the amount due. Employer Payment must be made or obtained within ten (10) calendar days of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer Payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no condition will Claim Administrator be responsible for payment of Reinsurance Contributions.

5.4 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim settlement shall be determined for each Claim settlement period indicated in the Fee Schedule specifications of the most current ASO BPA. The Claim settlement shall reflect the sum of the following:

- **a.** Claim Payments paid by Claim Administrator in the particular Claim settlement period.
- **b.** Claim Payments paid by Claim Administrator in prior Claim settlement periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the "Claim Settlement Total."

6.2 ***Employer underpayment.*** If, within the Claim settlement period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within sixty (60) days from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer overpayment.*** If, within the Claim settlement period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice in accordance with Section 8 of the Agreement.

No such termination will take place without a reasonable attempt to contact the Employer pursuant to Section 16 herein and allow the Employer to make corrective action. No termination will occur without written notification indicated in 8.2, above.

7.2 ***When Claim Administrator fails to Timely notify.*** Pursuant to Section 20 "SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

7.3 ***Late charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 8 of the Agreement, or on the date of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims

have been made by Claim Administrator, as of the date of termination or partial termination, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of partial termination. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments and the applicable service charges for such Extended Benefits.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

8.3 ***Final Settlement.*** A final settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed funds.*** As of the date of termination of the Agreement, any outstanding funds that are or become "stale" (over 365 days old) will be escheated by Claim Administrator, on Employer's behalf, in accordance with the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

Employer represents that it acknowledges and has communicated the substance of the provisions stated in each of the following sections of this Exhibit 2 (Sections 10 and after) to its Covered Persons, with modifications appropriate for communications with Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim Payment.*** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in 10.3, below. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***Claim dispute.*** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

10.3 ***Invalidity of assignments.*** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign

or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing a Provider.*** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider.

11.2 ***Claim Administrator's role.*** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service.

Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

11.3 ***If point–of–service coverage applies.*** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. ***Physician Selection.***

A Covered Person shall be entitled to select a Primary Care Physician through the Plan to act as the Covered Person's principal care giver and to provide or arrange for the provision of medical care.

b. ***Changing Physician Selection.***

Both the Covered Person and the Primary Care Physician may request a change from one Primary Care Physician to another by notifying Claim Administrator of the desire to change; provided, however, such a request by a Primary Care Physician shall not be based upon the type, amount or cost of services required by the Covered Person or the physical condition of the Covered Person except where reasonably necessary to provide optimal medical care.

11.4 ***Intent of terminology.*** The use of an adjective such as but not limited to, 'Approved,' 'Administrator,' 'Participating,' 'In–Network' or 'Network' in modifying the term 'Provider' shall in no way be construed as a recommendation, referral or statement as to the ability or quality of such Provider. Conversely, the omission, non-use or non-designation of the foregoing adjectives, or, alternatively, any similar modifier, or, alternatively, the use of a term such as 'Non-Approved,' 'Non-Administrator,' 'Non-Participating,' 'Out-of-Network,' or 'Non-Network' should not be construed as carrying any statement or inference, whether negative or positive, as to the ability or quality of such Provider.

11.5 ***Provider's role.*** Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (other than as an individual Covered Person) or the Plan.

SECTION 12: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non–Network professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Fee Schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance

and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

13.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, Section 24.3, subsection (d)(ii). All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, Section 24.3, subsection (d)(iii).

13.2 Claim Administrator hereby informs Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers)" for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual Network savings achieved for Covered Persons will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

13.3 Employer understands that Claim Administrator may receive such discounts during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator. For the mail-order pharmacy and specialty pharmacy program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

13.4 "Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34 day supply increments so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

13.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as

expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement. Additional information about these types of fees or the amount of these fees is available upon request.

SECTION 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

14.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC.

14.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM and Claim Administrator's own rebate contracts with pharmaceutical manufacturers. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls, and rebate arrangements between Claim Administrator and pharmaceutical manufacturers. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Claim Administrator may provide Employer with a rebate credit, the amount of which is set forth in the ASO BPA (the "Rebate Credit"). The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates provided to Claim Administrator by the PBM or pharmaceutical manufacturers. Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

14.3 As of the Effective Date, the maximum that a PBM has disclosed to Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%)of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to PBM at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed..

SECTION 15: INTER-PLAN ARRANGEMENTS

15.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator.

Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

15.2 *BlueCard® Program*

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Healthcare Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Claim Administrator's action will be consistent with the spirit of this description.

a. *Liability Calculation Method – In General*

(1) Covered Person Liability Calculation.

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on Claims for Covered Services will be based on the lower of the Participating Healthcare Provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

(2) Employer's Liability Calculation.

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

b. *Claims Pricing*

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

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

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

not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

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

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

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

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

c. *BlueCard Program Fees and Compensation*

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 15.9 below.

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer.

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Claim Administrator will pay the Host Blue's access fee and pass it along to Employer as stated above even though Employer paid little or had no Claim liability.

15.3 ***Negotiated Arrangements***

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue.

In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's Negotiated Arrangement(s) for national accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

a. ***Covered Person and Employer Liability Calculation***

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under 16.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area.

Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under 15.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments.

If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments.

Employer acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 15.9 below.

In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

15.4 ***Special Cases: Value-Based Programs***

a. ***Value-Based Programs Overview***

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

b. ***Value-Based Programs under the BlueCard Program***

(1) ***Value-Based Programs Administration***

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these Provider payments to Claim Administrator, which Claim Administrator will pass on to Employer in the form of either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

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

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

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

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

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

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

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

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

The Host Blue will not receive compensation resulting from how estimated average or PMPM price methods, described above, are calculated. If Employer terminates, Employer will not receive a refund

or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

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

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

(2) ***Care Coordinator Fees***

Host Blues may also bill Claim Administrator for Care Coordinator Fees for Provider services which Claim Administrator will pass onto Employer as follows:

a) PMPM billings; or

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

As part of this Agreement, Claim Administrator and Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

c. ***Value-Based Programs under Negotiated Arrangements***

If Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in BlueCard Program section.

15.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

15.6 ***Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees***

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, Claim Administrator will include any such surcharge, tax or other fee to Employer, which will be Employer's liability.

15.7 ***Non-Participating Healthcare Providers Outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Health Care Providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's Non-Participating Healthcare Provider local payment or the pricing requirements required by applicable law. The Covered Person may be responsible for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

a. In certain situations, Claim Administrator may use other payment bases to determine the amount Claim Administrator will pay for services rendered by Non-Participating Health Care Providers, such as:

i. Billed charges for Covered Services;

ii. The payment Claim Administrator would make if the healthcare services had been obtained within Claim Administrator's service area;

iii. A special negotiated payment, as permitted under Inter-Plan Arrangements; or

iv. The lessor of

1. the amount described in (1), above; or

2. for professional Providers, a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or for hospital or facility Providers, a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, a Covered Person may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 15.9 below.

15.8 ***Blue Cross Blue Shield Global Core®***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rice and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), the Covered Persons may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, the Covered Persons will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

(1) Inpatient Services

In most cases, if Covered Persons contact the Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the

Hospital will submit the Covered Person's Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

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

(3) Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Covered Persons need assistance with their Claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

b. ***Blue Cross Blue Shield Global Core Program-Related Fees***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core Program are available upon request. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 15.9 below.

15.9 ***Modifications or Changes to Inter-Plan Arrangement Fees or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective after ninety (90) days in accordance with Section 8.2(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

SECTION 16: MEDICARE SECONDARY PAYER INFORMATION REPORTING

16.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan Employer agrees so that Claim Administrator's ability to may make accurate primary/secondary MSP determinations depends on the breadth and accuracy of Claim Administrator's files concerning Covered Persons and the number of

individuals employed by Employer. Employer agrees to Timely and accurately use its best efforts in responding promptly and accurately respond to Claim Administrator's requests for information.

16.2 [Intentionally Omitted]

16.3 [Intentionally Omitted]

16.4 Further, to assure the continuing accuracy of Claim Administrator's files, Employer agrees that it is Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute.

16.5 Disclosure Statement: Employer acknowledges that Claim Administrator has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 17: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

17.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

- **a.** Claim Administrator on behalf of Employer has the right to reimbursement for all benefits Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the Provider's Allowable Charge for Covered Services for which Claim Administrator has provided benefits to the Covered Person.
- **b.** Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

17.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 18: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain replacement coverage, subject to the replacement coverage's applicable terms. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Hose Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 18.

EXHIBIT 3

ASO BENEFIT PROGRAM APPLICATION (“ASO BPA”)

AGR18-704-A-2
Exhibit "C"
EXHIBIT 3

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Services Corporation, a Mutual Legal Reserve Company, hereinafter referred to as the "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 251305 Group Number(s): 251307 Section Number(s): All

Legal Employer Name: Incorporated County of Los Alamos

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED.)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan* Administrator*: _____ Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date 01/01/2020 End Date 12/31/2020 (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/Day/Year) 01 / 01 / 2020

Anniversary Date: (Month/Day/Year) 01 / 01 / 2021

Account Information ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111 Employer Identification Number (EIN): 856000679

Address: 1000 Central Avenue Suite 230

City: Los Alamos State: NM ZIP: 87544

Administrative Contact: Kat Brophy Title: Benefits & Pension Manager

Email Address: kat.brophy@lacnm.us Phone Number: 505-662-8045 Fax Number: 505-662-8000

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered: Employer Identification Number (EIN):

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Blue Access for Employers (BAE) Contact: Kat Brophy
(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: kat.brophy@lacnm.us Phone Number: 505-662-8045 Fax Number: 505-662-8000

☒ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

ATTACHMENT C

Producer of Record Information ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for the Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

Producer, Agency, or Consultant: Commission to be paid: ☐ Yes* ☐ No

New Mexico Producer/Consultant #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email:

Is Producer/Agency appointed with HCSC in New Mexico? ☐ Yes ☐ No

*****The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Schedule of Eligibility ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

1. **Eligible Person means**:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of: (*name of union*)
   - ☐ A part-time employee of the Employer.
   - ☐ A retiree of the Employer. Define criteria: _____
   - ☐ Other:

   Are any classes of employees to be excluded from coverage? ☐ Yes ☐ No

   If yes, please identify the classes and describe the exclusion: _____

2. **Employee definition**:

   Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 20 hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

   Part-Time Employee means:
   - ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

3. **The Effective Date of termination for a person who ceases to meet the definition of Eligible Person**:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan **(**The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
   - ☐ The date of employment.
   - ☐ The _____ day of employment.
   - ☐ The _____ day of the month following _____ month(s) of employment.
   - ☐ The _____ day of the month following _____ days of employment.
   - ☒ The 1st day of the month following the date of employment.
   - ☐ Other: _____

   Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No

   Are there multiple new hire waiting periods? ☐ Yes ☐ No

   If yes, please attach eligibility and contribution details for each section.

5. **Domestic partners covered**: ☐ Yes ☒ No

   If yes, a domestic partner is eligible to enroll for coverage.

   If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

   If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No

   If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners.

6. **Limiting Age for covered children**: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

7. **Termination of coverage upon reaching the Limiting Age**:
   - ☐ The last day of coverage is the day prior to the birthday.
   - ☒ The last day of coverage is the last day of the month in which the limiting age is reached.
   - ☐ The last day of coverage is the last day of the billing month.
   - ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   - ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Automatically cancel dependents when they reach the day their coverage terminates? ☒ Yes ☐ No

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee?

   ☐ Yes ☒ No

   However, such coverage shall be extended in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

8. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

   ☐ Yes (specify number of days below) ☒ No

   Temporary Layoff: days Disability: days Leave of Absence: days

   However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

9. **Enrollment**:

   ***Special Enrollment**:* An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's

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Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period: ??????

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

Select one of the provisions below:

☒ Open Enrollment – Late applicants may only apply during Open Enrollment.

☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the off cycle allowed rules.

10. * Does COBRA Auto Cancel apply? ☒ Yes ☐No
Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.
**Not recommended for accounts with automated eligibility*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

☐ **NO CHANGES** ☒ **Current number of Employees enrolled** 501 ☐ **SEE ADDITIONAL PROVISIONS**

1. Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above). **Total number of employees** presently eligible for coverage: _____
2. Total number of employees serving new hire eligibility period: _____
3. Total number of employees with other coverage (i.e., other group coverage, Medicare, Medicaid, TRICARE/Champus): _____
4. Total number of individuals currently covered under COBRA: _____

Lines of Business (Check all applicable services)	☐ **NO CHANGES** ☐ ***See Additional Provisions***
Medical Plan Services: ☐ PPO: Plan Name ☒ Dual Option Plan Name: Blue PPO 35 Plan Name: Blue PPO 45 ☐ EPO ☐ POS Consortium Pricing (National Groups) ☐ Yes ☐ No Other: **Additional Services:**	**Consumer Driven Health Plan:** ☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)* ☐ FSA (Vendor: Select Vendor) ☐ HSA: (Vendor: Select Vendor) **Traditional Coverage:** ☐ Out-of-Area (Indemnity) **Prescription Drugs:** ☒ Covered under a pharmacy benefit *(If selected, the*

☐ Blue Care Connection® ☒ Wellbeing Management ☐ Wellness Incentives ☐ Health Advocacy Solutions ☐ Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)* ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☒ Other Well onTarget ☐ Other	*PBM Fee Schedule Addendum must be attached and is part of this BPA)* ☐ Covered under the medical benefit **Pharmacy Network (Select one):** ☒ Traditional Select Network ☐ Advantage Network ☐ Preferred Network ☐ Elite Network ☐ Network on PBM Fee Schedule Addendum Drug List**:** Basic Drug List Other (please specify): _____ **Ancillary Services:** ☐ Dental Plan Services ☐ Vision Plan Services ☒ Stop Loss *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)* ☒ Life or Disability Insurance provided by separate carrier *(if selected, complete separate application)* ☐ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum)*

FEE SCHEDULE

Payment Specifications ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Payment Method: ☐ **Online Bill Pay** ☒ **Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi-Monthly** ☐ **Monthly**

Claim Settlement Period: ☒ **Monthly**

Run-Off Period: Employer Payments are to be made for 12 months following end of Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: Months.

Administrative Per Employee Per Month (PEPM) Charges ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

	Medical			
Administrative Fee	**$58.26**	**$**_____	**$**_____	**$**_____
Dental	**$**_____	**$**_____	**$**_____	**$**_____
Limited Fiduciary Services	**$included**	**$**_____	**$**_____	**$**_____
Management of the Virtual Visits Program	**$included**	**$**_____	**$**_____	**$**_____

Blue Care Connection®	$_____	$_____	$_____	$_____
Wellbeing Management	$included	$_____	$_____	$_____
Health Advocacy Solutions	$_____	$_____	$_____	$_____
*Rebate Credit for the Prescription Drug Program	$-29.13	$_____	$_____	$_____
Commissions	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	$29.13	$_____	$_____	$_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
	Total:	$_____

Other Service and/or Program Fee(s) ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

External Review Coordination: ☒ Yes ☐ No

If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan.

Employer elects the following process:

☒ Federal Affordable Care Act Process

☐ Employer has selected outside External Review alternatives. Name of outside ERO vendor:

Reimbursement Service: ☒ Yes ☐ No

If yes*:* It is understood and agreed that in the event BCBSNM makes a recovery on a third-party liability claim, BCBSNM will retain 25% of any recovered amounts other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by BCBSNM's Third-Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSNM's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for Covered Services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☒ Yes ☐ No

If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Agreement or partial termination of Covered Employees****,* the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Agreement or partial termination of Covered Employees****,* the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category (*per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factor shown below.

Service	**Medical**			
Medical Run-off Administration Charge:	**$23.32**	**$____**	**$____**	**$____**
Dental Run-off Administration Charge	**$____**	**$____**	**$____**	**$____**
Miscellaneous	**$____**	**$____**	**$____**	**$____**
Miscellaneous	**$____**	**$____**	**$____**	**$____**

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Total:	**$23.32**	**$_____**	**$_____**	**$_____**

Other Provisions

☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. Summary of Benefits & Coverage:

a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

☒ Yes. Please answer question b. The SBC Addendum is attached.

☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

b. Will Claim Administrator distribute the Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.

☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Massachusetts Health Care Reform Act:

Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. Alternative Care Management Program (this is a component of the purchased medical management program):

☒ Yes ☐ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. Prior Authorization (this is a component of the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No

If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("EHB") Election:

Employer elects EHBs based on the following:

1. ☒ EHBs based on a HCSC state benchmark:
   ☐ Illinois ☐ Oklahoma ☐ Montana ☐ Texas ☒ New Mexico
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: ___
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Illinois benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation: The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: 1. Claim payments are settled within 10 days. 2. BlueCard Program/Network Access fees are the lesser of up to 10% of the discount or $2000 per claim. 3. Admin fee includes Claims Fiduciary, Wellbeing Management and Virtual Visits(MDLIVE). 4. The medical admin fee is capped at $61.09 for 2021. 5. Administrative

services includes performance guarantees for services and discounts. The PG Exhibit, Network Discount Exhibit and PG Addendum are part of this BPA.

I UNDERSTAND AND AGREE THAT:

1. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Signature

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

AGR18-704-A-2
Exhibit "C"
EXHIBIT 3

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ ZIP _____

Dated this _____ day of _____
Month Year

EXHIBIT 4
PHARMACY BENEFIT MANAGEMENT (PBM) ADDENDUM

PHARMACY BENEFIT MANAGEMENT SERVICES

(TRADITIONAL PRICING)

(FOR USE ONLY FOR 151+ EMPLOYEES)

EFFECTIVE DATE OF THIS EXHIBIT: JULY 1, 2018

1. **Pharmacy Management:** Claim Administrator has contracted with Prime Therapeutics LLC (Prime) and/or other pharmacy benefit manager(s), mail order pharmacies, specialty pharmacies or other pharmacies to furnish certain pharmacy benefit management and other prescription drug benefit programs, including Rebate management and fee schedule management, including but not limited to MAC List management. Other services Prime will provide may include certain account management, clinical management, Drug List management, and Utilization Management services as set forth in the agreement between Prime and Claim Administrator. Claim Administrator reserves the right to contract with other Pharmacy Benefit Managers and pharmacies for such services. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

The Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. The Employer further understands and agrees that fees and compensation that Prime receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to the Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Services to be provided include Drug List/Rebate Management Services; management of the pharmacy networks for Members; Claims processing (electronic and paper); management of clinical management programs; reporting and account support services. Claim Administrator pays a fee to Prime for pharmacy benefit management services, which may be factored into the pricing set forth in the ASO BPA and the PBM Fee Schedule Addendum to the ASO BPA (the "BPA Addendum").

3. **Drug List Services:** Claim Administrator utilizes its own Drug List and Prime supports Claim Administrator in the development, maintenance and updating of such Drug List. Prime performs Drug List exception reviews in accordance with the agreement between Prime and Claim Administrator. Prime provides Drug List management services, in accordance with NCQA and URAC standards, to Claim Administrator in supporting the Claim Administrator Pharmacy and Therapeutics ("P&T") and Business Committees.

Employer acknowledges and agrees that Claim Administrator may, in a manner consistent with the Benefit Plan, promote the dispensing of pharmaceuticals in a manner consistent with the designated Drug List.

4. **Prime's Rebate and Manufacturer Administrative Fee Management:** In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement.

In addition, Prime has advised Claim Administrator that Prime receives Manufacturer Administrative Fees as compensation for bona fide administrative services performed by Prime for the Manufacturer. Claim Administrator may also negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement. Prime or Claim Administrator contracts with Manufacturers for Rebates and Manufacturer Administrative Fees on its own behalf (or Claim Administrator's behalf, as applicable) and for its own benefit (or Claim Administrator's benefit, as applicable), and not on behalf of Employer. Accordingly, Prime (or Claim Administrator, as applicable) retains all right, title and interest to any and all actual Rebates and/or Manufacturer Administrative Fees received from manufacturers. Prime has advised Claim Administrator that Rebate arrangements are based on volume purchase discounts or other similar arrangements with Manufacturers. Employer will be provided with applicable Rebate Credits as set forth in the Agreement, the BPA, the Section of this PBM Exhibit entitled Rebates and in the PBM Fee Schedule Addendum to the BPA but otherwise shall have no right, title or interest in Rebates received by Prime, Claim Administrator under its agreement with Prime, or Claim Administrator under its agreements with Manufacturers. Employer shall have no right, title or interest in Manufacturer Administrative Fees. Prime may retain Manufacturers Administrative Fees or pass them along, in whole or in part, to Claim Administrator in accordance with Prime's agreement with Claim Administrator. As of the Effective Date, Prime has disclosed to Claim Administrator that the maximum that Prime will receive from any Manufacturer for Manufacturer Administrative Fees is five and one-half percent (5.5%) of the wholesale acquisition cost ("WAC") for all products of such Manufacturer dispensed during any given calendar year to members of Claim Administrator, as applicable; provided, however, Claim Administrator will advise Employer if such maximum has changed.

5. **Disclosures:** All other disclosures set forth in the Agreement will apply to pharmacy benefit management services.

6. **Pharmacy Network**

a. **Network Establishment and Maintenance:** In Prime's agreement with Claim Administrator, Prime has agreed to provide and maintain a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. The Employer acknowledges that in negotiating the Agreement and this Exhibit, it has taken into consideration that Claim Administrator and/or Prime will keep a portion of the discounts and/or other allowances that Claims Administrator or its pharmacy benefits manager has negotiated with the Network Participant. Prime will implement the methodology described in the Allowable Charge when calculating the Network Participant reimbursement, Copayment/Deductible, and Coinsurance amounts. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member.

b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts not to make payments to providers that are not licensed as required by law or that have been debarred, suspended or otherwise excluded from a federal or state program.

c. **Prime Maximum Allowable Cost ("MAC") Lists:** Prime owns and will maintain proprietary database listings of multi-source pharmaceutical drug products and supplies that also identifies a recommended maximum allowable cost for drugs or supplies within specified categories, commonly referred to as Prime's MAC Lists.

d. **Pharmacy Locator:** Prime will provide a means, either toll-free telephone line or electronic, to enable Members to identify Network Participants in a particular area.

e. **Mail Service:** Prime will provide or cause to be provided a mail order prescription drug service through which Members may receive Covered Prescription Drug Products and Services through the mail ("Mail Service"). Upon termination of the Agreement between Claim Administrator and Employer, Prime agrees to provide or cause to be provided mail order open refill and prior authorization files for purposes of transition to any new vendor selected by Employer at Prime's standard rate. Mail service and specialty pharmacy operates through an affiliate partially owned by Prime Therapeutics LLC.

f. **Pharmacy Network Audit Services:** Prime will perform or cause to be performed pharmacy Claims audits to promote Network Participant contract integrity.

g. **Audits:** In addition to the audit rights available elsewhere in the Agreement, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the Agreement. Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from Claim Administrator or Prime without prior written approval by Prime. Employer will bear its own cost and expenses for all such audits.

h. **Specialty Pharmacy:** Claim Administrator and Prime have contracted with specialty pharmacies and/or vendors to provide Members with access to in-network benefits for covered Specialty Drugs.

7. Claims Processing

a. **Adjudication of Prescription Drug Claims from Network Participants:** Prime will process Claims for Prescription Drugs Products and Services electronically submitted by Network Participants through the Claims Adjudication System, according to Benefit Plan benefit and eligibility information submitted by Claim Administrator to Prime and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Prime will also process and pay Paper Claims received from a Member at the benefit level set forth in the Benefit Plan, and based on the Allowable Charge, in accordance with the terms of the Benefit Plan, provided that the Benefit Plan allows such reimbursement.

b. **Material Change to AWP:** If after the Effective Date: (i) changes to the formula, methodology or manner in which AWP is calculated or reported by Medi-Span take effect or (ii) Medi-Span ceases to publish AWP for the Covered Prescription Drug Services under this Exhibit, then the financial terms of this Exhibit shall be automatically adjusted at the time of such change to return the parties to their respective economic positions as they existed under the Agreement immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Exhibit shall immediately and automatically be converted to an alternative pricing benchmark determined by Prime.

c. **Statement of Account:** Prime will furnish to Claim Administrator, at least weekly, a statement of account of the amount of payments that have become due for Claims processed by Prime.

d. **NDC File:** Prime will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC.

e. **Help Desk Service:** Prime will provide help desk service for pharmacist Claim and Benefit Plan inquiries.

8. Benefit Plan Design:

In the event the Employer wishes to implement Benefit Plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the ASO BPA Addendum will no longer be applicable and new ASO BPA Addendum pricing will need to be negotiated.

9. Term This PBM Exhibit will be in effect for the term of the Agreement or the Term as stated in the ASO BPA Addendum, whichever is shorter (the "Term").

10. Termination

This Exhibit may be terminated as follows:

a. By either party at the end of any period(s) of time for which guaranteed pricing is defined in the BPA Addendum ("Guaranteed Period(s)") upon ninety (90) days prior written notice to the other party; or

b. By both parties on any date mutually agreed to in writing; or

c. By termination of the entire Agreement by either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA upon ninety (90) days prior written notice to the other party; or

d. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Exhibit, upon written notice as provided in the "Notices" section of the Agreement; or

e. By Claim Administrator, upon the Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and ASO BPA Addendum.

11. Program Pricing Terms

The pricing terms for Pharmacy Benefit Management services are as follows:

a. **Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the pharmacy program at the pricing set forth in the ASO BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible and/or Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services. Member will pay the lower of the discounted AWP plus Dispensing Fee and applicable taxes, U&C, or Member Copayment/Deductible or Coinsurance. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

b. **Mail Service Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the mail pharmacy program at the pricing set forth in the ASO BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible, Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the mail order pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services. Member will pay the lower of the discounted AWP, U&C, or Member Copayment/Deductible or Coinsurance. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

c. **Specialty Drug Claims**

If covered under Employer Benefit Plan, notwithstanding anything to the contrary in Sections a and b above and elsewhere in the Agreement, Employer will reimburse Claim Administrator for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the lesser of (i) the pricing set forth in the BPA Addendum or (ii) the U&C price on the date the prescription transaction is processed, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other specialty pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims are not included in the retail and mail pharmacy pricing described above. Members will pay the lesser of the contracted rate, U&C, or Member Copayment/Deductible or Coinsurance.

d. **Copayments/Deductibles/Coinsurance**

The Brand Drug and Generic Drug Copayment/Deductible and Coinsurance will apply as indicated in the applicable Drug List for Employer.

e. **Rebates**

Rebate credits are paid prospectively to Employer as a credit on the monthly billing statement and shall not continue after termination of the Prescription Drug Program or the PBM Exhibit. Additional information about rebates and rebate credits are included in the Agreement and the ASO BPA.

12. DEFINITIONS

Certain terms are defined in the Administrative Services Agreement, but the following terms and phrases will have the meaning set forth below, for purposes of the services described in this Exhibit.

1. "Average Wholesale Price" or "AWP" means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the NDC-11 of the package size submitted.

2. "Benefit Plan" means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.

3. "Brand Drugs" means a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.

4. "Claim" or "Claims" means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.

5. "Claim Administrator" has the meaning set forth in the Agreement.

6. "Claims Adjudication" means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

7. "Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Allowable Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member's Benefit Plan.

8. "Copayment/Deductible" means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member's Benefit Plan.

9. "Covered Prescription Drug Products and Services" means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member's Benefit Plan, subject to any Copayment/Deductible or Coinsurance.

10. "Dispensing Fee" means the fee required to be paid to the Network Participant for the professional service of filling a prescription and is added to the Ingredient Cost for the prescription.

11. "Drug Utilization Review" or "DUR" means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Member's Benefit Plan. DUR can be prospective, concurrent or retrospective.

12. "Drug List" means a list of pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

13. "Generic Drug" means a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective

date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.

14. “Ingredient Cost” means the amount required to be paid to a Network Participant for a prescription drug and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable to such Network Participant for the given prescription drug and the professional service of dispensing such drug.

15. "MAC List" means the list of unit prices established by PBM for multi-source Covered Drugs, each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by PBM and updated from time to time at PBM's sole discretion.

16. “Mail Service” means the service through which Members may receive Covered Prescription Drug Products and Services through the mail.

17. “Manufacturer” means a company that manufactures, and/or distributes pharmaceutical drug products.

18. “Manufacturer Administration Fee” means all fixed fees received by Prime from any given Manufacturer relating to administration of Rebates under a Manufacturer Agreement.

19. “Maximum Allowable Cost” or “MAC” means the highest Ingredient Cost at which a Benefit Plan will reimburse any Network Participant or Member for a specific drug for products present on the MAC List at the time of service.

20. “Member” or “Members” means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.

21. “Network Contract” has the meaning set forth in the definition of “Network Participant.”

22. “Network Participant” means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement with Prime or Claim Administrator (“Network Contract”) to provide Covered Prescription Drug Products and Services to Members, as may be amended.

23. “Paper Claims” means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.

24. “Pricing Source” means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which established and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services. Claim Administrator will only use a single nationally recognized pricing source at any given time.

25. “Provider Tax” means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

26. “Rebate(s)” means compensation or remuneration of any kind received or recovered by Prime from any Manufacturer which is directly or indirectly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees which Prime is entitled to retain pursuant to the Agreement and this Exhibit unless otherwise required by law.

27. “Rebate Management Services” means the services which Prime is obligated to provide pursuant to Section 4.

28. “Specialty Drugs” means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are for serious or chronic conditions, oral medications and/or that have special handling or storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by Prime and subject to change.

29. “Usual and Customary” or “U&C” means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

30. “Utilization Management” means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members. Such services include, but are not limited to the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.

31. “Zero Balance Due Claim” means any Claim where the Member cost share covers 100% of the Allowable Charge for such Claim.

AGR18-704-A-2
Exhibit "C"
EXHIBIT 4

PBM Fee Schedule Addendum to the Benefit Program Application

Incorporated County of Los Alamos	
Term: 01/01/2020-12/31/2020	**Employees:** 493
Guaranteed Traditional Aggregate Pricing Arrangement D[1]* **Traditional Select Network and Basic Drug List**	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
18.50%	79.00%
DISPENSING FEE	
Brand	**Generic**
$1.15	$1.15
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
20.50%	83.00%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
19.75%	80.50%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 17.00%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	$29.13

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

[1] Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

a. "Brand" products include "Brand Drugs" as defined in the PBM Exhibit and also include generic products that are available from no greater than three (3) generic manufacturers; and
b. "Generic" products include all products not defined in (a), above, as "Brand" products.

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer's Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

Signature of Authorized Purchaser

Print Name

Title

Date

ATTACHMENT C

EXHIBIT 5
PG ADDENDUM

PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Administrative Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current Fee Schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current Fee Schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and its most current Exhibit-PG.

SECTION I
TIMING

A. The period for which the Claim Administrator's performance will be measured and for which Employer may receive a refund is referred to as the Settlement Period and is indicated on the most current Exhibit-PG.

B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG provided all of the requirements listed below are completed. The requirements are as follows:

1. Benefit information and claims administrative procedures have been provided by Employer to the Claim Administrator,

2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto the Claim Administrator's claims processing system,

3. Accurate and complete membership information has been received and loaded onto the Claim Administrator's claims processing system, and

4. Transfer Payment procedures have been established in accordance with the Agreement.

SECTION II
DETERMINATION

A. The Claim Administrator agrees to guarantee performance levels as indicated on the most current Exhibit-PG. In the event that the Claim Administrator's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG during a Settlement Period for which the Claim Administrator's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Claim Administrator's normal business operation, the Claim Administrator will be responsible for reimbursing Employer a portion of the Administrative Charge.

B. The Claim Administrator will measure Performance Guarantees and report the measurement results to Employer, and any refund amounts due in accordance with this Addendum PG within

120 days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

C. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon until the Administrative Services Agreement (including the most current Exhibit-PG) has been executed and is on file with the Claim Administrator by the close of the applicable Settlement Period.

D. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon for any portion of the Settlement Period in which the Employer:

1. Fails to provide the Claim Administrator with Timely changes in enrollment or membership information or any other reports or information as may be necessary for the Claim Administrator to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or

2. Fails to pay Administrative Charges in accordance with the terms of the Agreement or comply with all established Transfer Payment procedures.

E. The Claim Administrator will not be obligated to measure any Performance Guarantee impacted by changes requested in writing by Employer during the time period required to modify the Claim Administrator's system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to the Claim Administrator in accordance with the Agreement.

F. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Claim Administrator, Medicare payment systems, or if the enrollment of the Plan's benefit coverage administered by the Claim Administrator varies in number of enrolled Covered Employees as indicated in the most current Exhibit-PG attached to and made a part of this Addendum during any Settlement Period, the Claim Administrator reserves the right to re-evaluate and renegotiate the level of performance and/or the Administrative Charges at risk in this Addendum PG and the attached Exhibit-PG..

G. If for any reason the Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and Employer will not receive any refund, based on that part of the Settlement Period in which the Administrative Services Agreement was in effect.

H. If (i) changes to the formula, methodology or manner in which a third-party benchmark (such as AWP) is calculated or reported take effect, or (ii) such third party ceases to publish such benchmark, then the performance guarantees and/or standards based on such benchmark in this Agreement, if any, shall be re-evaluated and adjusted or converted to an alternative benchmark by Claim Administrator or its designee at the time of such change to return the parties to their respective economic positions with respect to such guarantees and/or standards as they existed under the Agreement immediately prior to such change.

EMPLOYER NAME: COUNTY OF LOS ALAMOS Employer Account Number: 251305
Employer Group Number: 251307

Effective for the Settlement Period beginning **January 1, 2020, and ending December 31, 2020**

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **450** Covered Employees. Performance measurement will begin **January 1, 2020**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Claims Processing Turnaround Time – All Claims	**Claims Processing Turnaround Time** means the period beginning on the date the Claim Administrator or Host Blue Plan receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Claim Administrator. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days. Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on claims processed for those customers assigned to the Unit.	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 1% 2%
Claim Processing Accuracy	**Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Claim Processing Accuracy refers to Claims without processing errors such as: 1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy	95.0% - 100% 93.0% - 94.9% 0% - 92.9%	0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of claims processed for those customers assigned to the Unit.		
Claim Financial Accuracy	**Claim Financial Accuracy** means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims paid during the Settlement Period. Total dollars overpaid and total dollars underpaid are projected over each stratum. Claim Financial Accuracy is computed by summing the projected overpayments and the projected underpayments (*absolute value*) from each stratum and dividing by the total dollars paid in the population. The end result is subtracted from one for the accuracy rate. Measurement is based on an audit of claims processed for those customers assigned to the Unit.	98.0% - 100% 96.0% - 97.9% 0% - 95.9%	0% 1% 2%
Customer Service	**Average Speed of Answer of Telephone Calls,** calculated over the complete business day, is defined as the time a caller spends on hold until a customer advocate becomes available. Method of measurement: The average speed of answer will be calculated by dividing the total length of time for all calls, measured from the time a call is queued by the automated telephone system for the next available customer advocate until the time the caller is connected with a customer advocate, by the total number of calls connected with a customer advocate during the Settlement Period. The Average Speed to Answer is provided by telephone reports that compute the average number of seconds that Callers spend on hold waiting for their Call to be answered. Standard is measured using member calls for those customers assigned to the Unit. **Abandoned Calls** are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a customer advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls for those customers assigned to the Unit.	0 - 30 seconds 31 - 60 seconds 61 seconds or more 0% - 3.0% 3.1% - 5.0% 5.1% - 100%	0% 1% 2% 0% 1% 2%
Total Medical			**10%**

FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Network Discount Savings	**Network Discount Savings** is defined as the percentage of total eligible provider billed charges saved due to Network Provider discounts. Method of measurement: Total Eligible billed amount less total Allowed amount equals Provider Savings. The total Provider Savings divided by the Eligible billed amount equals the overall Network Discount Savings. Excluded from measurement are Medicare-related claims, claims with Coordination of Benefits, prescription drug claims, and claims with total paid in excess of $100,000. Employer must maintain a minimum enrolled in the Plan.	See Attached Exhibit	See Attached Exhibit

IN WITNESS WHEREOF, the parties have executed this Exhibit-PG to remain in effect for the indicated period of time.

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

By: 

Douglas Lynch
Please Print Name

Title: Senior Vice President and Chief Actuary

Date: October 4, 2019

COUNTY OF LOS ALAMOS

By:

Please Print Name

Title:

Date:

ATTACHMENT C

EXHIBIT 6

STOP LOSS AGREEMENT

BlueCross BlueShield of New Mexico

[redacted]

APPLICATION FOR STOP LOSS COVERAGE

Employer Group Name:	Incorporated County of Los Alamos
Employer Group Address:	1000 Central Avenue Suite 230
City:	Los Alamos **State of Situs:** NM **Zip Code:** 87544
Account Number:	251305
Employer Group Number(s):	251307
Current Effective Date of Agreement	01/01/2020
Current Policy Period:	These specifications are for the Policy Period commencing on 01/01/2020 and ending on 12/31/2020
Stop Loss Premium Due:	30 Calendar days following receipt of billing

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Agreement terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Aggregate Stop Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from to

☐ Incurred with Run-Out: Claims incurred from to
and Claims paid from to

☐ Run-in coverage: Claims incurred from to
and Claims paid from to

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Agreement and paid during the Policy Period.

☐ Incurred with Run-Out: Claims incurred from to

and Claims paid from to

3. Aggregate Stop Loss Coverage shall apply to:

☒ Medical Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

☐ Dental Claims

☐ Other (please specify): _____

4. Average Claim Value: 1238.56 (per Employee per month)

Attachment Factor: 125% of the Average Claim Value

5. Aggregate Claim Liability and Run-Off Claim Liability Factors

a. Employer's Claim Liability for each Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Individual and Family Coverage Units for each Month by the following factors:

$1548.20 for each Employee Coverage Unit

$1548.20 for each Employee/Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

b. Employer's Run-Off Claim Liability shall be calculated by multiplying the sum average of all Coverage Units during each of the three calendar Months immediately preceding termination by the factors shown below. Settlement for the final accounting period will be described in the section of the Agreement entitled SETTLEMENTS.

$610.52 for each Employee Coverage Unit

$610.52 for each Employee/Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

6. CAP Arrangement: ☒ Yes ☐ No

7. Aggregate Stop Loss Claims

a. The amount of Paid Claims during the current Policy Period, less:

i. Individual (Specific) Stop Loss Claims

ii. Any claims in excess of the Individual (Specific) Stop Loss Claims per Covered Person per Lifetime Maximum

iii. Any claims in excess of the Individual (Specific) Stop Loss Claims maximum Point of Attachment

if any, that exceeds the Aggregate Point of Attachment. The Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in Item 5.a. above for the current Policy Period.

b. In the event of termination at the end of the current Policy Period, the Final Settlement Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in item 5.b. above. However, for the indicated Policy Period the minimum Aggregate Point of Attachment shall be $8,243,235.

8. Stop Loss Premium (Select one):

☐ Annual Premium (Due on the first day of the current Policy Period): $_____.

☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

$1.86 for each Employee Coverage Unit

$1.86 for each Employee/Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

9. The premium is based upon a current membership of 165 Individual Coverage Units and 328 Family Coverage Units.

B. Individual (Specific) Stop Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage Period:
☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from to

☐ Incurred with Run-Out: Claims incurred from to
and Claims paid from to

☐ Run-in coverage: Claims incurred from to
and Claims paid from to

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Agreement and paid during the Policy Period.

☐ Incurred with Run-Out: Claims incurred from to
and Claims paid from to

3. Individual (Specific) Stop Loss Coverage shall apply to:

☒ Medical Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug with Policyholder's Pharmacy Benefit Manager _____

☐ Dental Claims

☐ Vision Claims

☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Claims

   a. For each other Covered Person:
   The amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $155,000 per Covered Person but not to exceed a maximum Point of Attachment of $ unlimited per Policy Period. Paid Claims in excess of the maximum Point of Attachment shall not be eligible to satisfy the Aggregate Point of Attachment. Such amount shall apply for the current Policy Period.

   b. Covered Person per Lifetime Maximum:

   The Individual (Specific) Stop Loss Claims shall not exceed unlimited per Covered Person per Lifetime. Paid Claims in excess of the Covered Person per Lifetime Maximum shall not be eligible to satisfy the Aggregate Point of Attachment.

   Point of Attachment: ☒ Includes Claim Administrator's Provider Access Fee
   ☐ Excludes Claim Administrator's Provider Access Fee

5. Stop Loss Premium (select one):

   ☐ Annual Premium (Due on the first day of the current Policy Period): $_____.

   ☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

   $133.07 for each Employee Coverage Unit

   $133.07 for each Employee/Family Coverage Unit

   Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

   _____

6. The premium is based upon a current membership of 165 Individual Coverage Units and 328 Family Coverage Units.

Additional Provisions:

_____

The undersigned person represents that he/she is authorized and responsible for purchasing stop loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application the Agreement into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Agreement to the Employer Group. Upon acceptance of this Application and issuance of the Agreement, the Employer Group shall be referred to as the "Policyholder."

James Bloom	
Sales Representative	Signature of Authorized Purchaser
Cesar Guerrero	
Name of Underwriter	Title of Authorized Purchaser
Signature of Underwriter	Date

INTERNAL USE ONLY	Date Application approved by Underwriting:

EXHIBIT 7

BUSINESS ASSOCIATE AGREEMENT

CLAIM ADMINISTRATOR BUSINESS ASSOCIATE AGREEMENT

This Claim Administrator Business Associate Agreement ("Agreement") by and between Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("Claim Administrator") and County of Los Alamos ("Employer") and the Employer on behalf of its Group Health Plan ("GHP"), collectively the "Parties," is effective on January 1, 2013.

The purpose of this Agreement is to set forth the Parties' mutual agreement on the terms for their compliance with the Health Insurance Portability and Accountability Act ("HIPAA" or "Privacy Rule" or "Security Rule" or "Electronic Transactions Rule") and its implementing regulations (45 C.F.R. Parts 160-164) and the requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as incorporated in the American Recovery and Reinvestment Act of 2009 and the implementing regulations, as issued and amended by the Secretary, that are applicable to Business Associates. Capitalized terms used in this Agreement and not otherwise defined herein shall have the meanings set forth in HIPAA and/or HITECH which definitions are hereby incorporated by reference.

The Parties acknowledge and agree that Claim Administrator is a Business Associate and that the Group Health Plan ("GHP") established and maintained by the Employer is a Covered Entity as those terms are defined by HIPAA. Employer acknowledges that its employee welfare benefit plan meets the definition of Health Plan in 45 CFR 160.103.

1. **Obligations and Activities of Claim Administrator as Business Associate.**

(a) Claim Administrator agrees to use or disclose Protected Health Information (PHI) it creates or receives for or from Employer and GHP only as permitted or required by this Agreement or as Required by Law.

(i) Claim Administrator is permitted to use or disclose PHI to perform the functions, activities and services as the claim administrator for Employer's GHP. In addition, the Parties may enter into other agreements from time to time that include additional functions, activities, and services provided by the Claim Administrator, and to the extent that such agreements include the Use or Disclosure of PHI, the Parties agree that the terms of this Agreement shall also apply.

(ii) Claim Administrator is permitted to use or disclose PHI to perform functions, activities, or services for, or on behalf of, the GHP as Covered Entity, provided that such Use or Disclosure would not violate the Privacy Rule or HITECH if done by Covered Entity, including the minimum necessary and/or Limited Data Set requirements of the Privacy Rule and HITECH.

(iii) Except as otherwise limited in this Agreement, Claim Administrator may use PHI for the proper management and administration of the Agreement or to carry out the legal responsibilities of the Claim Administrator.

(iv) Except as otherwise limited in this Agreement, Claim Administrator may disclose PHI to carry out Claim Administrator's proper management, administration or legal responsibilities, provided that the Disclosures are: Required by Law; or Claim Administrator obtains reasonable assurances from the person/entity to whom the information is disclosed, that it will remain confidential and used or further disclosed only as Required by Law. An executed Business Associate Agreement or other applicable Confidentiality Agreement would be used as evidence to support this. Furthermore, the information disclosed will only be used for its intended purpose and if the confidentiality of the information has been breached, the person/entity will notify the Claim Administrator in all instances.

(v) Except as otherwise limited in this Agreement, Claim Administrator may use PHI to provide Data Aggregation services relating to the Health Care Operations of the GHP and as permitted by 45 CFR 164.504(e)(2)(i)(B).

(vi) Claim Administrator may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1) and HITECH.

(b) Claim Administrator agrees to use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement. Claim Administrator agrees to implement administrative, technical, and physical measures that reasonably and appropriately protect the confidentiality, integrity, and availability of the

ATTACHMENT C

Electronic PHI that Claim Administrator creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and/or as required by Section 13401 of HITECH.

(c) Claim Administrator agrees to report to Covered Entity any Use or Disclosure of PHI not provided for by this Agreement of which it becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of such Use or Disclosure not provided for by this Agreement.

(d) Claim Administrator agrees to report to Covered Entity any successful Security Incident of which Claim Administrator becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of any successful Security Incidents. To avoid unnecessary burden on either Party, Claim Administrator will only be required to report, upon the Covered Entity's request, attempted, but unsuccessful Security Incidents which Claim Administrator becomes aware; provided that the Covered Entity's request shall be made no more often than is reasonably based upon the relevant facts, circumstances and industry practices.

(e) Claim Administrator will report to Covered Entity, in writing without unreasonable delay after a determination is made that an incident has occurred that affects plan members, but no later than five (5) business in the case of electronic unsecured PHI and ten (10) business days in the case of breaches of hardcopy Unsecured PHI or as required by law of any "Breach" of "Unsecured Protected Health Information" as these terms are defined by HITECH. Claim Administrator shall cooperate with Covered Entity in investigating the Breach and in meeting the Covered Entity's obligations under HITECH and any other security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Claim Administrator to have been accessed, acquired, or disclosed during such Breach as required by law.

Covered Entity shall check "YES", below, if Covered Entity is electing to delegate to Claim Administrator the provision of the HITECH Act Security Breach services described in Attachment 1 of this Agreement ("Attachment 1"), Covered Entity shall check "NO", below, if Covered Entity is electing to retain the provision of the HITECH Act Security Breach services described in Attachment 1. If Covered Entity does not check "YES" or "NO" below, Claim Administrator will NOT provide the HITECH Act Security Breach services described in Attachment 1 and these services will become the responsibility of the Covered Entity.

☒ Yes ☐ No

(f) Claim Administrator agrees to ensure that any of its agents, including a subcontractor, to whom Claim Administrator provides PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, agree in writing to substantially the same restrictions, conditions, and security measures that apply through this Agreement to Claim Administrator with respect to such information.

(g) Claim Administrator agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the Use and Disclosure of PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, available to the Secretary, in a time and manner as reasonably requested by or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(h) Claim Administrator agrees to document such Disclosures of PHI and information related to such Disclosures as would be required for Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528 and HITECH.

(i) The Party identified on Attachment 2 of this Agreement ("Attachment 2") agrees to provide to an Individual, and in the time and manner mutually agreed by the Parties, information collected in accordance with Section 1(h) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528. Upon termination of this Agreement, Claim Administrator will respond to the Individual for a period of up to six years.

(j) The Party identified on Attachment 2 agrees to provide access, at the request of an Individual, and in the time and manner mutually agreed by the Parties, to PHI for an Individual in order to meet the requirements under

ATTACHMENT C

45 CFR 164.524 and HITECH. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(k) Prior to responding to an Individual's request for an amendment pursuant to 45 CFR 164.526, Covered Entity shall ask Claim Administrator if Claim Administrator created the PHI maintained in the designated record set. Claim Administrator will notify Covered Entity of its recommendation to deny or grant the individual's request. The Party identified on Attachment 2 will respond to Individual's request for an amendment. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(l) In those instances when Claim Administrator may conduct Standard Transactions on behalf of the Covered Entity, Claim Administrator will comply with the HIPAA requirements for Standard Transactions and Data Code Sets.

2. Obligations of GHP as Covered Entity.

(a) Covered Entity shall notify Claim Administrator of any limitation(s) in the Notice of Privacy Practices of Covered Entity on Attachment 2 in accordance with 45 CFR 164.520, to the extent that such limitation may affect Claim Administrator's Use or Disclosure of PHI. Employer or Covered Entity will notify Claim Administrator of any material change in privacy policies, procedures or practices.

(b) Covered Entity shall notify Claim Administrator of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Claim Administrator's Use or Disclosure of PHI.

(c) Prior to responding to an Individual's restriction request on the Use or Disclosure of PHI in accordance with 45 CFR 164.522, Covered Entity shall ask Claim Administrator if the proposed restriction will affect its functions, activities, or services under the Agreement. If such restriction would affect Claim Administrator's Use or Disclosure of PHI, Covered Entity will deny the Individual's request. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(d) If Covered Entity or Claim Administrator receives a request from an Individual for confidential communication of PHI by alternative means or at alternative locations in accordance with 45 CFR 164.522(b), Covered Entity, prior to responding to such a request, shall ask Claim Administrator for information on the feasibility of implementing or accommodating the request and on whether there may be an additional cost. Covered Entity shall promptly notify Claim Administrator of its decision on the request for confidential communication of PHI. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(e) Covered Entity shall provide Claim Administrator the necessary information to fulfill Claim Administrator's obligations under this Agreement, including but not limited to, a written statement of the restrictions for the Disclosure of PHI by Claim Administrator to the Employer. Employer certifies that the Employer's benefit Plan Documents have been amended in compliance with 45 CFR 164.314(b) and 45 CFR 164.504(f) and that information from the applicable amendments shall be included in the written statement provided to Claim Administrator.

(f) Covered Entity shall identify its Business Associates and Group Health Plan employees on Attachment 2 to whom Claim Administrator is permitted to directly Disclose PHI. Covered Entity shall provide information on any limitations or restrictions on Claim Administrator's Disclosure to a specific Business Associate or Group Health Plan employees of Covered Entity.

3. Permissible Requests by Covered Entity.

Covered Entity shall not request Claim Administrator to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, unless otherwise noted in this Agreement.

4. Term and Termination.

(a) **Term**. The Term of this Agreement shall be effective on the date stated on the first page of this Agreement and shall terminate without notice upon termination of any agreement or arrangement between the

ATTACHMENT C

Parties for Claim Administrator to provide administrative services to Employer's self-insured health benefit welfare plan.

(b) **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Claim Administrator, Covered Entity shall either:

(i) Provide an opportunity for Claim Administrator to cure the breach or end the violation and terminate this Agreement if Claim Administrator does not cure the breach or end the violation within the time specified by Covered Entity;

(ii) Immediately terminate this Agreement if Claim Administrator has breached a material term of this Agreement and cure is not possible; or

(iii) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) **Effect of Termination**. The Parties agree that returning or destroying the PHI is not feasible due to: (1) state or federal regulatory requirements applicable to Claim Administrator and Covered Entity, or (2) Claim Administrator's record retention policies. Therefore, Claim Administrator shall extend the protections of this Agreement to such PHI, limiting further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Claim Administrator maintains such PHI.

(d) **Cure of Non-material Breach.** Covered Entity shall provide an opportunity for Claim Administrator to cure a non-material breach within the time specified by Covered Entity.

5. Miscellaneous.

(a) **Regulatory References**. A reference in this Agreement to a section in the HIPAA Rules (45 C.F.R. Parts 160-64) and HITECH means the section as in effect and the implementing regulations, as issued and amended by the Secretary.

(b) **Amendment**. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA and HITECH and as the HIPAA Privacy, Security, and Electronic Transactions Rule may be amended from time to time.

(c) **Survival**. The respective rights and obligations of Covered Entity and Claim Administrator under Section 4(c) of this Agreement shall survive the termination of this Agreement.

(d) **Interpretation.**

(i) Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy, Security, Electronic Transactions Rule and HITECH.

(ii) Any conflict between terms of this Agreement and any other agreement between the Parties concerning the Employer's health welfare benefits plan shall be resolved so that the terms of this Agreement supersede and replace the relevant terms of any such other agreement concerning the confidentiality of GHP data, medical records information, and other records containing PHI.

(e) **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed an original, and all of which shall constitute one binding agreement.

(f) **Severability**. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained.

(g) **Identifying Information**. Employer's and Claim Administrator's respective Privacy Office information is provided in Attachment 2.

IN WITNESS WHEREOF, the Parties hereto have authorized this Agreement to be executed by their respective authorized officers as of December 28, 2012.

County of Los Alamos, Employer [*or Plan Sponsor*] and Employer on behalf of its Group Health Plan, the Covered Entity:	Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company Claim Administrator:
Signature: _____	Signature: Kurt Shipley
Printed Name: Enter the Name of the Person Signing Harry Burgess	Printed Name: Kurt Shipley
Title: Enter the Title of the Person Signing County Administrator	Title: President New Mexico Division

Attachments:
ATTACHMENT 1 - DELEGATION of HITECH BREACH NOTIFICATION
ATTACHMENT 2 - ADDITIONAL INFORMATION FORM

ATTACHMENT 1 – DELEGATION OF HITECH BREACH NOTIFICATION
Claim Administrator Business Associate Agreement

The following Health Information Technology for Economic and Clinical Health Act ("HITECH") Security Breach services will be provided as indicated by Covered Entity on the Claim Administrator Business Associate Agreement, as allowed by the HITECH Act and any subsequent regulation or guidance from the United States Department of Health and Human Services (DHHS):

- Investigate any unauthorized access, use, or disclosure of Group Health Plan member protected health information (PHI).
- Determine whether there is a significant risk of financial, reputational or other harm to any Group Health Plan member as provided for in the HITECH Act.
- Determine whether the incident falls under any of the HITECH Act Security Breach notification exceptions.
- Document and retain each HITECH Security Breach risk assessment and exception analyses, and make this information available to Group Health Plan members upon request.
- Provide Group Health Plan with written notification that describes the HITECH Security Breach incident in detail including a list of the impacted members and/or a copy of a member notification.
- Notify each Group Health Plan member impacted by the HITECH Security Breach by first class mail within the applicable statutory notification period, and provide toll-free numbers to the impacted members in order to handle any member questions regarding the incident. The notification will include the following:
    - A brief description of the incident, including the date of the Security Breach and the date it was discovered;
    - A description of the types of PHI involved in the Security Breach (i.e., name, birth date, home address, account number, Social Security Number, etc.);
    - The steps that individuals might take to protect themselves from potential harm; and
    - A brief description of what the Claim Administrator is doing to mitigate the harm and to avoid further incidents.
- Provide a substitute notice, as described in the HITECH Act, to impacted members if there is insufficient mailing address information.
- Maintain a log and submit to DHHS an annual report of Security Breaches that impact fewer than 500 members.
- Notify DHHS immediately, in the event the Security Breach impacts more than 500 individuals.
- Notify media when required under the HITECH Act and alert Group Health Plan if any such notifications are needed.

NOTE: If Covered Entity does not designate on the Business Associate Agreement which Party will provide the Security Breach services listed above, these services will NOT be provided by Claim Administrator and will be the responsibility of the Covered Entity.

The above listed HITECH Act Security Breach services may be changed from time to time by Claim Administrator as necessary, and as required by the HITECH Act, DHHS regulation and DHHS guidance.

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM
Self Funded Accounts
(Please Print or Type this form)

This document replaces any previous Attachment 2 – Business Associate Agreement Additional Information Documents.

Employer or Plan Sponsor:	**County of Los Alamos**
BCBSNM Account number:	**251305; 288516**
BCBSNM group number(s):	**251306; 288517**

Claim Administrator's Privacy Officer: Thomas C. Lubben
Address: HCSC Privacy Office; PO Box 804836; 300 E. Randolph St., Chicago, IL 60680-4110

Primary Privacy Officer Contact		Alternate Privacy Officer Contact	
Name:	**Kat Brophy**	Name:	**Denise Cassel**
Title:	**Benefits and Pension Manager**	Title:	**Human Resources Manager**
Phone #:	**505-662-8045**	Phone #:	**505-662-8047**
FAX #:	**505-662-8000**	FAX #:	**505-662-8000**
Mailing Address:	**2451 Central Avenue, Suite B**	Mailing Address:	**2451 Central Avenue, Suite B**
City, State, Zip:	**Los Alamos, NM 87544**	City, State, Zip:	**Los Alamos, NM 87544**
e-Mail Address:	**kat.brophy@lacnm.us**	e-Mail Address:	**denise.cassel@lacnm.us**

Authorized Signatory (Form should only be signed by authorized employee of the account)

Name of individual completing this form: **Kat Brophy**

Title of individual completing this form: **Benefits and Pension Manager**

Signature: Kat Brophy Date: 1/17/13

Limitations

Please identify any limitations in any of the following documents that may affect BCBSNM's use or disclosure of protected health information (PHI) in the Group Health Plan's:

(List the limitation or indicate "none")

a. Notice of Privacy Practices (NoPP) None
b. GHP Plan Document None
c. Other: None

HIPAA Individual Rights Requests

Employer or Plan Sponsor:	**County of Los Alamos**
BCBSNM Account number:	**251305; 288516**
BCBSNM group number(s):	**251306; 288517**

Upon receiving a request from a member to exercise one of the following HIPAA Individual Rights requests, should BCBSNM respond directly to the member or direct the member back to the Employer/Group Health Plan (GHP)?

Please select Employer/GHP OR BCBSNM (not Both).

1) Request to Access PHI:	☐ - Employer/GHP	☒ - BCBSNM
2) Request for Disclosure Accounting:	☐ - Employer/GHP	☒ - BCBSNM
3) Request to Amend PHI:	☐ - Employer/GHP	☒ - BCBSNM

Group Health Plan Authorizations

Please identify employees within your organization with whom BCBSNM is authorized to release PHI for Plan Administration functions. Please list by name or job title and indicate any limitations or restrictions on BCBSNM's disclosure of PHI to such employee.

Please list: JOB TITLE, NAME (optional), RESTRICTIONS
enter each position or person on a different line

Benefits and Pension Manager - Kat Brophy

HR Technician - Bernadette Martinez

Payroll Specialist - Kacie Caster

Business Associate Authorizations

Please identify your Business Associates and employees within that organization with whom BCBSNM is authorized to release PHI for HIPAA purposes. Please list company name, employee name or title, and indicate any limitations or restrictions on BCBSNM's disclosure of PHI to such Business Associate.

Please list: COMPANY NAME, JOB TITLE, NAME (optional), RESTRICTIONS
enter each position or person on a different line

Note: It is the Employer's/GHP's responsibility to notify HCSC of any updates to the information provided in this document.

AGR18-704-A-2
Exhibit "C"
EXHIBIT 8

BlueCross BlueShield of New Mexico

County of Los Alamos
January 1, 2020 - December 31, 2020
Network Discount Guarantee

Medical Claims Only
Claims Paid 01/01/20 Through 12/31/20

Guaranteed Discount Percentage 38.0%

Actual Discounts			Admin Fee Penalty
36.00%	or Higher		0.0%
35.00%	to	35.99%	1.0%
34.00%	to	34.99%	2.0%
33.00%	to	33.99%	3.0%
32.00%	to	32.99%	4.0%
31.99%	or Lower		5.0%

1. The formula for the Overall Network Discount Percentage calculation is as follows:
(Eligible/Covered Claims less Allowed Claims equals the Provider Savings. The Provider Savings divided by the Eligible/Covered Claims equals the Overall Network Discount %).

2. Both In-Network and Out-of-Network claims are included in the Overall Network Discount Percentage calculation.

3. Network Discount Guarantee applies only to eligible employees and retirees who enroll in the proposed BCBS benefit plans.

4. BCBS will exclude all claims in excess of $100,000, claims the Employer authorizes to be paid on an exception basis, Medicare claims, claims with COB, Prescription Drug claims, Specialty Rx, claims not covered/processed by BCBS, and claims for non-contracted providers paid at the in-network level of benefits.

5. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if participation changes by +/- 10.0%, and/or the distribution of enrolled employees between geographic areas, the single/family mix, or age/gender composition of the group changes significantly.

6. BCBS reserves the right to void this Network Discount Guarantee if there are less than 443 employees enrolled in the plan.

7. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if Medicare changes its payment systems during the term of this Network Discount Guarantee.

8. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if there is a change in the benefit plan design.

9. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if a narrow or high performance network is elected.

10. Administrative Fee at Risk will be finalized upon sale of the Network Discount Guarantee.

11. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, BCC, etc.

12. Any penalty paid will be dollar for dollar up to the maximum amount at risk for each tier.

13. Guaranteed Discount Percentage is only valid for the quoted policy period.

***Amount at Risk is based on current enrollment of 492 HCSC Primary employees. Actual amount at risk is subject to change based on final enrollment of employees who select BCBS coverage.**

ATTACHMENT C