County of Los Alamos

Los Alamos, NM 87544
www.losalamosnm.us

Agenda - Final

County Council - Regular Session

Randall Ryti, Council Chair; Ryn Herrmann, Vice-Chair; Theresa Cull; Melanee Hand; Beverly Neal-Clinton; Suzie Havemann; and David Reagor, Councilors

Tuesday, February 3, 2026 **6:00 PM** **Council Chambers - 1000 Central Avenue**

NOTE: This meeting is in person and open to the public. However, for convenience, the following Zoom meeting link and/or telephone call in numbers may be used for public viewing and participation:

https://us06web.zoom.us/j/85448619994

Or Telephone:
Dial(for higher quality, dial a number based on your current location):
+1 346 248 7799 or + 1 346 248 7799 or + +1 669 444 9171 US or + 1 719 359 4580
or +1 720 707 2699

Webinar ID: 854 4861 9994

1. OPENING/ROLL CALL

2. PLEDGE OF ALLEGIANCE

3. PUBLIC COMMENT

This section of the agenda is reserved for comments from the public on items that do not require action by the Council or are not otherwise on the agenda.

4. APPROVAL OF AGENDA

5. PUBLIC HEARING(S)

A. RE0671-26 Incorporated County of Los Alamos Resolution No. 26-05; A Resolution Certifying the 2026 Annual Road Mileage for the New Mexico Department of Transportation

Presenters: Eric Martinez, Public Works Director and Eric Ulibarri, County Engineer

Attachments: A - Incorporated County of Los Alamos Resolution No. 26-05
B - Road Mileage Certification Letter
C - Publication Notice

6. BUSINESS

A. AGR1190-26 Discussion and Possible Approval of Amendment No. 2 to Existing General Services Agreement No. AGR24-67 with Blue Cross Blue Shield of New Mexico

Presenters: Anne Laurent, County Manager and Victoria Pacheco, Benefits & Pension Manager

Attachments: A - AGR24-67-A2 Blue Cross Blue Shield
B - General Services Agreement No. AGR24-67 with 1 Amendment

B 21250-26 Overview of the Comprehensive Plan Update and Chapter 16 Code Amendments

Presenters: Elias Isaacson, Community Development Director

Attachments: A - Presentation

7. COUNCIL BUSINESS

A. General Council Business

B. Appointments

C. Board and Commission Vacancy Report

1) 21177-26 Board and Commission Vacancy Report

Presenters: County Council

Attachments: A - BCC Vacancy Report January 28, 2026

D. Boards and Commission Reports

E. County Manager's Report

F. Council Chair Report

G. Approval of Councilor Expenses

H. Preview of Upcoming Agenda Items

Note: This report shows tentative Council agenda items and is for planning purposes only. All items on the report are subject to changes such as item title, meeting date and/or being removed or not considered by Council.

1) 21087-26 Tickler Report of Upcoming Agenda Items

Presenters: County Council

Attachments: A - Tickler Report dated January 30, 2026

8. COUNCILOR COMMENTS

9. ADJOURNMENT

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing or meeting, please contact the County Human Resources Division at 662-8040 at least one week prior to the meeting or as soon as possible. Public documents, including the agenda and minutes can be provided in various accessible formats. Please contact the personnel in the Office of the County Manager at 663-1750 if a summary or other type of accessible format is needed.

Agenda No.:	A.
Index (Council Goals):	
Presenters:	Eric Martinez, Public Works Director and Eric Ulibarri, County Engineer
Legislative File:	**RE0671-26**

Title
Incorporated County of Los Alamos Resolution No. 26-05; A Resolution Certifying the 2026 Annual Road Mileage for the New Mexico Department of Transportation

Recommended Action
I move that Council certify the Incorporated County of Los Alamos Resolution No. 26-05; A resolution certifying the 2026 Road Mileage as presented and authorize submittal to the New Mexico Department of Transportation.

..County Manager's Recommendation
The County Manager recommends that Council approve the motion as presented.

Body
Each year, the New Mexico Department of Transportation requires counties to certify their roadway mileage. These figures are used to determine funding allocations under programs such as the Local Government Road Fund Cooperative Agreement, County Arterial Program, and School Bus Route Program. Certification must be submitted by April 1 annually.

Los Alamos County currently maintains 111.357 miles of roads. A copy of Resolution No. 26-05 and the letter of the certification are included for reference.

Fiscal and Staff Impact/Planned Item
Submitting the Annual Road Mileage Certification to the NMDOT makes the County eligible to participate in the Local Government Road Fund Cooperative Agreement, County Arterial, School Bus Route Programs, and the Municipal Arterial Program.

Attachments
A - Incorporated County of Los Alamos Resolution No. 26-05
B - Road Mileage Certification Letter
C - Publication Notice

INCORPORATED COUNTY OF LOS ALAMOS RESOLUTION NO. 26-05

A RESOLUTION ADOPTING THE 2026 ANNUAL CERTIFIED MAINTAINED MILEAGE REPORT

WHEREAS, the Council of the Incorporated County of Los Alamos ("Council") acted in its regularly scheduled meeting on February 3, 2026, to adopt the 2026 Annual Certified County Maintained Mileage Report, and desires that the New Mexico Department of Transportation (NMDOT) accept same; and

WHEREAS, pursuant to NMSA 1978, Section 67-3-28.3, the Incorporated County of Los Alamos ("County") shall certify and submit an Annual Certified County Maintained Mileage Report to the Secretary of the NMDOT, on or before April 1st of each year; and

WHEREAS, the mileage verified by the Secretary of the NMDOT shall be the official mileage of public roads maintained by each county and reported to the New Mexico State Treasurers Office for funding distribution purposes; and

.

WHEREAS, County continues to reassess its road inventory.

NOW, THEREFORE, BE IT RESOLVED by the Council of the Incorporated County of Los Alamos that:

Section 1. The 2026 Annual Certified County Maintained Mileage Report is an accurate reflection of County maintained roads as of April 1, 2025.

Section 2. This is to certify that the Incorporated County of Los Alamos maintains up to 111.357 miles of roadway within Los Alamos County.

Section 3. County submits the attached Report to the Secretary of the New Mexico Department of Transportation in meeting its obligation pursuant to statutory requirements.

PASSED AND ADOPTED this 3rd day of February 2026.

COUNCIL OF THE INCORPORATED COUNTY OF LOS ALAMOS, NEW MEXICO

_____

Randall T. Ryti,
Council Chair

ATTEST: (Seal)

_____

Michael D. Redondo,
Los Alamos County Clerk

New Mexico DEPARTMENT OF TRANSPORTATION
MOBILITY FOR EVERYONE

February 17, 2026

Ms. Anne Laurent
Los Alamos County Manager
1000 Central Ave
Los Alamos, NM 87544

Re: April 1st Submission of the 2026 Annual Certified County Maintained Mileage Report

Dear Ms. Laurent:

This is notification that the **2026 Annual Certified County Maintained Mileage Report is due on April 1st, 2026**. Pursuant to New Mexico Statutes 67-3-28.3, the Board of County Commissioners of each county shall certify and submit an Annual Certified County Maintained Mileage Report to the Secretary of the New Mexico Department of Transportation (NMDOT), on or before April 1st of each year.

By July 1st of every year, representatives for the Secretary of the Department of Transportation shall verify the submittal of each county and revise, if necessary, the total mileage of public roads maintained by each county. The mileage acknowledged by these representatives, shall be the official mileage of the public roads maintained by each county and will be reported to the New Mexico State Treasurer's Office. After August 1st, distribution of funding to each county for road maintenance purposes is made in accordance with the aforementioned NMSA section.

NMTRD Financial Distribution Bureau employees use this information for rate calculations in both the Combined Fuel and the Motor Vehicle Excise Tax programs. NMDOT's Data Management Bureau reports this information to the Federal Highway Administration (FHWA) Office of Highway Policy Information annually in accordance with Highway Performance Monitoring System (HPMS) federal reporting requirements.

Pursuant to NMSA 1978, Section 67-3-28.3 (1988), any county not complying with the required certified submittal by April 1st of each year, will have their mileage estimated and then reduced by one-third each month for that fiscal year, by the Secretary of the Department of Transportation. The amount of mileage deducted from the counties, not in compliance, shall be equally distributed between all counties in compliance, by the Secretary of the Department of Transportation.

To meet these requirements each county shall submit a complete set of information, correctly labeled and identified, which contains the following:

- A fully attributed Geographic Information System (GIS) data set identifying certified county-maintained road features with mileage information. The NMDOT updates its database with the county submitted data and information, annually.

Note: The New Mexico Department of Transportation utilizes the following GIS software packages:

a. ArcPro 3.5. As such, GIS information can be either in shapefile or geodatabase format. Shapefiles must include at a minimum .shp, .shx, .dbf, and .prj files. All formats shall provide metadata and attributes. .pptx and .mxd projects are acceptable as long as they include all the data in your submitted package to NMDOT.

b. PDF File for map(s) and Microsoft Word or Excel for route listing.

If the counties are currently utilizing a GIS software package not listed above, or they have further questions, they can contact us at the phone numbers provided on our request letter.

c. A package to include either a hard copy or digital spreadsheet or document that was used to generate a Route Listing and County Map(s). The digital data can be provided on CD or USB and should be in a standard application format such as MS Excel or MS word. Counties must adhere to the following guidelines for submitting the following required information.

a. **An Administrative Resolution** signed and dated by the county commissioners, specifying the total maintained mileage for the current year.

b. **A Route Listing** identifying each county-maintained route and including the following: 1.) County road name and/or county road number (in alpha, numeric, or alphanumeric order); 2.) Route description with the beginning and ending termini of each maintained route; 3.) Total length of the maintained mileage for each road in tenths, hundredths or thousandths of a mile, (not in feet); 4.) Roadway width (in feet).
5.) Surface type (i.e., paved, graveled, dirt); 6.) Subtotals of the maintained mileage for each section or district; 7.) Grand total for the entire submittal.

c. **A Legible County Map** with correctly plotted routes and identification for each route, by name and/or number

(highlighted if possible), corresponding to the above-mentioned Route Listing. For legal purposes, please ensure that the Administrative Resolution, the Route Listing and the Maps are labeled with the corresponding year of the submittal.

For legal purposes, please ensure that the Administrative Resolution, the Route Listing, and the Map are labeled with the corresponding year of the submittal.

Your prompt response to the certification and submittal of your county-maintained mileage report is imperative for funding your county road maintenance programs. Please mail or deliver these documents by April 1st, 2026, to:

Camille Valdez
New Mexico Department of Transportation
Highway Operations Division, SB-2
P.O. Box 1149
Santa Fe, NM 87504-1149

E-Mail: Camille.Valdez@dot.nm.gov

If you have any questions or concerns, or if I can provide any additional information, please do not hesitate to contact me. You can contact me at the above mailing and e-mail addresses.

Sincerely:

Camille Valdez

Camille Valdez, Engineering Technician

NOTICE OF RESOLUTION NO. 26-05
STATE OF NEW MEXICO, COUNTY OF LOS ALAMOS

Notice is hereby given that the Council of the Incorporated County of Los Alamos, State of New Mexico, has directed publication of Los Alamos County Resolution No. 26-05. This will be considered by the County Council at an open meeting on Tuesday, February 3, 2026, at 6:00 p.m., at the County Municipal Building, located at 1000 Central Avenue, Los Alamos, New Mexico 87544. The full copy is available for inspection or purchase, during regular business hours, in the County Clerk's Office: 1000 Central Avenue, Suite 240.

INCORPORATED COUNTY OF LOS ALAMOS RESOLUTION NO. 26-05
A RESOLUTION ADOPTING THE 2025 ANNUAL CERTIFIED MAINTAINED MILEAGE REPORT
Council of the Incorporated County of Los Alamos
By: /s/ Randall T. Ryti, Council Chair
Attest: /s/ Michael D. Redondo, County Clerk

LA DAILY POST,
Publication Date: Thursday, January 22, 2026
Type of Publication: Notice of Public Hearing of Resolution No. 26-05

Agenda No.:	A.
Index (Council Goals):	Quality Excellence - Employee Recruitment and Retention; Quality Excellence - Effective, Efficient, and Reliable Services; Quality of Life - Health, Wellbeing , and Social Services
Presenters:	Anne Laurent, County Manager and Victoria Pacheco, Benefits & Pension Manager
Legislative File:	**AGR1190-26**

Title

Discussion and Possible Approval of Amendment No. 2 to Existing General Services Agreement No. AGR24-67 with Blue Cross Blue Shield of New Mexico

Recommended Action

I move that Council approve Amendment No. 2 to the contract for general services, Agreement No. AGR24-67 with Blue Cross and Blue Shield of New Mexico, a division of Health Care Service Corporation, to correct the individual and aggregate stop loss premium rates in Exhibit B of the original agreement.

County Manager's Recommendation

The County Manager recommends that Council approve the motion as presented.

Body

On October 9, 2024, Council approved AGR24-67 for Medical Insurance benefits for Los Alamos County Employees. In Exhibit B of the original agreement, the County and BCBS negotiated in good faith that the Individual Stop Loss Premium rate is $220.17 per employee per month (PEPM) and the Aggregate Stop Loss Premium Rate is $2.36 PEPM.

In the signed Agreement, Exhibit B contained the erroneous Individual Stop Loss Premium rate at $235.05 PEPM and the Aggregate Stop Loss Premium Rate at $2.19 PEPM.

This Amendment will correct the previously approved rates. BCBS will also audit and reconcile the premiums paid in error.

Should Council choose not to approve Amendment No. 2 to Existing General Services Agreement AGR24-67 with Blue Cross Blue Shield of New Mexico, possible alternatives would include paying higher rates that negate the previously negotiated rates.

Fiscal and Staff Impact/Planned Item

There is no fiscal impact to this item, as the rates were approved; however, the exhibit in the original Agreement was in error.

Attachments

A - AGR24-67 Amendment No. 2General Services Agreement No. AGR24-67
B - General Services Agreement No. AGR24-67 with 1 Amendment

AMENDMENT NO. 2
INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT NO. 24-67

This **AMENDMENT NO. 2** ("Amendment") 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 Association, an association of independent Blue Cross and Blue Shield Plans, (the "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, collectively (the "Parties"), to be effective for all purposes February 4, 2026 ("Effective Date").

WHEREAS, County and Contractor entered into Services Agreement No. AGR24-67 dated January 1, 2025, and Amendment No. 1 dated January 1, 2026 (collectively the "Agreement") for Medical Insurance Benefits for Los Alamos County Employees; and

WHEREAS, Parties negotiated in good faith and agreed upon the Individual and Aggregate Stop Loss Premiums ("Premiums") that were to be included in the Agreement; and

WHEREAS, due to an administrative error, the amounts of the Premium Rates were erroneously entered into Exhibit B of the Agreement; and

WHEREAS, Contractor applied the Premiums throughout 2025 in accordance with the erroneously entered Premium Rates shown in the final executed Agreement instead of at the negotiated Premium rates; and

WHEREAS, upon discovery of this error, both Parties wish to amend the Agreement to reflect the correct Premiums originally negotiated and agreed upon for 2025; and

WHEREAS, an audit is currently underway to determine any overcharges or undercharges due to either party; and

WHEREAS, County Council approved this Amendment at a public meeting held on February 3, 2026; and

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

I. **Correction of Premium Rates.** The individual Stop Loss Premium Rate and Aggregate Stop Loss Premium Rate set forth in the original Agreement are hereby amended and replaced with the corrected rates as follows to be effective as of January 1, 2025, and shall apply to all applicable premium calculations from that date to December 31, 2025:
    a) Individual Stop Loss Premium Rate: $220.17
    b) Aggregate Stop Loss Premium Rate: $2.36

II. **Audit and Reconciliation.** Upon completion of the ongoing audit, the Parties shall reconcile any overpayments or underpayments resulting from the erroneous rates. Any identified discrepancies shall be corrected by refund, credit, or additional payment, as appropriate, within thirty (30) days of the audit's conclusion.

III. To delete **Exhibit B – STOP LOSS APPLICATION (1/1/2025 – 12/31/2025)** in its entirety and replace it with **REVISED EXHIBIT B – STOP LOSS APPLICATION (1/1/2025 – 12/31/2025) CORRECTED VIA AGR24-67-A2**, attached hereto and made a part hereof for all purposes, and to replace all references to Exhibit B throughout the Agreement with "Revised Exhibit B (Per Amendment 2)."

Except as expressly modified by this Amendment No. 2, 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

_____
MICHAEL D. REDONDO
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

BY: _____
ANNE W. LAURENT **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: _____
MARLENE BACA **DATE**
VICE PRESIDENT OF SALES

Revised Exhibit B
Stop Loss Application
(1/1/2025 – 12/31/2025)
Corrected Via
AGR24-67-A2

BlueCross BlueShield of New Mexico

APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

Employer Group Name:	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
Original Effective Date of Stop Loss Policy	01/01/2018
Current Policy Effective Date:	01/01/2025
Current Policy Period	These specifications are for the Policy Period commencing on 01/01/2025 and ending on 12/31/2025.

The specifications below shall become effective on the first date 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 Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:

Number of Single Coverage Units:	246
Number of Family Coverage Units:	312

B. Individual Stop Loss Coverage:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss coverage during the Current Policy Period

   ☐ Choose an item
   Coverage for Claims incurred from _____ to _____ and Claims paid from _____ to _____.

   For new coverage only, if a run-in contract as explained in the policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

   ☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

   ☒ Medical Claims:
   ☒ Prescription Drug Claims with: Prime _____
   ☐ For **Hospital Employer Groups only:** Excludes_____% of Home Hospital Medical claims
   ☐ Other (for example Dental/Vision): _____.

4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $165,000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:
_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:
_____

e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$220.17 Composite; or
$_____ for each Single Coverage Unit
$_____ for each Family Coverage Unit

C. Aggregate Stop Loss Coverage: Yes ☒ No ☐
If yes, complete Items 1. through 5. Below:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss Coverage during the current Policy Period

☐ Choose an item
Coverage for Claims incurred from _____ to _____ and Claims paid from _____ to _____.

For new coverage only, if a run-in contract as explained in the policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

☒ Medical Claims
☒ Prescription Drug Claims with: Prime _____
☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

a. Attachment Factor 125% of the Average Claim Value
b. Aggregate Claim Factors:

Group Number:	251307	_____	_____	_____
Composite; or	$1,532.03	$_____	$_____	$_____
For each Single Coverage Unit	$_____	$_____	$_____	$_____
For each Family Coverage Unit	$_____	$_____	$_____	$_____

c. Minimum Aggregate Point of Attachment: $9,232,596

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:
☒ Monthly Premium
Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:
$2.36 Composite; or
$_____ for each Single Coverage Unit
$_____ for each Family Coverage Unit

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

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
Pre-65: ☐ or Post-65: ☐

2. Reserved

3. Monthly Aggregate Accommodation: ☐ Yes ☐ No

4. Additional information: _____

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecuting under Federal Mail Fraud, Federal Wire Fraud, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act Statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that they are 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 and the Stop Loss Coverage Policy 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 Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Employer Group".

Martha E. Jarrett
Sales Representative

Signature of Authorized Purchaser

Title of Authorized Purchaser

Date

AGR24-67

LOS ALAMOS

INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT

This **SERVICES AGREEMENT** ("Agreement") 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 Association, an association of independent Blue Cross and Blue Shield Plans, (the "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, collectively (the "Parties"), to be effective for all purposes January 1, 2025 ("Effective Date").

WHEREAS, the County Purchasing Officer determined in writing that the use of competitive sealed bidding was either not practical or not advantageous to County for procurement of the Services and County issued Request for Proposals No. 24-67 ("RFP") on April 10, 2024, requesting proposals for **Medical Insurance Benefits for Los Alamos County Employees**, as described in the RFP; and

WHEREAS, Contractor timely responded to the RFP by submitting a response dated May 14, 2024, ("Contractor's Response"); and

WHEREAS, based on the evaluation factors set out in the RFP, Contractor was the successful Offeror for the services listed in the RFP; and

WHEREAS, the County Council ("Council") approved this Agreement at a public meeting held on October 29, 2024; and

WHEREAS, Contractor shall provide the Services, as described below, to County.

NOW, THEREFORE, and in consideration of the premises and the covenants contained herein, County and Contractor agree as follows:

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 the Stop Loss Application and the Sample Benefits Booklet, ("Services"). The final Benefits Booklet shall be provided by the Contractor within sixty (60) days of the Effective Date of this Agreement. The ASA (Exhibit A), Stop Loss Application (Exhibit B,) Sample Benefits Booklet (Exhibit C) are incorporated herein by reference for all purposes. Contractor is solely responsible for providing Services and benefit determinations under Exhibits A, B and C above.

SECTION B. TERM: The term of this Agreement, for claims administration, shall commence January 1, 2025, and shall continue through December 31, 2027, unless sooner terminated, as provided herein. At County's sole option, the County Manager may renew this Agreement for up to four (4) consecutive one-year period(s), unless sooner terminated, as provided therein.

The Term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Application (Exhibit B), shall commence January 1, 2025, and shall continue through December 31, 2025, unless

ATTACHMENT B
~~**ATTACHMENT A**~~

sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to six (6) consecutive one-year periods, unless sooner terminated, as provided therein.

SECTION C. COMPENSATION:

Amount of Compensation.

1. County shall pay compensation for performance of the Services for the Term of this Agreement, not to include any subsequent renewal periods, in an amount not to exceed ONE MILLION THREE HUNDRED THOUSAND DOLLARS ($1,300,000.00), in accordance with the rate schedule as set forth in the Administrative Services Agreement (Exhibit A), which amount shall include applicable New Mexico gross receipts taxes ("NMGRT"). For any subsequent renewal periods as set forth in Section B, "Term," above, compensation will be strictly based upon rate negotiations with Contractor and upon Council approval of said negotiations.
2. **Monthly 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 shall be due and payable thirty (30) days after County's receipt of the invoice.

SECTION D. TAXES: Contractor shall be solely responsible for timely and correctly billing, collecting and remitting all NMGRT levied on the amounts payable under this Agreement.

SECTION E. STATUS OF CONTRACTOR, STAFF, AND PERSONNEL: This Agreement calls for the performance of services by Contractor as an independent contractor. Contractor is not an agent or employee of County and shall not be considered an employee of County for any purpose. Contractor, its agents, or employees shall make no representation that they are County employees, nor shall they create the appearance of being employees by using a job or position title on a name plate, business cards, or in any other manner, bearing County's name or logo. Neither Contractor nor any employee of Contractor shall be entitled to any benefits or compensation other than the compensation specified herein. Contractor shall have no authority to bind County to any agreement, contract, duty, or obligation. Contractor shall make no representations that are intended to, or create the appearance of, binding County to any agreement, contract, duty, or obligation. Contractor shall have full power to continue any outside employment or business, to employ and discharge its employees or associates as it deems appropriate without interference from County; provided, however, that Contractor shall at all times during the term of this Agreement maintain the ability to perform the obligations in a professional, timely, and reliable manner.

SECTION F. STANDARD OF PERFORMANCE: Contractor agrees and represents that it has and shall maintain the personnel, experience, and knowledge necessary to qualify it for the particular duties to be performed under this Agreement. Contractor shall perform the Services described herein in accordance with a standard that meets the industry standard of care for performance of the Services.

SECTION G. Ownership and Reports.

The Parties shall retain ownership of all their respective intellectual property rights in and to their property under this Agreement. Contractor shall provide County with a license to any documentation related to its Services and the documentation may be used and copied by County officials, employees or other agents for its use consistent with the terms of this Agreement.

SECTION H. EMPLOYEES AND SUB-CONTRACTORS: Contractor shall be solely responsible for payment of wages, salary, or benefits to any and all employees or contractors retained by Contractor in the performance of the Services. Contractor agrees to indemnify, defend, and hold harmless County for any and all claims that may arise from Contractor's relationship to its employees and subcontractors.

SECTION I. INSURANCE: Contractor shall obtain and maintain insurance of the types and in the amounts set out below throughout the term of this Agreement with an insurer acceptable to County. Compliance with the terms and conditions of this Section is a condition precedent to County's obligation to pay compensation

for the Services, and Contractor shall not provide any Services under this Agreement unless and until Contractor has met the requirements of this Section. County requires Certificates of Insurance, or other evidence acceptable to County, stating that Contractor has met its obligation to obtain and maintain insurance and. Should any of the policies described below be cancelled before the expiration date thereof, notice shall be delivered in accordance with the policy provisions. General Liability Insurance and, Automobile Liability Insurance, shall name County as an additional insured **General Liability Insurance:** ONE MILLION DOLLARS ($1,000,000.00) per occurrence; ONE MILLION DOLLARS ($1,000,000.00) aggregate.

1. **Workers' Compensation:** In an amount as may be required by law. County may immediately terminate this Agreement if Contractor fails to comply with the Worker's Compensation Act and applicable rules when required to do so.
2. **Automobile Liability Insurance for Contractor and its Employees:** ONE MILLION DOLLARS ($1,000,000.00) combined single limit per occurrence; ONE MILLION DOLLARS ($1,000,000.00) aggregate on any owned, and/or non-owned motor vehicles used in performing Services under this Agreement.
3. **Professional Liability Insurance:** ONE MILLION DOLLARS ($1,000,000.00). Professional Liability Insurance shall provide coverage for Services provided hereunder during the term of this Agreement and for a period of at least five (5) years thereafter.
4. **Cyber Insurance:** In addition to insurance required under the Agreement, Contractor shall, at its sole cost and expense, procure and maintain through the term of the Agreement and for two (2) years following the termination or expiration of the Agreement, cyber/network privacy insurance with limits of THREE MILLION DOLLARS ($3,000,000.00) per claim/in aggregate. Such policy shall provide coverage for disclosures and/or breaches of County Data arising out of or relating to Contractor's Services. Such policy shall also include coverage for the costs associated with restoring lost or damaged County Data, sending breach notifications to affected individuals, public relations expenses, fines, and penalties. Such policy shall not contain exclusions for the acts or omissions of either Contractor, County, or their respective employees, agents, subcontractors, or volunteers, whether intentional or unintentional, resulting in or relating to any use of County Data not expressly permitted by this Agreement. Contractor must notify County at least thirty (30) days prior to the cancellation or modification of such policy.

SECTION J. RECORDS: Contractor shall maintain, throughout the term of this Agreement and for a period of six (6) years thereafter, records that indicate the date, and nature of the services rendered. Contractor shall make available, for inspection by County, all records, books of account, memoranda, and other documents pertaining to Contractor's Services for County under Section 3.8 of the ASA at any reasonable time upon request.

SECTION K. DUTY TO ABIDE: Contractor shall abide by all applicable federal, state, and local laws, regulations, and policies and shall perform the Services in accordance with all applicable laws, regulations, and policies during the term of this Agreement.

SECTION L. NON-DISCRIMINATION: During the term of this Agreement, Contractor shall not discriminate against any employee or applicant for an employment position to be used in the performance of the obligations of Contractor under this Agreement, with regard to race, color, religion, sex, age, ethnicity, national origin, sexual orientation or gender identity, disability, or veteran status.

SECTION M. CHOICE OF LAW: The interpretation and enforcement of this Agreement shall be governed by and construed in accordance with the laws of the State of New Mexico.

SECTION N. INDEMNITY: The Parties acknowledge and agree that (a) Contractor does not insure or underwrite the liability of County under the plan and has no responsibility for designing the terms of the plan

or the benefits to be provided thereunder, and (b) County 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 Contractor. Contractor shall indemnify, , and hold harmless County and its directors, its Council members, officers and employees, against any and all loss, liability, damages, penalties and expenses, losses, costs, or expenses, including reasonable attorney fees, or other cost or obligation resulting from or, to the extent that the liability, claims, demands, actions, damages, losses, costs, and expenses are caused by, or arise out of, the acts or omissions of the Contractor or Contractor's officers, in the performance or breach of the Services under this Agreement.

SECTION O. FORCE MAJEURE: Neither County nor Contractor shall be liable for any delay in the performance of this Agreement, nor for any other breach, nor for any loss or damage arising from uncontrollable forces such as fire, theft, storm, war, or any other force majeure that could not have been reasonably avoided by exercise of due diligence; provided, however, that the Party failing to perform shall (i) as soon as possible, inform the other Party of the occurrence of the circumstances preventing or delaying the performance of its obligations, and describe at a reasonable level of detail the circumstances causing such delay, and (ii) exert reasonable efforts to eliminate, cure, or overcome any of such causes and to resume performance of its Services with all possible speed. In such event, the non-performing Party may be excused from any further performance or observance of the obligation(s) so affected for as long as such circumstances prevail and such Party continues to use its best efforts to recommence performance or observance whenever and to whatever extent possible without delay.

SECTION P. NON-ASSIGNMENT: Contractor shall not assign this Agreement or any privileges or obligations herein and shall not novate this Agreement to another without the prior written consent of the **County Manager**.

SECTION Q. LICENSES: Contractor shall maintain all required licenses including, without limitation, all necessary professional and business licenses, throughout the term of this Agreement. Contractor shall require and shall assure that all of Contractor's employees and subcontractors maintain all required licenses including, without limitation, all necessary professional and business licenses.

SECTION R. PROHIBITED INTERESTS: Contractor agrees that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor further agrees that it shall not employ any person having such an interest to perform services under this Agreement. No County Council member or other elected official of County, or manager or employee of County shall solicit, demand, accept, or agree to accept, a gratuity or offer of employment contrary to Section 31-282 of the Los Alamos County Code.

SECTION S. TERMINATION:

Subject to the terms identified in this Agreement, Agreement may be terminated as follows:

1. The County Manager may terminate this Agreement with or without cause upon thirty (30) days prior written notice to Contractor. Upon such termination, Contractor shall be paid for Services actually completed to the satisfaction of County at the rate set out in Section C of the Service Agreement. Contractor shall render a final report of the Services performed to the date of termination, and shall turn over to County originals of all materials prepared pursuant to this Agreement.
2. By both Parties on any date mutually agreed to in writing; or
3. 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 6.1 of the ASA; or
4. By Contractor, if County 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 County's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to County as provided in Section 7.1 of Exhibit 2 "FEE SCHEDULE,

AND FINANCIAL TERMS" of the ASA.

5. This Agreement shall terminate without further action by County on the first day of any County fiscal year for which funds to pay compensation hereunder are not appropriated by County Council. County shall make reasonable efforts to give Contractor at least ninety (90) days advance notice that funds have not been and are not expected to be appropriated for that purpose.
6. Upon such termination, Contractor shall be paid for Services actually completed to the satisfaction of Contractor at the rate set out in Section C of the Service Agreement.
7. No such termination will take place without a reasonable attempt to contact the County pursuant to Section 4.9 in the ASA, and allow the Contractor to make corrective action. No termination will occur without written notification indicated in Section 6.1 of the ASA.

SECTION T. NOTICE: Unless otherwise provided in this Agreement, any notices required under this Agreement shall be made in writing. Notices shall be sent via 1) hand-delivery; 2) registered or certified mail; 3) a nationally recognized overnight courier service; or 4) electronic mail (with copy by mail or courier). All notices shall be sent to each party at the addresses set out in this section or any address later provided by such party in writing, with postage prepaid by the sender, and shall be deemed delivered upon hand delivery, verified proof of delivery by courier, or three (3) days after deposit in the United States Mail.

County:

Benefits and Pension Manager
Incorporated County of Los Alamos
1000 Central Avenue, Suite 230
Los Alamos, New Mexico 87544
E-mail: Bernadette.martinez@lacnm.us

With a copy to:
County Attorney's Office
1000 Central Avenue, Suite 340
Los Alamos, New Mexico 87544

E-mail: ~Attorney@lacnm.us

Contractor:

Account Manager
Blue Cross and Blue Shield of New Mexico
5701 Balloon Fiesta Parkway
Albuquerque, New Mexico 87113
E-mail: martha_jarett@bcbsnm.com

SECTION U. INVALIDITY OF PRIOR AGREEMENTS: This Agreement supersedes all prior contracts or agreements, either oral or written, that may exist between the parties with reference to the services described herein, and expresses the entire agreement and understanding between the parties with reference to said services. It cannot be modified or changed by any oral promise made by any person, officer, or employee, nor shall any written modification of it be binding on County until approved in writing by both authorized representatives of County and Contractor. In the event of any conflict between the terms, conditions, and provisions of this Agreement, and the terms, conditions and provisions of any exhibits or attachments, the terms, conditions and provisions of this Agreement shall control and take precedence.

SECTION V. NO IMPLIED WAIVERS: The failure of County to enforce any provision of this Agreement is not a waiver by County of the provisions, or of the right thereafter, to enforce any provision(s).

SECTION W. SEVERABILITY: If any provision of this Agreement is held to be unenforceable for any reason: (i) such provision shall be reformed only to the extent necessary to make the intent of the language and purpose of the Agreement enforceable; and (ii) all other provisions of this Agreement shall remain in effect so long as the substantive purpose of the Agreement is possible.

SECTION X. CAMPAIGN CONTRIBUTION DISCLOSURE FORM: A Campaign Contribution Disclosure Form was submitted as part of the Contractor's Response and is incorporated herein by reference for all purposes.

SECTION Y. LEGAL RECOGNITION OF ELECTRONIC SIGNATURES: Pursuant to NMSA 1978 § 14-16-7, this Agreement may be signed by electronic signature.

SECTION Z. DUPLICATE ORIGINAL DOCUMENTS: This document may be executed in two (2) counterparts, each of which shall be deemed an original.

SECTION AA. NEGOTIATED TERMS: This Agreement reflects negotiated terms between the Parties, and each Party has participated in the preparation of this Agreement with the opportunity to be represented by counsel, such that neither party shall be considered to be the drafter of this Agreement or any of its provisions for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter of this Agreement.

SECTION AB. CONFIDENTIAL INFORMATION: Any confidential information of one party that is provided to the other party during the term of this Agreement shall be kept confidential and shall not be made available to any individual or organization in accordance with the Confidential Information Disclosure Statement in Exhibit D. The Confidential Information Disclosure Statement shall be completed by Contractor as a condition precedent and submitted as part of this Agreement. Its terms shall govern as if fully set forth herein.

IN WITNESS WHEREOF, the Parties have executed this Agreement 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

NAOMI D. MAESTAS
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

BY: Linda Matteson for 11/7/2024

ANNE W. LAURENT **DATE**
COUNTY MANAGER

Approved as to form:

Kathryn S. Thwaits for

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: Kathleen Selck 11/9/2024

Kathleen Selck **DATE**
Vice President and Chief Underwriter

Exhibit A
AGR24-67

BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2025.

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

Account Number: 251307

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and consent to all of its terms and conditions 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 ("EMPLOYER")**
By: Kathleen Selck	By: Linda Matteson for
Title: Vice President and Chief Underwriter	Title: County Manager
Date: Effective Date of Coverage noted above	Date: 11/7/2024

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This Agreement made as of the Effective Date, 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, for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a Plan as defined herein; and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA, Service Agreement AGR24-67, 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: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services as set forth herein in connection with the administration of the Plan ("Services).

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state, or local laws that may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. 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 that 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.

1.3 **Claim Appeals.** Appeals will be reviewed with a new full and fair review. If the denial reason was due to medical necessity or experimental/investigational clinical rationale, the appeal will be reviewed by a qualified Physician who had no involvement in the initial review or any prior reviews. If, pursuant to such review, the clinical decision is upheld, then the Covered Person may have the right to seek Independent External Review by the independent review organization ("IRO"). The decision of the IRO will be final and binding.

1.4 **External Review Coordination**. If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by IROs as described

in Exhibit 1 and/or the most current ASO BPA, but in no event shall Claim Administrator have any liability or responsibility for any claim determination, act, or omission by an IRO in connection with any Independent External Review.

1.5 **Claim Administrator Review of Eligibility Records.** 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 reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the 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, any subsidiary or affiliate of Claim Administrator, and any successor entity or entities to Claim Administrator, whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** 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. If applicable, Employer shall remain fully responsible and liable for the performance of any of Employer's Vendor(s) (as defined below) to extent Employer contracts for services related to the Plan or delegates to other entities any of its obligations under the Plan.

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.

2.2 **Employer's Vendor's Responsibility, if applicable**. Employer will identify to Claim Administrator any of Employer's Vendor(s), and Employer will represent and warrant that it has entered into separate contracts with any of Employer's Vendors. Employer agrees that in connection with any services the Employer's Vendor(s) perform related to the Plan, Employer's Vendor(s) shall not engage with or contact any Providers except as permitted by Claim Administrator. Employer agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of Employer's Vendor(s). Employer also agrees Claim Administrator or any of Claim Administrator's affiliates, delegates, subcontractors, or assigns performance under this Agreement shall be excused to the extent they are unable to perform due to the performance or lack of performance of Employer's Vendor(s).

2.3 **Plan Benefit Design.** Employer shall provide Claim Administrator with the terms and scope of benefits under the Plan and as documented in a benefit matrix, highlight sheets, and similar documentation (collectively, "Matrix"), and the ASO BPA. Parties agree that Claim Administrator shall process Claims in accordance with the Matrix and the ASO BPA. Parties agree Claim Administrator may rely on the most current version of the Matrix and the ASO BPA 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.

2.4 **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 that 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.

2.5 **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 6.1, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 3 to Covered Persons.

2.6 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform 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 with respect to any Covered Persons.

c. Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement.

d. By providing Covered Persons information that may include a telephone and text number, the Employer agrees that Claim Administrator may use that information to secure the Covered Person's consent to contact them via their preferred method of communication (e.g., phone, text, email) with the Claim Administrator.

e. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.7 **Grandfathered Health Plans (If Applicable).** Employer represents and warrants that none of its plans is a "grandfathered health plan" under the Affordable Care Act and applicable regulations. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status.

2.8 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans (If Applicable).** If Claim Administrator provides Services for any retiree-only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans are 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 this Agreement. 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.

2.9 **Summary of Benefits and Coverage ("SBC").** Unless otherwise provided in the applicable ASO BPA and SBC Addendum (if applicable), 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 that 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.

2.10 **Massachusetts Health Care Reform Act.** If elected by Employer on the applicable ASO BPA, Claim Administrator will provide required written statements of creditable coverage to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, in accordance with the Massachusetts Health Care Reform Act 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 it has or will review the Plan for Massachusetts Health Care Reform Act compliance, and, to the best of its knowledge, that such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health

Care Reform Act. Employer acknowledges that Claim Administrator will not verify and 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.

2.11 **Employer Audits Claim Administrator.** 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 reasonable approval) may, upon at least ninety (90) days' prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Any review of Claim information by Employer or an authorized agent of Employer to evaluate Claim Administrator's performance of the administrative services provided according to the terms of this Agreement shall be subject to the terms of this Section. Contingency fee-based audits are not 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, 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 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. In such event, Employer's agent shall agree to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 **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. The Parties agree the BAA will govern the use, access, or disclosure of all 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 of the BAA and agrees to fulfill any other obligations related to PII as required therein.

3.2 **Electronic Exchange of Information.** If Employer and Claim Administrator exchange 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.

3.3 **Providing Data to Employer's Vendor(s).** If Employer requests for itself or directs Claim Administrator to provide data directly to Employer's third-party consultant and/or vendor ("Employer's Vendor(s)"), Employer acknowledges and agrees that it will execute and shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement. Employer hereby acknowledges and agrees, and Employer's Vendor(s) shall acknowledge and agree:

a. That the requested documents, records, and other information (for purposes of this Section 3, "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 3, 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 the extent permitted by law, 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.

d. To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

e. 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.

f. 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.

g. To not sell, re-sell, or lease the Information.

h. To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter.

Employer shall 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 and provide written authorization and specific directions with respect to such release, disclosure, or exchange. If Employer's Vendor(s) perform services that involve the use, access or disclosure of PHI as defined by HIPAA, the identity of Employer's Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 **Business Confidential Information and Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information ("BCI"). Employer shall not use or disclose such Business Confidential Information, including this Agreement, to any third party without prior written consent of Claim Administrator. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, 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 has the opportunity to object and ensure appropriate confidentiality protections are in place. 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.

3.5 **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 ("BCBSA" or "the Association"). Employer

agrees not to contest (i) the Association's ownership of, or the license granted by the Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

3.6 **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 Association and utilized by Claim Administrator under a license with the Association.

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. In accordance with applicable law, 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 material containing trade secrets, 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 Confidential Information Disclosure Statement attached hereto as Exhibit "D", the terms and conditions of which shall govern the disclosure of information, including information deemed or identified by Claim Administrator to be confidential.

3.7 **Records.**

a. **Records Retention.** Claim Administrator shall retain all Claim records for the longer of (i) the time period required by applicable law or (ii) the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator. Notwithstanding the foregoing, Claim Administrator shall retain Claim records for no less than six (6) years. The failure to agree upon a retention period shall not constitute breach of this Agreement.

b. **Record Requests.** For a period of one (1) year following termination of this Agreement, Claim Administrator shall, upon the request of the Employer for general purposes ("Data Reclamation Request"), provide to Employer, a copy of 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. Within a mutually agreeable time frame of receipt of the Data Reclamation Request, Claim Administrator shall transmit the dataset in a form mutually agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. The time period for general record requests does not impact nor restrict any legal, regulatory, or mandated data requests.

3.8 **Use of Data for Industry Improvement Activities.** Claim Administrator may use or disclose a limited data set or de-identified data ("Data") as permitted by the executed BAA, HIPAA, and other applicable federal and state laws for the purpose of supporting industry improvement activities such as analytic reviews, research studies, and other similar projects focused solely on promoting quality health care, managing health care costs, reducing administrative costs, or enhancing the Plan's performance. Any Data used or disclosed will be managed and coordinated by the Claim Administrator or by the Association including any vendors that assist the Claim Administrator and the BCBSA in the industry improvement activities. The Data shall not be sold, used, or disclosed for the financial benefit or profit of the Claim Administrator, BCBSA, or vendor.

SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS, AND DISPUTE RESOLUTION

4.1 **Litigation.** Each party shall, to the extent practical, advise the other party of any legal actions against one or both Parties 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. Employer shall undertake the defense of such action only to the extent that it alleges breach or wrongdoing, action or failure to act on the part of the Employer., including but not limited to attorneys' fees and costs,

external claim reviews, and other expenses. Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action, in which event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists. Some defense support by Claim Administrator, such as external claim review, may require an additional fee, the costs of which shall be Employer's responsibility.

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator is authorized to 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 or intentional misconduct by Claim Administrator caused the Overpayment.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, 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 Section 4.2(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, "Offset").

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 4.

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 4, Employer agrees that Claim Administrator shall administer Overpayment recoveries 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. Employer agrees that it will not perform or engage any other party to perform

Overpayment recovery activities with respect to Providers or Covered Persons without prior written consent of Claim Administrator.

4.3 **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 post Claim Payment. Third parties' fees, as defined in the ASO BPA, 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, are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA, and shall not 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.

4.4 **Claim Administrator Indemnifies Employer.** 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, fraudulent, or criminal or (ii) in material breach of the terms of this Agreement.

4.5 **Adjudication of Preventative Care.** If, either on the applicable ASO BPA or other document, Employer directs Claim Administrator to process and adjudicate Claims at one hundred percent (100%) of the applicable Allowable Amount and/or Allowable Charge, regardless of whether the high-deductible health plan's deductible has been met ("First Dollar Coverage"), Employer acknowledges and agrees that such direction is a benefit design decision and the responsibility of the Employer. Notwithstanding any other provision of this Agreement, Employer acknowledges and agrees that Employer shall be responsible for its own liability for its negligent acts and omissions.

4.6 **Assignment.** Except as otherwise permitted by Section 1 of Exhibit 3 to Exhibit A 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.

4.7 **Applicable Law.** This Agreement shall be governed by and construed in accordance with applicable federal laws and the laws of the state of New Mexico without regard to any state choice–of–law statutes. 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.

4.8 **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 (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) 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. All notices given under this Agreement 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.

4.9 **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 not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred unless any such errors or omissions are adjudged to be the result of gross negligence, fraud, or criminal actions by Claim Administrator.

4.10 **Transparency and Surprise Billing Procedures.** Unless another effective date is stated for a specific service, for plan years on or after January 1, 2022, Claim Administrator agrees to provide Employer the services and processes described in this section consistent with the Consolidated Appropriations Act of 2021 ("CAA"), Transparency in Coverage Final Rule, and the No Surprises Act ("NSA").

a. Transparency Procedures.

1. ***Contracted Provider Data Verification.*** Claim Administrator will maintain a central database of Contracted Providers' demographic information, which shall include name, address, phone number, specialty, and web address ("Data Elements"). Claim Administrator will initiate an outreach to Contracted Providers to verify the accuracy of the Data Elements up to ninety (90) days following the last recorded update or verification. Claim Administrator has implemented commercially reasonable procedures to track the receipt of updated data from a Contracted Provider and update the central database within appropriate timeframes.

2. ***Directory of Verified Contracted Providers.*** Claim Administrator will provide an online Provider directory representing the Contracted Providers who render Covered Services which may be billed to plans and policies administered by Claim Administrator. This directory shall include Providers contracted with Claim Administrator, Providers contracted with any Blue Cross and Blue Shield Plan, and any other entity performing Covered Services on behalf of Claim Administrator. The directory will not reflect services administered by external claims administrators or other Providers not contracted through Claim Administrator.

Providers who fail to confirm the accuracy of the Data Elements may be subject to removal from the Provider directory until they confirm the accuracy of their information.

To the extent information for the Provider directory is provided by a third party, Claim Administrator shall not be responsible for delays in updates to Provider data directories, or misinformation due to such delays in receiving information from such third party.

3. ***Provider Network Status Verification.*** Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide written, electronic, or print confirmation of the Provider's Network status within an appropriate timeframe. This

verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

Employer acknowledges that Claim Administrator will not issue a written confirmation of Provider Network status when request is sought through a third-party service center.

4. ***ID Cards.*** Claim Administrator will include up to four (4) lines of text for deductible limits and up to four (4) lines of text for out-of-pocket maximum limits for major medical coverage on the member ID card. The limits will reflect both family and individual limits when applicable to policy, together with in- and out-of-network limits.

   For policies that include prescription drug coverage through Prime with an independent out-of-pocket maximum limit or Deductible, one (1) line of text for deductible limits and one (1) line of text for out-of-pocket maximum limits will be included on the ID card.

   Claim Administrator will include a phone number and a website URL for consumer assistance information on ID cards issued by Claim Administrator.

   Claim Administrator will issue physical ID cards in accordance with its standard processes and will not re-issue physical ID cards unless requested by Employer, in which case additional charges may apply. All newly issued physical ID cards will contain the information reflected in this section.

5. ***Machine-Readable Files.*** Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by the Centers for Medicare and Medicaid Services ("CMS") standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The files will not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer's contract with that Vendor shall require indemnity and hold harmless protections from the Vendor for all acts or omissions related to the Machine-Readable Files. ***Cost Sharing Estimator Tool.*** Claim Administrator will make available a Cost Sharing Estimator Tool ("CSET") to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through either self-service tools or telephone upon member request, a secure member portal, and via a mobile application, for active policies, and include services in accordance with the following schedule:

   Effective with the plan year beginning on or after January 1, 2023, enrollees will be able to search for the cost of five hundred (500) services, as defined by CMS, covered by the Plan administered by Claim Administrator, to identify the estimated cost for the procedure, illustrate how the member's benefits will apply to the procedure, and disclose if there may be any prerequisites to care, such as requiring a prior authorization for a service or procedure.

For each plan year beginning on or after January 1, 2024, the services that can be estimated through the CSET will be expanded to support all services and procedures covered by the Plans that are administered by Claim Administrator.

To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer's contract with that Vendor shall require indemnity and hold harmless protections from the Vendor for all acts or omissions related to the Machine-Readable Files.

6. ***Drug Cost Reporting.*** Claim Administrator will provide on behalf of Employer, based on the type of pharmacy coverage and data Claim Administrator administers and maintains for Employer, health and drug cost reporting to the extent within the possession of Claim Administrator as contemplated by Section 204 of the CAA according to Claim Administrator's standard processes and procedures, unless otherwise mutually agreed in writing.

7. ***Continuity of Care.*** In the event of a Provider or facility termination for reasons other than failure to meet quality standards or fraud, Claim Administrator shall notify individuals enrolled under the Plan who are continuing care patients with respect to the Provider or facility at the time of the termination. Claim Administrator will provide each individual who is a continuing care patient of a terminated Provider or facility, the opportunity to request to continue to have the treatment provided under the same benefits provided, under the same terms and conditions as would have applied under the Plan had the termination not occurred, for a specified duration (for purposes of this section, "Continuity of Care"). Claim Administrator will identify continuing care patients and provide Continuity of Care in accordance with Claim Administrator policies.

8. ***Required Disclosure/Notices.*** Claim Administrator will post the disclosure on patient protections against balance billing on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the Plan's behalf.

9. ***Mental Health Parity.*** Claim Administrator has or will timely establish processes and procedures, in accordance with sound professional practices and prevailing industry standards, reasonably necessary for Claim Administrator to timely support good faith requests of Employer for data or other documentation that Employer may need to analyze and document the Plan's compliance with applicable Mental Health Parity requirements, including amendments to Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008. So long as Employer has elected to implement Claim Administrator's standard non-quantitative treatment limitations ("NQTLs") and so long as Claim Administrator administers both mental health/substance abuse benefits and medical/surgical benefits on behalf of Employer, this may include applicable comparative documentation with respect to Claim Administrator's administered NQTLs under the Plan which may be necessary for addressing and complying with the requirement to analyze and document NQTL parity between mental health/substance abuse benefits and medical/surgical benefits, as required by Division BB, Title II, Section 203 of the CAA and guidance issued thereunder. In addition, in the event that the U.S. Department of Labor or other regulatory agency ("Agency") with competent jurisdiction over the Plan initiates an audit or other assessment related to the Plan's compliance with mental health parity requirements, including the obligation to perform and/or make available the comparative analyses described above, Claim

Administrator agrees to provide expedited support to enable Employer and the Plan to timely provide documentation requested by the Agency. Both Parties agree and understand that no data or other documentation provided by Claim Administrator under this Section shall be reasonably interpreted as a certification of the compliance of the Plan or any Claim Administrator's administered NQTLs or other processes with State or Federal Mental Health Parity requirements. Employer agrees that compliance of the Plan with such requirements is solely the responsibility of Employer.

b. Surprise Billing Requirements of the No Surprises Act.

1. ***Qualifying Payment Amount.*** As it pertains to Employer's self-funded plans, Employer acknowledges that NSA requires, among other things, that member cost-share for certain items and services the Plan covers are calculated based on the lesser of the Provider's billed charge or the NSA's "Qualifying Payment Amount" ("QPA"). With respect to the calculation of QPA, Employer elects to use and adopts the QPA calculated by Claim Administrator based on Claim Administrator's self-funded business and not a QPA customized for Employer's Plan(s).

2. ***Negotiation and Independent Resolution Process.*** Employer acknowledges that Claim Administrator will make on the Plan's behalf an initial payment amount on Claims consistent with Employer's direction as established by Employer's Plan and this Agreement. For covered NSA-eligible items and services reported on Claims from nonparticipating Providers (i.e., generally noncontracted), a Provider may seek additional payment through a dispute process established by the NSA and related regulations. This process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

   Employer authorizes Claim Administrator, or for Claims for service rendered outside of Claim Administrator's service area another Blue Cross and Blue Shield licensee, to represent the Plan with respect to any Claim with items or services for which a Provider seeks to negotiate as provided by the NSA, or for which a Provider institutes IDR.

   With respect to any negotiations where Claim Administrator represents the Plan to resolve any disputed Claim, Employer expressly authorizes Claim Administrator in such negotiations to attempt to resolve any disputed Claim, (i) for an amount not to exceed the greater of the QPA or the amount allowed on the initial notice of payment or denial of the claim, or (ii) as otherwise directed by Employer in the ASO BPA and agreed to by Claim Administrator.

   Claim Administrator will maintain a summary description of its currently applicable approach to negotiation of services or Claims subject to the dispute resolution process of the NSA. The approach will be generally the same or similar for Claims under Employer's Plan as for similarly-situated Claims under Claim Administrator's fully insured health insurance policies. Claim administrator shall provide Employer with a copy of the summary description for Employer's records.

   Employer acknowledges and agrees that Claim Administrator shall follow its then-current negotiation approach, that such negotiations may not be successful, and may result in institution of IDR despite the approach outlined above or as otherwise directed by the Employer (with or without exhaustion of the full settlement authority Employer may grant to Claim Administrator), which in turn may result in additional administrative fees, as well as IDR entity fees in the event of settlement after institution of an IDR or an IDR loss. Notwithstanding the additional administrative fee and other possible expenses, Employer acknowledges that the approach set forth herein, or as it may direct (subject to Claim Administrator's agreement) in the

ASO BPA for attempting to resolve these Claims, notwithstanding the potential for IDR losses, is in the Plan's interest.

Negotiation services Claim Administrator provides shall include communicating with Provider, supplying requested documentation as appropriate, and proposing and documenting resolution of disputed Claims. Services in connection with an IDR shall also include handling interactions with the IDR entity and Provider, supplying requested information in connection with the IDR, and analyzing circumstances of disputed Claims to determine position on disputed Claims. On a quarterly basis, Claim Administrator shall provide Employer with information regarding the status of negotiations and IDR decisions.

Employer acknowledges that Claim Administrator undertakes negotiations at the direction of the Employer, undertakes such negotiations because they are necessary to the operation of the Plan, that the compensation to be paid to Claim Administrator for such negotiations is reasonable, and that, notwithstanding any other section of this Agreement, Claim Administrator does not act as a fiduciary, including under ERISA in connection with the negotiation or IDR of any disputed Claim. Employer is solely responsible for payment of any amounts determined to be payable as a result of such negotiations, awards, or judgments entered through IDR on NSA-eligible items and services. In the event that an award or judgment is entered against Claim Administrator in connection with IDR of any disputed Claim, Employer agrees to reimburse Claim Administrator for amounts paid to satisfy the award or judgment. Employer acknowledges that other terms, conditions, or fees may apply with respect to any negotiations or IDR processes performed by another Blue Cross and Blue Shield licensee.

c. **Effect of Future Changes in Law and Regulations.** The laws and regulations that are the subject of this Section 4.10 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective ninety (90) days after such notice.

Employer acknowledges that Employer, and not Claim Administrator, shall be responsible for making the necessary adjustments to its ERISA Plan Document(s) (if applicable) and Summary Plan Description(s) to be consistent with Employer's election, including any amendments to governing Plan documents.

SECTION 5: ERISA

5.1 **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) that an employee welfare benefit plan must be established and maintained through a separate plan document, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of Employer, Employer agrees that no allocation or delegation of any responsibilities under the Plan or any other employee welfare benefit plan of Employer 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.

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

5.3 **In Relation to Claim Administrator's Responsibilities.** Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of Employer's Plan. Claim Administrator is intended to be a service provider but not a fiduciary with respect to Employer's employee welfare benefit plan., Claim Administrator may, render advice with respect to claims and administer claims on behalf of the plan administrator of Employer's welfare benefit plan. Claim Administrator has no other authority or responsibility with respect to Employer's employee welfare benefit plan.

SECTION 6: OTHER PROVISIONS

6.1 **Term and Termination.** The term of this Agreement, for Administrative Services, shall commence January 1, 2025 and shall continue through December 31, 2027, 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 Application (Exhibit B), shall commence January 1, 2025 and shall continue through December 31, 2025, unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to six (6) consecutive one-year periods, unless sooner terminated, as provided therein.

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.; or

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 4.9 above; 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 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 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.

6.2 **Relationship of the Parties and Non-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. 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. 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. Claim

Administrator or its subsidiaries or affiliates may also have ownership interests in certain Providers who provide Covered Services to Covered Persons, and/or in vendors or other third parties who provide services related to this Agreement or provide services to certain Providers. Upon Employer request (not more than once per calendar year), Claim Administrator will provide a list of such entities to Employer.

6.3 **Entire Agreement.** Service Agreement AGR24-67 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 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.

The Exhibits and Addenda of this Agreement are:

1. Exhibit A – Administrative Services Agreement
   - **1)** Exhibit 1 – Claim Administrator Services
   - **2)** Exhibit 2 – Fee Schedule and Financial Terms
   - **3)** Exhibit 3 – Notices/Required Disclosures
   - **4)** Exhibit 4 – ASO BPA
     - (i) BPA Addendum – Pharmacy Benefit Fee Schedule
   - **5)** Exhibit 5 – Blue Cross and Blue Shield Association Disclosures and Provisions
   - **6)** Exhibit 6 – Recovery Litigation Authorization
   - **7)** Exhibit 7 – Pharmacy Benefit Management ("PBM") Services
2. Exhibit B – Stop Loss Application
3. Exhibit C – Sample Benefits Booklet
4. Exhibit D – Confidential Information Disclosure Statement
5. Exhibit E – Business Associate Agreement

6.4 **Amending.** This Agreement may be amended only by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation, or order ("Law") or by Claim Administrator or the 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. If the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to dispute resolution, as set forth in Section 4.

6.5 **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 1 "Claim Administrator Responsibilities"; Section 2 "Employer Responsibilities"; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); and Section 8 of Exhibit 2 "Financial Obligations Upon Agreement Termination."

6.6 **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 scheduled to be 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. Employer is also hereby notified that, 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 7: DEFINITIONS

Capitalized terms used in this Agreement shall have the meanings set forth in this Section 7, unless otherwise provided in the Agreement.

7.1 **"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.

7.2 **"Allowable Amount"** means the maximum amount for dental benefits coverage, if elected on the most current ASO BPA, determined by the Claim Administrator to be eligible for consideration of payment for a particular service, supply, or procedure.

i. ***For Dentists contracting with the Claim Administrator*** – The Allowable Amount is based on the terms of the Dentist's contract and the Claim Administrator's methodology in effect on the date of service.

ii. ***For Dentists not contracting with the Claim Administrator*** – The Allowable Amount is based on the amount the Claim Administrator would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and the Claim Administrator:

i. ***For services performed in New Mexico*** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

ii. ***For services performed outside of New Mexico*** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.

iii. ***For multiple surgical procedures performed in the same operative area*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.

7.3 **"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 Covered Services.**

i. ***For 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.

ii. ***For Providers other than Medical Network Providers ("Non-Contracting Providers")-*** The Allowable Charge will be the lesser of:

1. the Provider's billed charges, or;
2. 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 one hundred percent (100%) of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, or is unable to be determined based on the information submitted on a Claim, 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 may 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 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 one-hundred percent (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.

b. 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/or Blue Shield of New Mexico or with the local Blue Cross and/or Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and/or 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.

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

i. **Participating Pharmacy** – 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 Employer Payment and the Covered Persons' required deductible and Coinsurance, shall be the cost mutually agreed upon by Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference, if applicable.

ii. **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 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 twenty-five percent (25%) unless otherwise agreed upon by Claim Administrator and Employer.

7.4 **"Business Confidential Information"** means, 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), 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 developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and/or Blue Shield licensees through Inter-Plan Arrangements, 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.

7.5 **"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.

7.6 **"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.

7.7 **"Claim Payment"** means 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 Amount and/or 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."

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

7.9 **"Contracting Dentist"** means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a dental Provider.

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

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

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

7.13 **"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.

7.14 **"Dentist"** means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

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

7.16 **"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.

7.17 **"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.

7.18 **"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").

7.19 **"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.

7.20 **"Inpatient"** means the Covered Person is a registered room and board patient and treated as such in a health care facility.

7.21 **"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.

7.22 **"Non-Contracting Dentist"** means a Dentist who is not a Contracting Dentist as defined herein.

7.23 **"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.

7.24 **"Overpayment"** means a payment to a Provider or a Covered Person that was more than it should have been based on the Plan's benefit design and Claim Administrator's or other Blue Cross and/or Blue Shield companies' Provider contracts and policies, or a payment that was made in error, including but not limited to, Provider's unsupported billing practices.

7.25 **"Physician"** means a physician duly licensed to practice medicine in any of its branches recognized by applicable state law.

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

7.27 **"Primary Care Practitioner"** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to Covered Persons, who initiates the patient's referral for specialist care, who maintains continuity of patient care, who is a Network Provider at the time Covered Services are rendered, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care. Primary Care Practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also serve as Primary Care Practitioners, as defined by the State in which the professional is in practice (otherwise known as a "Primary Care Provider").

7.28 **"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.

7.29 **"Reminder Notice"** means a notice sent when claims have not been paid within 10 (ten) days.

7.30 **"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.

7.31 **"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, 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.

7.32 **"Timely"** means the following:

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 Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; 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.

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 applicable benefit plan terms and design, 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, when scheduled in advance based on staffing availability, 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.

- **DISABLED DEPENDENT CERTIFICATION**

  Certify the disabled status of any dependent children of Covered Persons, based on Claim Administrator's review of information provided by Employer, the Covered Person, or the dependent's medical Provider(s), following either the Standard or Custom Rules as indicated on the most current ASO BPA, for purposes of administering the Employer's age limit for eligibility.

- **CLIENT SERVICES AND MATERIALS**

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

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

  b. ***Standard Identification Cards.*** Prepare 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 Service Telephone Number.*** 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 service telephone number 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.

- **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 settlements (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 UNDERWRITING**

  Provide 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 if the Employer is a target of a pattern of fraudulent or abusive activities inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 6.

- **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 health care coverage and benefits, currently verifying the status of finalized Claims, 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.

- **MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING**

  Pursuant to Exhibit 3, Section 6 titled "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 three hundred and sixty-five (365) days old), Claim Administrator will 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 and unless stated otherwise in the Agreement, Claim Administrator will remit such funds to Employer, less any amount(s) owed to Claim Administrator from such funds, in accordance with Claim Administrator's established procedures, for disposition by Employer as may be required under applicable law. If requested by Employer via prior written notice as required by Claim Administrator, Claim Administrator will escheat such funds on behalf of Employer, less any amount(s) owed by payees to Claim Administrator, from such funds, to the state of payee's last known address 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**

  Services under Exhibit 1 do not include providing Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations such as support functions.

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **ADVANCED PAYMENT REVIEW ("APR")**

  Provide a program that may include post-service, prospective, and retrospective Claim coding or billing reviews to identify discrepancies, errors, or billing inconsistencies of Claim Payments as identified by Claim Administrator.

- **EXTERNAL REVIEW COORDINATION**

  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.

- **WELLBEING MANAGEMENT**

  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. Audits relating to Wellbeing Management shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  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 subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING ("RBP")**

  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**

  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")**

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator. Audits relating to Health Advocacy Solutions shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator.

- **FLEXACCESS™**

  Claim Administrator or its designee(s) will proactively enroll Covered Persons into a program designed to lower specialty drug costs through manufacturer copay assistance programs. Under this program, copays for a select list of applicable drugs are maximized within the benefit plan design, and the manufacturer-provided copay assistance programs are applied to offset medication costs. The manufacturer copay assistance will not apply to Covered Persons' deductibles and out-of-pocket maximum accumulators. Through active outreach to Covered Persons, Claim Administrator or its designee(s) will help Covered Persons attempt to enroll in a copay assistance program prior to paying for any Covered Person's claim.

- **FLEXACCESS™ QUALIFIED HDHP**

  Claim Administrator or its designee(s), through active outreach to Covered Persons, will help Covered Persons attempt to enroll in a manufacturer assistance program. Under this program, the manufacturer provided assistance may be used by the Covered Person at the point of sale to offset their out-of-pocket medication costs. Claim Administrator or its designee(s) will ensure manufacturer assistance funds used by Covered Persons do not apply to the Covered Persons accumulators.

EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

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 Fee Schedule Addendum, if applicable. 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 Fee Schedule Addendum, if applicable; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Fee Schedule Addendum, if applicable; or iii) the date the Agreement is terminated (or, if applicable, in the case of the PBM Fee Schedule Addendum, the date such PBM Exhibit is terminated).

Inter-Plan Arrangement Fees:

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

1.2 **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).

1.3 **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).

**If applicable, 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 two thousand dollars ($2,000) per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 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 Exhibit 3 Section 6 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 the termination of Covered Employees but not the Agreement, 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 Fee Schedule Addendum, if applicable, 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 Fee Schedule Addendum, if applicable, 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 by Employer, 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 +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (e.g., benefit levels, census/demographics, producer/broker fees) 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 of Covered Employees by Employer, 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); and/or

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, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or

d. 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." 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 ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

4.3 ***Covered Person's Certain Liability.*** Under certain circumstances, if Claim Administrator pays the health care 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 forty-eight (48) hours 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 ***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 ninety (90) 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 the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent. If defaults are not cured following notice via email 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 termination language contained herein.

7.2 ***When Claim Administrator Fails to Timely Notify.*** Pursuant to Section 6.5 "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 6 of the Agreement, or on the date which Employer terminates a part of the population 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 termination of Covered Employees but not the Agreement, 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 termination of Covered Employees but not the Agreement.

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 ninety (90) 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 or recoveries for Overpayments, including, but not limited to, subrogation or litigation activities, regardless of when such adjustments or recoveries 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 and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old), less any amount(s) owed by payees to Claim Administrator from such funds, will be escheated by Claim Administrator on Employer's behalf to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **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 Section 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

1.2 **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.

1.3 **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. 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; however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 "Claim Overpayments."

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship to 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. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **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 that 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 nor that any Provider is a subcontractor of Claim Administrator with respect to any aspect of this Agreement. 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.

2.3 **Physician Ratings and Rankings.** Employer acknowledges that Claim Administrator may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and guidelines to rate and rank certain Physicians, and may publish and make available to Employer and Covered Persons certain Physician-specific information that includes, and is not limited to, ratings, rankings, and other comparisons of a Physician's performance against certain standards, measures and other physicians, and that Claim Administrator may publish and/or share such information with Employer, Covered Persons and other third parties. Notwithstanding this or any other provisions of this Agreement to the contrary, in no event shall any reference or statement by Claim Administrator about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee as to future services provided by any Physician or Provider or the anticipated outcome of such services.

SECTION 3: 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 Provider for a Covered Service in non-emergency situations, benefit payments to such non-Network Provider are not based upon the amount billed. Non-Network Providers may bill the Plan's Covered Person for any amount up to the difference between the billed charge and the amount the Claim Administrator has paid for the Plan's portion of the bill. For more detailed information regarding benefit payments for Network and Non-Network Providers, please see the definition of Allowable Charge in Section 7 Definitions of this Agreement. A Covered Person may obtain further information about the Network status of Providers and information on out-of-pocket expenses by calling the toll-free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

4.1 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", subsection (c)(i). 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 for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the "Allowable Charge", subsection (c)(ii).

4.2 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 payments, discounts and/or other allowances for prescription drugs dispensed to Covered Persons under the Agreement. 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.

4.3 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or allowances 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, payments and/or other allowances that Prime has negotiated with pharmacies (or other suppliers) are passed through to Claim Administrator. For the administrative services that Prime provides as part of the mail order and specialty pharmacy program, Prime may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the mail-order and/or specialty pharmacy. 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.

4.4 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.

SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

5.1 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, the mail-order pharmacy and specialty pharmacy shall be operated through a third party, which may be an affiliate of or partially owned by Prime Therapeutics, LLC.

5.2 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). PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. 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 notwithstanding the actual amount of rebates, payments, discounts and/or other allowances 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 Plan have no right to, or legal interest in, any portion of the rebates, payments, discounts and/or other allowances provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates, payments, discounts and/or other allowances. Rebate Credits shall not continue after termination of the prescription drug program.

5.3 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 6: MEDICARE SECONDARY PAYER INFORMATION REPORTING

6.1 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 RRE and shall report information to 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 so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

6.2 It shall be 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. Employer's failure to provide accurate and timely information in response to Claim Administrator's request may impact Claim payments.

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

6.4 Notwithstanding any other provision herein, in instances where the Employer has carved out prescription drug coverage administration to an entity other than Claim Administrator, Claim Administrator shall not serve as the RRE for prescription drug coverage under the Plan.

SECTION 7: REIMBURSEMENT PROVISION

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

7.1 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 or guardians 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.

7.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to exercise 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 8: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for, and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. 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 Host 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 8.

EXHIBIT 4
ASO BPA

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 Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSNM"

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 Effective Date of Coverage 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:
Select from Drop Down ; 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 __/__/__ End Date __/__/__
(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 / 2025

Anniversary Date: (Month/Day/Year) 01 / 01 / 2026

Retiree-Only Plan(s) Identification:
For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

[‡] **NOTE – This Group plan does not include the individual pharmaceutical drug cost-sharing protections included in a fully insured plan as provided for in § 59A-23-12.3 NMSA. Please confer with your Producer about options to purchase a fully-insured plan with pharmaceutical drug cost-sharing protections for individuals.**

Account Information	☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): 9111	Employer Identification Number (EIN): 856000679	
Address: 1000 Central Ave, Suite 230		
City: Los Alamos	State: NM	ZIP: 87544
Administrative Contact: Bernadette Martinez	Title: Deputy HR Manager	
Email Address: bernadette.martinez@lacnm.us	Phone Number: 505-662-8067	Fax Number: 505-662-8000
Wholly Owned Subsidiaries to be covered:		

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

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for Employers℠ ("BAE℠") Contact: Bernadette Martinez

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: bernadette.martinez@lacnm.us Phone Number: 505-662-8067 Fax Number: 505-662-8000

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

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 a representative in negotiations with and to receive commissions from BCBSNM, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for the Employer's employee benefit program(s). 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/Consultant Compensation:
The Employer acknowledges that if its POR 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 POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer, Agency, or Consultant: Aon Consulting, Inc. Commission to be paid: ☐Yes* ☒ No

New Mexico Producer/Consultant #: 900001881

Address:6501 America's Parkway NE, Suite 650

City: Albuquerque State: NM ZIP: 87110

Phone: 505-889-6721 Fax: 847-956-0916 Email: charlene.fairchild@aon.com

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

Commissions:

☐ PCPM $____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Flat $____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss:____%

ADDITIONAL COMMISSIONS: _____

*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: _____

1. **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: _____

2. **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: _____

3. 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.

4. **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 and/or dependents of domestic partners.

5. **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: ____

6. **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
**Automatically canceling dependents is not recommended for accounts with automated eligibility*

☐ Yes ☒ No

However, such coverage shall be extended in accordance with any applicable federal or state law and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSNM of any instance where the continuation of disabled dependent coverage is required.

1. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

   To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSNM will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSNM will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

(a) ☒ Disabled dependent administration will follow **Standard Rules.**

A disabled dependent is eligible to ***continue*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to ***add*** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSNM; a disabled dependent certification form must be submitted to BCBSNM.

(b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*
☐ The disability must have begun before the child attained the age of 26.
☐ All disabled dependents are covered regardless of when the disability began.

Proof of prior coverage: *Please select required or not required below:*
When ***adding*** coverage, proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification review: *Please select one option regarding the administration of certification review.*
☐ Certification review is administered by BCBSNM; a disabled dependent certification form must be submitted to BCBSNM.
☐ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSNM, *please select one option regarding forms:*
☐ Utilize BCBSNM disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSNM, please *select allowed or not allowed below:*
A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

2. 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 BCBSNM of such requirements.

***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 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 group coverage 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 otherwise eligible to do so, during the Employer's annual 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 otherwise 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 rules governing off-cycle enrollments.

1. * 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** 614 ☐ **SEE ADDITIONAL PROVISIONS**

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:

1. on payroll: _____
2. presently eligible for coverage: _____
3. serving new hire probationary period: _____
4. with other coverage (i.e., other group coverage, Medicare, Medicaid, TRICARE/Champus): _____
5. total number of individuals currently covered under COBRA: _____
6. with retiree coverage (if applicable):_____

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:

☒ Wellbeing Management
☐ Wellness Incentives
☐ Health Advocacy Solutions
☐ Mercer Health Advantage
☐ Custom Care Management Unit
☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)*

☒ Limited Fiduciary Services for Claims and Appeals
☐ Other Select Product
☐ Other Select Product
☐ Other Select Product
☐ Other Select Product
☐ Other
☐ Other

Consumer Driven Health Plan:

☐ BlueEdge℠ HCA Administrative Services *(if selected, complete separate HCA BPA)*
☐ BlueEdge℠ HSA: (Preferred Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSNM to send HSA enrollment to HealthEquity, Inc
☐ Yes ☐ No
Non-Preferred Vendor:
☐ FSA (Preferred Vendor: Select Vendor)*
Non-Preferred Vendor:
☐ HRA (vendor: Select Vendor)*
Non-Preferred Vendor:

Traditional Coverage:

☐ Out-of-Area (Indemnity)

Prescription Drugs:

☒ Covered under a pharmacy benefit *(If selected, the 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
☐ Network on PBM Fee Schedule Addendum
Drug List: Select Drug List
Other (please specify):
PPO/HSA Preventive Drug List:
Please specify: Select Option
Other RX programs: Select Program

Ancillary Services:

☐ Dental Plan Services
☐ Vision Insurance *(if selected, complete a separate application)*
☒ Stop Loss *(if selected, complete separate Application and Policy Schedule for Stop Loss Coverage)*
☒ Life, Disability, Critical Illness, Accident or Hospital Indemnity Insurance *(if selected, complete a separate application for those coverages)*
☐ COBRA Administrative Services *(if selected, complete separate HCSC COBRA Administrative Services Addendum)*

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of New Mexico.
Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of New Mexico.
Medical and Dental benefits and services are administered by 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.
Life, Disability, Critical Illness, Accident, Hospital Indemnity and Vision products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of New Mexico is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this 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** (cannot be selected if Check is selected as payment method above)

☐ **Monthly**

Claim Settlement Period:

☐ **Weekly Run-Off Period:** Employer payments are to be made for weeks following end of Fee Schedule Period.

☒ **Monthly Run-Off Period:** Employer payments are to be made for 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	**$66.49**	$	$	$
Dental	$	$	$	$
Claims Fiduciary	$	$	$	$
Advanced Payment Review	**25%** **$**	% $	% $	% $
*Medical Drug Rebate Credit	**$(2.50)**	$( )	$( )	$( )
*Rebate Credit for the Prescription Drug Program	**$(73.90)**	$( )	$( )	$( )
Telehealth (Virtual Visits)	**$Included**	$	$	$
Wellbeing Management	**$Included**	$	$	$
Health Advocacy Solutions	$	$	$	$
Commissions: _____	$	$	$	$
Commissions: _____	$	$	$	$
Commissions: _____	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Miscellaneous:	$	$	$	$
Miscellaneous:	$	$	$	$

*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 Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges ☐ SEE ADDITIONAL PROVISIONS	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: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____%
	Total:	$_____

Other Service and/or Program Fee(s) ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS
NSA Fees In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees: • Fifty dollars ($50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and • An additional seventy-five dollars ($75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.
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 for external reviews to be performed under the Affordable Care Act external review process. ***If no,*** provide name and address of administrator(s) of external review coordination and indicate if administrating medical claims and/or pharmacy claims: **Administrator:** Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address: **Administrator:** Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party vendor.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (3) not applying the manufacturer assistance to Covered Persons' deductibles and out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will hold Claim Administrator harmless for, the legal and regulatory compliance of the Plan and its plan design.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as follows:
The difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility with the FlexAccess Program is the cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the member's cost share for the member enrolled in the program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the member cost share if the member was not enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the member's estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Member out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – member out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon… Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services):
Employer will pay no more than 35% of any recovered amount made by Claim Administrator'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 between the Claim Administrator and the Employer.

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 Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of New Mexico. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charge

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. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.

Service	Medical			
Medical Run-off Administration Charge	$22.76	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	$22.76	$_____	$_____	$_____

Other Provisions ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. **Summary of Benefits & Coverage**:
   a. Will Claim Administrator create Summary of Benefits and 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 (SBC) to Covered Persons?
   ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (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 Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar and fifty cents ($1.50) per package.

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 (1) it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act or (2) that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

1. **Alternative Care Management Program** (applicable to 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.

2. **Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

3. **Essential Health Benefits ("EHB") Election**:
   Employer elects EHBs based on the following:
   1. ☒ EHBs based on a Claim Administrator state benchmark:
      ☐ Illinois ☐ Montana ☒ New Mexico ☐ Oklahoma ☐ Texas
   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 New Mexico benchmark plan.

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

5. **Independent Dispute Resolution Process**:
   Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions:

4. BCBSNM will provide a one-time wellness credit in the amount of $50,000 for a three year period beginning on the Contract Effective Date 1/1.2025, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. [For ERISA plans: Employer is accepting the wellness credit on behalf of the wellness program, which is or is part of an ERISA plan. Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan.] If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSNM the full amount of the wellness credit.

BCBSNM will provide a one time credit in the amount of $25,000 ("Allowed Amount") to cover three year Wellness Consulting effective 1/1/2025. [For ERISA plans: Employer is accepting the wellness implementation fund on behalf of the wellness program, which is or is part of an ERISA plan. Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan.] Amounts unused at the end of the policy period will remain property of BCBSNM. If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSNM the full amount of the used portion of the wellness implementation fund.

Signature

Martha E. Jarrett	Linda Matteson for
Sales Representative	Signature of Authorized Purchaser
NM 505-816-2635	Linda Matteson for
District Phone & FAX Numbers	Print Name
Charlene Fairchild	Acting County Manager
Producer Representative	Title
Aon Consulting, Inc.	11/7/2024
Producer Firm	Date
6501 America's Parkway NE Suite 650 Albuquerque, NM 87110	
Producer Address	
505-889-6721 847-956-0916	
Producer Phone & FAX Numbers	
charlene.fairchild@aon.com	
Producer Email Address	
95-3252415	
Tax I.D. No.	

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 HCSC 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 either 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 its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: 251307

By: Linda Matteson for
Print Signer's Name Here

➡ Linda Matteson for Acting County Manager
Signature and Title

Group Name: Incorporated County of Los Alamos

Address: 1000 Central Ave, Suite 230

City: Los Alamos State: NM ZIP: 87544

Dated this day of
Month Year

BPA Addendum – Pharmacy Benefit Fee Schedule

Blue Cross and Blue Shield of New Mexico

Los Alamos County	
Effective Date:	1/1/2025
Members:	558
Employees:	1,304

Contract Period	Traditional Select	Advantage
BRAND DISCOUNTS		
Retail Network		
1/1/2025 to 12/31/2025	19.40%	20.75%
Extended Supply Network (ESN) - 90 Day Channel		
1/1/2025 to 12/31/2025	22.55%	23.60%
Mail		
1/1/2025 to 12/31/2025	25.65%	25.65%
GENERIC DISCOUNTS		
Retail Network		
1/1/2025 to 12/31/2025	83.35%	84.55%
Extended Supply Network (ESN) - 90 Day Channel		
1/1/2025 to 12/31/2025	85.55%	86.15%
Mail		
1/1/2025 to 12/31/2025	86.35%	86.35%
BRAND DISPENSING FEES		
Retail Network		
1/1/2025 to 12/31/2025	$0.65	$0.40
Extended Supply Network (ESN) - 90 Day Channel		
1/1/2025 to 12/31/2025	$0.00	$0.00
Mail		
1/1/2025 to 12/31/2025	$0.00	$0.00
GENERIC DISPENSING FEES		
Retail Network		
1/1/2025 to 12/31/2025	$0.65	$0.40
Extended Supply Network (ESN) - 90 Day Channel		
1/1/2025 to 12/31/2025	$0.00	$0.00
Mail		
1/1/2025 to 12/31/2025	$0.00	$0.00
AGGREGATE SPECIALTY		
Discount		
1/1/2025 to 12/31/2025	20.65%	20.65%
Specialty Pharmacy Dispensing Fee		
1/1/2025 to 12/31/2025	$0.00	$0.00

Notes:
- Discounts are based on the actual NDC-11 dispensed on the fill date.
- Guarantees are based upon the above selected BCBSNM Network rate sheet.
- Guarantees are based upon an implemented BCBSNM Extended Supply Network (90-day retail). If not implemented, Retail rates apply.
- For the purpose of reconciliation at contract year end, discount and dispensing fee guarantees are reconciled in aggregate, as long as the contract remains in effect.
- Discount and dispensing fee rates exclude compound, long term care (LTC) pharmacy, home infusion (HIF) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, 340B, Medicare/Medicaid, out-of-network, member-submitted, foreign, coordination of benefits (COB), subrogation, paper, invalid, usual and customary (U&C) claims and non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBSNM specialty drug pricing file) claims.
- For discount purposes, Specialty is defined by the BCBSNM specialty drug pricing file.
- Guarantees are based upon a exclusive specialty network arrangement.
- Aggregate Specialty discount guarantees do not include limited distribution drugs (LDDs) nor any new specialty drugs brought to market and added to the specialty list during the term of each contract year.
- For discount and dispensing fees, Brand drugs are defined as drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".
- For discount and dispensing fees, Generic drugs are defined as drugs available that have a Medi-Span multisource code field equal to "Y".
- 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 Drugs, Foreign Claims, and out-of-network claims) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule that is intended to achieve, on an aggregate annual basis, the AWP discounts and Dispensing Fees shown above (the "Employer's Contract Rates").
- 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 contract year basis.
- Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.
- Compound 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 number of employees drops to under 500, the discount and rebate guarantees become illustrative and annual reconciliation will not occur.

Blue Cross and Blue Shield of New Mexico

Los Alamos County	
Effective Date:	1/1/2025
Members:	558
Employees:	1,304

Contract Period	Basic	Balanced
REBATES PER BRAND		
Retail Network		
1/1/2025 to 12/31/2025	$171.00	$215.70
Extended Supply Network (ESN) - 90 Day Channel		
1/1/2025 to 12/31/2025	$513.00	$647.00
Mail		
1/1/2025 to 12/31/2025	$573.00	$715.40
Specialty		
1/1/2025 to 12/31/2025	$2,606.20	$3,017.30
REBATES PER EMPLOYEE PER MONTH		
1/1/2025 to 12/31/2025	$88.66	$88.66

Notes:
- For rebate purposes, Specialty is defined by the BCBSNM specialty drug pricing file.
- For the purpose of reconciliation at contract year end, all rebate guarantees are reconciled in aggregate as long as the contract remains in effect.
- Compound, long term care (LTC) pharmacy, home infusion (HI) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, 340b, Medicare/Medicaid, out of network, member-submitted, foreign, coordination of benefits (COB), subrogation, paper, invalid, vaccine, over-the-counter (OTC), and zero balance due (100% member paid) claims are excluded from rebate guarantees.
- For rebate purposes, Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".
- Rebates will be trued up annually to the greater of the PEPM rebate credits or per brand Rx rebate guarantees
- Rebate guarantees are inclusive of and assume WAC reduction effective 1/1/2024 due to AMP CAP. BCBSNM reserves the right to adjust the reconciliation of guarantees for any other products with a WAC decrease.
- If the number of employees drops to under 500, the discount and rebate guarantees become illustrative and annual reconciliation will not occur.

Blue Cross and Blue Shield of New Mexico

Los Alamos County	
Effective Date:	1/1/2025
Members:	558
Employees:	1,304

ADMINISTRATIVE FEE	
Contract Period	Per Employee Per Month
1/1/2025 to 12/31/2025	$0.00

Notes:
- Administrative Fees will be charged at the above rate on a per employee per month basis.

Additional Caveats:
- Guarantees are based on adoption and adherence of an above BCBSNM drug list, including associated utilization management, recommended drug list strategies, and clinical programs. BCBSNM reserves the right to make an equitable modification to the pricing terms of the agreement for the following: changes in any law or regulation, changes in interpretation of a law or regulation, changes within PBM marketplace which lead to a significant deviation from the current economic environment, unexpected market events, unexpected generic launches, authorized generic launches, biosimilar products, products launched at risk, products under patent litigation, new lower cost NDCs priced net of rebates from the innovator, products with WAC decreases, biosimilar utilization or mix being materially different from underwriting assumptions, implementation of new clinical programs, removal of existing clinical programs, changes in pharmacy benefit plan design, specialty drug pricing file, limited distribution list, or drug list changes.
- Members will pay the lower of the contracted rate, U&C, or their applicable copayment. Zero balance logic is not employed.
- Assumes client does not have 340B pricing.
- Guarantees provided does not include savings from DUR or other clinical programs.
- Specialty drugs dispensed through the medical benefit will not be included in reconciliation of guarantees.
- Guarantees assumes current channel utilization. BCBSNM reserves the right to rerate to equitably adjust the guarantees in the event of significant changes in utilization.
- BCBSNM reserves the right to equitably adjust the guarantees in the event that membership in high deductible (CDHP) plan increases significantly over the current CDHP membership during the course of the contract.
- BCBSNM reserves the right to equitably adjust the guarantees in the event the number of covered members or pharmacy claims volume materially changes over the course of the contract.
- Covid-19 related testing, vaccines, and treatments are excluded from guarantee reconciliation.
- Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on Employer's Contracted Rates or the applicable out-of-network pricing. Zero balance logic is not employed.
- 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.
- Employer will be billed for Foreign Claims in an amount based on 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.
- Guarantees will be calculated as described in this Addendum and the PBM Exhibit to the Administrative Services Agreement.
- 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.
- Rx offer is contingent on BCBSNM being the medical benefits administrator.
- The Claim Administrator will not be obligated to provide Rx reconciliation and will not be obligated to refund Employer until The PBM Addendum has been executed and is on file with the Claim Administrator by the close of the applicable Reconciliation Period.
- If the number of employees drops to under 500, the discount and rebate guarantees become illustrative and annual reconciliation will not occur.
- Net of Commissions
- BCBSNM is offering a one time payment of $40,000 if group moves to the Advantage Network.

EXHIBIT 5
BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

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

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

1.3 **"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 Home 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 4.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, 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 4.4 of this Exhibit. 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 Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 4.4 of this Exhibit). Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, 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 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.

1.4 **"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.

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

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

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

1.8 **"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.

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

1.10 **"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.

1.11 **"Non-Participating Healthcare Provider"** means a health care Provider that does not have a contractual agreement with a Host Blue.

1.12 **"Participating Healthcare Provider"** means a health care Provider that has a contractual agreement with a Host Blue.

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

1.14 **"Provider Incentive"** means an additional amount of compensation paid to a health care 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.

1.15 **"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.

1.16 **"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.

SECTION 2: ADMINISTRATIVE SERVICES ONLY

Claim Administrator provides administrative Claims payment services only as set forth in this Agreement and does not assume any financial risk or obligation with respect to Claims.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

Employer, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that 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/or Blue Shield Service Mark in the State of New Mexico, 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.

SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 ***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 health care 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.

4.2 ***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 health care 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 health care 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 4.9 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 health care provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a health care provider may bill for non-covered health care 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.

4.3 ***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 health care 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 Section 4.2.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 Section 4.2.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 4.9 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.

4.4 ***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 Home, 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 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.

4.5 ***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, health care 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 health care 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.

4.6 ***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 charge any such surcharge, tax or other fee to Employer, which will be Employer's liability.

4.7 ***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 health care services had been obtained within Claim Administrator's service area;

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

iv. The lesser 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 4.9 below.

4.8 ***Blue Cross Blue Shield Global Core***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico, 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 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 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 service center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the service center or online at bcbsglobalcore.com. If Covered Persons need assistance with their Claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 4.9 below.

4.9 ***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 in accordance with Section 6.1(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.

EXHIBIT 6
PHARMACY BENEFIT MANAGEMENT SERVICES
(GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT)

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 directly for such services or to authorize Prime to subcontract certain services pursuant to the terms of Claim Administrator's agreement with Prime. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

   Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. 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 or compensation otherwise received by Prime related to network administration, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Pharmacy Benefit Management services to be provided include Drug List management services, 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 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 selected by Employer.

4. **Prime's Rebate and Manufacturer Administrative Fee Management:** In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers directly or through a group purchasing organization 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 for bona fide administrative services provided to 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 directly or indirectly, 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, payments, discounts, or other allowances and/or Manufacturer Administrative Fees received from

manufacturers. Prime has advised Claim Administrator that Rebate arrangements are based on formulary status, market share, 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 titled "Rebates" and in the PBM Fee Schedule Addendum to the BPA but otherwise shall have no right, title or interest in Rebates, payments, discounts, or other allowances 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 it is responsible for providing and maintaining a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. 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 Copayment/Deductible, and Coinsurance amounts. Prime will reimburse Network Participants in accordance with the applicable Network Contract. Employer acknowledges actual network savings achieved may vary by Network Participant and plan size and/or other demographics. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member and/or the Member's Physician.

   b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts to not 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. Prime's MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Employer after 30 days' prior written request submitted by Employer to Claim Administrator, and subject to Employer's execution of Prime's non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. Prime's MAC List will only be made available for viewing at Prime's corporate headquarters or another secured location designated by Prime.

   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.

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. Subject to the audit terms elsewhere in 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 or Claim Administrator as applicable. 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. Claim Administrator shall inform Employer in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services and give Employer a reasonable opportunity to review such new benchmark. Thereafter, but not less than forty-five (45) days of Claim Administrator's notice, Employer will be deemed to have approved the designation, which will become part of this Agreement, unless Employer terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract.

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 assistance in processing a pharmacy Claim.

f. **Benefit Plan Design:**

In the event Employer wishes to implement Benefit Plan design changes; for example, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the BPA Addendum may no longer be applicable. If such Benefit Plan design changes impact the existing pricing, a new BPA Addendum pricing must be negotiated.

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

9. **Termination**

This Exhibit may be terminated as follows:

a. By either Party at the end of the Guarantee Period, 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 "Notice and Satisfaction" section of the Agreement; or

e. By Claim Administrator, upon 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 BPA Addendum.

If Employer terminates this Exhibit under sections 9(a), 9(b), or 9(c) above, or by Claim Administrator under sections 9(d) or 9(e), prior to the end of the Guarantee Period, then applicable network discount and/or minimum Rebate guarantees set forth in the BPA Addendum will not be effective for such Guarantee Period.

10. **Program Pricing Terms**

The pricing terms for Pharmacy Benefit Management services are as follows, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan:

a. **Pharmacy Program Claims**

i. Employer will reimburse Claim Administrator for Claims submitted under the pharmacy program based on the pricing set forth in the BPA Addendum.

ii. 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 (i) 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 one hundred percent (100%) of the Covered Prescription Drug Products and Services. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes. Zero balance logic is not employed.

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

b. **Rebates for Drugs Covered under the Prescription Drug Program**

In connection with Rebates earned for drugs covered under the prescription drug program, Rebate Credits are paid to Employer pursuant to the terms of the BPA Addendum 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.

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 pricing set forth in the BPA Addendum, 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 under the Specialty Drug program is not included in the retail and mail pharmacy pricing described in the BPA Addendum and the Specialty Drug pricing terms in the BPA Addendum will apply. Member is responsible for the applicable Copayment plus applicable taxes.

d. Copayments/Deductibles/Coinsurance

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

11. 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 actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.
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 Drug"** means, except as otherwise designated in the Additional Provisions of the BPA Addendum, 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. **"Compound Drug"** means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added.

8. **"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.
9. **"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.
10. **"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.
11. **"Dispensing Fee"** means the negotiated fee for Network Participants' professional service of filling a prescription and is added to the Ingredient Cost for the prescription.
12. **"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.
13. **"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.
14. **"Extended Supply Network"** or **"ESN"** means claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Eighty-Four (84) days' quantity supply of medication, provided that the Member's Benefit Plan provides for an ESN benefit.
15. **"Foreign Claim"** means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.
16. **"Generic Drug"** means, unless otherwise designated in the Additional Provisions of the BPA Addendum, 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.
17. **"Guarantee Period"** means the period of time set forth in the BPA Addendum for which the AWP network discount and Dispensing Fees and/or Rebates are guaranteed.
18. **"Ingredient Cost"** means the negotiated rate (e.g., discount of AWP or MAC) for a prescription drug dispensed by a Network Participant and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable for the given prescription drug and the professional service of dispensing such drug.
19. **"Legend Drugs"** means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.
20. **"Limited Distribution Drug"** or **"LDD"** means a Specialty Drug whose dispensing is restricted by the pharmaceutical manufacturer to specified pharmacies as reflected on the limited distribution list provided by Prime or Claim Administrator.
21. **"MAC List"** means the list of unit prices established by Prime for multi-source Covered Drugs, with 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 Prime and updated from time to time in accordance with this Exhibit and the BPA Addendum.
22. **"Mail Service"** means the service through which Members may receive Covered Prescription Drug Products and Services through the mail from a pharmacy designated by

Claim Administrator or PBM to dispense prescription drugs from one or more central locations.

23. **"Manufacturer"** means a company that manufactures, and/or distributes pharmaceutical drug products.

24. **"Manufacturer Administration Fee"** means all negotiated fees received by Prime from any given Manufacturer, directly or through a group purchasing organization, relating to administration of Rebates under a Manufacturer Agreement.

25. **"Maximum Allowable Cost"** or **"MAC"** means the unit price established by Prime for a specific multi-source drug present on the MAC List at the time of service.

26. **"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.

27. **"Network Contract"** has the meaning set forth in the definition of "Network Participant."

28. **"Network Participant"** means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with Prime or Claim Administrator ("Network Contract") to provide Covered Prescription Drug Products and Services to Members, as may be amended. References to "Network Participant" may exclude Specialty Pharmacies and/or Mail Service pharmacies (separately defined in this Exhibit) as context dictates.

29. **"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.

30. **"Pricing Source"** means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which establishes 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.

31. **"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.

32. **"Rebate(s)"** means any discount or other remuneration of any kind received or recovered by Prime, directly or through a group purchasing organization, from any Manufacturer which is directly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees or fees retained by a group purchasing organization for its role in securing Rebates and/or Manufacturer Administrative Fees.

33. **"Rebate Credit"** has the meaning set forth elsewhere in this Agreement.

34. **"Rebate Management Services"** means the services which Prime is obligated to provide pursuant to Section 4.

35. **"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, or are infused medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by Prime or Claim Administrator and subject to change.

36. **"Specialty Pharmacy(ies)"** means a pharmacy designated by Claim Administrator or PBM to dispense Specialty Drugs to a Member through the mail or other similar delivery method from one or more central locations.

37. **"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.

38. **"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.

39. **"Zero Balance Due Claim"** means any Claim where the Member cost share covers one hundred percent (100%) of the Allowable Charge for such Claim.

Exhibit B
AGR24-67

BlueCross BlueShield of New Mexico

APPLICATION AND POLICY SCHEDULE 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		
Original Effective Date of Stop Loss Policy	01/01/2025		
Current Policy Effective Date:	01/01/2025		
Current Policy Period	These specifications are for the Policy Period commencing on 01/01/2025 and ending on 12/31/2025.		

The specifications below shall become effective on the first date 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 Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. **Covered Employees**:

Number of Single Coverage Units:	246
Number of Family Coverage Units:	312

B. **Individual Stop Loss Coverage**:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss coverage during the Current Policy Period

☐ Choose an item
Coverage for Claims incurred from _____to _____and Claims paid from _____to _____.

For new coverage only, if a run-in contract as explained in the policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

☒ Medical Claims:
☒ Prescription Drug Claims with: Prime _____
☐ For **Hospital Employer Groups only:** Excludes_____% of Home
☐ Hospital Medical claims Other (for example Dental/Vision): _____.

4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $165,000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:

_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:

e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts): ☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$235.05 Composite; or
$_____ for each Single Coverage Unit
$_____for each Family Coverage Unit

C. Aggregate Stop Loss Coverage:
Yes ☒ ☐ No If yes, complete Items 1. through 5. Below:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss Coverage during the current Policy Period

☐ Choose an item
Coverage for Claims incurred from _____to _____and Claims paid from _____to _____.

For new coverage only, if a run-in contract as explained in the policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

☒ Medical Claims
☒ Prescription Drug Claims with: Prime _____
☐ For **Hospital Employer Groups only:** Excludes _____% of Home
☐ Hospital Medical claims Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

a. Attachment Factor 125% of the Average Claim Value
b. Aggregate Claim Factors:

Group Number:	251307	_____	_____	_____
Composite; or	$1,521.53	$_____	$_____	$_____
For each Single Coverage Unit	$_____	$_____	$_____	$_____
For each Family Coverage Unit	$_____	$_____	$_____	$_____

c. Minimum Aggregate Point of Attachment: $9,169,318

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item
C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:

☒ Monthly Premium

Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$2.19 Composite; or

$_____for each Single Coverage Unit

$_____for each Family Coverage Unit

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

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
Pre-65: ☐ or Post-65: ☐

2. Reserved

3. Monthly Aggregate Accommodation: ☐ Yes ☐ No

4. Additional information:

_____

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecuting under Federal Mail Fraud, Federal Wire Fraud, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act Statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that they are 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 and the Stop Loss Coverage Policy 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 Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Employer Group".

Martha E. Jarrett
Sales Representative

Linda Matteson for
Signature of Authorized Purchaser

Acting County Manager
Title of Authorized Purchaser

11/7/2024
Date

Exhibit C
Sample Benefits Booklet
AGR24-67

Exhibit D
Confidential Information Disclosure Statement
AGR24-67

The Incorporated County of Los Alamos is a governmental entity subject to certain disclosure laws including, but not limited to, the New Mexico Inspection of Public Records Act, NMSA 1978, §§ 14-2-1, et seq. Nothing in this Agreement is intended to diminish or expand the application of any applicable disclosure laws to any proprietary or confidential information.

This Confidential Information Disclosure Statement ("Statement") defines obligations and waivers related to Confidential Information disclosed pursuant to the above referenced Agreement between County and Contractor. County and Contractor agree to the following:

1. Statement Coordinator – Each party designates the following person as its Statement Coordinator for coordinating the disclosure or receipt of Confidential Information:

	Contractor	County
Name:		
Title:		
Address:		
City/State/Zip:		Los Alamos, New Mexico 87544
Email:		

2. Definitions:
   a) **Confidential Information** - any form of information, in any format, disclosed by the Discloser to the Recipient and identified in writing as confidential.
   b) **Discloser** - the party disclosing Confidential Information.
   c) **Exception** – An exception is satisfied if the Confidential Information disclosed: (i) was in Recipient's possession prior to receipt from Discloser, (ii) is publicly known or readily ascertainable by legal means, (iii) is lawfully received by Recipient from a third party without a duty of confidentiality, (iv) is disclosed by Discloser to a third party without a duty of confidentiality on the third party, (v) is independently developed or learned by Recipient, or (vi) is disclosed by Recipient with Discloser's prior written approval.
   d) **Recipient** – the party receiving Confidential Information.
3. Obligations – Recipient shall protect and ensure its participating subcontractors, agents, or associates shall protect all Confidential Information by using the same degree of care, but no less than a reasonable degree of care, to prevent the unauthorized use, dissemination, or publication of the Confidential Information as Recipient uses to protect its own information of a like nature. If any person or entity requests or demands, by subpoena or otherwise, all or any portion of the Confidential Information provided by one party to another, the party receiving such request shall immediately notify the Discloser of such request or demand. The party receiving the request or demand shall independently determine whether the information sought is subject to disclosure under applicable law including the New Mexico Inspection of Public Records Act. If the party receiving the request or demand determines that the information is subject to disclosure, it shall notify the Discloser of its intent to permit the disclosure with sufficient time to permit the Discloser to invoke the jurisdiction of an appropriate court or administrative body to raise any legitimate objections or defenses it may have to the disclosure. In the absence of an appropriate order prohibiting the disclosure, the party receiving the request or demand shall permit and proceed with the disclosure without incurring any duty, obligation or liability to the Discloser.

Exhibit E
Business Associate Agreement
AGR24-67

BUSINESS ASSOCIATE AGREEMENT

This Agreement ("Agreement") is made and entered into on this 1st **day** of January **2025_,** by and between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,** ("Business Associate"), and the Incorporated County of Los Alamos, an incorporated county of the State of New Mexico ("Covered Entity").

WHEREAS, Business Associate acknowledges that Covered Entity has in its possession data that contains individual identifiable health information as defined by Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ("HIPAA") and the regulations promulgated thereunder; and

WHEREAS, Business Associate and Covered Entity are parties to an agreement (the "Service Agreement"), pursuant to which the fulfillment of the Parties' obligations thereunder necessitates the exchange of, or access to, data including individual identifiable health information.

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the meanings set forth below.

1.1 "HHS" shall mean the U.S. Department of Health and Human Services.

1.2 "HHS Transaction Standard Regulation" means the Code of Federal Regulations ("CFR") at Title 45, Sections 160 and 162.

1.3 "Individual" means the subject of protected health information or, if deceased, his or her personal representative.

1.4 "Parties" shall mean the Covered Entity and Business Associate. (Covered Entity and Business Associate, individually, may be referred to as a "Party.")

1.5 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

1.6 "PHI" shall have the same meaning as the term "protected health information" found in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of the Covered Entity.

1.7 "Required by law" shall have the same meaning as "required by law" in 45 CFR §164.501.

1.8 "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

ARTICLE 2
CONFIDENTIALITY

2.1 Obligations and Activities of Business Associate. Business Associate agrees as follows:

(a) not to use or further disclose PHI other than as permitted or required by this Agreement or as Required By Law;

(b) to establish, maintain, and use appropriate safeguards to prevent use or disclosure of the PHI other than as permitted herein;

(c) to report to Covered Entity any use, access or disclosure of the PHI not provided for by this Agreement, or any misuse of the PHI, including but not limited to systems compromises of which it becomes aware and to mitigate, to the extent practicable, any harmful effect that is known to Business Associate as a result thereof;

(d) to enforce and maintain appropriate policies, procedures, and access control mechanisms to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The access and privileges granted to any such agent shall be the minimum necessary to perform the assigned functions;

(e) to provide access, at the request of Covered Entity, and in the time and manner reasonable designated by Covered Entity, to PHI in a Designated Record Set (as defined in the Privacy Rule), to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR §164.524;

(f) to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR §164.526 at the request of Covered Entity or an Individual, and in the time and manner reasonably requested by Covered Entity.

(g) to make, enact, and maintain internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner reasonably requested by Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule;

(h) 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;

(i) to provide to Covered Entity or an Individual, in a time and manner reasonably requested by Covered Entity, information collected in accordance with Section 2.1(i) above 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;

(j) to promptly notify Covered Entity of all actual or suspected instances of deliberate unauthorized attempts (both successful and unsuccessful) to access PHI;

(k) to maintain and enforce policies, procedures and processes to protect physical access to hardware, software and/or media containing PHI (e.g., hardcopy, tapes, removable media, etc.) against unauthorized physical access during use, storage, transportation, disposition and /or destruction; and

(l) to ensure that access controls in place to protect PHI and processing resources from unauthorized access are controlled by two-factor identification and authentication: a user ID and a Token, Password or Biometrics.

2.2 Disclosures Required By Law.

In the event that Business Associate is required by law to disclose PHI, Business Associate will immediately provide Covered Entity with written notice and provide Covered Entity an opportunity to oppose any request for such PHI or to take whatever action Covered Entity deems appropriate.

2.3 Specific Use and Disclosure Provisions.

(a) Except as otherwise limited in this Agreement, Business Associate may use PHI only to carry out the legal responsibilities of the Business Associate under the Service Agreement.

(b) Except as otherwise limited in this Agreement, Business Associate may only disclose PHI (i) as Required By Law, or (ii) in the fulfillment of its obligations under the Service Agreement and provided that Business Associate has first obtained (A) the consent of Covered Entity for such disclosure, (B) reasonable assurances from the person to whom the information is disclosed that the PHI will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, (C) reasonable assurances from the person to whom the information is disclosed that such person will notify the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached, and (D) "except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

2.4 Obligations of Covered Entity.

(a) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

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

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

(d) For any PHI received by Covered Entity from Business Associate on behalf of a third party or another covered entity, Covered Entity agrees to be bound to the obligations and activities of Business Associate enumerated in Section 2.1 as if and to the same extent Covered Entity was the named Business Associate hereunder.

2.5 Permissible Requests by Covered Entity.

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

2.6 Policy and Procedure Review.

Upon request, Business Associate shall make available to Covered Entity any and all documentation relevant to the safeguarding of PHI including but not limited to current policies and procedures, operational manuals and/or instructions, and/or employment and/or third party agreements.

ARTICLE 3
SECURITY

3.1 Government Healthcare Program Representations.

Business Associate hereby represents and warrants to Covered Entity, its members, directors, officers, agents, representatives, or employees that Business Associate has not been excluded or has not been served a notice of exclusion or has not been served with a notice of proposed exclusion, or has not committed any acts which are cause for exclusion, from participation in, or had any sanctions, or civil or criminal penalties imposed under, any federal or state healthcare program, including but not limited to Medicare or Medicaid, and has not been convicted, under federal or state law (including without limitation a plea of nolo contendere or participation in a first offender deterred adjudication or other arrangement whereby a judgment of conviction has been withheld), of a criminal offense related to (a) the neglect or abuse of a patient, (b) the delivery of an item or service, including the performance of management or administrative services related to the delivery of an item or service, under a federal or state healthcare program, (c) fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a healthcare item or service or with respect to any act or omission in any program operated by or financed in whole or in party by any federal, state or local government agency, (d) the unlawful, manufacture, distribution, prescription, or dispensing of a controlled substance, or (e) interference with or obstruction of any investigation into any criminal offense described in (a) through (d) above. Business Associate further agrees to notify Covered Entity immediately after Business Associate becomes aware that the foregoing representation and warranty may be inaccurate or may be incorrect.

3.2 Security Procedures.

Each Party shall employ security procedures that comply with HIPAA and all other applicable state and federal laws and regulations (collectively, the "Law") and that are commercially reasonable, to ensure that transactions, notices, and other information that are electronically created, communicated, processed, stored, retained or retrieved are authentic, accurate, reliable, complete and confidential. Moreover, each Party shall, and shall require any agent or subcontractor involved in the electronic exchange of data to:

(a) require its agents and subcontractors to provide security for all data that is electronically exchanged between Covered Entity and Business Associate;

(b) provide, utilize, and maintain equipment, software, services and testing necessary to assure the secure and reliable transmission and receipt of data containing PHI;

(c) maintain and enforce security management policies and procedures and utilize mechanisms and processes to prevent, detect, record, analyze, contain and resolve unauthorized access attempts to PHI or processing resources;

(d) maintain and enforce polices and guidelines for workstation use that delineate appropriate use of workstations to maximize the security of data containing PHI;

(e) maintain and enforce policies, procedures and a formal program for periodically reviewing its processing infrastructure for potential security vulnerabilities; and

(f) implement and maintain, and require its agents and subcontractors to implement and maintain, appropriate and effective administrative, technical and physical safeguards to protect the security, integrity and confidentiality of data electronically exchanged between Business Associate and Covered Entity, including access to data as provided herein. Each Party and its agents and subcontractors shall keep all security measures current and shall document its security measures implemented in written policies, procedures or guidelines, which it will provide to the other Party upon the other Party's request.

ARTICLE 4
EXCHANGE OF STANDARD TRANSMISSIONS

4.1 Obligations of the Parties. Each of the Parties agrees that for the PHI:

(a) it will not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation.

(b) it will not add any data elements or segments to the maximum denied data set as proscribed in the HHS Transaction Standard Regulation.

(c) it will not use any code or data elements that are either marked "not used" in the HHS Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications.

(d) it will not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications.

4.2 Incorporation of Modifications to HHS Transaction Standards.

Each of the Parties agrees and understands that from time-to-time, HHS may modify and set compliance dates for the HHS Transaction Standards. Each of the Parties agrees to incorporate by reference into this Agreement any such modifications or changes.

4.3 Business Associate Obligations.

(a) Business Associate shall not submit duplicate transmissions unless so requested by Covered Entity.

(b) Business Associate shall only perform those transactions, which are authorized by Covered Entity. Furthermore, Business Associate assumes all liability for any damage, whether direct or indirect, to the electronic data or to Covered Entity's systems caused by Business Associate's unauthorized use of such transactions.

(c) Business Associate shall hold Covered Entity harmless from any claim, loss or damage of any kind, whether direct or indirect, whether to person or property, arising out of or related to (1) Business Associate's use or unauthorized disclosure of the electronic data; or (2) Business Associate's submission of data, including but not limited to the submission of incorrect, misleading, incomplete or fraudulent data and agrees to indemnify Covered Entity for any damages, costs, expenses or liabilities, including legal fees and costs, arising from or related to a breach of the Business Associate's obligations hereunder.

(d) Business Associate agrees to maintain adequate back-up files to recreate transmissions in the event that such recreations become necessary. Back-up devices shall be subject to this Agreement to the same extent as original data.

(e) Business Associate agrees to trace lost or indecipherable transmissions and make reasonable efforts to locate and translate the same. Business Associate shall bear all costs associated with the recreation of incomplete, lost or indecipherable transmissions if such loss is the result of an act or omission of Business Associate.

(f) Business Associate shall maintain, for seven (7) years, true copies of any source documents from which it produces electronic data.

(g) Except encounter data furnished by Business Associate to Covered Entity, Business Associate shall not (other than to correct errors) modify any data to which it is granted access under this Agreement or derive new data from such existing data. Any modification of data is to be recorded, and a record of such modification is to be retained by Business Associate for a period of seven (7) years.

(h) Business Associate shall not disclose security access codes to any third party in any manner without the express written consent of Covered Entity. Business Associate furthermore acknowledges that Covered Entity may change such codes at any time without notice. Business Associate shall assume responsibility for any damages arising

from its disclosure of the security access codes or its failure to prevent any third party use of the system without the express written consent of Covered Entity.

(i) Business Associate shall maintain general liability coverage, including coverage for general commercial liability, for a limit of not less than one million dollars, as well as other coverage as Covered Entity may require, to compensate any parties damaged by Business Associate's negligence. Business Associate shall provide evidence of such coverage in the form of a certificate of insurance and agrees to notify Covered Entity and/or HOI immediately of any reduction or cancellation of such coverage.

(j) Business Associate agrees to conduct testing with Covered Entity to ensure delivery of files that are HIPAA-AS Compliant and to accommodate Covered Entity specific business requirements.

4.4 Confidential and Proprietary Information.

Business Associate acknowledges that it will have access to certain proprietary information used in Covered Entity's business. Covered Entity's proprietary information derives its value from the fact that it is not available to competitors or any third parties, and the disclosure of this information would or could impair Covered Entity's competitive position or otherwise prejudice its ongoing business. Business Associate agrees to treat as confidential, and shall not use for its own commercial purpose or any other purpose, Covered Entity's proprietary information. Business Associate shall safeguard Covered Entity's proprietary information against disclosure except as may be expressly permitted herein. Such proprietary information includes, but is not limited to, confidential information concerning the business operations or practices of Covered Entity, including specific technology processes or capabilities.

ARTICLE 5
MISCELLANEOUS

5.1 Term and Termination.

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

(b) Termination for Cause. Upon a material breach by Business Associate of it obligation hereunder, Covered Entity may (i) terminate this Agreement and the Service Agreement; and (ii) report the violation to the Secretary.

(c) Effect of Termination.

(i) Except as provided in paragraph 5.1(c)(ii), upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(ii) In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

5.2 Disputes.

In any lawsuit or legal dispute arising from the operation of this Agreement, Business Associate agrees that the laws of the State of New Mexico shall govern. Venue shall be in the First Judicial District Court of New Mexico in Los Alamos County, New Mexico.

5.3 Injunctive Relief.

Notwithstanding any rights or remedies provided for in Section 5.2, Covered Entity retains all rights to seek injunctive relief to prevent the unauthorized use of disclosure of PHI by Business Associate or any agent, contractor or third party that received PHI from Business Associate.

5.4 Regulatory References.

A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

5.5 Amendment.

The Parties agree to take such action as is necessary to amend this Agreement from time to time to the extent necessary for Covered Entity to comply with the requirements of HIPAA and its regulations. All amendments to this agreement shall be in writing and signed by both parties.

5.6 Survival.

The respective rights and obligations of Business Associate and Covered Entity under Sections 4.4, and 5.1(c) of this Agreement shall survive the termination of this Agreement.

5.7 Interpretation.

Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

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

Business Associate:

By: Kathleen Selck

TITLE: VP & Chief Underwriter

DATED: 11/9/2024

Covered Entity:

INCORPORATED COUNTY OF LOS ALAMOS

By: Linda Matteson for
ANNE W. LAURENT, COUNTY MANAGER

DATED: 11/7/2024

AMENDMENT NO. 1
INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT NO. 24-67

This **AMENDMENT NO. 1** ("Amendment") 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 Association, an association of independent Blue Cross and Blue Shield Plans, (the "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, collectively (the "Parties"), to be effective for all purposes January 1, 2026 ("Effective Date").

WHEREAS, County and Contractor entered into Services Agreement No. AGR24-67 dated January 1, 2025, 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, County Council approved this Amendment at a public meeting held on October 28, 2025; 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 B. TERM** in its entirety and replace it with the following:

SECTION B. TERM:

1. The term of this Agreement, for claims administration, shall commence January 1, 2025, and shall continue through December 31, 2027, unless sooner terminated, as provided herein. At County's sole option, the County Manager may renew this Agreement for up to four (4) consecutive one-year period(s), unless sooner terminated, as provided therein.

2. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Application (Exhibit B), shall commence January 1, 2025, and shall continue through December 31, 2025, unless sooner terminated, as provided herein. At County's sole option, the Agreement may be renewed for up to six (6) consecutive one-year periods, unless sooner terminated, as provided therein.

3. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Application (Exhibit B-1), shall commence January 1, 2026, and shall continue through December 31, 2026, unless sooner terminated, as provided

herein. At County's sole option, the Agreement may be renewed for up to five (5) consecutive one-year periods, unless sooner terminated, as provided therein.

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

SECTION C. COMPENSATION:

1. County shall pay compensation for performance of the Services for the term of this Agreement, including agreed-upon compensation defined in Amendment No. 1, but not including any subsequent renewal periods, in an amount not to exceed THREE MILLION ONE HUNDRED FIFTY THOUSAND DOLLARS ($3,150,000.00), which amount shall include applicable New Mexico gross receipts taxes ("NMGRT"). For any subsequent renewal periods as set forth in Section B, "Term" above, compensation will be strictly based upon rate negotiations with Contractor and upon Council approval of said negotiations.

2. **Monthly 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 shall be due and payable thirty (30) days after County's receipt of the invoice.

III. To delete **Paragraphs 1 and 2 only of Section 6.1, Term and Termination, in Exhibit A, Administrative Services Agreement** and replace it in its entirety with the following:

6.1 Term and Termination. The term of this Agreement, for Administrative Services, shall commence January 1, 2025, and shall continue through December 31, 2027, 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 Application (Exhibit B), shall commence January 1, 2025, and shall continue through December 31, 2025, unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to six (6) 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 Application (Exhibit B-1), shall commence January 1, 2026, and shall continue through December 31, 2026, 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.

IV. To delete **Section 6.3, Entire Agreement, in Exhibit A, Administrative Services Agreement,** and replace it in its entirety as shown below to (i) delete Exhibit 6, Recovery Litigation Authorization, which was erroneously included in the list of Exhibits in the original Agreement; (ii) add a new Exhibit 7, Performance Guarantees, to be incorporated in its entirety with this Amendment and Exhibit A to AGR26-37, the Administrative Services Agreement; and (iii) add Exhibits for calendar year 2026, to be incorporated in their entirety with this Amendment and Exhibit A to AGR26-37, the Administrative Services Agreement, to reflect renewal dates, terms, and rates:

Entire Agreement. Service Agreement AGR24-67 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 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.

The Exhibits and Addenda of this Agreement are:

1. Exhibit A – Administrative Services Agreement
   - Exhibit 1 – Claim Administrator Services
   - Exhibit 2 – Fee Schedule and Financial Terms
   - Exhibit 3 – Notices/Required Disclosures
   - Exhibit 4 – ASO BPA (1/1/2025 – 12/31/2025)
     (i) BPA Addendum – Pharmacy Benefit Fee Schedule (1/1/2025 – 12/31/2025)
   - Exhibit 4-1 – ASO BPA (1/1/2026 – 12/31/2026)
     (i) BPA Addendum – Pharmacy Benefit Fee Schedule (1/1/2026 – 12/31/2026
   - Exhibit 5 – Blue Cross and Blue Shield Association Disclosures and Provisions
   - Exhibit 6 – Pharmacy Benefit Management ("PBM") Services
   - Exhibit 7 – Addendum PG - Performance Guarantees
     (i) Exhibit PG Medical Preferred Provider Organizations
   - (ii) Exhibit PG Prescription Drug Program
2. Exhibit B – Stop Loss Application (1/1/2025 – 12/31/2025)
3. Exhibit B-1 – Stop Loss Application (1/1/2026 – 12/31/2026)
4. Exhibit C – Sample Benefits Booklet
5. Exhibit D – Confidential Information Disclosure Statement
6. Exhibit E – Business Associate Agreement

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

(This section intentionally left blank)

IN WITNESS WHEREOF, the Parties have executed this Amendment No. 1 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

MICHAEL D. REDONDO
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

BY: Anne W. Laurent 10/30/2025

ANNE W. LAURENT **DATE**
COUNTY MANAGER

Approved as to form:

Kathryn S. Thwaits for

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: Marlene Baca 10/31/2025

MARLENE BACA **DATE**
VICE PRESIDENT OF SALES

Exhibit A.4-1
ASO BPA
(1/1/2026 – 12/31/2026)
AGR24-67-A1

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 Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSNM"

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 Effective Date of Coverage 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:
Select from Drop Down : 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 __/__/___ End Date __/__/___ (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 / 2026

Anniversary Date: (Month/Day/Year) 01 / 01 / 2027

Retiree-Only Plan(s) Identification:
For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

[₮] NOTE – **This Group plan does not include the individual pharmaceutical drug cost-sharing protections included in a fully insured plan as provided for in § 59A-23-12.3 NMSA. Please confer with your Producer about options to purchase a fully-insured plan with pharmaceutical drug cost-sharing protections for individuals.**

Account Information	☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): 9111	Employer Identification Number (EIN): 856000679	
Address: 1000 Central Ave. Suite 230		
City: Los Alamos	State: NM	ZIP: 87544
Administrative Contact: Victoria Pacheco	Title: Benefits & Pension Manager	
Email Address: victoria.pacheco@losalamosnm.gov	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):

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for Employers℠ ("BAE℠") Contact: Victoria Pacheco

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: victoria.pacheco@losalamosnm.gov Phone Number: 505-662-8045 Fax Number: 505-662-8000

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 a representative in negotiations with and to receive commissions from BCBSNM, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for the Employer's employee benefit program(s). 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/Consultant Compensation:

The Employer acknowledges that if its POR 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 POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

Producer, Agency, or Consultant: Aon Consulting, Inc. Commission to be paid: ☐Yes* ☒ No

New Mexico Producer/Consultant #: 900001881

Address: 6501 America's Parkway NE, Suite 650

City: Albuquerque State: NM ZIP: 87110

Phone: 303-639-4117 Fax: 847-956-0916 Email: charlene.fairchild@aon.com

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

Commissions:

☐ PCPM $_____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Flat $_____ Does a Monthly Cap Apply ☐ Yes ☐ No $_____ (If cap is annual, divide by twelve)

☐ Percentage of Stop Loss: _____%

ADDITIONAL COMMISSIONS: _____

*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 and/or dependents of 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
**Automatically canceling dependents is not recommended for accounts with automated eligibility*

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 and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSNM of any instance where the continuation of disabled dependent coverage is required.

8. **Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. per Internal Revenue Code Section 22(e)(3).

To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSNM will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below. BCBSNM will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age. proof of prior coverage, certification review. forms, and previous medical certification approvals.

(a) ☒ Disabled dependent administration will follow **Standard Rules.**

A disabled dependent is eligible to *continue* coverage beyond the limiting age. provided the disability began before the child attained the age of 26. A disabled dependent is eligible to *be added to* coverage beyond the limiting age, provided the disability began before the child attained the age of 26. and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSNM: a disabled dependent certification form must be submitted to BCBSNM.

(b) ☐ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*
☐ The disability must have begun before the child attained the age of 26.
☐ All disabled dependents are covered regardless of when the disability began.

Proof of prior coverage: *Please select required or not required below:*
When *adding* coverage. proof of prior coverage as a disabled dependent is ☐ required ☐ not required.

Certification review: *Please select one option regarding the administration of certification review.*
☐ Certification review is administered by BCBSNM: a disabled dependent certification form must be submitted to BCBSNM.
☐ Certification review is administered by the Employer: there are no disabled dependent certification form requirements.

If certification review is administered by BCBSNM. *please select one option regarding forms:*
☐ Utilize BCBSNM disabled dependent certification forms.
☐ Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSNM. please *select allowed or not allowed below:*
A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

9. 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 BCBSNM in any instance where an extension of benefits is to be provided due to a temporary layoff. disability, or leave of absence.

10. 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 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 group coverage 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 otherwise eligible to do so. during the Employer's annual 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 otherwise 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 rules governing off-cycle enrollments.

11. * 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 570 ☐ SEE ADDITIONAL PROVISIONS

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:

1. on payroll: _____
2. presently eligible for coverage: _____
3. serving new hire probationary period: _____
4. with other coverage (i.e.. other group coverage. Medicare, Medicaid, TRICARE/Champus): _____
5. total number of individuals currently covered under COBRA: _____
6. with retiree coverage (if applicable):_____

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:** ☒ Wellbeing Management ☐ Wellness Incentives ☐ Health Advocacy Solutions ☐ Mercer Health Advantage ☐ Custom Care Management Unit ☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)* ☒ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other	**Consumer Driven Health Plan:** ☐ BlueEdge℠ HCA Administrative Services *(if selected, complete separate HCA BPA)* ☐ BlueEdge℠ HSA: (Integrated Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSNM to send HSA enrollment to HealthEquity, Inc ☐ Yes ☐ No Non-Integrated Vendor: ☐ FSA (Integrated Vendor: Select Vendor)* Non-Integrated Vendor: ☐ HRA (vendor: Select Vendor)* Non-Integrated Vendor: **Traditional Coverage:** ☐ Out-of-Area (Indemnity) **Prescription Drugs:** ☒ Covered under a pharmacy benefit *(If selected, the 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 ☐ Network on PBM Fee Schedule Addendum Drug List: Basic Drug List Other (please specify): PPO/HSA Preventive Drug List: Please specify: Select Option Other RX programs: Select Program **Ancillary Services:** ☐ Dental Plan Services ☐ Vision Insurance *(if selected, complete a separate application)* ☒ Stop Loss *(if selected, complete separate Application and Policy Schedule for Stop Loss Coverage)* ☒ Life, Disability, Critical Illness, Accident or Hospital Indemnity Insurance *(if selected, complete a separate application for those coverages)* ☐ COBRA Administrative Services *(Please provide name of entity administering COBRA:)*

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counsel to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of New Mexico.
Custom Care Management Unit is offered by WTW, an independent company, and is administered by Blue Cross and Blue Shield of New Mexico.
Medical and Dental benefits and services are administered by 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.
Life, Disability, Critical Illness, Accident, Hospital Indemnity and Vision products are issued by Dearborn Life Insurance Company, 751 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of New Mexico is the trade name of Dearborn Life Insurance Company, an Independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield Plans.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this 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** (cannot be selected if Check is selected as payment method above)

☐ 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	$67.68	$	$	$
Dental	$	$	$	$
Claims Fiduciary	$	$	$	$
Advanced Payment Review	25% $	% $	% $	% $
*Medical Drug Rebate Credit	$(2.50)	$( )	$( )	$( )
*Rebate Credit for the Prescription Drug Program	$(77.44)	$( )	$( )	$( )
Telehealth (Virtual Visits)	$Included	$	$	$
Wellbeing Management	$Included	$	$	$
Health Advocacy Solutions	$	$	$	$
Commissions: _____	$	$	$	$
Commissions: _____	$	$	$	$
Commissions: _____	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Miscellaneous:	$	$	$	$
Miscellaneous:	$	$	$	$
Total	$(12.26)	$	$	$

*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 Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges ☐ **SEE ADDITIONAL PROVISIONS**	**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: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____%
	Total:	$_____

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

NSA Fees

In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees:

- Fifty dollars ($50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and
- An additional seventy-five dollars ($75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and

All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.

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 for external reviews to be performed under the Affordable Care Act external review process.

If no, provide name and address of administrator(s) of external review coordination and indicate if administrating medical claims and/or pharmacy claims:

Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:
Administrator: Medical claims: ☐ Pharmacy claims: ☐ Name: Mailing Address:

Advanced Payment Review (APR): ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program. Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party vendor.

Reimbursement Services: ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

FlexAccess™: ☐ Yes ☒ No

As part of its plan design. Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program. including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance. (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (iii) not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for. and will hold Claim Administrator harmless from. the legal and regulatory compliance of the Plan and its plan design. to the extent permitted by law.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as the difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the Covered Person's cost share if the Covered Person was not enrolled in the program. The Employer responsibility with the FlexAccess Program is the cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the cost share for the Covered Persons enrolled in the program.

FLEXACCESS™ QUALIFIED HDHP: ☐ Yes ☒ No

As part of its plan design. Employer has directed Claim Administrator to administer claims, copay and co-insurance requirements for Covered Persons enrolled in FlexAccess Qualified HDHP. including applying such manufacturer copay assistance to reduce Covered Persons' out of pocket costs, and not applying the manufacturer assistance to Covered Persons' deductibles and/or out of pocket maximum accumulators. Employer agrees that FlexAccess Qualified HDHP is a plan design decision of Employer and is consistent with its plan design and supported by the Employer's plan documents. Employer further agrees it is solely responsible for. and will hold Claim Administrator harmless from. the legal and regulatory compliance of the Plan and its plan design. to the extent permitted by law.

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the Covered Persons' estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

WITH FLEXACCESS QUALIFIED HDHP: Cost of drug – amount manufacturer copay assistance used – Covered Persons' out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

WITHOUT FLEXACCESS QUALIFIED HDHP: Cost of drug – Covered Persons' out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon… Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

Third-Party Law Firms Provisions (other than Reimbursement Services):

Employer will pay no more than 35% of any recovered amount made by Claim Administrator'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 between the Claim Administrator and the Employer.

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 Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of New Mexico. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charge

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. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.

Service	Medical			
Medical Run-off Administration Charge	$23.68	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	$23.68	$_____	$_____	$_____

Other Provisions ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. **Summary of Benefits & Coverage:**
   a. Will Claim Administrator create Summary of Benefits and 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 (SBC) to Covered Persons?
      ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (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 Administrative Services Agreement) and distribute SBC to Covered Persons via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar and fifty cents ($1.50) per package.

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 if required by the Massachusetts Health Care Reform Act or ☐ that it does not believe it is subject to the notification and reporting requirements of the Massachusetts Health Care Reform Act.

Please note Employer will be responsible for conducting or otherwise performing creditable coverage eligibility testing. By electing Claim Administrator to disseminate the above written statements, Employer is representing that any such coverage qualifies as creditable coverage under the applicable Massachusetts Health Care Reform Act requirements.

3. **Alternative Care Management Program** (applicable to 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** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. **Essential Health Benefits ("EHB") Election:**
Employer elects EHBs based on the following:
1. ☒ EHBs based on a Claim Administrator state benchmark:
☐ Illinois ☐ Montana ☒ New Mexico ☐ Oklahoma ☐ Texas
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 New Mexico benchmark plan.

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

7. **Independent Dispute Resolution Process:**
Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

Additional Provisions: 1. Claim Payments are settled within 10 days.
2. Claims incurred outside HCSC service areas through the BlueCard program may be assessed a BlueCard access fee of no more than 3.79% of the discount applied, not to exceed $2,000 per claim. An estimate of this access fee is included in our projected claim figures.
3. Administrative services includes performance guarantees for services and discounts. The PG Exhibit, Network Discount Exhibit and PG Addendum are part of this BPA.

Signature

Martha E. Jarrett	Anne W. Laurent
Sales Representative	Signature of Authorized Purchaser
NM 505-816-2635	Anne W. Laurent
District Phone & FAX Numbers	Print Name
Charlene Fairchild	County Manager
Producer Representative	Title
Aon Consulting, Inc.	10/30/2025
Producer Firm	Date
6501 America's Parkway NE Suite 650 Albuquerque, NM 87110	
Producer Address	
303-639-4117 847-956-0916	
Producer Phone & FAX Numbers	
charlene.fairchild@aon.com	
Producer Email Address	
95-3252415	
Tax I.D. No.	

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 HCSC 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 either 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 its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

☐ Intentionally left blank by the Employer

Group No.: 251307

By: Anne W. Laurent
Print Signer's Name Here

➡ Anne W. Laurent
Signature and Title

Group Name: Incorporated County of Los Alamos

Address: 1000 Central Ave, Suite 230

City: Los Alamos State: NM ZIP: 87544

Dated this 30th day of October 2025
Month Year

Exhibit A.4-1(i)
BPA Addendum – Pharmacy Benefit Fee Schedule
(1/1/2026 – 12/31/2026)
AGR24-67-A1

PBM Fee Schedule Addendum to the Benefit Program Application

County of Los Alamos	
Term: 01/01/2026-12/31/2026	Employees: 563
Guaranteed Traditional Aggregate Pricing Arrangement[1]*	
Traditional Select Network and Basic Drug List	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
19.45%	83.45%
DISPENSING FEE	
Brand	**Generic**
$0.75	$0.75
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
23.70%	85.90%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
22.70%	85.90%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 21.65%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	. . .

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Consulting Fee/Commission:	. . .	Please select

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 arrangements ("Groups with the Pricing Arrangements") and use the above Networks (the "Employer's Contract Rates").

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

a. Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".

b. Generic drugs are defined as all drugs available in sufficient supply that have a Medi-Span multisource code field equal to "Y".

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 Arrangements 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 +/-1.5% from the applicable AWP discounts 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 Arrangements that use the above Network, then Employer will be credited, 120 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 Arrangements 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, Foreign, reversed, member submitted, long-term care (LTC), home infusion, veterans affairs, Indian/tribal/urban pharmacy, 340B eligible, Medicare/Medicaid coordination of benefits (COB), subrogation, paper, invalid, lost and customary (U&C), Direct Member Submitted, Covid related, 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.

- Non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBS specialty drug pricing file).

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

HCSC GEN ASO Traditional PBM Fee Addendum 6.19

- 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).

- MedsYourWay program claims will be included in calculation of the discount and Dispensing Fee pricing guarantees. MedsYourWay is the embedded drug discount card comparison program utilized where available and applicable to Employer, Network Pharmacy, and the Covered Drug.

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

Member's 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 B40B 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 agreements on the amendments 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.

Aggregate Specialty Discounts and Dispensing Fee guarantees include limited distribution drugs (LDD) and new to market specialty drugs.

- 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, ESI 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, PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

Anne W. Laurent

Signature of Authorized Purchaser

Anne W. Laurent

Print Name

County Manager

Title

10/30/2025

Date

Exhibit A.7
Addendum PG – Performance Guarantees
AGR24-67-A1

ADDENDUM PG
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.

Exhibit A.7(i)
Exhibit PG Medical Preferred Provider Organizations
AGR24-67-A1

EXHIBIT-PG
EMPLOYER NAME: COUNTY OF LOS ALAMOS
Employer Account Number: 251305
Employer Group Number: 251307
Effective for the Settlement Period beginning January 1, 2025, and ending December 31, 2025
Effective for the Settlement Period beginning January 1, 2026, and ending December 31, 2026
Effective for the Settlement Period beginning January 1, 2027, and ending December 31, 2027

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 **503** Covered Employees, based on a total of **559** contracts. Performance measurement will begin **January 1, 2025.** 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 1/1/2025 – 12/31/2025	**Network Discount Savings** is defined as the percentage of total eligible provider billed charges saved due to Network Provider discounts. Method of measurement: See Exhibit for sample calculation.	See Attached Financial Exhibit	See Attached Financial 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: [signature]

Kathy Selck
Please Print Name

Title: Vice President & Chief Underwriter

Date: November 5, 2024

COUNTY OF LOS ALAMOS

By: Anne W. Laurent

Anne W. Laurent
Please Print Name

Title: County Manager

Date: 2/13/2025

Exhibit A.7(ii)
Exhibit PG Prescription Drug Program
AGR24-67-A1

PRESCRIPTION DRUG PROGRAM EXHIBIT-PG
EMPLOYER NAME: COUNTY OF LOS ALAMOS
Employer Account Number: 251305
Employer Group Number: 251307
Effective for the Settlement Period beginning January 1, 2025, and ending December 31, 2025
Effective for the Settlement Period beginning January 1, 2026, and ending December 31, 2026
Effective for the Settlement Period beginning January 1, 2027, and ending December 31, 2027

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 prescription drug program benefit coverage administered by Claim Administrator of not less than **503** Covered Employees, based on a total of **559** contracts. Performance measurement will begin **January 1, 2025**. Performance Guarantees are measured annually unless otherwise noted. Performance Guarantees are reported and settled on an annual basis only.

SERVICE - PRESCRIPTION DRUG	Defined Performance Guarantees	Performance Guarantee	Dollars at Risk
Implementation Activities (Initial Year Only)	**ID Card Production Turn Around** means that 95% of new participants will be mailed ID cards within ten (10) business days if complete and accurate eligibility data is received on or before November 30, 2024. Measurement: BlueSTAR ID Card Statistical Report. Measured annually on an Employer specific basis.	95% - 100% 94% or less	$0 $2,000
Ongoing Service	**Eligibility Processing** is defined as processing updates within an average of 5 business days from receipt of complete and accurate electronic information. Note: Open enrollment activities are excluded from this measure.	Average 0-5 Business Days = Met Average >5 Business Days = Not Met	$0 $2,000
	Eligibility Error Report is an error report on eligibility file updates that will be provided within five (5) business days of receiving updates. Measured quarterly on an Employer specific basis.	0 - 5 days 6 days or greater	$0 $2,000
	Plan Administration Accuracy means new and revised benefits shall be setup without issue. Setup issues are defined as production variance against BET submissions as identified via audit activity. Prime guarantees an accuracy rate for all Benefit Plan setups. Excluded from PG are benefit setup issues that are a result of erroneous or misinformed client direction or BET submissions. Member benefit setup errors will be counted in the month and year they are confirmed to be an error. The percent accuracy will be measured by using member impact. Measured quarterly at the Blue Plan book of business basis.	98% - 100% 96% - 97% 95% or less	$0 $1,000 $2,000

Docusign Envelope ID: 7221B6AD-6FC7-4415-B06A-F14B664354B4

SERVICE - PRESCRIPTION DRUG	Defined Performance Guarantees	Performance Guarantee	Dollars at Risk
Retail Network Program	**Average Speed of Answer** is defined as the time a Caller spends on hold, after being placed in queue, until a service representative becomes available. Standard is measured by determining the average number of seconds the Caller spends waiting for a service representative, calculated over the complete workday. Measurement is based on calls from those customers assigned to the Unit. Note – This guarantee does not apply to HMO populations.	0 - 30 seconds 31 seconds or greater	$0 $2,000
	Abandoned Calls are defined as Calls, calculated over the complete workday, that reach the facility and are placed in a queue, but are not answered because the Caller hangs up before a service representative becomes available. Measurement is based on calls from those customers assigned to the Unit. Note – This guarantee does not apply to HMO populations.	0% - 3% 4% or greater	$0 $2,000
	RxClaim System Availability 99.75% measured 24 hours a day, 7 days a week based on Prime's book of business. Reports of unplanned downtime (planned downtime is excluded) from Prime's service management ticketing system will be utilized for reporting the availability of key systems. Excludes any occurrence of power outages; downtime occurring during the scheduled maintenance window; hardware, software, network or communications failure beyond Prime's control; and downtime/availability experienced by HCSC.	99.75% - 100% 99.74% or less	$0 $2,000
	Claims Processing Accuracy - 99% of Claims will be adjudicated accurately. A random audit of adjudicated claims will occur monthly and will be validated against the Benefit Edit Tool submissions and test claims. Measured annually at the Blue Plan book of business basis.	99% - 100% 98% or less	$0 $2,000
	Paper Claim Turn Around Time means that within fourteen (14) business days, 99% of all paper claims not requiring clarification shall be processed. Measurement does not include payment. Measured annually at the Blue Plan book of business basis.	99% - 100% 98% or less	$0 $2,000
	Geographic Access – Network Members will have access to Network Participants for covered prescription drug services. Measured at the Blue Plan book of business level. Geographic Access means the Claims Administrator guarantees that a Network Participant will be within two (2) miles of a Member in an urban area 90% of the time. Note – These networks do not apply to limited networks, only broad networks.	90% - 100% 89% or less	$0 $2,000
	Geographic Access – Network Members will have access to Network Participants for covered prescription drug services. Measured at the Blue Plan book of business level. Geographic Access means the Claims Administrator guarantees that a Network Participant will be within five (5) miles of a Member in a suburban area 90% of the time. Note – These networks do not apply to limited networks, only broad networks.	90% - 100% 89% or less	$0 $2,000

S

SERVICE - PRESCRIPTION DRUG	Defined Performance Guarantees	Performance Guarantee	Dollars at Risk
	Geographic Access – Network Members will have access to Network Participants for covered prescription drug services. Measured at the Blue Plan book of business level. Geographic Access means the Claims Administrator guarantees that a Network Participant will be within fifteen (15) miles of a Member in a rural area 70% of the time. Note – These networks do not apply to limited networks, only broad networks.	70% - 100% 69% or less	$0 $2,000
Mail Service Program ESI	**Turnaround time for routine prescriptions** is defined as the processing time for mail service prescriptions. Measurement is based on the processing time from the date received to the date shipped. The performance guarantee will be measured as a percent of clean prescriptions processed within 2 business days. Measured at the Blue Plan book of business.	96% - 100% 95% or less	$0 $2,000
	Turnaround time for non-routine prescriptions is defined as the processing time for mail service prescriptions. Measurement is based on the processing time from the date the order was received to the date the order was shipped. The performance guarantee will be measured as a percent of prescriptions requiring intervention processed within 5 business days. Intervention means additional information is required before the document claim or prescription can be processed. Measured at the Blue Plan book of business.	98% - 100% 97% or less	$0 $2,000
	Prescription (Mail) Dispensing Accuracy Overall mail service pharmacy accuracy rate of 99.99%. An error will include incorrect patient, incorrect directions, incorrect strength, or incorrect medication in the container. Notwithstanding the foregoing, an error will not include immaterial matters such as generic substitution not addressed, incorrect spelling of a plan member's name on the label, or incorrect spelling of a physician's name. Accuracy is determined by dividing the total number of errors by the total number of prescriptions shipped for its book of business. Measured annually at Prime's book of business.	99.99% - 100% 99.98% or less	$0 $2,000
	Mail Service Member Satisfaction - A survey of Prime Members who have received Covered Drugs from ESI Mail Pharmacy will be completed quarterly by Pharmacy specific to Prime on a Prime Book of Business basis. Pharmacy guarantees a Prime Member satisfaction rate of 90% based on overall satisfaction. Guarantee assumes the number of responses is statistically significant provided Pharmacy makes commercially reasonable efforts to obtain responses from a statistically significant number of Prime Members. The survey will focus on the end-to-end Home Delivery experience. Measured annually at Prime's book of business.	90% - 100% 89% or less	$0 $2,000
Specialty Service Program Accredo	**Delivery Success Rate for Specialty Medications** means that 99.8% of Specialty Drug orders will be delivered to the Prime Member within the agreed upon delivery date (i.e., Need by Date). Includes Clean Orders but excludes orders where the Prime Member and/or the physician requested that Pharmacy change the date. Measured at the Blue Plan book of business. If minimum volume of 20k specialty prescriptions per year is not met, measured at Prime's book of business.	99.8% - 100% 99.7% or less	$0 $2,000

Exhibit B-1
Stop Loss Application
(1/1/2026 – 12/31/2026)
AGR24-67-A1

BlueCross BlueShield of New Mexico

APPLICATION AND POLICY SCHEDULE 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		
Original Effective Date of Stop Loss Policy	01/01/2018		
Current Policy Effective Date:	01/01/2026		

Current Policy Period These specifications are for the Policy Period commencing on 01/01/2026 and ending on 12/31/2026

The specifications below shall become effective on the first date 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 Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:

Number of Single Coverage Units:	254
Number of Family Coverage Units:	315

B. Individual Stop Loss Coverage:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss coverage during the Current Policy Period

   ☐ Choose an item
   Coverage for Claims incurred from _____ to _____ and Claims paid from _____ to _____.

   For new coverage only, if a run-in contract as explained in the policy is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

   ☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

   ☒ Medical Claims:
   ☒ Prescription Drug Claims with: Prime _____
   ☐ For **Hospital Employer Groups only:** Excludes_____% of Home Hospital Medical claims
   ☐ Other (for example Dental/Vision): _____.

4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $165.000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible:

_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:

_____

e. If a run-in contract is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with Run-Out contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$242.17 Composite; or
$_____for each Single Coverage Unit
$_____ for each Family Coverage Unit

C. **Aggregate Stop Loss Coverage**: Yes ☒ No ☐
If yes, complete Items 1. through 5. Below:

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss Coverage during the current Policy Period

☐ Choose an item
Coverage for Claims incurred from _____ to _____ and Claims paid from _____ to _____.

For new coverage only, if a run-in contract as explained in the policy is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

☒ Medical Claims
☒ Prescription Drug Claims with: Prime _____
☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

a. Attachment Factor 125% of the Average Claim Value
b. Aggregate Claim Factors:

Group Number:	251307	_____	_____	_____
Composite; or	$1,716.39	$_____	$_____	$_____
For each Single Coverage Unit	$_____	$_____	$_____	$_____
For each Family Coverage Unit	$_____	$_____	$_____	$_____

c. Minimum Aggregate Point of Attachment: $10,547,544

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with Run-Out contracts):
☒ Yes ☐ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:
☒ Monthly Premium
Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:
$2.60 Composite; or
$_____ for each Single Coverage Unit
$_____ for each Family Coverage Unit

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

D. **Additional Provisions (if elected)**:

1. Retirees Covered (select if included):
Pre-65: ☐ or Post-65: ☐

2. Reserved

3. Monthly Aggregate Accommodation: ☐ Yes ☒ No

4. Additional information: _____

NM-SL-APP-REV-03-25
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company
an Independent Licensee of the Blue Cross and Blue Shield Association

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecuting under Federal Mail Fraud, Federal Wire Fraud, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act Statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that they are 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 and the Stop Loss Coverage Policy 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 Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Employer Group".

Martha E. Jarrett
Sales Representative

Anne W. Laurent
Signature of Authorized Purchaser

County Manager
Title of Authorized Purchaser

10/30/2025
Date

Agenda No.:	B
Index (Council Goals):	
Presenters:	Elias Isaacson, Community Development Director
Legislative File:	**21250-26**

Title

Overview of the Comprehensive Plan Update and Chapter 16 Code Amendments

Body

The Comprehensive Plan is a long-range policy document that guides land use, housing, transportation, infrastructure, economic development, and environmental stewardship. The existing Los Alamos County Comprehensive Plan <https://www.losalamosnm.us/files/sharedassets/public/v/3/departments/community-development/documents/comprehensive-plan-2016.pdf> was adopted in 2016. The previous Los Alamos County Comprehensive Plan was from 1987.

Council will receive an update on the progress of both the Comprehensive Plan Update process and amendments to Chapter 16 of municipal code.

The presentation (Attachment A) will include a briefing from the Comprehensive Planning consultants (czb), and a briefing from Community Development Department staff on the status of the Chapter 16 amendments.

Attachments

A - Presentation


February 3, 2026
Comprehensive Plan for Los Alamos County
County Council Update
czb
LOS ALAMOS
1

czb's team

Thomas Eddington, AICP, ASLA
Co-manager

Pete Lombardi
Co-manager

Charles Buki

Lauren Holm

Matt Ingalls, AICP, ASLA

Karen Beck Pooley, Ph.D.

Amber Lynch, AICP

Eric Ameigh

Recent Plans

- Wheat Ridge, CO
- Grand County, UT
- High Point, NC
- Fargo, ND
- Altoona, PA
- Poughkeepsie, NY
- Muncie, IN
- Greenville, SC
- Millcreek, PA
- Waynesboro, VA
- Southern Alleghenies, PA
- **Española, NM**
- Ashland, WI
- Geneva, NY
- Erie, PA

Project Overview

What are we producing?

- Long-range plan for the county
- Sets general direction, goals, and strategic priorities
  - Where and how to grow
  - Budgets and capital investment planning
- Doesn't confer or grant vested land use rights, but serves as the foundation for zoning and development regulations

A great plan

Gets the big things right

Plans for what is known

Creates a decision making framework for what is unknown

Scope of Work

Phase 1 – Patterns and Priorities

- Project kick-off
- Review current plans & policies
- Analyze demographics, economics, housing, land use, open space, infrastructure, etc.
- Engage public on key issues, values, and priorities

Phase 2 – Vision and Path Forward

- Develop vision scenarios; analyze implications and trade-offs associated with each scenario
- Engage public on selection of preferred scenario for the future of Los Alamos County
- Draft planning framework of values, principles, priorities, and preferred path forward

Phase 3 – Plan Development

Produce draft plan

Gather feedback and make revisions

Produce and present final plan

Support adoption procedures

Timeline

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Phase 1: Patterns and Priorities												
Phage 2: Vision and Path Forward												
Phase 3: Plan Development												
Site Visits and Meetings	X		X		X Virtual	X		X		X		

Timeline

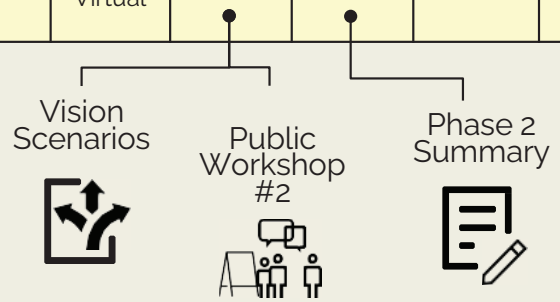
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Phase 1: Patterns and Priorities												
Phage 2: Vision and Path Forward												
Phase 3: Plan Development												
Site Visits and Meetings	X		X		X Virtual	X		X		X		

Milestones Phase 1

Timeline

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Phase 1: Patterns and Priorities												
Phage 2: Vision and Path Forward												
Phase 3: Plan Development												
Site Visits and Meetings	X		X		X Virtual	X		X		X		

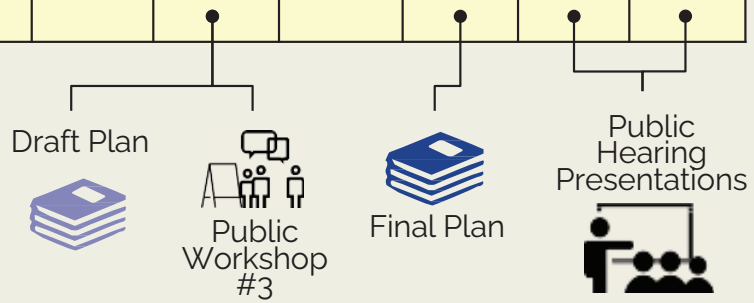
Milestones Phase 2



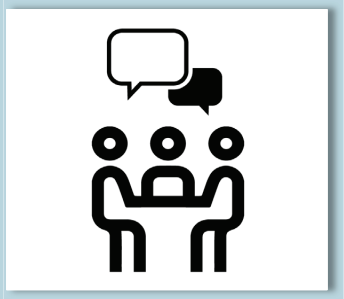
Timeline

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Phase 1: Patterns and Priorities												
Phage 2: Vision and Path Forward												
Phase 3: Plan Development												
Site Visits and Meetings	X		X		X Virtual	X		X		X		

Milestones Phase 3



How will the broader public be engaged?



Stakeholder Interviews

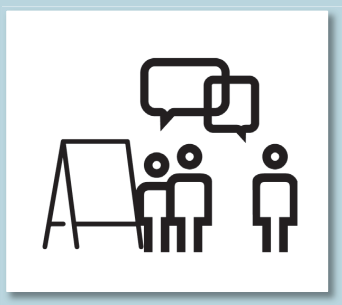
By czb, with direction from Steering Committee and staff

February through September

Community Survey

Month-long online survey at a critical juncture in the project

March



Public Workshops

Informal meetings to present findings, solicit feedback, and discuss key issues

March, June, August

Online Feedback

Online public feedback available through the project website 24/7

March through December

Chapter 16 Explained

Article I – Governing Provisions; Purpose, authority, applicability, interpretation, relationship to other laws, severability, vested rights.

Article II – Zone Districts; Defines zoning districts, intent, permitted/conditional/prohibited uses, zoning maps and boundaries.

Article III – Use Regulations; Regulates land uses, includes Use Table, accessory and temporary uses, standards for specific uses.

Article IV – Development Standards; Lot/building standards, parking, landscaping, signage, lighting, screening, open space, infrastructure.

Article V – Administration & Enforcement; Roles and authority, application procedures, review processes, hearings, variances, appeals, enforcement.

Article VI – Definitions; Technical and land-use definitions

LOS ALAMOS

Chapter 16 – Next Steps

- Articles III & VI (Complete)
  - Adopted by Council in September 2025
- Articles I & V
  - CDD and CAO actively drafting revisions
  - Targeting June 2026 Adoption by Council
- Articles II & IV
  - Regulate Zoning and Development Standards
  - Topics such as ADUs, Parking Standards, and Zoning/Future Land Use Map (FLUM) to be discussed with public as part of Comp Plan process
  - Will begin drafting revisions to these Articles as draft Comp Plan Update is finalized (Summer 2026)

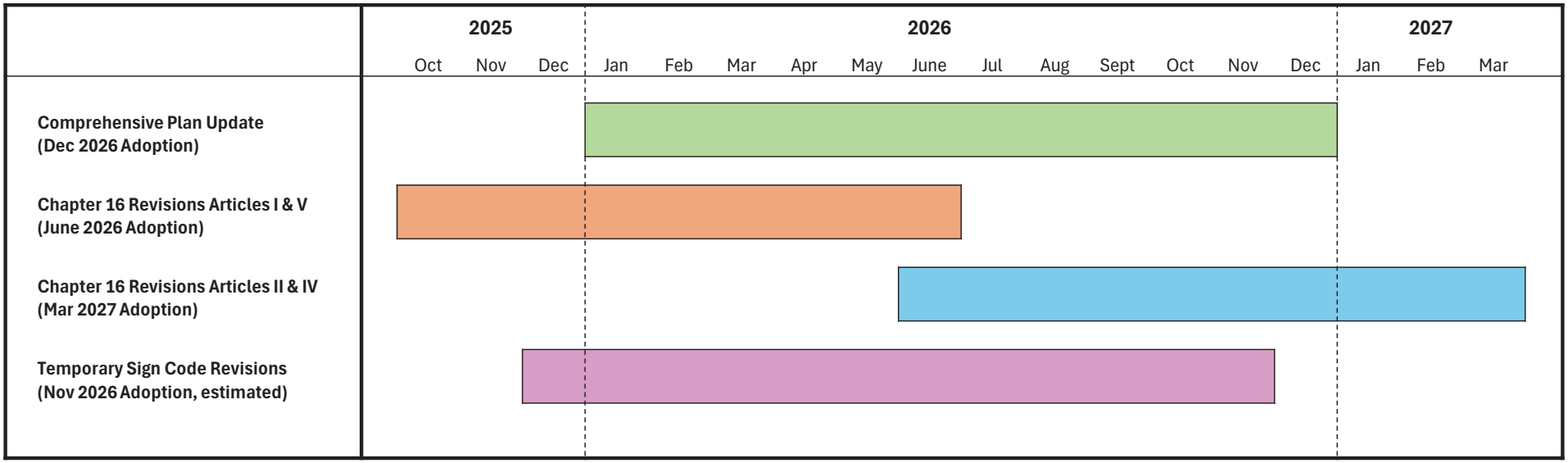
LOS ALAMOS

Temporary Sign Code

- Temporary Sign Code revised in response to Supreme Court Case *Reed v. Town of Gilbert*
  - In practice, most sign and speech regulations are far more vulnerable to constitutional challenge
- Current Temporary Sign Code addresses regulation of size and duration, However, locations where temporary signs are allowed is unclear
- Revisions aimed at addressing allowable locations, clarifying dimensional standards, and providing actionable guidance for enforcement of duration
- CDD and CAO are currently working together to bring recommendations forward to PZC Spring 2026

LOS ALAMOS

Project Timelines



LOS ALAMOS

Agenda No.:	1)
Index (Council Goals):	Quality Governance - Communication and Engagement
Presenters:	County Council
Legislative File:	**21177-26**

Title

Board and Commission Vacancy Report

Body

Attachment A includes an overview of current Boards and Commissions vacancies for Council information and discussion.

Attachments

A - BCC Vacancy Report January 28, 2026

Boards and Commissions Vacancies as of January 28, 2026

Art in Public Places
No Current Vacancies
No Upcoming Vacancies

Board of Public Utilities
No Current Vacancies
No Upcoming Vacancies

County Health Council
5 Current Vacancies
No Upcoming Vacancies

Environmental Sustainability
1 Current Vacancy
0 Upcoming Vacancies

Historic Preservation
1 Current Vacancy
No Upcoming Vacancies

Library Board
1 Current Vacancy
No Upcoming Vacancies

Lodgers Tax
No Current Vacancies
No Upcoming Vacancies

Parks and Recreation
No Current Vacancies
No Upcoming Vacancies

Personnel Board
1 Current Vacancy
No Upcoming Vacancy

Planning and Zoning
No Current Vacancies
No Upcoming Vacancies

Transportation Board

No Current Vacancy
No Upcoming Vacancies

Agenda No.:	1)
Index (Council Goals):	Quality Governance - Communication and Engagement
Presenters:	County Council
Legislative File:	**21087-26**

Title

Tickler Report of Upcoming Agenda Items

Body

Attachment A is a report of the upcoming Council agenda items for upcoming meetings beginning February 10, 2026. Note: This report shows tentative Council agenda items and is for planning purposes only. All items on the report are subject to changes such as item title, meeting date and/or being removed or not considered by Council.

Attachments

A - Tickler Report dated January 30, 2026

County of Los Alamos

Los Alamos, NM 87544
www.losalamosnm.us

Tickler

Note: This report shows tentative Council agenda items and is for planning purposes only. All items on the report are subject to changes such as item title, meeting date and/or being removed or not considered by Council.

Criteria: Agenda Begin Date: 2/10/2026, Agenda End Date: 3/3/2026

File Number	Title	
Agenda Date: 02/10/2026		
21075-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Business**
	Approval of County Council Minutes for the January 27, 2026, Regular Session	
	Department Name: CLERK	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Michael Redondo, County Clerk
21145-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Council Business**
	Council Discussion of Possible Changes to the Charter	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21253-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Council Business**
	Overview of Focus Area (either Operational Excellence or Quality Governance)	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
Agenda Date: 02/17/2026		
21255-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Business**
	Placeholder for Approval of Easement in Bayo Canyon	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Linda Matteson, Deputy County Manager
20992-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Business**
	Placeholder - Discussion and Possible Approval of Task Order for Brewer Arena Construction Improvements	
	Department Name: PW/CSD	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Eric Martinez, Public Works Director and Cory Styron, Community Services Director
21076-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**
	Approval of County Council Minutes for the February 3, 2026, Regular Session	

File Number	Title	
	Department Name: CLERK	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Michael Redondo, County Clerk
21249-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**
	Approval of Budget Revision XXXX-XX for NMDOT EVSE Grant and Task Order No. X with R&M Construction under AGRXXXXXX for Construction Services	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Angelica Gurule
21259-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**
	Approval of Purchased Power	
	Department Name: DPU	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Ben Olbrich, Deputy Utility Manager-Power Supply
21211-26	**Appointment**	**Consent**
	Board/Commission Appointments - Transportation Board	
	Department Name: PW	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** David Hampton, Chair-Transportation Board
21229-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**
	Contract for General Services, Agreement No. AGR [number] with National Car Charging in the Amount of_____, plus Applicable Gross Receipts Tax, for the Purpose of electric vehicle charging equipment	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Angelica Gurule, Sustainability Manager
21067-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**
	Approval of a Signal and Lighting Maintenance Agreement with the New Mexico Department of Transportation for a High-Intensity Activated Crosswalk (HAWK) Signal on NM 4	
	Department Name: PW	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Keith Wilson, Deputy Public Works Director
AGR1193-26	**General Services Agreement**	**Consent**
	Approval of Novation for General Services Agreement No. AGR22-32b: Transfer of Rights and Obligations from ACTenviro to Republic Services, Inc. for Household Hazardous Waste (HHW) Program Services	
	Department Name: PW	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Armando Gabaldon, Environmental Services Manager and Eric Martinez, Public Works Director
MOU046-26	**Memorandum of Understanding**	**Consent**
	Memorandum of Understanding (MOU) Entered into by and Between the Incorporated County of Los Alamos and the North Central Regional Transit District (NCRTD) for FY2026, Providing the NCRTD with $350,000.00	

File Number	Title	
	Department Name: PW	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** James Barela, Transit Manager and Keith Wilson, Deputy Public Works Director
21254-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Council Business**
	Placeholder for Approval of BBC Work Plans	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21251-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Council Business**
	Consideration and Possible Approval of Council's Work Plan Review Working Group Report and Recommendations on the Boards and Commission Work Plans for Calendar Year 2026	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21227-26	**Briefing/Report (Dept, BCC) - No action requested**	**Council Business**
	Quarterly Briefing on Climate Action Plan Implementation	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Angelica Gurule, Sustainability Manager
20815-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Council Business**
	Consideration and Possible Action of 2026 Los Alamos Federal Priorities	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Theresa Cull, Councilor, Randall Ryti, County Council Chair, Suzie Havemann, Councilor and Danielle Duran, Intergovernmental Affairs Manager
21089-26	**Briefing/Report (Dept, BCC) - No action requested**	**Council Business**
	Tickler Report of Upcoming Agenda Items	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21113-26	**Briefing/Report (Dept, BCC) - No action requested**	**Council Business**
	County Manager's Report for January 2026	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Anne Laurent, County Manager
OR1117-26	**Ordinance**	**Introduction of Ordinance**
	Introduction of Incorporated County of Los Alamos Ordinance No. 753; An Ordinance Authorizing a Lease for a Certain Portion of the County-owned Golf Course Community Building to XXX, a New Mexico XXX	
	Department Name: CSD	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Cory Styron, Community Services Director and Anne Laurent, County Manager

File Number	Title	
RE0672-26	**Resolution**	**Public Hearing**

Incorporated County of Los Alamos Resolution No. 26-06, a Resolution Relating to the Issuance of the Incorporated County of Los Alamos, New Mexico Gross Receipts Tax Improvement Revenue Bonds, Series 2026 (The “Bonds”) in an Original Aggregate Principal Amount Not to Exceed $40,000,000 For the Purpose of Acquiring, Extending, Enlarging, Bettering, Repairing And Otherwise Improving a Broadband Communications System and Other Public Buildings, Facilities and Infrastructure; Authorizing the Distribution and Use of a Preliminary Official Statement Relating to the Bonds; and Authorizing Related Action in Connection With the Preliminary Official Statement

Department Name: ASD
Length of Presentation: 2mins
Drop Dead Date:
Sponsors: Helen Perraglio, Administrative Services Director and Anne Laurent, County Manager

21243-26	**Recognition**	**Recognition**

Recognition of the Government Finance Officers Association Triple Crown Honor in Awards for the FY2025 Budget, FY2024 ACFR, FY2024 PAFR and for the NMC-OSA Audit Accountability Award for Mid-Size County

Department Name: ASD
Length of Presentation: 5min
Drop Dead Date:
Sponsors: Helen Perraglio

Agenda Date: 03/03/2026

21147-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Business**

Possible Acceptance and Final Presentation of Fleet Conversion Plan and Community-Wide Electric Vehicle Charging Plan

Department Name: CMO
Length of Presentation:
Drop Dead Date:
Sponsors: Angelica Gurule, Sustainability Manager

21237-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**

Approval of Budget Revision No. 2026-___ for the Purpose of Service to Clean Water Tank, Repair Tank Access Patches, and Repair Tank Level Infrastructure.... with [Name of Vendor] in the Amount of $[amount of contract], plus Applicable Gross Receipts Tax for the Term of _____

Department Name: DPU
Length of Presentation:
Drop Dead Date:
Sponsors: Joann Gentry, Deputy Utility Manager-Finance & Admin. and James Alarid, Deputy Utility Manager-Engineering

20441-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**

Award of Bid No. IFB__-___ for the Purpose of [Piedra Loop Electric Primary Replacement Project] with [Name of Vendor] in the Amount of $[amount of contract], plus Applicable Gross Receipts Tax

Department Name: DPU
Length of Presentation:
Drop Dead Date:
Sponsors: Dennis Astley, Deputy Utility Manager-Electric Distribution

21077-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Consent**

File Number	Title	
	Approval of County Council Minutes for the February 10, 2026, Work Session and the February 17, 2026, Regular Session	
	Department Name: CLERK	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** Michael Redondo, County Clerk
21176-26	**Briefing/Report (Dept, BCC) - No action requested**	**Council Business**
	Tickler Report of Upcoming Agenda Items	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21178-26	**Briefing/Report (Dept, BCC) - No action requested**	**Council Business**
	Board and Commission Vacancy Report	
	Department Name: CC	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council
21256-26	**Briefing/Report (Dept,BCC) - Action Requested**	**Presentation**
	Presentation from Ted Wyka, NNSA Los Alamos Field Office Manager	
	Department Name: CMO	**Length of Presentation:**
	Drop Dead Date:	**Sponsors:** County Council