BlueCross BlueShield of Texas

BLUE BALANCE FUNDED[SM] ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is .

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

Account Number: .

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and consent to all of its terms and conditions as of the date and year specified below.

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

("EMPLOYER")

By:

Title: Vice President and Chief Underwriter

Date: Effective Date of Coverage noted above

By:_____

Title:_____

Date:_____

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This Agreement made as of the Effective Date, by and between **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and Employer, for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

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

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4; and

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

WHEREAS, the Parties agree that it is desirable to set forth more fully the obligations, duties, rights, and liabilities of Claim Administrator and Employer.

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

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services set forth in Exhibit 1 in connection with the administration of the Plan ("Services"). Employer agrees that it will not perform or engage any other party to perform the Services with respect to any Covered Persons while this Agreement is in effect.

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state or local laws that may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state, and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state, and local rules, laws, and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements, and disclosure requirements that may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state, or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or through Claim Administrator.

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

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA. Claim Administrator will coordinate, and Employer shall pay for, external reviews by IROs as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall Claim Administrator have any liability or responsibility for any claim determination, act, or omission by an IRO in connection with any Independent External Review.

1.5 **Claim Administrator Review Of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days prior written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the Services, Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, any subsidiary or affiliate of Claim Administrator, and any successor entity or entities to Claim Administrator, whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of Claims under the Plan, determinations of eligibility under the Plan, and its operation; notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed. Employer shall remain fully responsible and liable for the performance of any of Employer's Vendor(s) (as defined below) to the extent Employer contracts for services related to the Plan or delegates to other entities any of its obligations under the Plan.

The Parties acknowledge and agree Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

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

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

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

2.5 **Notices To Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 6.1, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 3 to Covered Persons.

2.6 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform its duties including, but not limited to, the following:

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

b. All data as may be required by Claim Administrator with respect to any Covered Persons.

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

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

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

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

2.8 **Massachusetts Health Care Reform Act.** If elected by Employer on the applicable ASO BPA, Claim Administrator will provide required written statements of creditable coverage to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, in accordance with the Massachusetts Health Care Reform Act based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that it has or will review the Plan for Massachusetts Health Care Reform Act compliance, and, to the best of its knowledge, that such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator will not verify and is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

2.9 **Employer Audits Claim Administrator.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Any review of Claim information by Employer or an authorized agent of Employer to evaluate Claim Administrator's performance of the administrative services provided according to the terms of this Agreement shall be subject to the terms of this Section. Contingency fee based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information, and to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 **Use and Disclosure Of Covered Persons' Information.** The Parties acknowledge and agree that they have entered into a Business Associate Agreement ("BAA") as required by HIPAA. The Parties agree the BAA will govern the use, access, or disclosure of all personally identifiable information ("PII"), including Protected Health Information ("PHI"), Claim Administrator may collect or receive. While Claim Administrator does not anticipate receiving or collecting PII about Covered Persons that is not PHI, Claim Administrator agrees to protect and secure any PII of Covered Persons according to the terms of the BAA and agrees to fulfill any other obligations related to PII as required therein.

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

Employer authorizes Claim Administrator to submit reports, data, and other information to Employer in the electronic format mutually agreed to by the Parties.

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

a. That the requested documents, records, and other information (for purposes of this Section 3, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.

b. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 3, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed.

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

e. To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

f. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.

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

h. To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter. If it is impractical or infeasible to securely return or securely destroy the information, Employer's Vendor and/or third party consultant agrees to protect the confidentiality of the data at the same level as under the current confidentiality agreement even after the termination of the Agreement.

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

3.4 **Business Confidential Information And Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed acquired or owns certain Business Confidential Information ("BCI"). Employer shall not use or disclose such Business Confidential Information, including this Agreement, to any third party without prior written consent of Claim Administrator. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has the opportunity to object and ensure appropriate confidentiality protections are in place. Employer will at all times remain responsible for maintaining the confidentiality of this Agreement and shall ensure that any affiliated entities or third-party representatives to whom the Agreement is disclosed are bound in writing not to further disclose this Agreement without the prior written consent of Claim Administrator.

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

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

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

3.7 **Records.**

a. **Records Retention.** Claim Administrator shall retain all Claim records for the longer of (i) the time period required by applicable law or (ii) the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator. The failure to agree upon a retention period shall not constitute breach of this Agreement.

b. **Record Requests.** For a period of one (1) year following termination of this Agreement, Claim Administrator shall, upon the request of the Employer for general purposes ("Data Reclamation Request"), provide to Employer a copy of all Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator. Within a mutually agreeable time frame of receipt of the Data Reclamation Request, Claim Administrator shall transmit the dataset in a form mutually agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. The time period for general record requests does not impact nor restrict any legal, regulatory, or mandated data requests.

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

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

4.1 **Litigation.** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against one or both Parties that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either Party under the Plan and this Agreement. Employer shall undertake the defense of such action and be responsible for the costs of defense, including but not limited to attorneys' fees and costs, external claim reviews, and other expenses. Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action, in which event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists. Some defense support by Claim Administrator, such as external claim review, may require an additional fee, the costs of which shall be Employer's responsibility.

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator is authorized to follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement. Nor will Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

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

For purposes of Section 4.2(a.-e.) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

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

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

c. **Division Of Recovery for Multiple Plans.** If Claim Administrator has made Overpayments to a Network Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 4.

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

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator shall administer Overpayment recoveries in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan. Employer agrees that

it will not perform or engage any other party to perform Overpayment recovery activities with respect to Providers or Covered Persons without prior written consent of Claim Administrator.

4.3 **Third Party Recovery Vendors And Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third parties' fees, as defined in the ASO BPA, associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

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

4.5 **Employer Indemnifies Claim Administrator.** Employer agrees to indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, governmental inquiries or actions, settlements, or judgments brought or asserted against Claim Administrator in connection with the design, operation, or administration of the Plan, including but not limited to (a) any failure to provide or the provision of inaccurate information to Claim Administrator, (b) any disclosure of information Employer directs Claim Administrator to make, or (c) selection of Employer's Essential Health Benefits benchmark for the purpose of ACA; unless the liability therefor was the direct consequence of the acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) and the acts or omissions are adjudged to be (i) grossly negligent, dishonest, fraudulent, or criminal or (ii) in material breach of the terms of this Agreement.

4.6 **Adjudication of Preventive Care.** If either on the applicable ASO BPA or other document Employer directs Claim Administrator to process and adjudicate claims at one hundred percent (100%) of the applicable allowed amount Allowable Amount regardless of whether the high-deductible health plan's deductible has been met ("First Dollar Coverage"), Employer acknowledges and agrees that such direction is a benefit design decision and the responsibility of the Employer. Notwithstanding any other provision of this Agreement, Employer shall indemnify and hold harmless (and upon request defend) Claim Administrator against claims brought by any employees of Employer, participants in any benefit plan provided by Employer, or any governmental agency, in connection with or arising out of, directly or indirectly of the First Dollar Coverage. Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to provide First Dollar Coverage.

4.7 **Assignment.** Except as otherwise permitted by Section 1 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both Parties. Any such attempted assignment in the absence of the prior written consent of the Parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates, or successors to the Parties.

4.8 **Applicable Law.** This Agreement shall be governed by and construed in accordance with applicable federal laws and the laws of the state of Texas without regard to any state choice–of–law statutes, and any applicable federal law. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Dallas, Texas**.** Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

4.9 **Notice And Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such, including but not limited to initiation of Dispute Resolution under Section 4.11 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon Timely prior written notification to the other Party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

4.10 **Limitations; Limitation Of Liability.** No action or dispute shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents, or independent contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of gross negligence, fraud, or criminal actions by Claim Administrator.

4.11 **Dispute Resolution.** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this section, which shall be the sole and exclusive procedures for the resolution of any such disputes.

a. **Initial Notice And Negotiation.** Employer or Claim Administrator shall give written notice to the other Party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the Parties shall seek to resolve that dispute through informal discussions between authorized representatives of the Parties with appropriate authority to approve any resolution. All negotiations pursuant to this section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

b. **Confidential Arbitration.** In the event the Parties fail to agree with respect to any matter covered herein and only after making good faith efforts to resolve any dispute under this Agreement under this section, Employer or Claim Administrator may submit the dispute to confidential, binding arbitration before the American Arbitration Association ("AAA"), subject to the following:

1. For matters in which the amount in controversy is $10,000 or less, Claim Administrator shall select an arbitrator. For matters in which the amount in controversy exceeds $10,000, the arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the AAA. If the Parties are unable to agree on an arbitrator from the list, AAA shall appoint an arbitrator.

2. Arbitration shall be held in Dallas, Texas.

3. Arbitration proceedings will be governed by the AAA Commercial Rules.

4. The arbitrator shall be required to issue a written opinion resolving all disputes in any matter in which the controversy exceeds $10,000 and designating one Party as the prevailing Party.

5. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction over the dispute.

6. The arbitrator's fees and any costs imposed by the arbitrator will be shared equally by the Parties. All costs and expenses, including but not limited to reasonable attorney and witness fees shall be borne by the non-prevailing Party or as apportioned by the arbitrator.

7. This provision precludes Employer from filing an action at law or in equity and from having any dispute covered by this Agreement heard by a judge or jury.

8. Except as may be required by law, neither a Party nor an arbitrator may disclose the existence, content, or results of any arbitration pursuant to this Section without the prior written consent of both Parties.

c. Except as provided otherwise in this Agreement, each Party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

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

a. Transparency Procedures.

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

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

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

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

3. ***Provider Network Status Verification***. Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide written, electronic, or print confirmation of the Provider's Network status within an appropriate timeframe. This verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

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

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

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

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

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

5. ***Machine-Readable Files***. Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by the Centers for Medicare and Medicaid Services ("CMS") standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The files will not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the performance, acts, or omissions of any of Employer's Vendors.

6. ***Cost Sharing Estimator Tool***. Claim Administrator will make available a Cost Sharing Estimator Tool ("CSET") to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through either self-service tools or telephone upon member request, a secure member portal, and via a mobile application, for active policies, and include services in accordance with the following schedule:

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

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

To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the acts or omissions of any of Employer's Vendors.

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

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

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

10. ***Mental Health Parity.*** Claim Administrator has or will timely establish processes and procedures, in accordance with sound professional practices and prevailing industry standards, reasonably necessary for Claim Administrator to timely support good faith requests of Employer for data or other documentation that Employer may need to analyze and document the Plan's compliance with applicable Mental Health Parity requirements, including the amendments to the Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008. So long as Employer has elected to implement Claim Administrator's standard non-quantitative treatment limitations ("NQTLs") and so long as Claim Administrator administers both mental health/substance abuse benefits and medical/surgical benefits on behalf of Employer, this may include applicable comparative documentation with respect to Claim Administrator-Administered non-quantitative treatment limitations (NQTLs) under the Plan which may be necessary for addressing and complying with the requirement to analyze and document NQTL parity between mental health/substance abuse benefits and medical/surgical benefits, as required by Division BB, Title II, Section 203 of the CAA and guidance issued thereunder. In addition, in the event that the U.S. Department of Labor or other regulatory agency ("Agency") with competent jurisdiction over the Plan initiates an audit or other assessment related to the Plan's compliance with mental health parity requirements, including the obligation to perform and/or make available the comparative analyses described above, Claim Administrator agrees to provide expedited support to enable Employer and the Plan to timely provide documentation requested by the Agency. Both Parties agree and understand that no data or other documentation provided by Claim Administrator under this Section shall be reasonably interpreted as a certification of the compliance of the Plan or any Claim Administrator-Administered NQTLs or other processes with State or Federal Mental Health Parity requirements. Employer agrees that compliance of the Plan with such requirements is solely the responsibility of Employer.

b. Surprise Billing Requirements of the No Surprises Act.

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

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

process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

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

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

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

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

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

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

c. **Effect of Future Changes in Law and Regulations.** The laws and regulations that are the subject of this Section 4.12 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective ninety (90) days after such notice.

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

SECTION 5: ERISA

5.1 **In Relation To The Plan.** Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a plan document, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of Employer, Employer agrees that no allocation or delegation of any responsibilities under the Plan or any other employee welfare benefit plan of Employer is effective with respect to or accepted by Claim Administrator except as set forth in this Agreement.

5.2 **In Relation To The Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's separate employee welfare benefit plan as defined under ERISA. Employer represents and warrants that (i) Employer has a named Plan Administrator and a Named Fiduciary within the meaning of §414(g) of the Internal Revenue Code of 1986, as amended; and (ii) said Plan Administrator serves within the meaning of §3(16)(A) of ERISA.

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

SECTION 6: OTHER PROVISIONS

6.1 **Term And Termination.** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein. This Agreement may be terminated as follows:

a. By either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with ninety (90) days prior written notice to the other party; or

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

c. By either Party, in the event of conduct by the other Party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 4 above; or

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

6.2 **Relationship Of The Parties And Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented, or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers, or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. Nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents.

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

6.3 **Entire Agreement.** This Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the Parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement shall prevail in the event of a conflict with any Prior Communications that either Party or a third party asserts to be a component of the Agreement between the Parties. The Exhibits and Addenda of this Agreement are:

a. Exhibit 1 - Claim Administrator Services

b. Exhibit 2 - Fee Schedule and Financial Terms

c. Exhibit 3 - Notices/Required Disclosures

d. Exhibit 4 - ASO BPA

e. Exhibit 5 – Blue Cross Blue Shield Association Disclosures and Provisions

f. Exhibit 6 – Recovery Litigation Authorization

g. Exhibit 7 – Promissory Note

6.4 **Amending.** This Agreement may be amended only by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation, or order ("Law") or by Claim Administrator or the Blue Cross and Blue Shield Association may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. If the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to dispute resolution, as set forth in Section 4.

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

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

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

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 1 “Claim Administrator Responsibilities”; Section 2 “Employer Responsibilities”; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); and Section 8 of Exhibit 2 "Financial Obligations Upon Agreement Termination".

6.6 **Notice Of Annual Meeting.** Employer is hereby notified that it is a member of Health Care Service Corporation (“HCSC”), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M. For purposes of this Section, the term “member” means the group, trust, association, or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee, or agent consistent with HCSC’s bylaws then in force and as otherwise required by applicable law.

SECTION 7: DEFINITIONS

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

7.1 **“Administrative Fee”** means the monthly service charge and the deferred Administrative Fees described in Sections 6 and 8 of Exhibit 2 that are required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Fee(s) is set forth in the Fee Schedule and Sections 6 and 8 of Exhibit 2.

7.2 “**Allowable Amount”** means the maximum amount determined by Claim Administrator to be eligible for consideration of payment for a Covered Service in accordance with the type of medical benefits coverage(s) elected on the most current ASO BPA.

a. ***For Medical Covered Services.*** The Allowable Amount means:

i. ***For Network Providers.*** For a Provider who has a written agreement with Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered (“Network Provider”), the contracting Allowable Amount is based on the terms of the Network Provider’s contract and the payment methodology in effect on the date of the Covered Service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

ii. ***For Non-Network Providers.*** For a Provider who does not have a written agreement with Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered (“Non-Network Provider”), the Allowable Amount will be the lesser of:

1. the Non-Network Provider's Claim Charge, or;
2. Claim Administrator’s Non-Contracting Allowable Amount. Except as otherwise provided in this section ii, the Non-Contracting Allowable Amount is developed from base Medicare reimbursements adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on a Claim, the non-contracting Allowable Amount for Non-Network Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Non-Network Providers which may also alter the Allowable Amount for a particular Covered Service. In the event Claim Administrator does not have any Claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's Claim Charge and Covered Persons receiving Covered Services from a Non-Network Provider will be responsible for the difference between the non-contracting Allowable Amount and the Non-Network Provider's Claim Charge, and this difference may be considerable. To find out Claim Administrator's non-contracting Allowable Amount for a particular Covered Service, Covered Persons may call customer service at the number on the back of Claim Administrator-issued identification card.

iii. ***For multiple surgeries***. The Allowable Amount for Covered Services for all surgical procedures performed on the same Covered Person on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other Covered Service procedures performed.

iv. ***For procedures, services, or supplies provided to Medicare recipient*s.** The Allowable Amount will not exceed Medicare's limiting charge.

b. ***For Prescription Drug Covered Services.*** For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the lesser of such Provider's Claim Charge or the cost agreed upon by the Participating Prescription Drug Provider. The Allowable Amount for a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services for prescription drug benefits are rendered ("Non-Network Provider Pharmacies") will be based on the lesser of the charge which the particular Non-Network Provider Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus 20% unless otherwise agreed upon by Claim Administrator and Employer.

7.3 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and/or Blue Shield licensees through Inter-Plan arrangements,

that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications, enhancements, derivatives, and improvements of the Business Confidential Information described in the preceding sentence.

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

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

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

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

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

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

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

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

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

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

7.14 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule of the most current ASO BPA.

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

7.16 **"Home Health Agency"** means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

7.17 **"Home Health Care"** means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

7.18 **"Hospital"** means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean

health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

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

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

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

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

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

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

7.25 **"Primary Care Physician"** means a Physician who is a Network Provider at the time Covered Services are rendered under Claim Administrator's point–of–service managed care health benefits coverage program, if applicable to the Plan under this Agreement, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who approves and makes medically appropriate referrals for any non–primary care Physician services and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine, and family practice.

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

7.27 **"Reminder Notice"** means a notice sent when monthly charges have not been paid within 20 (twenty) days.

7.28 **"Supplemental Charge"** means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any customized reports, forms, or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

7.29 **"Surcharges"** means local, state, or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor, paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits.

7.30 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, within twenty (20) calendar days of notification to Employer by Claim Administrator; or

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

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

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

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

- **CLAIMS ADJUDICATION**

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

- **EXPLANATION OF BENEFITS ("EOB")**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

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

- **ENROLLMENT SERVICE**

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

- **DISABLED DEPENDENT CERTIFICATION**

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

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

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

- **INTERNAL APPEALS**

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

- **MEMBERSHIP**

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

- **STANDARD REPORTS**

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

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement.

- **REPORTING SERVICES**

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

- **ACTUARIAL AND UNDERWRITING**

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

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and if the Employer is a target of a pattern of fraudulent or abusive activities inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 6.

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

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

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

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

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange, and maintain a Network(s) through contractual arrangements with Providers.

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 3, Section 7 entitled "Medicare Secondary Payer Information Reporting", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), Claim Administrator will issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, Claim Administrator will remit such funds to Employer, less any amount(s) owed to Claim Administrator from such funds, in accordance with Claim Administrator's established procedures, for disposition by Employer as may be required under applicable law. If requested by Employer via prior written notice as required by Claim Administrator, Claim Administrator will escheat such funds on behalf of Employer, less any amount(s) owed by payees to Claim Administrator, from such

funds, to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the Parties in writing prior to their performance and may be subject to Supplemental Charge.

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

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

- **DOCUMENTATION PREPARATION**

  Upon Employer request, draft and prepare Summary Plan Description(s) and/or benefit booklets for Employer review, approval, and adoption. As a group health plan sponsor, Employer remains responsible for the accuracy and compliance with applicable legal requirements with respect to all documentation associated with its group health plan.

- **EXTERNAL REVIEW COORDINATION**

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

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, which may include behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well onTarget® digital tools and resources as determined by Employer and agreed to by Claim Administrator. Audits relating to Wellbeing Management shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator.

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

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

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app, or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE ("SBC")**

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

EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

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

Inter-Plan Arrangement Fees:

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

ii. **Negotiated Arrangement/Custom Fees (as Applicable):** Additional information is available upon request; included in the medical Administrative Fee(s) noted in the ASO BPA and in any Termination (Run-Out) Administrative Fee(s) noted in the ASO BPA calculated on the basis of such medical Administrative Fee(s).

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

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

SECTION 2: EXHIBIT DEFINITIONS

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

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

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

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

2.4 **"Medicare Secondary Payer ("MSP")** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Exhibit 3 Section 7 titled "Medicare Secondary Payer Information Reporting.")

2.5 **"Projected Claim Funding"** means the monthly portion of the annual projected claims multiplied by the Aggregate Claim Liability Factor set forth in the Exhibit to the Blue Balance Funded℠ Stop Loss Coverage Policy. The Projected Claim Funding is calculated by Claim Administrator based on Employer-specific demographics and projected Claims, interest earnings and utilization.

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

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

2.8 **"Termination (Run-Out) Administrative Fee"** means the consideration that is owed by Employer to Claim Administrator for any services that may be performed by Claim Administrator during the Run–Off Period

The Termination (Run-Out) Administrative Fee is included in the monthly Administrative Fee as indicated in the Fee Schedule specifications of the most current ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

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

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

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

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that sixty (60) days prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (e.g., benefit levels, census/demographics, producer/broker fees) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service Charges.*** Employer will Timely pay Claim Administrator the Termination (Run-Out) Administrative Fee.

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

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

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

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

SECTION 4: CLAIM PAYMENTS

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

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

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

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

SECTION 5: EMPLOYER PAYMENT

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

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

- **a.** ***If Employer Payment Method Is By Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If Employer Payment Method Is Other Than Check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the Parties, of the amount due.
- **c.** Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Float Compensation.*** When Claim Administrator obtains the Employer Payment as set forth in this section, this payment will be transferred to designated bank accounts maintained by Claim Administrator and titled in Claim Administrator's name. Claim Administrator will retain any interest derived from such bank account ("Float Compensation") beginning on the date Clam Administrator receives Employer Payment through the plan year and ending on the date of the Final Settlement. Claim Administrator, at its discretion, may use the Float to offset bank charges and other reasonable administrative expenses incurred by Claim Administrator in performing its duties under this Agreement.

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

SECTION 6: CLAIM SETTLEMENTS

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

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

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

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

6.2 ***Reserves.*** Except at termination, a monthly percentage of the Projected Claim Funding as determined by Claim Administrator designated as the "Reserve" will be held by Claim Administrator to account for an estimate of claims incurred prior to the end of but not paid during the Claim settlement period. If Claim Administrator changes the amount of the Reserve, the changed amount will be funded at the time of the Claim settlement by the Projected Claim Funding payments made by Employer during the particular Claim settlement period.

6.3 ***Employer Underpayment.*** If, within the Claim settlement period, the Claim Settlement Total exceeds the sum of the Projected Claim Funding payments made by Employer Projected Claim Funding payments, and the Reserves (including any adjustments in Reserves required by Section 6.2 where an increase of the Reserves could result in a reduction of the Claim settlement), Claim Administration will advance the difference to Employer in accordance with the terms and conditions set forth in Exhibit 7, and Employer agreed to repay any such advance upon demand by Claim Administrator in accordance with the Employer Payment Method. The costs may be reimbursed by Aggregate Stop Loss, if applicable. Except at termination, the Claim settlement will be determined within ninety (90) days from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement.

6.4 ***Employer Overpayment.*** If, within the Claim settlement period, the sum of the Projected Claim Funding payments made by Employer and the Reserves (including any adjustments in Reserves required by Section 6.2 where an increase of the Reserves could result in a reduction of the Claim settlement) exceeds the Claim Payments described in Section 6.1(a.) and (b.) above, not including Claim Payments covered under the Individual (Specific) Stop Loss Insurance, a "Surplus" exists. Claim Administrator will retain a percentage of the Surplus as a deferred Administrative Fee.

Employer acknowledges that the percentage of any Surplus that Claim Administrator will retain in relation to Employer and its group health plan has been disclosed in Claim Administrator's proposal to Employer and such disclosure of the percentage of the Surplus is incorporated into this Agreement.

For the remainder of any Surplus, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer Fails To Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent. If defaults are not cured following notice via email to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice.

7.2 ***When Claim Administrator Fails To Timely Notify.*** Pursuant to Section 6.5 "Severability; Enforcement; Force Majeure; Survival" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

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

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

b. The maximum rate permitted by state law.

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

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, or on the date which Employer terminates a part of the population of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or termination of Covered Employees but not the Agreement, including, but not limited to, Claim Payments made in accordance with MSP laws and these Claims will be accounted for as part of the final settlement as described in Section 8.3.

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

8.3 ***Final Settlement.*** A final settlement shall be made within ninety (90) days after the last day of the Run–Off Period. This final settlement shall compare the sum of the Employer Payments and the Reserves held from the prior Claim settlement period, against the Claim Payments described in Section 6.1(a.) and (b.) above for all Run–Off Claims paid up to the date of the final settlement, not including Claim Payments covered under the Individual (Specific) Stop Loss Insurance. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if the sum of the Employer Payments and Reserves exceed the Claim Payments described in Sections 6.1(a.) and (b.) above for all Run–Off Claims paid up to the final settlement, not including Claim Payments covered under the Individual (Specific) Stop Loss Insurance, a Surplus exists. Claim Administrator will retain a percentage of the Surplus as a deferred Administrative Fee.

Employer acknowledges that the percentage of any Surplus that Claim Administrator will retain in relation to Employer and its group health plan has been disclosed in Claim Administrator's proposal to Employer and such disclosure of the percentage of the Surplus is incorporated into this Agreement.

For the remainder of any Surplus, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement. Further, after the final settlement, any refunds resulting from Claim adjustments or recoveries for Overpayments, including, but not limited to, subrogation or litigation activities, regardless of when such adjustments or recoveries occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed Funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old), less any amount(s) owed by payees to Claim Administrator from such funds, will be escheated by Claim Administrator on Employer's behalf to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **Claim Payment.** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in Section 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

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

1.3 **Invalidity Of Assignments.** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. If Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 of the Agreement.

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship To A Provider.** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service nor that any Provider is a subcontractor of Claim Administrator with respect to any aspect of this Agreement. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

2.3 Physician Ratings and Rankings. Employer acknowledges that Claim Administrator may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and guidelines to rate and rank certain Physicians, and may publish and make available to Employer and Covered Persons certain Physician-specific information that includes, and is not limited to, ratings, rankings, and other comparisons of a Physician's performance against certain standards, measures and other physicians, and that Claim Administrator may publish and/or share such information with Employer, Covered Persons and other third parties. Notwithstanding this or any other provisions of this Agreement to

the contrary, in no event shall any reference or statement by Claim Administrator about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee as to future services provided by any Physician or Provider or the anticipated outcome of such services.

2.4 **If Point–Of–Service Coverage Applies.** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. **Physician Selection.**

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

b. **Changing Physician Selection.**

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

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non-Network Provider for a Covered Service in non-emergency situations, benefit payments to such non–Network Provider are not based upon the amount billed. Non Network Providers may bill the Plan's Covered Person for any amount up to the difference between the billed charge and the amount the Claim Administrator has paid for the Plan's portion of the bill. For more detailed information regarding benefit payments for Network and Non-Network Providers, please see the definition of Allowable Amount in Section 7 Definitions of this Agreement. A Covered Person may obtain further information about the Network status of Providers and information on out-of-pocket expenses by calling the toll-free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

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

4.1 All amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator under the pharmacy benefit and applicable service charges pursuant to the terms of the Agreement and all required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Amount or the agreed upon cost between the Participating Prescription Drug Provider, and Claim Administrator, whichever is less.

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

4.3 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons hereunder are

entitled to receive any portion of any such payments, discounts and/or other allowances except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts, payments and/or other allowances that Prime has negotiated with pharmacies (or other suppliers) are passed through to Claim Administrator. For the administrative services that Prime provides as part of the mail order and specialty pharmacy program, Prime may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the mail-order and/or specialty pharmacy. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Fee charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

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

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

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

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains).PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. The Claim Administrator will retain those rebates which will offset a portion of the administrative expenses when setting the Administrative Fee. The offset will be based on the average rebates projected for all Blue Balance Funded groups during the contract period. The projected rebates will be based on past rebates and expected changes to them as well as demographics and prescription drug utilization. Employer acknowledges that it and its group health plan have no right to the rebates, payments, discounts and/or other allowances retained by Claim Administrator and expressly consent to Claim Administrator's retention of all such rebates, payments, discounts and/or other allowances.

5.3 Employer acknowledges that the estimated amount of rebates that Claim Administrator expects to retain in relation to Employer and its group health plan has been disclosed in Claim Administrator's proposal to Employer and such disclosure of the estimated rebates is incorporated into this Agreement. Employer understands that Claim Administrator may receive such rebates during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service changes specified in the Agreement.

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

SECTION 6: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

6.1 All amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Provider's Eligible Charge or Provider's Claim Charge less the ADP, for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Administrator Provider or Employer and Claim Administrator.

6.2 Employer acknowledges that Claim Administrator has contracts with certain Providers ("Administrator Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates, agreements and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Administrator Providers, under certain circumstances described therein, Claim Administrator may receive substantial payments from Administrator Providers with respect to services rendered to all such persons for which Claim Administrator was obligated to pay Administrator Providers, or Claim Administrator may pay Administrator Providers less than their Claim Charges for services, by discounts or otherwise, or may receive from Administrator Providers other allowances under Claim Administrator's contracts with them. Employer acknowledges that in negotiating the service charges set forth in the Agreement, it has taken into consideration that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement and that the service charges specified in the Agreement reflect the amount of additional consideration expected to be received by Claim Administrator in the form of such payments, discounts or allowances. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP as part of any Claim settlement or otherwise except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

6.3 Claim Administrator's compensation for its services under the Agreement shall include the difference between the Claim Payments reimbursed to Claim Administrator by Employer under the Agreement and the net amounts paid to Providers by Claim Administrator after giving effect to Claim Administrator's separate financial arrangements with Providers.

SECTION 7: MEDICARE SECONDARY PAYER INFORMATION REPORTING

7.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the CMS about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining

to Medicare–eligible Covered Persons under the Plan. So that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

7.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer's failure to provide accurate and timely information in response to Claim Administrator's request may impact Claim payments.

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

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

SECTION 8: REIMBURSEMENT PROVISION

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

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

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

b. Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

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

SECTION 9: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for, and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from

the Host Blue in which the Covered Person resides. To do this, Claim Administrator or Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 9.

EXHIBIT 4
ASO BPA

EXHIBIT 5
BLUE CROSS BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

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

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

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

1.3 **"Alternative Provider Compensation Arrangement Payments"** means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Homes payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments, and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 3.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 3.4 of this Exhibit. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 3.4 of this Exhibit. Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons. Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by Employer's Covered Persons per month. Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2: ADMINISTRATIVE SERVICES ONLY

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

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

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

SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator. Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below. This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

4.2 *BlueCard® Program*

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

a. ***Liability Calculation Method – In General***

(1) Covered Person Liability Calculation.

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

(2) Employer's Liability Calculation.

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

b. ***Claims Pricing***

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

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

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

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

The Host Blue determines whether it will use an actual, estimated or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Covered Person and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account. Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

c. ***BlueCard Program Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 4.9 below.

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

(2) How the BlueCard Program Access Fee Affects Employer

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

4.3 ***Negotiated Arrangements***

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

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

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

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section 4.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area. Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under Section 4.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments. If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments. Employer acknowledges that, in negotiating the Administrative Fee set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees And Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 4.9 below. In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

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

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

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

b. ***Value-Based Programs Under The BlueCard Program***

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

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

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

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

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

When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings. The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program. At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

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

The Host Blue will not receive compensation resulting from how estimated average or PMPM price methods, described above, are calculated. If Employer terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement. Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds in variance accounts. Note: Covered Persons will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

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

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

a) PMPM billings; or

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

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

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

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

4.5 ***Return Of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer. Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

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

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

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

a. Covered Person Liability Calculation

(1) General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Healthcare Providers, the amount(s) a Covered Person pays for such services will be calculated using the methodology described in the Agreement for Non-Network Providers located inside our service area. The Covered Person may be responsible for the difference between the amount that the Non-Participating Healthcare Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, Claim Administrator may, but is not required to, negotiate a payment with such Non-Participating Healthcare Provider on an exception basis. If a negotiated payment is not available, then Claim Administrator may make a payment based on the lesser of:

a. the amount calculated using the methodology described in Section 4.7(a)(1) above; or

b. the following:

i. for professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Agreement for Non-Network Providers located inside our service area; or an amount based on publicly available provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

ii. for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Agreement for Non-Network Providers located inside our service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

b. Fees And Compensation

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 4.9 below.

4.8 *Blue Cross Blue Shield Global Core®*

a. General Information

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

(1) Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the service center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

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

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

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International

Claim form and send the Claim form with the Provider's itemized bill(s) to the service center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the service center or online at www.bcbsglobalcore.com. If Covered Persons need assistance with their Claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 4.9 below.

4.9 ***Modifications Or Changes To Inter-Plan Arrangement Fees Or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective in accordance with Section 6.1(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

EXHIBIT 6
RECOVERY LITIGATION AUTHORIZATION

Employer hereby acknowledges and agrees that Claim Administrator may, at its election, pursue claims of Employer and/or the Plan, which are related to claims that Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

1. Claim Administrator shall have the right to select and retain legal counsel.

2. Any lawsuit filed or arbitration initiated by Claim Administrator will be done in the name of Claim Administrator for its own benefit, as well as on behalf of Employer and possibly other parties. Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of Employer and/or the Plan without Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of Employer and/or the Plan with attorneys identified as counsel for Employer or in the name of two or more parties, including Employer and Claim Administrator, with attorneys identified as counsel for Employer, Claim Administrator and possibly other parties.

3. The Parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit.

4. Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

5. Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated, or litigated.

6. Claim Administrator shall have the right to assign claims belonging to Employer and/or the Plan to a third party for the purpose of allowing the third party to pursue the claims on Employer's behalf via mediation, arbitration, or litigation. If such an assignment is made, the rights and obligations of Claim Administrator in this Exhibit 6 shall become the rights and obligations of the third party for purposes of the assigned claims only.

7. Any and all recoveries, net of all investigative and other expenses relating to the recovery made through any means pursuant to the provisions of this Exhibit, including any costs of settlement, mediation, arbitration, litigation or trial including attorney's fees, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by Claim Administrator on any reasonable basis it deems appropriate.

8. Any and all information, documents, communications, or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions, and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of Claim Administrator.

9. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

10. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.

11. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration, or settlement negotiation; therefore, Employer acknowledges that the efforts of Claim Administrator may not result in recovery or in full recovery in any particular case.

12. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require Claim Administrator to assert any claims on Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after Claim

Administrator has asserted a claim on behalf of Employer and/or the Plan but before any recovery, Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

13. If Employer should desire to participate in a class or multi–district settlement rather than defer to Claim Administrator, Employer may revoke the grant of authority established herein for that specific matter by affirmatively opting into a class settlement and by notifying Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 4.8 Notice and Satisfaction of the Agreement.

14. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 4.8 Notice and Satisfaction of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes Claim Administrator, on behalf of Employer and/or the Plan, consistent with Section 2 above, to:

- **a.** Pursue, without advance notice to Employer, claims that Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, private lien resolution programs, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business, or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
- **b.** Opt out of any class action settlement or keep Employer and/or the Plan in the class, if Claim Administrator reasonably determines that it should do so;
- **c.** Investigate and pursue recovery of monies unlawfully, illegally, or wrongfully obtained from the Plan.

15. Employer further acknowledges and agrees that Claim Administrator's decision to pursue recovery in connection with particular claims shall be in Claim Administrator's sole discretion and Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of Employer and/or the Plan when, as, and if, Claim Administrator determines that such claims may be pursued in the common interest of the parties.

16. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Exhibit.

17. The Parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail with respect to the subject matter hereof.

EXHIBIT 7
PROMISSORY NOTE

For value received, the Employer (the "**Borrower**") promises to pay to the order of the Claim Administrator (the "**Lender**"), the aggregate unpaid principal balance of each advance (an "Advance" and collectively the "Advances") made on or after the effective date of this Agreement by the Lender to the Borrower (or made by payment by the Lender to a third party for the Borrower's benefit), upon demand by the Lender. Such Advances shall only constitute sums advanced by the Lender for the benefit of the Borrower in connection with the payment of ordinary operating expenses of Borrower's Plans, including the payment of benefits in accordance with the terms of such Plans, or for a purpose incidental to the ordinary operation and administration of such Plans.

The Lender agrees that there will be no interest or other fee charged to the Borrower in relation to these Advances, and any lien rights or other security interests the Lender holds with respect to the Borrower's property shall not secure the Lender's right to receive the aggregate unpaid principal balance of the Advances under this Promissory Note from the Borrower. The Lender agrees that it shall waive its right to seek repayment of any Advance hereunder if the Lender does not make a demand for payment hereunder within 210 days after the last day of the plan year of the Borrower in which such Advance was made by the Lender.

This Promissory Note shall bind the Borrower, its successors and assigns, and shall inure to the benefit of the Lender, its successors and assigns.

This Promissory Note shall be effective as of the date of each Advance made by the Lender to the Borrower hereunder, and also shall apply to any Advance made on or after the effective date of this Agreement.