

**AMENDMENT NO. 1
INCORPORATED COUNTY OF LOS ALAMOS
SERVICES AGREEMENT NO. 18-704**

This **AMENDMENT NO. 1** 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, 2019.

WHEREAS, County and Contractor entered into Services Agreement No. AGR18-704 dated January 1, 2018 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 30, 2018; 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, 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.
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.

- 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. Stop Loss Insurance coverage for January 1, 2018 through December 31, 2018, in the amount of SEVEN HUNDRED THOUSAND DOLLARS (\$700,000.00);
 - c. 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);
 - d. Total compensation for performance of Services between January 1, 2018 and December 31, 2019 shall not exceed ONE MILLION EIGHT HUNDRED THIRTY THOUSAND DOLLARS (\$1,830,000.00), which amount shall include applicable New Mexico gross receipts taxes ("NMGRT").
 - e. For any subsequent renewal periods set forth in Section B, "Term," above, compensation will be strictly based upon rate negotiations with Contractor and Council approval of said negotiations;
2. **Invoices.** Contractor shall submit weekly invoices to County's Human Resources Division showing claims paid for covered employees, as well as monthly invoices for administrative services, showing amount of compensation due, amount of any NMGRT, and total amount payable. Payment of undisputed amounts shall be due and payable ten (10) calendar days after County's receipt of the invoice.

- II. To add the following Exhibits, for calendar year 2019, to be incorporated in their entirety with this Amendment and Exhibit A to AGR18-704, the ASA, to reflect renewal dates, terms and rates:
- a. Exhibit "8" – Benefit Program Application ("ASO-BPA")
 - b. Exhibit "9" – Pharmacy Benefit Management ("PBM") Fee Schedule Addendum to the Benefit Program Application
 - c. Exhibit "10" – Defined Performance Guarantees
 - d. Exhibit "11" – Application for Stop Loss Coverage
 - e. Exhibit "12" – Network Discount Guarantee

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. 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

NAOMI D. MAESTAS
COUNTY CLERK

INCORPORATED COUNTY OF LOS ALAMOS

By:

HARRY BURGESS
COUNTY MANAGER

2/2/8
DATE

Approved as to form:

J. ALVIN LEAPHART
COUNTY ATTORNEY

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

BY:

NAME:

DATE

TITLE:

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

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

Group Status: Renewing ASO Account

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

Legal Employer Name: Incorporated County of Los Alamos

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

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

If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

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

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:

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

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

If not, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ 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 / 2019

Anniversary Date: (Month/Day/Year) 01 / 01 / 2020

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:

Affiliated Companies:

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

Blue Access for Employers (BAE) Contact: Kat Brophy

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

Email Address: kat.brophy@lacnm.us

Phone Number: 505-
662-8045

Fax Number: 505-662-8000

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

Producer of Record Information

NO CHANGES

SEE ADDITIONAL PROVISIONS

Effective: _____

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

Producer or Agency to whom commissions are to be paid*: _____

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.

Exhibit A
Exhibit "8"
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Tax ID Number (TIN) of ☐ Producer or ☐ Agency: _____

Producer #: _____

NPN: _____

Address: _____

City: _____

State: _____

ZIP: _____

Phone: _____

Fax: _____

Email: _____

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

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

Schedule of Eligibility

NO CHANGES

SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

1. Eligible Person means:

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

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

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

2. Employee Definition

Full-Time Employee means:

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

Part-Time Employee means:

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

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

- ☐ The date such person ceases to meet the definition of Eligible Person.
☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other: _____

4. Select an effective date rule for 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.

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5. Domestic Partners covered: ☐ Yes ☒ No

If yes: a Domestic Partner, is eligible to enroll for coverage.

If yes, are Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☐ Yes ☐ No

If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

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

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

7. Termination of coverage upon reaching the Limiting Age:

☐ The last day of coverage is the day prior to the birthday.

☒ The last day of coverage is the last day of the month in which the limiting age is reached.

☐ The last day of coverage is the last day of the billing month.

☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.

☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

Automatically cancel dependents when they reach the day their coverage terminates

☒ Yes ☐ No

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

☐ Yes ☒ No

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

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

☐ Yes (specify number of days below) ☒ No

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

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

9. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

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

Special Enrollment: ☒ Yes ☐ No

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

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- ☒ Annual open enrollment – late applicant may apply during open enrollment and be subject to the late applicant provisions.
- ☐ Late applicants may apply at any time – coverage effective date is determined by receipt date and the off cycle allowed rules.

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

Specify Open Enrollment Period: November 8 - December 14

10. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No

Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

**Not recommended for accounts with automated eligibility.*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

☐ **NO CHANGES** ☒ **Current number of Employees enrolled 503** ☐ **SEE ADDITIONAL PROVISIONS**

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

Lines of Business (Check all applicable services)	NO CHANGES	See Additional Comments
<u>Medical Plan Services:</u> <input type="checkbox"/> PPO: Plan Name <input checked="" type="checkbox"/> Dual Option Plan Name: Blue PPO 35 Plan Name: Blue PPO 45 Plan Name: Blue PPO Options <input type="checkbox"/> EPO <input type="checkbox"/> POS Consortium Pricing (National Groups) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Blue Distinction® Flexible Network <u>Additional Services:</u> <input type="checkbox"/> Blue Care Connection® <input checked="" type="checkbox"/> Wellbeing Management <input type="checkbox"/> Wellness Incentives <input type="checkbox"/> Health Advocacy Solutions <input checked="" type="checkbox"/> Well onTarget®	<u>Consumer Driven Health Plan:</u> <input type="checkbox"/> Health Care Account (HCA) Administrative Services (if purchased, complete separate HCA BPA) <input type="checkbox"/> FSA (Vendor: Select Vendor) <input type="checkbox"/> HSA: (Vendor: Select Vendor) <u>Traditional Coverage:</u> <input type="checkbox"/> Out-of-Area (Indemnity) <u>Prescription Drugs:</u> <input checked="" type="checkbox"/> Covered under a pharmacy benefit (If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA) <input type="checkbox"/> Covered under the medical benefit Pharmacy Network (Select one): <input checked="" type="checkbox"/> Traditional Select Network <input type="checkbox"/> Advantage Network <input type="checkbox"/> Preferred Network	

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<input type="checkbox"/> Blue Directions (Private Exchange) <i>(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)</i> <input type="checkbox"/> Limited Fiduciary Services for Claims and Appeals <input type="checkbox"/> Other Select Product <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	<input type="checkbox"/> Elite Network <input type="checkbox"/> Network on PBM Fee Schedule Addendum Drug List: Basic Drug List Other (please specify): _____ <u>Ancillary Services:</u> <input type="checkbox"/> Dental Plan Services <input type="checkbox"/> Vision Plan Services <input checked="" type="checkbox"/> Stop Loss <i>(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)</i> <input checked="" type="checkbox"/> Dearborn National Life Insurance <i>(if selected, complete separate application)</i> <input type="checkbox"/> COBRA Administrative Services <i>(if selected, complete separate COBRA Administrative Services Addendum)</i>
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FEE SCHEDULE

Payment Specifications	NO CHANGES	SEE ADDITIONAL PROVISIONS
Employer Payment Method: <input type="checkbox"/> Online Bill Pay <input checked="" type="checkbox"/> Electronic <input type="checkbox"/> Auto Debit <input type="checkbox"/> Check Employer Payment Period: <input checked="" type="checkbox"/> Weekly <i>(cannot be selected if Check is selected as payment method above)</i> <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Claim Settlement Period: <input checked="" type="checkbox"/> Monthly Run-Off Period: Employer Payments are to be made for <u>12</u> months following end of Fee Schedule Period. <i>Standard is twelve (12) months.</i> Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: 12 Months.		

Administrative Per Employee Per Month (PEPM) Charges	NO CHANGES	SEE ADDITIONAL PROVISIONS
	Medical	
Administrative Fee	<u>\$57.03</u>	\$ _____
Dental	\$ _____	\$ _____
Limited Fiduciary Services	<u>\$Included</u>	\$ _____
Management of the Virtual Visits Program	<u>\$Included</u>	\$ _____
Wellbeing Management	<u>\$Included</u>	\$ _____
Health Advocacy Solutions	\$ _____	\$ _____
*Rebate Credit for the Prescription Drug Program	<u>\$(26.74)</u>	\$ _____
Commissions	\$ _____	\$ _____

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Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____
Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____
Other: Select Service Category List Service: _____	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous: _____	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous: _____	\$ _____	\$ _____	\$ _____	\$ _____
Total	\$30.29	\$ _____	\$ _____	\$ _____

*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) to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

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

Other Service and/or Program Fee(s)	NO CHANGES	SEE ADDITIONAL PROVISIONS
Not applicable to Grandfathered Plans		
External Review Coordination: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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: <input checked="" type="checkbox"/> Federal Affordable Care Act Process <input type="checkbox"/> Employer has selected outside External Review alternatives. Name of outside ERO vendor: _____		

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Reimbursement Service: ☒ Yes ☐ No

If yes: The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services):

Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.

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

Virtual Visits Program: ☒ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

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

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

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

Service	Medical			
Medical Run-off Administration Charge:	\$21.96	\$ _____	\$ _____	\$ _____
Dental Run-off Administration Charge	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Miscellaneous	\$ _____	\$ _____	\$ _____	\$ _____
Total:	\$21.96	\$ _____	\$ _____	\$ _____

Other Provisions

NO CHANGES

SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:

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

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

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

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

- ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.
- ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.
- ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is \$1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

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

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

3. Case Management Program: ☒ Yes ☐ No *The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, and other health care management programs.*

4. Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

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

Employer elects EHBs based on the following:

☒ 1. EHBs based on a HCSC state benchmark: ☐ Illinois ☐ Oklahoma ☐ Montana ☐ Texas ☒ New Mexico

☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

If so, indicate the state's benchmark that Employer elects: ____

☐ 3. Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the 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 with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation

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

Additional Provisions: 1. Claim payments are settle within 10 days. 2. BlueCard Program/Network Access fees are the lesser of up to 10% of the discount or \$2000 per claim. 3. Admin fee includes Claims Fiduciary, Wellbeing Management and Virtual Visits(Md Live). 4. The medical admin fee is capped at \$59.03 for 2020 and \$61.09 for 2021. 5.

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A minimum rebate credit of \$20.03 is guaranteed for 2020. 6. Administrative services includes performance guarantees for services and discounts. The PG Exhibit, Network Discount Exhibit and PG Addendum are part of this BPA. 7. \$25,000 Wellness Consulting Package for three years to be billed in 2019. 8. A one-time wellness credit of \$25,000 will be provided in 2019 to cover the cost of the Wellness Consulting Package.

I UNDERSTAND AND AGREE THAT:

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

Signature

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

[Handwritten Signature]
Harry Burgess
County Manager
11/2/18

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.

Exhibit A
Exhibit "8"
AGR18-704-A1

PROXY

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

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

Group No.: _____

By: Harry Burgess
Print Signer's Name Here

➔ [Signature] County Manager
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ ZIP _____

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.

PBM Fee Schedule Addendum to the Benefit Program Application

Incorporated County of Los Alamos	
Term: 01/01/2019-12/31/19	Employees: 503
Guaranteed Traditional Aggregate Pricing Arrangement C¹	
Traditional Select Network and Basic Drug List	
RETAIL	
Brand	Generic
AWP minus	AWP minus
19.25%	82.55%
DISPENSING FEE	
Brand	Generic
\$1.05	\$1.05
MAIL	
Brand	Generic
AWP minus	AWP minus
22.25%	82.85%
DISPENSING FEE:	\$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	Generic
AWP minus	AWP minus
21.05%	81.95%
DISPENSING FEE:	\$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 18.00%
DISPENSING FEE:	\$0.00
Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	\$26.74
Employer Administration Fees:	
PBM Administration Fees PEPM:	\$0.00

Additional Provisions:

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

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

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

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

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

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

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

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

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

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

Exhibit A
Exhibit "9"
AGR18-704-A1

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

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

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

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

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

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

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

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

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



Signature of Authorized Purchaser

Harry Burgess
Print Name

County Manager
Title

1/26/18
Date

Exhibit "10"
AGR18-704-A1
EMPLOYER NAME: COUNTY OF LOS
ALAMOS Employer Account Number: 251305
Employer Group Number: 251307

Effective for the Settlement Period beginning **January 1, 2019, and ending December 31, 2019**

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **450** Covered Employees. Performance measurement will begin **January 1, 2019**. 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	<p>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.</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>
Claim Processing Accuracy	<p>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:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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. <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 accurately processed Claims by the number of Claims selected in the stratum. Each accuracy</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>

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	<p>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.</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%
Customer Service	<p>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.</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>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.</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%
Total Medical			10%

FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Network Discount Savings	<p>Network Discount Savings is defined as the percentage of total eligible provider billed charges saved due to Network Provider discounts.</p> <p>Method of measurement: Total Eligible billed amount less total Allowed amount equals Provider Savings. The total Provider Savings divided by the Eligible billed amount equals the overall Network Discount Savings. Excluded from measurement are Medicare-related claims, claims with Coordination of Benefits, prescription drug claims, and claims with total paid in excess of \$100,000. Employer must maintain a minimum enrolled in the Plan.</p>	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, COUNTY OF LOS ALAMOS
a Division of Health Care Service Corporation, a Mutual
Legal Reserve Company



By:

Joseph P. Hrinda, Jr.
Please Print Name

Divisional Senior Vice President,
Title: Chief Underwriting Officer

Date: August 31, 2018



By:

Harry Burgess
Please Print Name

Title: County Manager

Date: 11/2/18

EXHIBIT A

Exhibit "11"
AGR18-704-A1

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: 01/01/2019
Current Policy Period: These specifications are for the Policy Period commencing on 01/01/2019 and ending on 12/31/2019
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

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

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

- 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 \$7,726,620.

8. Stop Loss Premium (Select one):

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

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

\$1.46 for each Employee Coverage Unit

\$1.46 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 156 Individual Coverage Units and 345 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 \$125,000 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:

\$118.40 for each Employee Coverage Unit

\$118.40 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 156 Individual Coverage Units and 345 Family Coverage Units.

Additional Provisions:

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


James Bloom
Sales Representative

Cesar Guerrero
Name of Underwriter

Signature of Underwriter


Signature of Authorized Purchaser


Title of Authorized Purchaser


Date

INTERNAL USE ONLY	Date Application approved by Underwriting:
-------------------	--

Exhibit A
Exhibit "12"
AGR18-704-A1



County of Los Alamos

January 1, 2019 - December 31, 2019

Network Discount Guarantee

Medical Claims Only

Claims Paid 01/01/19 Through 12/31/19

Guaranteed Discount Percentage 38.0%

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

1. The formula for the Overall Network Discount Percentage calculation is as follows:
(Eligible/Covered Claims less Allowed Claims equals the Provider Savings. The Provider Savings divided by the Eligible/Covered Claims equals the Overall Network Discount %).
2. Both In-Network and Out-of-Network claims are included in the Overall Network Discount Percentage calculation.
3. Network Discount Guarantee applies only to eligible employees and retirees who enroll in the proposed BCBS benefit plans.
4. BCBS will exclude all claims in excess of \$100,000, claims the Employer authorizes to be paid on an exception basis, Medicare claims, claims with COB, Prescription Drug claims, Specialty Rx, claims not covered/processed by BCBS, and claims for non-contracted providers paid at the in-network level of benefits.
5. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if participation changes by +/- 10.0%, and/or the distribution of enrolled employees between geographic areas, the single/family mix, or age/gender composition of the group changes significantly.
6. BCBS reserves the right to void this Network Discount Guarantee if there are less than 451 employees enrolled in the plan.
7. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if Medicare changes its payment systems during the term of this Network Discount Guarantee.
8. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if there is a change in the benefit plan design.
9. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if a narrow or high performance network is elected.
10. Administrative Fee at Risk will be finalized upon sale of the Network Discount Guarantee.
11. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, BCC, etc.
12. Any penalty paid will be dollar for dollar up to the maximum amount at risk for each tier.
13. Guaranteed Discount Percentage is only valid for the quoted policy period.

***Amount at Risk is based on current enrollment of 501 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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an Independent Licensee of the Blue Cross and Blue Shield Association