

**AMENDMENT NO. 4  
INCORPORATED COUNTY OF LOS ALAMOS  
SERVICES AGREEMENT NO. 18-704**

This **AMENDMENT NO. 4** is entered into by and between the **Incorporated County of Los Alamos**, an incorporated county of the State of New Mexico ("County"), and **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association** ("Contractor" or "BCBSNM"), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Plans, ("Association"), permitting BCBSNM to use the Blue Cross and Blue Shield Service Marks in the State of New Mexico, and that BCBSNM is not contracting as the agent of the Association, to be effective for all purposes, January 1, 2022.

**WHEREAS**, County and Contractor entered into Services Agreement No. AGR18-704 dated January 1, 2018, Amendment No. AGR18-704-A1 dated January 1, 2019, Amendment No. AGR18-704-A2 dated January 1, 2020 and Amendment No. AGR18-704-A3 dated January 1, 2021 (as amended, the "Agreement") for Medical Insurance Benefits for Los Alamos County Employees; and

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

**WHEREAS**, the County Council approved this Amendment at a public meeting held on October 5, 2021; 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 Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2022, unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to two (2) consecutive one-year periods, unless sooner terminated, as provided therein.
2. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2018 and shall continue through December 31, 2018, unless sooner terminated, as provided herein.
3. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 11 of the ASA), shall commence January 1, 2019

and shall continue through December 31, 2019 unless sooner terminated, as provided herein. 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.

4. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 6 of the ASA), shall commence January 1, 2020 and shall continue through December 31, 2020 unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to four (4) consecutive one-year periods, unless sooner terminated, as provided therein.
5. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 12 of the ASA), shall commence January 1, 2021 and shall continue through December 31, 2021 unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to three (3) consecutive one-year periods, unless sooner terminated, as provided therein.
6. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 6 of the ASA), shall commence January 1, 2022 and shall continue through December 31, 2022 unless sooner terminated, as provided herein. At County's sole option the Agreement may be renewed for up to two (2) 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. **Amount of Compensation.** County shall pay the following compensation for performance of the Services, not to include any subsequent renewal periods, as follows:
  - a. Administrative Services provided between January 1, 2018 and December 31, 2019, in the amount of FOUR HUNDRED NINE THOUSAND DOLLARS (\$409,000.00);
  - b. Administrative Services provided between January 1, 2020 and December 31, 2020, in the amount of ONE HUNDRED EIGHTY THOUSAND DOLLARS (\$180,000.00);
  - c. Administrative Services provided between January 1, 2021 and December 31, 2021, in the amount of ONE HUNDRED TWO THOUSAND DOLLARS (\$102,000.00);
  - d. Administrative Services provided between January 1, 2022 and December 31, 2022, in the amount of SEVENTY-THREE THOUSAND DOLLARS (\$73,000.00)
  - e. Stop Loss Insurance coverage for January 1, 2018 through December 31, 2018, in the amount of SEVEN HUNDRED THOUSAND DOLLARS (\$700,000.00);

- f. Stop Loss Insurance coverage for January 1, 2019 through December 31, 2019, in the amount of SEVEN HUNDRED TWENTY-ONE THOUSAND DOLLARS (\$721,000.00);
  - g. Stop Loss Insurance coverage for January 1, 2020 through December 31, 2020, in the amount of EIGHT HUNDRED ONE THOUSAND DOLLARS (\$801,000.00);
  - h. Stop Loss Insurance coverage for January 1, 2021 through December 31, 2021, in the amount of EIGHT HUNDRED EIGHTY-FIVE THOUSAND DOLLARS (\$885,000.00);
  - i. Stop Loss Insurance coverage for January 1, 2022 through December 31, 2022, in the amount of NINE HUNDRED EIGHTY-NINE THOUSAND DOLLARS (\$989,000.00);
  - j. Total compensation for performance of Services between January 1, 2018 and December 31, 2022 shall not exceed FOUR MILLION EIGHT HUNDRED SIXTY THOUSAND DOLLARS (\$4,860,000.00), which amount shall include applicable New Mexico gross receipts taxes ("NMGR").
  - k. For any subsequent renewal periods set forth in Section B, "Term," above, compensation will be strictly based upon rate negotiations with Contractor and Council approval of said negotiations;
2. **Invoices.** Contractor shall submit weekly invoices to County's Human Resources Division showing claims paid for covered employees, as well as monthly invoices for administrative services, showing amount of compensation due, amount of any NMGR, and total amount payable. Payment of undisputed amounts shall be due and payable ten (10) calendar days after County's receipt of the invoice.

- III. To delete Section 8.1 "Term" in Exhibit C, and replace it in its entirety with the following:

**Term.** The term of this Agreement, for Administrative Services, shall commence January 1, 2018 and shall continue through December 31, 2022, unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to two (2) consecutive one-year periods, unless sooner terminated, as provided therein.

The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 7 of the ASA), shall commence January 1, 2020 and shall continue through December 31, 2020. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 12 of the ASA), shall commence January 1, 2021 and shall continue through December 31, 2021. The term of this Agreement, for Stop Loss Insurance Coverage, as defined in the Stop Loss Agreement (Exhibit 17 of the ASA), shall commence January 1, 2022 and shall continue through December 31, 2022 unless sooner terminated, as provided herein. At Employer's sole option the Agreement may be renewed for up to two (2) consecutive one-year periods, unless sooner terminated, as provided therein.

IV. To add the following Exhibits, for calendar year 2022, to be incorporated in their entirety with this Amendment and Exhibit C to AGR18-704-A2, the ASA, to reflect renewal dates, terms and rates:

- a) Exhibit "14" – Benefit Program Application ("ASO-BPA")
- b) Exhibit "15" – Pharmacy Benefit Management ("PBM") Fee Schedule Addendum to the Benefit Program Application
- c) Exhibit "16" – Defined Performance Guarantees
- d) Exhibit "17" – Application for Stop Loss Coverage
- e) Exhibit "18" – Network Discount Guarantee

V. Add two (2) new Sections titled "X." and "Y."

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

**SECTION Y. SEVERABILITY:** If any provision of this Agreement is held to be unenforceable for any reason: (i) such provision will be reformed only to the extent necessary to make the intent of the language enforceable; and (ii) all other provisions of this Agreement will remain in effect.

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

**IN WITNESS WHEREOF**, the parties have executed this Amendment No. 4 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**

**INCORPORATED COUNTY OF LOS ALAMOS**

\_\_\_\_\_  
**NAOMI D. MAESTAS**  
**COUNTY CLERK**

BY: \_\_\_\_\_  
**STEVEN LYNNE** **DATE**  
**COUNTY MANAGER**

**Approved as to form:**

\_\_\_\_\_  
**J. ALVIN LEAPHART**  
**COUNTY ATTORNEY**

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

BY: \_\_\_\_\_

NAME: \_\_\_\_\_  
TITLE: \_\_\_\_\_

DATE



## 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, 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:

Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: \_\_\_\_\_

Is your Non-ERISA Plan Year\* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes

If not, please specify your Non-ERISA Plan Year\*: Beginning Date \_\_\_/\_\_\_/\_\_\_ 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 / 2022

Anniversary Date: (Month/Day/Year) 01 / 01 / 2023

#### Account Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 856000679

Address: 1000 Central Avenue Suite 230

City: Los Alamos

State: NM

ZIP: 87544

Administrative Contact: Kat Brophy

Title: Benefits & Pension Manager

Email Address: kat.brophy@lacnm.us

Phone Number: 505-662-8045

Fax Number: 505-662-8000

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered:

Employer Identification Number (EIN):

(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<sup>SM</sup> ("BAE<sup>SM</sup>") Contact: Kat Brophy

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

Email Address: kat.brophy@lacnm.us

Phone Number: 505-662-8045

Fax Number: 505-662-8000

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

#### Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

**Producer of Record Information**

☒ **NO CHANGES**

☐ **SEE ADDITIONAL PROVISIONS**

Effective: \_\_\_\_\_

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from 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. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

**Producer, Agency, or Consultant:** Aon Risk Insurance Services West, Inc. Commission to be paid: ☐ Yes\* ☒ No

New Mexico Producer/Consultant #: 900001881

Address: 6501 Americas 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: \_\_\_\_\_

**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:

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

- ☐ The date of employment.  
☐ The \_\_\_\_\_ day of employment.  
☐ The \_\_\_\_\_ day of the month following \_\_\_\_\_ month(s) of employment.  
☐ The \_\_\_\_\_ day of the month following \_\_\_\_\_ days of employment.  
☒ The 1st day of the month following the date of employment.  
☐ Other: \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

7. **Termination of coverage upon reaching the Limiting Age:**

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

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

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

☐ Yes ☒ No

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

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.

*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.

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

(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 of such requirements.

#### 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.

Proprietary and Confidential Information of Claim Administrator

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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 489      ☐ **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): \_\_\_\_\_

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Lines of Business (Check all applicable services)	<input checked="" type="checkbox"/> NO CHANGES <input type="checkbox"/> See Additional Provisions
<b><u>Medical Plan Services:</u></b> <input type="checkbox"/> PPO: Plan Name <input checked="" type="checkbox"/> Dual Option Plan Name: Blue PPO 35 Plan Name: Blue PPO 45 <input type="checkbox"/> EPO <input type="checkbox"/> POS Consortium Pricing (National Groups) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  Other:  <b><u>Additional Services:</u></b> <input checked="" type="checkbox"/> Wellbeing Management <input type="checkbox"/> Wellness Incentives <input type="checkbox"/> Health Advocacy Solutions <input type="checkbox"/> Mercer Health Advantage <input type="checkbox"/> Custom Care Management Unit <input type="checkbox"/> Blue Directions <sup>SM</sup> (Private Exchange) <i>(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)</i>  <input type="checkbox"/> Limited Fiduciary Services for Claims and Appeals  <input type="checkbox"/> Other No Data iSight out of state <input type="checkbox"/> Other Select Product <input type="checkbox"/> Other Select Product <input type="checkbox"/> Other Select Product <input type="checkbox"/> Other <input type="checkbox"/> Other	<b><u>Consumer Driven Health Plan:</u></b> <input type="checkbox"/> BlueEdge <sup>SM</sup> HCA Administrative Services <i>(if purchased, complete separate HCA BPA)</i> <input type="checkbox"/> BlueEdge <sup>SM</sup> HSA: (Vendor: Select Vendor) <input type="checkbox"/> FSA: (Vendor: Select Vendor) <input type="checkbox"/> HRA: (Vendor: Select Vendor)  <b><u>Traditional Coverage:</u></b> <input type="checkbox"/> Out-of-Area (Indemnity)  <b><u>Prescription Drugs:</u></b> <input checked="" type="checkbox"/> Covered under a pharmacy benefit <i>(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA)</i> <input type="checkbox"/> Covered under the medical benefit   <b><u>Pharmacy Network (Select one):</u></b> <input checked="" type="checkbox"/> Traditional Select Network <input type="checkbox"/> Advantage Network <input type="checkbox"/> Preferred Network  <input type="checkbox"/> 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  <b><u>Ancillary Services:</u></b> <input type="checkbox"/> Dental Plan Services <input type="checkbox"/> Vision Insurance <i>(if selected, complete a separate application)</i> <input checked="" type="checkbox"/> Stop Loss <i>(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)</i> <input checked="" type="checkbox"/> Life or Disability Insurance <i>(if selected, complete a separate application for those coverages)</i> <input type="checkbox"/> COBRA Administrative Services <i>(if selected, complete separate COBRA Administrative Services Addendum)</i>

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 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.

**Proprietary and Confidential Information of Claim Administrator**

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### 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		<input checked="" type="checkbox"/> NO CHANGES <input type="checkbox"/> SEE ADDITIONAL PROVISIONS		
<b>Employer Payment Method:</b> <input type="checkbox"/> Online Bill Pay <input checked="" type="checkbox"/> Electronic <input type="checkbox"/> Auto Debit <input type="checkbox"/> Check				
<b>Employer Payment Period:</b> <input checked="" type="checkbox"/> Weekly (cannot be selected if Check is selected as payment method above) <input type="checkbox"/> Semi Monthly (cannot be selected if Check is selected as payment method above) <input type="checkbox"/> Monthly				
<b>Claim Settlement Period:</b> <input type="checkbox"/> Monthly <b>Run-Off Period:</b> Employer Payments are to be made for _____ months following end of Fee Schedule Period. <i>Standard is twelve (12) months.</i>				
<b>Fee Schedule Period:</b> 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		<input type="checkbox"/> NO CHANGES <input checked="" type="checkbox"/> SEE ADDITIONAL PROVISIONS		
	<b>Medical</b>			
Administrative Fee	<b>\$62.33</b>	\$	\$	\$
Dental	\$	\$	\$	\$
Limited Fiduciary Services	<b>\$Included</b>	\$	\$	\$
Advanced Payment Review	25% \$	% \$	% \$	% \$
Management of the Virtual Visits Program	<b>\$Included</b>	\$	\$	\$
Wellbeing Management	<b>\$Included</b>	\$	\$	\$
Health Advocacy Solutions	\$	\$	\$	\$
*Medical Drug Rebate Credit	<b>\$2.50</b>	\$	\$	\$
*Rebate Credit for the Prescription Drug Program	<b>\$47.50</b>	\$	\$	\$
Commissions: _____	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$
Other: Select Service Category List Service: _____	\$	\$	\$	\$
Other: Select Service Category List Service: _____	\$	\$	\$	\$
Other: Select Service Category List Service: _____	\$	\$	\$	\$
Miscellaneous: _____	\$	\$	\$	\$
Miscellaneous: _____	\$	\$	\$	\$
<b>Total</b>	<b>\$12.33</b>	\$	\$	\$

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

\*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	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: _____	\$ _____
<b>Total:</b>		<b>\$ _____</b>

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

**External Review Coordination:** ☒ Yes ☐ No

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

**Employer elects the following process:**

☒ Federal Affordable Care Act Process

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

**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 recovered amounts identified by Claim Administrator or third-party vendor other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

**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.

**Third-Party Law Firms Provisions (other than Reimbursement Services):** ☒ Yes ☐ No

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.

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

**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	\$21.36	\$_____	\$_____	\$_____
Dental Run-off Administration Charge	\$_____	\$_____	\$_____	\$_____
Miscellaneous	\$_____	\$_____	\$_____	\$_____
Miscellaneous	\$_____	\$_____	\$_____	\$_____
<b>Total:</b>	\$21.36	\$_____	\$_____	\$_____

### 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 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 Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to Covered Persons as required by law.

☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to plan participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is \$1.50 per package.

**Proprietary and Confidential Information of Claim Administrator**

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

**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.

**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 "Agreement" unless specified otherwise.

**7. 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 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.

**Additional Provisions:** 1. Claim Payments are settled within 10 days.

2. BlueCard Program/Network Access fees are the lesser of us to 10% of the discount or \$2000 per claim.

3. The medical admin fee is capped at \$62.33 for 2022.

4. Full Advanced Payment Review (APR) effective 1/1/2022.

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

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

**Signature**

Maureen Sergel

Sales Representative

NM 505-816-2251

District Phone & FAX Numbers

Charlene Fairchild

Producer Representative

Aon Risk Insurance Services West, Inc.

Producer Firm

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.

Signature of Authorized Purchaser

Print Name

Title

Date

**Proprietary and Confidential Information of Claim Administrator**

**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.**

## 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.

Group No.: 251305 By: \_\_\_\_\_  
\_\_\_\_\_  
Print Signer's Name Here  
➡ \_\_\_\_\_  
Signature and Title

Group Name: Incorporated County of Los Alamos

Address: 1000 Central Avenue, Suite 230

City: Los Alamos State: NM ZIP: 87544

Dated this \_\_\_\_\_ day of \_\_\_\_\_  
Month Year

**Proprietary and Confidential Information of Claim Administrator**

**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.**

HCSC GEN ASO Traditional PBM Fee Addendum 6.19

## PBM Fee Schedule Addendum to the Benefit Program Application

<b>Employer Name: County of Los Alamos</b>	
<b>Term:</b> 01/01/2022-12/31/2022	<b>Employees:</b> 489
<b>Guaranteed Traditional Aggregate Pricing Arrangement D<sup>1*</sup></b>	
<b>Traditional Select Network and Basic Drug List</b>	
<b>RETAIL</b>	
<b>Brand</b>	<b>Generic</b>
<b>AWP minus</b>	<b>AWP minus</b>
18.85%	81.80%
<b>DISPENSING FEE</b>	
<b>Brand</b>	<b>Generic</b>
\$0.80	\$0.80
<b>MAIL</b>	
<b>Brand</b>	<b>Generic</b>
<b>AWP minus</b>	<b>AWP minus</b>
22.75%	82.25%
<b>DISPENSING FEE:</b>	\$0.00
<b>EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)</b>	
<b>Brand</b>	<b>Generic</b>
<b>AWP minus</b>	<b>AWP minus</b>
22.00%	84.75%
<b>DISPENSING FEE:</b>	\$0.00
<b>Aggregate Specialty Discount</b>	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 18.90%
<b>DISPENSING FEE:</b>	\$0.00
<b>Rebate Credits to Employer:</b>	
<b>PEPM Rebate Credits to Employer:</b>	<b>\$47.50</b>
<b>Employer Administration Fees:</b>	
<b>PBM Administration Fees PEPM:</b>	\$0.00

Additional Provisions:

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

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

- Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".
- 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 Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

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

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

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

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

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

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.
- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have \$0.00 Dispensing Fees.
- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.
- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.
- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

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

HCSC GEN ASO Traditional PBM Fee Addendum 6.19

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

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

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

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

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

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

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

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

Signature of Authorized Purchaser

Print Name

Title

Date

**EXHIBIT-PG**  
**EMPLOYER NAME: COUNTY OF LOS ALAMOS**  
**Employer Account Number: 251305**  
**Employer Group Number: 251307**

Effective for the Settlement Period beginning **January 1, 2022, and ending December 31, 2022**

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 **440** Covered Employees. Performance measurement will begin **January 1, 2022**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
<b>Claims Processing Turnaround Time – All Claims</b>	<p><b>Claims Processing Turnaround Time</b> 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.</p> <p>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.</p>	<p>97.0% - 100%</p> <p>95.0% - 96.9%</p> <p>0% - 94.9%</p>	<p>0%</p> <p>1%</p> <p>2%</p>
<b>Claim Processing Accuracy</b>	<p><b>Claim Processing Accuracy</b> 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:</p> <ol style="list-style-type: none"> <li>1. Coding - incorrect claim data entry.</li> <li>2. Failure to adhere to the Employer's health care benefit program design.</li> <li>3. Failure to adhere to the administrative procedures.</li> <li>4. System generated errors, benefit programming errors, calculation errors.</li> <li>5. Excluding: <ol style="list-style-type: none"> <li>a. Any administrative inaccuracies that do not impact claims disposition or customer reporting;</li> <li>b. Errors entered by providers of service;</li> <li>c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Claim Administrator.</li> </ol> </li> </ol> <p>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</p>	<p>95.0% - 100%</p> <p>93.0% - 94.9%</p> <p>0% - 92.9%</p>	<p>0%</p> <p>1%</p> <p>2%</p>

## Exhibit "16" – Defined Performance Guarantees

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	accurately processed Claims by the number of Claims selected in the stratum. Each accuracy 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.		
<b>Claim Financial Accuracy</b>	<p><b>Claim Financial Accuracy</b> means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator.</p> <p>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 (<i>absolute value</i>) 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.</p>	98.0% - 100% 96.0% - 97.9% 0% - 95.9%	0% 1% 2%
<b>Customer Service</b>	<p><b>Average Speed of Answer of Telephone Calls</b>, calculated over the complete business day, is defined as the time a caller spends on hold until a customer advocate becomes available.</p> <p>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.</p> <p><b>Abandoned Calls</b> 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.</p>	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%
<b>Total Medical</b>			<b>10%</b>

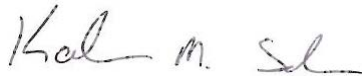
FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Network Discount Savings	<b>Network Discount Savings</b> is defined as the percentage of total eligible provider billed charges saved due to Network Provider discounts.  Method of measurement: See Exhibit for sample calculation.	See Attached Exhibit	See Attached Exhibit

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

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

**COUNTY OF LOS ALAMOS**

By: \_\_\_\_\_



Kathy Selck

Please Print Name

By: \_\_\_\_\_

Please Print Name

Title: \_\_\_\_\_

Title: Vice President & Chief Underwriter

Date: July 1, 2021

Date: \_\_\_\_\_



BlueCross BlueShield  
of New Mexico

## APPLICATION FOR STOP LOSS COVERAGE

**Employer Group Name:** Incorporated County of Los Alamos  
**Employer Group Address:** 1000 Central Avenue Suite 230  
**City:** Los Alamos **State of Situs:** NM **Zip Code:** 87544  
**Account Number:** 251305  
**Employer Group Number(s):** 251307  
**Current Effective Date of Agreement** 01/01/2022  
**Current Policy Period:** These specifications are for the Policy Period commencing on 01/01/2022 and ending on 12/31/2022  
**Stop Loss Premium Due:** 30 Calendar days following receipt of billing

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

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

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

- ☐ Incurred and paid during the Policy Period: Claims incurred and paid from \_\_\_\_\_ to \_\_\_\_\_
- ☐ Incurred with Run-Out: Claims incurred from \_\_\_\_\_ to \_\_\_\_\_  
and Claims paid from \_\_\_\_\_ to \_\_\_\_\_
- ☐ Run-in coverage: Claims incurred from \_\_\_\_\_ to \_\_\_\_\_  
and Claims paid from \_\_\_\_\_ to \_\_\_\_\_

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

☒ Renewal of Existing Coverage:

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

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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company  
an Independent Licensee of the Blue Cross and Blue Shield Association

3. Aggregate Stop Loss Coverage shall apply to:

- ☒ Medical Claims
- ☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager
- ☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: \_\_\_\_\_
- ☐ Dental Claims
- ☐ Other (please specify): \_\_\_\_\_

4. Average Claim Value: 1,307.30 (per Employee per month)

Attachment Factor: 125% of the Average Claim Value

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

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

\$1,634.13 for each Employee Coverage Unit

\$1,634.13 for each Employee/Family Coverage Unit

*Please use the continuous text field directly below for any other structure (leaving the fields above blank).*

*Note: you can use the "return" key to create additional rows, if needed:*

\_\_\_\_\_

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

\$558.32 for each Employee Coverage Unit

\$558.32 for each Employee/Family Coverage Unit

*Please use the continuous text field directly below for any other structure (leaving the fields above blank).*

*Note: you can use the "return" key to create additional rows, if needed:*

6. CAP Arrangement: ☒ Yes ☐ No

7. Aggregate Stop Loss Claims

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

i. Individual (Specific) Stop Loss Claims

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

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

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

- b. In the event of termination at the end of the current Policy Period, the Final Settlement Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in item 5.b. above. However, for the indicated Policy Period the minimum Aggregate Point of Attachment shall be \$8,630,141.

8. Stop Loss Premium (Select one):

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

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

\$2.35 for each Employee Coverage Unit

\$2.35 for each Employee/Family Coverage Unit

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

\_\_\_\_\_

9. The premium is based upon a current membership of 174 Individual Coverage Units and 315 Family Coverage Units.

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

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage Period:

☐ New Coverage (Select one from below):

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

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

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

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

☒ Renewal of Existing Coverage:

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

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

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

☒ Medical Claims

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

☐ Outpatient Prescription Drug with Policyholder's Pharmacy Benefit Manager \_\_\_\_\_

☐ Dental Claims

☐ Vision Claims

☐ Other (please specify): \_\_\_\_\_

4. Individual (Specific) Stop Loss Claims

a. For each other Covered Person:

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

b. Covered Person per Lifetime Maximum:

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

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

5. Stop Loss Premium (select one):

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

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

\$165.11 for each Employee Coverage Unit

\$165.11 for each Employee/Family Coverage Unit

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

\_\_\_\_\_

6. The premium is based upon a current membership of 174 Individual Coverage Units and 315 Family Coverage Units.

**Additional Provisions:**

\_\_\_\_\_

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

\_\_\_\_\_  
Maureen Sergel  
Sales Representative

\_\_\_\_\_  
Signature of Authorized Purchaser

\_\_\_\_\_  
Cesar Guerrero  
Name of Underwriter

\_\_\_\_\_  
Title of Authorized Purchaser

\_\_\_\_\_  
Signature of Underwriter

\_\_\_\_\_  
Date

INTERNAL USE ONLY	Date Application approved by Underwriting:
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## County of Los Alamos

January 1, 2022 - December 31, 2022  
Network Discount Guarantee

### Medical Claims Only

**Guaranteed Discount Percentage:** **40.4%**

Actual Discounts		Reimbursement
37.40%	or Higher	0.0%
36.40%	to	37.39%
35.40%	to	36.39%
35.39%	or Lower	20.0%

BCBS does not exclude any large claims from the guarantee.

**Administration Fee At Risk:** **\$55.31**

### Conditions/Caveats

1. The formula for the Overall Network Discount Percentage calculation is as follows:

(Eligible/Covered Claims less Allowed Claims equals the Provider Savings. The Provider Savings divided by the Eligible/Covered Claims equals the Overall Network Discount %).

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

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

4. BCBS will exclude all claims the Employer authorizes to be paid on an exception basis, Medicare claims, Prescription Drug claims, and claims not covered/processed by BCBS.

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

6. BCBS reserves the right to void this Network Discount Guarantee if there are less than 440 employees enrolled in the plan.

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

8. Administrative Fee at Risk will be finalized upon sale of the Network Discount Guarantee. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, WBM, HAS, etc.

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

**\*Amount at Risk is based on current enrollment of 489 HCSC Primary employees. Actual amount at risk is subject to change based on final enrollment of employees who select BCBS coverage.**

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