

NOTICE OF SPECIAL MEETING

In accordance with §38-431.02 of the Arizona Revised Statutes of the State of Arizona, notice is hereby given to the Employee Benefit Trust Board and to the general public that the Mayor and Trustees of the Employee Benefit Trust Board will hold an Employee Benefits Trust Board Meeting at 4:30 PM., Thursday, May 4, 2023. The meeting will take place at the City Council Chambers, located at 1090 E. Union Street, San Luis, Arizona, 85349.

In accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, the City of San Luis does not discriminate on the basis of disability in the admission of or access to, or treatment of employment in its programs, activities, or services. For information regarding rights and provisions of the ADA or Section 504, or to request reasonable accommodations for participation in City programs, activities or services contact: ADA/Section 504 Coordinator, City of San Luis Human Resources Department, 1090 East Union Street, San Luis, Arizona 85349; (928) 341-8579.

Notice is hereby given that pursuant to A.R.S. §1-602.A.9, subject to certain specified statutory exceptions, parents have a right to consent before the State or any of its political subdivisions make a video or audio recording of a minor child. Meetings of the City Council are audio and/or video recorded, and, as a result, proceedings in which children are present may be subject to such recording. Parents in order to exercise their rights may either file written consent with the City Clerk to such recording, or take personal action to ensure that their child or children are not present when a recording may be made. If a child is present at the time a recording is made, the City will assume that the rights afforded parents pursuant to A.R.S. §1-602.A.9 been waived.

THIS NOTICE IS APPROVED BY:

/s/ Maria Barajas, HR Benefits Coordinator

AVISO DE JUNTA ESPECIAL

De acuerdo con los Estatutos del Estado de Arizona A.R.S. §38-431.02, se le informa a los miembros del la Junta Fiduciaria de Beneficios para Empleados y al público en general que el Presidente y la Mesa Directiva de Fondo de Beneficios Medicos de San Luis, Arizona, tendrán una Junta Regular a las 4:30 PM, el día Jueves, 4 de Mayo, 2023. La junta se llevará a cabo en la Sala del Cabildo, ubicada en el 1090 E. Union Street, San Luis, Arizona, 85349.

De acuerdo con el Acta de Americanos con discapacidades y la Sección 504 del Acta de Rehabilitación del 1973, la Ciudad de San Luis no discrimina por causa de discapacidad la admisión y acceso a sus programas, actividades, servicios o en el trato en cuanto a empleo. Para mas información referente a derechos y provisiones del Acta de Americanos con discapacidades o Sección 504, o para solicitar adaptaciones que sean razonables para la participación en programas, actividades o servicios de la ciudad, contactar al: Coordinador del Acta de Americanos con discapacidades/Sección 504, Departamento de Recursos Humanos de la Ciudad de San Luis, 1090 Este Calle Unión, San Luis, Arizona, 85349; (928) 341-8579.

Por medio de este aviso y de acuerdo con los Estatutos Revisados del Estado de Arizona, sujeto a ciertas excepciones reglamentarias, los padres de familia tienen el derecho de dar o no dar el consentimiento antes que el Estado o alguna subdivisión política grabe a un menor de edad, ya sea en audio o video. Las juntas del Concilio se graban en audio y/o video y como resultado, el hecho de que haya menores presentes puede ser sujeto a que sean grabados. Para que los padres de familia puedan ejercer sus derechos pueden solicitar por escrito con la Secretaria de la Ciudad a tal grabación, o tomar acción personal para asegurarse que su hijo/hija menor no esté presente cuando la grabación se lleve a cabo. Si un menor de edad esta presente en el momento de la grabación, la Ciudad asumirá que los padres de familia están cediendo los derechos sobre una posible grabación de acuerdo con el Estatuto Revisado del Estado de Arizona §1-602.A.9.

ESTE AVISO ES APROBADO POR:

/f/ Maria Barajas, Coordinadora de Beneficios de Recursos Humanos

AGENDA
Special Meeting
City of San Luis Employee Benefit Trust
Council Chambers – City Hall
1090 E Union Street
San Luis, AZ 85349
Thursday, May 4, 2023
4:30PM

NOTE: Some members of the Board of Trustees of the City of San Luis Employee Benefit Trust may attend the meeting telephonically. If authorized by majority vote of the Board of Trustees, an executive session will be held immediately following the vote in accordance with A.R.S. §38-431.03(A) and the meeting will be temporarily recessed while the Board retires to executive session which will not be open to the public.

1. CALL TO ORDER/ROLL CALL

2. CONSENT AGENDA

2. A. MINUTES OF:

-Special meeting held on April 5, 2023

3. DISCUSSION AND POSSIBLE ACTION ITEMS:

3. A. Discussion and possible action on any and all matters regarding the service agreement with SIARMED. **(Susan Posada, Consultant and Broker).**

3. B. Discussion and possible action on any and all matters regarding the final Stop Loss Insurance carriers' quotes. **(Susan Posada, Broker, and Consultant)**

3. C. Discussion and possible action on any and all matters regarding the approval of Run-Out Claims Process by 90 Degrees. **(Susan Posada, Broker and Consultant)**

3. D. Discussion and possible action on any and all matters regarding the Service Agreement for HealthComp as the Third-Party Administrator. **(Susan Posada, Benefits Consultant).**

3. E. Discussion and possible action on any and all matters regarding the Southern Scripts Pharmacy Products and Services Administration Agreement. **(Susan Posada, Broker and Consultant)**

3. F. Discussion and possible action on any and all matters regarding newly hired employees' benefits eligibility date. **(Mary Barajas, Human Resources Coordinator)**

3. G. Discussion and possible action on any and all matters regarding benefit trust fund reserves. **(Monica Castro, Director of Finance)**

4. ADJOURNMENT

Special Employee Benefit Trust Board Meeting

2. A.

Meeting Date: 05/04/2023

Summary

MINUTES OF:

-Special meeting held on April 5, 2023

Attachments

EBT MINUTES 04.05.23

**MINUTES
SPECIAL MEETING
EMPLOYEE BENEFITS TRUST
COUNCIL CHAMBERS
1090 E. Union Street San Luis, Arizona 85349
April 5, 2023
4:30 PM**

1. **CALL TO ORDER/ROLL CALL** meeting was called to order at approximately 4:33 PM

Those present:

Board Member Gustavo MacGrew
Secretary Maria Sabori
Chairman Tadeo De La Hoya

Those not present:

Board Member Maria Gonzalez
Vice-Chairman Emma Torres

Others present:

Kay Marion Macuil, City Attorney
Janet Taylor, Legal Secretary, Clerk of the Board
Susan Posada, Benefits Coordinator
Mary Barajas Gutierrez, Human Resources Coordinator
Adela Cortez, Director of Human Resources
Ralph Velez, Acting City Manager
Roula Encinas, Finance Operations Manager
Domingo Sosa, Graphics Specialist
Ruben Lopez, IT Technician

2. **CONSENT AGENDA**

All matters are considered routine by the Employee Benefit Trust Board and will be enacted by one motion. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.

2. A. **MINUTES OF:**

- Special meeting held on February 8, 2023

MOTION: Chairman De La Hoya and Board member Gustavo Macgrew approve the minutes of the meeting held February 8, 2023. **Motion passed unanimously.**

The vote was as follows:

Chairman Tadeo De La Hoya	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye

3. DISCUSSION AND POSSIBLE ACTION ITEMS:

3.A. Discussion and possible direction to executive advisors or broker/consultant on any and all matters regarding Stop Loss Insurance. **(Susan Posada, Broker, and Consultant)**

Susan Posada, Broker and Consultant, discussed the Stop Loss Insurance and the fact that there were major claims and that the plan was looking at a one million dollar cost increase. She stated that we do not have final figures yet, but we have to budget what the final increase is going to be for the council to approve the budget.

Ms. Posada stated that we are looking at a 20% increase, but none of it will be passed on to the employee. That is the recommendation at this time, and it would be a 20% increase to the city. She also stated that the city had not had an increase for five years.

Chairman De La Hoya asked if the 20% increase was the total for the premium or the stop loss.

Ms. Posada stated that the 20% she was talking about is the total cost of the plan. She stated that every year the Trust pays about three million toward the plan, including costs of claims. This year the Trust was looking at paying about four million. Ms. Posada stated she would need another meeting to approve the Stop-Loss. She also recommends that the city take the \$600,000.00 loss when that claim comes to be. And then, have them charge us more money, and they pay that \$600,000.00 because the renewals will be based on that increase.

Secretary Maria Sabori asked if the \$600,000.00 claim was still ongoing and could there be more.

Ms. Posada stated that it all depends on the member's decision.

Discussion only, no action.

3.B. Discussion and possible action on any and all matters regarding the Employee Benefits Plan proposal, which takes effect on July 1, 2023. **(Susan Posada, Broker, and Consultant)**

Ms. Posada stated that we have been with 90 degrees for about five years. There have been some difficulties. The service was the number one issue, but the second issue is that they came in with a proposal of about a 44% increase. Ms. Posada pointed out some of the rate increases that were being proposed.

City Attorney Kay Macuil addressed Susan and explained that she was discussing agenda item 3.C. and not item 3.B., Which is the Wellness Plan.

Ms. Posada apologized and began discussing the Wellness Program and stated that HR is given a budget of \$18,000.00 because they put on biometrics and classes.

Chairman De La Hoya stated for clarification to Ms. Posada that we were on item 3.B. Ms. Posada then proceeded to discuss the fact that we got a really good deal with Blue Cross/Blue Shield. We were given a one-year and two-year renewal. Ms. Posada is recommending that we take the two-year renewal, which would take us to an increase of \$22 dollars per employee per month. It is a 4.76 percent increase.

The second would be the prescription medication management, which was just part of the contract last year, and this is not a new item. The administrative fee was \$10.00 per claim, and the second year would be \$10.25 and \$10.50 the third year.

The Telemedicine contract remains at \$13.00, including Teledoc, nutrition, dermatology, and many other benefits.

The Wellness program is budgeted at \$18,000.00 annually.

Chairman De La Hoya asked about the prescription program, and Ms. Posada explained that there were two elements to it. One is how much we pay, and then they give us rebates or money back. Last year it was \$65,000.00. Mr. De La Hoya stated that it was his understanding that we were not able to use money from the Trust for the Wellness Program. Ms. Posada stated that as long as you are doing a "Wellness Program" for everyone, then it is okay to use the money. We just couldn't give reimbursements for certain things because that money would be taxed to the employee. Ms. Posada stated that she has always given the Wellness Program a budget. The first year was \$10,000. The second year was \$18,000. And this year, it will be \$18,000. They did not use all of it last year, but this year with new management, they will use it.

Ms. Sabori stated that it was originally with HR, but it was voted on by the Trust and was approved through the Trust.

Adela Cortez, HR Director, replied to Mr. De La Hoya's question regarding the Wellness Program, and she stated that she had seen that it was allocated on the HR side and then on the Trust, so she inquired about it and is now utilizing the money from the Trust. And had received approval from finance to use it. So now we don't have to budget for that on the HR side. She also stated there are certain challenges where employees win for their participation. Now will use money from the Trust if it is wellness related.

Secretary Maria Sabori had a follow-up question on the Healthiest You program. She stated that a few years back, we weren't using it as much before COVID and that since then, we have been using it. Ms. Sabori asked if participation had gone up. Ms. Posada responded that it is being used well, but not as much as during COVID. Ms. Posada stated that it is seasonal and can bring a report, but it will be seasonal. Ms. Posada stated she sees more Zoom and teleconference. She said where it is not being utilized is dermatology and weight loss. Ms. Posada stated that it does take a couple of years, and once one person tells another person and another person and so on. Ms. Posada continued with a brief discussion on Telehealth.

MOTION: Chairman De La Hoya and Secretary Sabori approve the Blue Cross / Blue Shield 2-year contract as presented. **Motion passed unanimously.**

The vote was as follows:

Chairman De La Hoya	Aye
Secretary Maria Sabori	Aye
Board member Gustavo MacGrew	Aye

MOTION: Chairman De La Hoya and Board member Gustavo MacGrew approve the \$18,000.00 budget for the Wellness Program from the Trust reserves. **Motion passed unanimously.**

The vote was as follows:

Board member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Chairman De La Hoya	Aye

3.C. Discussion and possible action on any and all matters regarding the Benefits Third Party Administrator (Susan Posada, Benefits Consultant)

Ms. Posada discussed going out to bid for a new Third Party Administrator and presented a PowerPoint to show the difference in pricing and what that included. Ms. Posada is recommending HealthComp as the new TPA for a total cost of \$118,641.33. This is for a three-year contract and a maximum of a three percent increase.

Chairman De La Hoya asked what we were basing it on the customer service, and Ms. Posada replied and the cost.

Ms. Sabori asked Ms. Posada if we were going to discuss the enrollment process because that would be a big issue and would be something we need. Ms. Posada responded yes, and that she had it handled.

Ms. Posada discussed enrollment and Employee Navigation, a company that handles enrollment with an annual cost of \$6,030.00. Ms. Posada also stated that she would be attending training that could possibly remove the implementation fee of \$2,750.00. Ms. Posada answered questions regarding support and believed we could get this done with Employee Navigation.

Secretary Sabori asked how will the information be merged. Ms. Posada replied that she would try and get the census from 90 degrees and upload them to the new system. They will help with that because that is a difficult process.

Chairman De La Hoya asked if Healthcomp is going to be able to process our claims from Mexico. Ms. Posada replied yes, which would not affect our current agreement with Siarmed. The chairman also asked when the Siarmed contract was due, and Ms. Posada stated June 30th. And should be approved by the next meeting.

Motion: Secretary Maria Sabori and Board member Gustavo MacGrew approve Healthcomp as the Third Party Administrator (TPA) for the City of San Luis benefit plan.
Motion passed unanimously.

The vote was as follows:

Board member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Chairman De La Hoya	Aye

3. ADJOURNMENT

Chairman De La Hoya adjourned the meeting at approximately 5:16 PM.

PENDING APPROVAL



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. A.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the service agreement with SIARMED. **(Susan Posada, Consultant and Broker).**

SUMMARY:

The City of San Luis Employee Benefit Trust ("COSLEBT") provides healthcare benefits (medical and dental) for employees and their dependents in Mexico. Since 2015, COSLEBT has contracted the services of SIARMED to provide medical, dental, and administrative services to our members in Mexico.

SIARMED's agreement is due to expire on June 30, 2023. COSLEBT and SIARMED's administrators have expressed interest in renewing the existing agreement. In addition, SIARMED's administration has agreed to maintain the same administrative fees, which are \$3 per employee per month (PEPM) for medical and \$1.50 PEPM for dental.

Attached to this agenda is a copy of the Amendment to extend SIARMED's Agreement for three (3) years, through June 30, 2026.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE AMENDMENT TO EXTEND SIARMED'S AGREEMENT THROUGH JUNE 30, 2026.

Fiscal Impact

Fiscal Impact:

No increase in the three-year contract of the per employee per month rate.

Attachments

SIARMED - AGREEMENT

**AMENDMENT EXTENDING TO JUNE 30, 2026
THE MEDICAL PROVIDER ADMINISTRATION SERVICE
AGREEMENT**

This Amendment Extending to June 30, 2026, the Medical Provider Administrator's Agreement is made and entered into as of this ___ day of ____, 2023 by and among **City of San Luis Employee Benefit Trust** ("Payer"), and **SIARMED** Medical Provider Administrator ("MPA") with reference to the following facts:

WHEREAS, the Medical Provider Administration Service Agreement between Payer and MPA expires on June 30, 2023;

WHEREAS, under said agreement at the expiration of the term, the agreement automatically renews for one year as under section 5.1.

WHEREAS, Payer and MPA desire to extend the term to June 30, 2026; and

WHEREAS, such an extension requires an amendment to said agreement;

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein and for other good and valuable consideration, the parties hereby agree as follows:

Section 1. The Medical Provider Administration Service Agreement entered into between Payer and MPA on December 23, 2015 shall hereinafter be referred to as "Agreement", is attached as Exhibit 1 and is hereby incorporated by this reference as if fully set forth herein except for section 5.1 which is amended below.

Section 2. Section 5.1 of the Agreement is hereby amended to read:

Term. This Agreement is effective as of December 23, 2015 and continues until June 30, 2023. After June 30, 2023, this Agreement will continue to June 30, 2026, unless it has been terminated pursuant to the terms of this Agreement or unless any party provides ninety (90) days written Notice of Non-Renewal or ninety (90) days' Notice of Termination without Cause.

Section 3. This amendment may be executed in counterparts, any of which shall be deemed to be an original.

*****SIGNATURE PAGE ON NEXT PAGE*****

IN WITNESS WHEREOF, the Parties have executed this agreement in the day, month and year first set forth above in San Luis, Arizona.

**PAYER:
CITY OF SAN LUIS
EMPLOYEE BENEFIT TRUST**

Tadeo A. De La Hoya, Chairman

Attest:

Sonia Cornelio
San Luis City Clerk

Date: _____

Approved as to form

Kay Marion Macuil
General Counsel for the
City of San Luis Employee Benefit Trust

MPA:
SIARMED

Rafael Galindo Ferreris, CEO

Attest:

09/12/2023

Date: _____



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. B.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the final Stop Loss Insurance carriers' quotes. **(Susan Posada, Broker, and Consultant)**

SUMMARY:

During this last fiscal year, there have been several large claims that have impacted the renewal cost of Stop Loss Insurance. Our current Stop Loss Insurance carrier, Symetra Financial, provided the following proposed quotes:

1. Policy with Laser of \$605,000 – Specific deductible of \$50,000 with an annual premium of \$898,002.72. Percentage of increase over current 19.76%.
2. Policy without Laser – Specific deductible of \$50,000 with an annual premium of \$1,163,065.56. Percentage of increase over current 55.11%.
3. Policy with Laser of \$605,000 – Specific deductible of \$75,000. Total annual premium of \$697,116.36. Percentage of increase over current 15.86%.
4. Policy with Laser of \$605,000 – Specific deductible of \$100,000. Total annual premium of \$590,364. Percentage of increase over current -1.88%.

Research was conducted to see if we could find a more cost-efficient policy. Matrix Group Benefits, LLC presented the following options:

5. Policy with a Laser of \$185,000. Specific deductible of \$50,000. Total annual premium of \$703,480.68. Percentage of increase over current -6.18%.
6. Policy with a Laser of \$185,000. Specific deductible of \$75,000. Total annual premium of \$669,575.16. Percentage of increase over current -10.71%.
7. Policy with a Laser of \$185,000. Specific deductible of \$100,000. Total annual premium of \$590,450.76. Percentage of increase over current -34.25%.

Due to the increased rates of our current Stop Loss Insurance carrier, it is our recommendation to switch our Stop Loss Insurance to Matrix Group Benefits, LLC. We are specifically recommending Option 5 as that provides the lower Specific Deductible. (Note: On the attached proposal says option 1, but it has the terms of option 5).

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE STOP-LOSS INSURANCE CARRIER TO MATRIX GROUP BENEFITS, LLC AND START NEW POLICY -WITH OPTION #5- AS PRESENTED, AND DIRECT THE EXECUTIVE ADVISERS TO TAKE ALL FURTHER ACTION NECESSARY TO OBTAIN THE POLICY.

Fiscal Impact

Fiscal Impact:

Fiscal impact as shown in the summary and attached proposal.

Attachments

STOP LOSS QUOTES

MATRIX AGREEMENT

**CITY OF SAN LUIS
STOP LOSS AND ADMINISTRATION RENEWAL EFFECTIVE JULY 1, 2023**

Carrier	2022 - 2023	2023 - 2024	2023 - 2024	2023 - 2024	2023 - 2024	2023 - 2024	2023 - 2024	2023 - 2024	2023 - 2024
	Current	With \$605K Laser	No Laser	With \$605K Laser	With \$605K Laser	Laser \$185,000	Laser \$185,000	Laser \$185,000	Laser \$185,000
	Symetra	Option 1 Final Symetra	Option 2 Final Symetra	Option 3 Final Symetra	Option 4 Final Symetra	Option 5 Final Matrix/Fidelity Security	Option 6 Preliminary Matrix/Fidelity Security	Option 7 Preliminary Matrix/Fidelity Security	
STOP LOSS POLICY TERMS	\$50,000	\$50,000	\$50,000	\$75,000	\$100,000	\$50,000	\$75,000	\$100,000	
Specific Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Specific Annual Reimbursement	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Specific Deductible	\$ 50,000	\$ 50,000	\$ 50,000	\$ 75,000	\$ 100,000	\$ 50,000	\$ 75,000	\$ 100,000	
Specific Contract Basis	Paid	Paid	Paid	Paid	Paid	24/12	24/12	24/12	
Specific Coverage	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card
Specific Run-In Limits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lasered Individuals	None	None	None	None	None	None	None	None	None
Aggregate Maximum	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000	\$ 1,000,000
Aggregate Coverage	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card	Medical & RX Card
Aggregate Contract Basis	Paid	Paid	Paid	Paid	Paid	24/12	24/12	24/12	
Aggregate Run-In Limits	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Corridor	25%	25%	25%	25%	25%	20%	25%	25%	
STOP LOSS PREMIUM									
Specific Premium									
Employee Rate	157 \$ 121.64	\$ 142.22	\$ 184.87	\$ 109.68	\$ 89.47	\$ 103.95	\$ 96.44	\$ 83.05	
Employee + Spouse Rate	0 \$ 361.21	\$ 438.48	\$ 570.04	\$ 338.15	\$ 288.79	\$ 332.48	\$ 314.31	\$ 270.10	
Employee + Child(ren) Rate	0 \$ 361.21	\$ 438.48	\$ 570.04	\$ 338.15	\$ 288.79	\$ 332.48	\$ 314.31	\$ 270.10	
Employee + Spouse & Children Rate	117 \$ 361.21	\$ 438.48	\$ 570.04	\$ 338.15	\$ 288.79	\$ 332.48	\$ 314.31	\$ 270.10	
Projected Total Monthly Specific Premium	274 \$ 61,359.05	\$ 73,630.70	\$ 95,719.27	\$ 56,783.31	\$ 47,835.22	\$ 55,220.31	\$ 51,915.35	\$ 44,910.65	
Aggregate Rate PEPM	274 \$ 4.12	\$ 4.39	\$ 4.39	\$ 4.78	\$ 4.97	\$ 12.42	\$ 14.17	\$ 15.67	
Projected Monthly Aggregate Premium	\$ 1,128.88	\$ 1,202.86	\$ 1,202.86	\$ 1,309.72	\$ 1,361.78	\$ 3,403.08	\$ 3,882.58	\$ 4,293.58	
TOTAL PROJECTED PREMIUM									
Monthly	\$ 62,487.93	\$ 74,833.56	\$ 96,922.13	\$ 58,093.03	\$ 49,197.00	\$ 58,623.39	\$ 55,797.93	\$ 49,204.23	
Annual	\$ 749,855.16	\$ 898,002.72	\$ 1,163,065.56	\$ 697,116.36	\$ 590,364.00	\$ 703,480.68	\$ 669,575.16	\$ 590,450.76	
Percentage of increase over current		19.76%	55.11%	15.86%	-1.88%	-6.18%	-10.71%	-34.25%	
MAXIMUM CLAIM FUNDING FACTORS									
Employee	157 \$409.87	\$ 433.09	\$ 433.09	\$ 433.09	\$ 433.09	\$ 416.75	\$ 462.72	\$ 493.18	
Employee + Spouse	0 \$1,123.89	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,346.81	\$ 1,495.35	\$ 1,593.81	
Employee + Children	0 \$996.90	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,346.81	\$ 1,495.35	\$ 1,593.81	
Employee + Spouse + Child(ren)	117 \$996.90	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,192.71	\$ 1,346.81	\$ 1,495.35	\$ 1,593.81	
TOTAL PROJECTED MAXIMUM FUNDING	274								
Monthly	\$ 180,986.89	\$ 207,542.20	\$ 207,542.20	\$ 1,357,318.68	\$ 1,357,318.68	\$ 223,006.52	\$ 247,602.99	\$ 186,475.77	
Annual	\$ 2,171,842.68	\$ 2,490,506.40	\$ 2,490,506.40	\$ 16,287,824.14	\$ 16,287,824.14	\$ 2,676,078.24	\$ 2,971,235.88	\$ 2,237,709.24	
Corridor	25%	25%	25%	25%	25%	20%			
Percentage of increase over current		14.67%	14.67%	678.19%	678.19%	26.85%	36.81%	-10.15%	
Rate Cap - Second Year						20.00%			

Laser - \$605,000 with Symetra - Matrix about \$185,000 and 20% cap for the following year
Matrix is the Plan Manager with underwriting from Fidelity Security Life
Matrix - Insures Prescott, Yuma & Mesa - RMS is excluded
Aggregate Factors may be recalculated if avg claims in past 3 mos vary more than 10%



APPLIED EXPERTISE

190 U.S. Route One Box 365 Falmouth, ME 04105 Telephone: (207) 523-8408 Facsimile: (207) 846-8834

PROPOSAL FOR EXCESS LOSS REINSURANCE COVERAGE

Issuing Carrier **Fidelity Security Life Insurance Company**
 Requested By **Arizona Benefit Plans, Inc.**
 Underwriter **Katy Beaulieu**
 Group **City of San Luis**

Proposal No **19911**
 Proposal **04/19/2023** Valid Thru **07/11/2023**
 Effective **07/01/2023** Expiration **06/30/2024**
 All previous proposals are void and withdrawn.

SPECIFIC EXCESS LOSS COVERAGE

Simultaneous Reimbursement

Option 1

Coverages			Medical, Rx Card, Platinum Program
Contract Type			24/12
Annual Specific Deductible per Individual			50,000
except for			185,000
Maximum Annual Reimbursement			Unlimited
Rate Per Month	<u>Enrollment</u>		
Single	157	\$	103.95
Family	117	\$	332.48
Composite	274	\$	201.54
Estimated Annual Premium		\$	662,643
Rate(s) includes Commissions of			0.00%

FIXED COST ANALYSIS

Specific Premium Composite	201.54
Aggregate Premium	4.92
MATRIX RMS Fees per Emplo	7.50
Monthly Total Per Employee	213.96
Annual Total	703,480

AGGREGATE EXCESS LOSS COVERAGE

		<u>Option 1</u>	
Coverages		Medical, Rx Card	
Contract Type			24/12
Loss Limit per Individual			50,000
Maximum Annual Reimbursement		\$	1,000,000
Rate Per Month	<u>Enrollment</u>		
Composite	274	\$	4.92
Estimated Annual Premium		\$	16,177
Rate(s) includes Commissions of			0.00%
Annual Aggregate Deductible		\$	2,676,079
Minimum Aggregate Deductible		\$	2,408,471
Run In / Out Limited To		\$	401,412
Monthly Aggregate Claim Factors	<u>Enrollment</u>		
<u>Medical</u>			
Single	157	\$	285.19
Family	117	\$	1,002.44
Composite	274	\$	591.46
<u>Rx Card</u>			
Single	157	\$	131.56
Family	117	\$	344.37
Composite	274	\$	222.43
<u>Total</u>			
Single	157	\$	416.75
Family	117	\$	1,346.81
Composite	274	\$	813.89

Required fees for services not part of the excess loss rates illustrated above and performed by:

MATRIX RMS Fees per Emplo	\$	7.50
---------------------------	-----------	-------------

CONDITIONS

We are pleased to present you with the attached proposal for Excess Loss Reinsurance Coverage provided for City of San Luis . Our proposed excess loss coverage including rates and terms of coverage is subject to modification based upon receipt and review of the following information:

1C Enrollment information up to the proposed Effective Date of coverage.

2C The proposed excess loss coverage requires minimum participation of 60% of the eligible group.

3C Actively at work provisions have been waived subject to Underwriter approval of signed complete Disclosure Statement.

4C Non-disclosure of any individual who should have been identified on the Disclosure Statement, on which the Company relies, or the incomplete or inaccurate disclosure of his/her true medical condition, may result in having this individual's claims being excluded from or limited in the calculation of the Aggregate and Specific Benefit.

5C This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the issuing carrier from providing insurance, including, but not limited to, the payment of claims.

6C If we have not received the Signed Plan Document and all Amendments within 60 days after the proposed effective date, we reserve the right to refund all premiums received, and the application will be null and void when signed. Therefore, coverage is not effective until receipt and acceptance of the signed plan document and all amendments.

7C If the proposal is accepted by the Plan Sponsor, please refer to the last page of this proposal.

QUALIFICATIONS

--This proposal is offered using our PLATINUM risk model initiated in 2001. This product is not a contractual provision or guarantee. This program strives to provide plan sponsors renewal minimum rate increases with maximum rate caps. Ongoing known cost specific claims will be semi pooled. References are available. Matrix RMS reports and consultative support will work proactively with the Plan Sponsors, and applicable parties. Matrix RMS is a separate fee for service company and required with the PLATINUM program. Matrix offers two other product platforms that differ in initial rating and renewal underwriting approach.

--This proposal requires employer due diligence report to identify employees on COBRA, FMLA, extended sick leave or short term disability, worker's compensation, or any other form of leave of absence, or who are known or believed to have an ongoing medical condition or to be pregnant.

--Rates and/or factors may be recalculated if the number of Covered Units under the Plan increases or decreases by 15% from the number of Covered Units on the first day of the Contract Period or by 15% in any Contract Month.

--Aggregate Run In is limited to 15% of the Aggregate Attachment Point.

--Aggregate factors may be recalculated if the average claims in the last 3 months of the current plan period vary by more than 10% from the information provided with the initial request for proposal.

--This contract is based on the utilization of the Blue Cross Blue Shield of Arizona and Siamed PPOs, for In-Network and Out-of-Network benefits that apply according to plan.

--This proposal requires MATRIX Risk Management Services, LLC as the LCM Oversight program.

--Marketing, sales, distribution activities and administrative support services are provided by, and at the expense of, U.S. Group & Pension, L.L.C. (USGP) and/or Arizona Benefits on behalf of MATRIX Group Benefits, LLC. USGP and Arizona Benefits may receive compensation for these services from Matrix Group Benefits, LLC. If you have any questions regarding this arrangement, please contact Matrix Group Benefits, LLC.

MATRIX RISK MANAGEMENT SERVICES

Matrix Risk Management Services, LLC (Matrix RMS) program is referenced within the body of the Excess Loss Reinsurance proposal by Matrix Group Benefits, LLC. It is listed within the Proposal because Matrix RMS is a completely separate fee for service company that is a required Qualification of a Matrix Group Benefits' Excess Loss Reinsurance proposal. Matrix RMS services may, be purchased independently from the Excess Loss Reinsurance when such services are desired by Plan Sponsor's.

The Plan Sponsor hereby accepts the services and support offered and provided by Matrix RMS and authorizes and directs its contracted service providers for:

- 1) medical utilization review, pre-admission certification, prior authorization, concurrent review discharge planning, outpatient service review, and medical case management; and
- 2) claims administration; and
- 3) prescription benefit management; and
- 4) disease management and wellness programs

to provide Matrix RMS with information on a regular monthly basis as requested by Matrix RMS and agrees to consider accessing and utilizing specialty service providers identified by Matrix RMS for oversight of a potentially catastrophic medical claims and review of provider bills that represent significant charges that can be expected to accumulate to over \$ 50,000.00, prior to their payment.

Resource assistance provided by Matrix RMS includes accessing a variety of specialty resources firms that provide services such as:

- 1) Neonatal case management and bill review, including accuracy of bill, appropriateness of coding and charges, and negotiation of allowable amounts;
- 2) Hemophilia case management and support services including drug acquisition for blood disorders;
- 3) Review of large hospital bills for accuracy of bill. Appropriateness of coding and charges, negotiation of allowable amounts and negotiation of patient specific discounts. Reviews of this scope require the UB -92 bill summary, the itemized billing statement and information related to the nature and amount of potential contract adjustments related to PPO's ;
- 4) Transplant networks for potential organ transplant cases;
- 5) Complete claim processing and payment audit for plan sponsor's to determine incorrect payments and recover overpayments;
- 6) Oncology case management and support services including chemotherapy drug acquisition for administration in outpatient settings.
- 7) Dialysis management program; and
- 8) Preferred PBM resources with participant education programs based on medical conditions to improve medication management outcomes

Charges for the services provided by these specialty resource companies are paid by the Plan Sponsor as part of the participant's claim and will be reimbursed by the medical stop loss contract if the benefit amount for the claimant exceeds the specific stop loss deductible amount in the contract of the Plan Sponsor. Matrix RMS makes these firms available to the Plan Sponsor and its contracted service providers to assist the Plan Sponsor in the management of its Plan. Matrix RMS is not compensated by these firms.

Matrix RMS will also provide the following services:

- 1) Administration of the Loss Adjustment Program, (a pre-approved Matrix Group Benefits, LLC program) that provides funds to Plan Sponsors to contract for independent specialists /consultants, Independent Review Organization (IRO's) or other resource services deemed necessary and appropriate by the Plan Sponsor to help make final adjudication decisions;
- 2) Administration of ICD-10 or ICD-9 notification information at the medical management level with follow up to identify the services being provided to a plan participant;
- 3) Directions for and assistance with completion of the employer due diligence disclosure process;
- 4) Assistance with out of network / state provider contracting on a patient specific basis;
- 5) Assistance with identification and contracting specialty hospitals / "centers of excellence" on a patient specific basis;
- 6) Administration of a management review process for coordination of medical management and claim adjudication processes for potential and actual large claims;
- 7) Assistance in the coordination of Risk Assessments with medical management processes and the receipt of Consent (when needed)for the use of Protected Health Information (PHI);
- 8) Access to any of the Excess Loss carriers' provider agreements and comparison of agreements for proposed providers of service.

The Risk Management Program does not:

- 1) Provide direct consulting to the Plan Sponsor or its employee benefit plan;
- 2) Provide pre-adjudication decisions or advice to administrators related to the Excess Loss contract;
- 3) Make medical decisions, financial decisions or perform medical review functions;
- 4) Replace other contracted services or adjudication services or consultants.

City of San Luis
Print Plan's Legal Name

City of San Luis
Company's Legal Name

By _____
(Officer's Signature)

Date _____

Print Name _____

Title _____

I have read all pages of this proposed excess loss coverage. I understand excess loss coverage is not effective until we provide all information required and an application is approved. Plan Sponsor appoints person named below as its authorized agent.

Applicant's Appointed Agent Susan Posada
Print Agent Name

Appointed Agency Name & Address Susan Posada Agency, Inc.
Print Agency Name

17 West Vernon Avenue Unit 105
Address

Phoenix, AZ 85012
City, State, Zip Code

** Please attach valid license (Insurance Agency and Agent) for appropriate state.

THIS IS NOT A CONTRACT OR BINDER OF INSURANCE

The persons presenting this proposal for excess loss coverage to the Plan Sponsor are agents of the Plan Sponsor and not of the insurer, reinsurer, or MGU. This proposal for excess loss coverage is non-occupational and the Excess Loss Policy will be issued when all required information has been submitted.

Applicant, its broker and/or TPA, being Agent of the Applicant, understand and expressly agree that all information material to the risk of insuring the Plan is under their control and is part of the inducement and consideration offered for coverage, and warrant that such information will be accurate in all material respects. MGU And Carrier will rely on the accuracy of the information in underwriting and setting rates and factors for the excess loss coverage applied for. Accordingly, the application is part of the contract. If we later learn of any material inaccuracy in such information, or failure or refusal to disclose any such information, including all claims or possible claims which you should know about, we may reject a claim to which such information applies, reject the application, change the terms, conditions, or premium rates and factors, or void coverage.

MONTHLY PREMIUM STATEMENT

FOR THE MONTH OF _____

NAMED INSURED: City of San Luis POLICY NUMBER: EL116-3307012023
 ADMINISTRATOR: Healthcomp, LLC
 POLICY PERIOD: July 1, 2023 through June 30, 2024 CHECK NUMBER: _____

A. SPECIFIC PREMIUM

	# Current Units	Adjust- Ments +/-	=	Total Units	X	Premium Rate	=	Gross Premium
Employee	_____	_____	=	_____	X	\$103.95	=	_____
Family	_____	_____	=	_____	X	\$332.48	=	_____
Composite	_____	_____	=	_____	X	\$201.54	=	_____

B. AGGREGATE PREMIUM

	# Total Units	X	Monthly Premium Rate	=	Gross Premium
Composite	_____	X	\$4.92	=	_____

C. TOTALS OF A & B ABOVE

Gross
Premium

<u>Matrix Risk Management Services Fee</u>	# Total Units	X	Monthly Fee per Unit	=	Total Fee Amount
Composite	_____		\$7.50		_____

Authorized Signature: _____ Date: _____

Mail this form with premium to:

Fidelity Security Life Insurance Company
 c/o MATRIX Group Benefits, LLC
 190 U.S. Route One PMB 365
 Falmouth, Maine 04105
 Phone: (207) 523-8408 Fax: (207) 846-8834

**Premium payments are due in advance on the first of each month.
 Premium payments not received by the end of the month will expose the Policy to the Termination Provision.**



FIDELITY SECURITY LIFE INSURANCE COMPANY
 3130 Broadway
 Kansas City, Missouri 64111

**APPLICATION FOR
 EXCESS LOSS
 REIMBURSEMENT INSURANCE**

GENERAL INFORMATION

1. Full Legal Name of Applicant: City of San Luis
 Address of Applicant: 1090 East Union Street
 City: San Luis State: AZ Zip Code: 85349
2. Type of Entity: Corporation Labor Union
 Partnership Association
 Limited Liability Co. Trusteeship
 Proprietorship Other: _____
3. Requested Effective Date: July 1, 2023
4. Other Locations: _____
5. **Primary Contact at Applicant:** _____
6. Full Legal Name of Subsidiary or Affiliated Companies to be included: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
7. Nature of Applicant's Business: Executive & Legislative Combined SIC Code: 9131
8. Full Name of Applicant's Plan: City of San Luis Employee Benefit Trust
 (A signed copy of such Plan must be attached to this Application.)
9. Name and Address of Plan Administrator or Third Party Administrator: Healthcomp, LLC
 Address: 621 Santa Fe Ave
 City: Fresno State: CA Zip Code: 93721
 Social Security No. or Tax ID: _____ Phone Number: (559)499-2450
10. Name and Address of Writing Agent: Susan Posada Agency, Inc. / Susan Posada
 (Attach a current copy of license(s) if not on file.) **Copy on File**
 Address: 17 West Vernon Avenue Unit 105
 City: Phoenix State: AZ Zip Code: 85012
 Social Security No. or Lic No: 2679435 Phone Number: (602)212-9400
11. Estimated initial enrollment:
 Employee/Member 157
 Family 117
 Employee/Member (Composite) 274
12. Other Covered Persons included in your Plan:

	Yes	No	Covered Units
Retired Employee/Member	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
COBRA Beneficiaries	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
Disabled Persons	<input checked="" type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
13. Actively At Work Limitation: Waived Applied
14. Deposit Premium: None

SPECIFIC EXCESS LOSS INSURANCE: Yes No

1. Plan Benefit Payments included in Your Plan to be covered by Specific Excess Loss Insurance:
 Medical Prescription Drug Expenses Other(s) _____
 Dental Vision
2. Contract Basis: 24 / 12 Covered Expenses Incurred from 07/01/2022 through 06/30/2024
Paid from 07/01/2023 through 06/30/2024
3. Run-in Period claims Incurred prior to the Effective Date will be limited to: \$ Not Applicable
4. Specific Deductible (per Covered Person): \$ 50,000
Specific Deductible/Contract Basis for the following Covered Persons: _____
\$ 185,000
5. Specific Reimbursement Maximum per Contract Period: \$ Unlimited
(per Covered Person excess of Specific Deductible)
6. Specific Percentage Reimbursable (excess of Specific Deductible): 100%
7. Aggregating Specific Deductible: Yes No
If Yes, the Aggregating Specific Deductible is: \$ Not Applicable
8. Terminal Specific Liability: Yes No
If Yes, the Monthly Terminal Specific Liability Premium (per Covered Person): \$ Not Applicable
9. Specific Monthly Premium Rates:
Employee/Member \$ 103.95
Family \$ 332.48
Employee/Member (Composite) \$ 201.54

AGGREGATE EXCESS LOSS INSURANCE: Yes No

1. Plan Benefit Payments included in Your Plan to be covered by Aggregate Excess Loss Insurance:
 Medical Prescription Drug Expenses Other(s) _____
 Dental Vision
2. Contract Basis: 24 / 12 Covered Expenses Incurred from 07/01/2022 through 06/30/2024
Paid from 07/01/2023 through 06/30/2024
3. Run-in Period claims Incurred prior to the Effective Date will be limited to: \$ 401,412
4. Minimum Aggregate Annual Deductible: \$ 2,408,471
5. Aggregate Reimbursement Maximum (excess of Aggregate Annual Deductible): \$ 1,000,000
6. Aggregate Percentage Reimbursable (excess of Aggregate Annual Deductible): 100%
7. Aggregate Monthly Factor(s):
- | | <u>Medical</u> | <u>Dental</u> | <u>Vision</u> | <u>Prescription Drug</u> | <u>Total</u> |
|-----------------------------|--------------------|---------------|---------------|--------------------------|--------------------|
| Employee/Member | \$ <u>285.19</u> | \$ <u>N/A</u> | \$ <u>N/A</u> | \$ <u>131.56</u> | \$ <u>416.75</u> |
| Family | \$ <u>1,002.44</u> | \$ <u>N/A</u> | \$ <u>N/A</u> | \$ <u>344.37</u> | \$ <u>1,346.81</u> |
| Employee/Member (Composite) | \$ <u>591.46</u> | \$ <u>N/A</u> | \$ <u>N/A</u> | \$ <u>222.43</u> | \$ <u>813.89</u> |
8. Loss Limit (per Covered Person): \$ 50,000
9. Terminal Aggregate Liability Option: Yes No
If Yes, Monthly Terminal Aggregate Liability Premium (per Covered Person): \$ Not Applicable
10. Monthly Aggregate Accommodation Option: Yes No
If Yes, Monthly Aggregate Accommodation Premium (per Covered Person): \$ Not Applicable
11. Monthly Aggregate Premium Rate (per Covered Person): \$ 4.92

MEDICAL DATA

The Company will rely on the data below to assist in approving the Application and underwriting the Contract. Note that without the Company's review and approval of each risk, the Applicant's Losses will not be reimbursable under the Excess Loss Reimbursement Contract; therefore, please answer the following questions:

1. Has an eligible employee/member or dependent received or is such individual expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? Yes No

2. Will any former employee/member or dependent be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? Yes No

If Yes to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign and date a separate sheet if needed):

Name: _____ DOB: _____ Sex: Male Female Status: _____
 (Ee/Mbr, Dep, COBRA, Retiree)

Diagnosis: _____
 Prognosis: _____
 Amount of Claim(s): _____

3. Are expected benefits available from the prior insurer for presently disabled eligible employees/ members and/or dependents? Yes No

4. Are any eligible employees/members or dependents presently disabled or confined in a hospital or similar facility? Yes No

Please explain any "Yes" answers to questions 3 or 4 (Please attach, sign and date a separate sheet if needed):

SPECIAL CONDITIONS/LIMITATIONS: _____

See attached Disclosure Statement.

The contract is based on the utilization of the Blue Cross Blue Shield of Arizona and Siamed PPOs, for In-Network and Out-of-Network benefits that apply according to plan.

Aggregate Run In is limited to 15% of the Aggregate Attachment Point.

SIGNATURE

Application is hereby made for Specific and/or Aggregate Excess Loss Insurance through Fidelity Security Life Insurance Company ("Company"). This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

It is understood and agreed by the Applicant that:

1. the Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;
2. the Plan Administrator or Third Party Administrator retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent;
3. all documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within 90 days of the Effective Date;
4. the Company will evaluate the Applicant's risk, and may require adjustments of rates, factors, deductibles and/or Special Limitations to accommodate for abnormal risks;
5. premiums are not considered paid until the premium check or transfer is received by the Company and at the rates set forth in the Schedule;
6. this Application will be attached to and made a part of any Excess Loss Reimbursement Contract issued by the Company in connection with this Application;
7. the Applicant's Plan Document shall be the basis of any Excess Loss Insurance Reimbursement provided by the Company and such Plan Document conforms with applicable state and federal laws;
8. any reimbursement under the Excess Loss Reimbursement Contract provided by the Company shall be based on eligible Plan Benefits Paid in accordance with the Plan Document;
9. claims under the Plan Document for any employee/member who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such employee/member returns to active, full-time employment for at least one full working day;
10. unless otherwise indicated above, claims under the Plan Document for any Covered Person who is confined in a medical facility on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such person is discharged from the hospital or similar facility; and

Application and Authorization for Services by MATRIX Risk Management Services, LLC

Plan Sponsor/Client: City of San Luis Effective Date: July 1, 2023

Application is hereby made to MATRIX Risk Management Services, LLC for services provided by MATRIX Risk Management Services, LLC.

1) Full Legal Name of Applicant: City of San Luis

2) Address: 1090 East Union Street San Luis, AZ 85349

3) Full name of Employee Benefit Plan: City of San Luis Employee Benefit Trust

4) Name, address, and contact person for the Designated Medical Management Firm (Utilization Firm):
Healthcomp, LLC 621 Santa Fe Ave. Fresno, CA 93721

5) Name, address, and contact person for the Claim Administrator for the Employee Benefit Plan:
Healthcomp, LLC 621 Santa Fe Ave. Fresno, CA 93721

6) Estimated enrollment for the Employee Benefit Plan and MATRIX RMS fee:

MATRIX RMS PEPM FEE: \$7.50

TOTAL ENROLLED: 274

RISK MANAGEMENT SERVICES

The Plan Sponsor hereby accepts the services and support offered and provided by MATRIX Risk Management Services, LLC (MATRIX RMS) and authorizes and directs its contracted service providers for:

- 1) Medical utilization review, pre-admission certification, prior authorization, concurrent review discharge planning outpatient service review, and medical case management; and
- 2) Claims administration; and
- 3) Prescription benefit management; and
- 4) Population health, disease management and wellness programs

to provide MATRIX RMS with information on a regular basis as requested by MATRIX RMS and to access specialty service providers identified by MATRIX RMS for the medical oversight of a potentially catastrophic medical claims and review of provider bills prior to their payment, that represent significant charges that can be expected to accumulate to over 50% of the specific deductible or \$50,000.00, whichever is less.

Resource assistance provided by MATRIX RMS includes accessing a variety of specialty resource firms that RMS has established relationships with for our clients, such as:

- 1) Neonatal case management and bill review, including accuracy of bill, appropriateness of coding and charges, and negotiation of allowable amounts;
- 2) Gene and cellular therapy services including, but not limited to, CAR-T and Hemophilia drug acquisition, preferred pricing and treatment through an access agreement with Emerging Therapy Solutions (ETS);
- 3) Review of large hospital bills for accuracy of bill, appropriateness of coding and charges, negotiation of allowable amounts and negotiation of patient specific discounts. Reviews of this scope require the UB-92 bill summary, the itemized billing statement and information related to the nature and amount of potential contract adjustments related to PPO's contracted by the Plan or on a per patient claim basis;
- 4) Access to national transplant networks including INTERLINK, LifeTrac, LifeSource and Optum for potential organ transplant cases;
- 5) Oncology treatment oversight and collaboration with treating Oncologist's and patient support services through the INTERLINK CancerCARE program, including drug review;
- 6) Dialysis management programs.

Initials _____

Application and Authorization for Services by MATRIX Risk Management Services, LLC

Charges for the services provided by these specialty resource companies for specific patient claim situations are paid by the Plan Sponsor as part of the participant's claim and will be considered for reimbursement by the medical stop loss contract if the benefit amount for the claimant exceeds the specific stop loss deductible amount in the contract of the Plan Sponsor. Services that are contracted on an annual basis and paid on a PEPM basis are administrative expenses and are not considered claim expenses.

MATRIX RMS makes these firms available to the Plan Sponsor and its contracted service providers to assist the Plan Sponsor in the management of its Plan. MATRIX RMS is not compensated by these firms.

MATRIX RMS will also provide the following services:

- 1) Coordination and oversight of specialty resource services recommended by RMS and selected by a Plan Sponsor;
- 2) Administration of the Loss Adjustment Program, (a pre-approved MATRIX Group Benefits, LLC program) that provides funds to Plan Sponsors to contract for independent specialists /consultants, Independent Review Organization (IRO's) or other resource services deemed necessary and appropriate by the Plan Sponsor to help make final adjudication decisions;
- 3) Administration of ICD-10 notification information at the medical management level with follow up to identify the services being provided to a plan participant;
- 4) Directions for and assistance with completion of the employer due diligence disclosure process;
- 5) Assistance with out of network / state provider contracting on a patient specific basis;
- 6) Assistance with identification and contracting specialty hospitals / "centers of excellence" on a patient specific basis;
- 7) Administration of a management review process for coordination of medical management and claim adjudication processes for potential and actual large claims;
- 8) Assistance in the coordination of Business Associate Agreements (BAA) to obtain medical claim information for disclosure and underwriting when necessary.

The Risk Management Program does not:

- 1) Provide direct consulting to the Plan Sponsor or its employee benefit plan;
- 2) Provide pre-adjudication decisions or advice to administrators related to the Excess Loss contract;
- 3) Make medical decisions, financial decisions or perform medical review functions;
- 4) Replace or duplicate other contracted services or adjudication services or consultants;
- 5) Contact plan participants.

Plan Sponsor/Client: City of San Luis hereby authorizes MATRIX Risk Management Services, LLC to obtain protected health information ("PHI") for the purpose of completing the services provided by this agreement.

The MATRIX Risk Management Program IS NOT a risk bearing program or a component of an excess loss rate but may be required by an excess loss carrier and is a required component of all MATRIX Group Benefits, LLC underwritten Excess Loss Proposals.

Acceptance of this MATRIX Risk Management Program Proposal is made this _____ day/Month of _____ by:

Signed: _____

Name: _____

Title: _____

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is entered into on July 1, 2023 between MATRIX Risk Management Services, LLC (the "Business Associate") and City of San Luis, (the "Covered Entity").

RECITALS

Because the Covered Entity will make available and/or disclose to the Business Associate certain Protected Health Information (as defined below), in order to facilitate services that are being provided between the Business Associate to the Covered Entity; and

Because the Business Associate will have access to and/or receive from the Covered Entity certain Protected Health Information (as defined below), that can be used or shared only in compliance with this Agreement and the HIPAA Rules (as defined below).

The Covered Entity and Business Associate agree as follows:

I. Definitions.

The below capitalized terms shall have the following meaning in this Agreement:

- a. "Breach" shall mean the unauthorized acquisition, access, use or disclosure of Unsecured Protected Health Information (as defined below), which compromise the security or privacy of such information.
- b. "Designated Record Set" shall mean a group of records maintained by the Covered Entity that is either; (1) the medical records and billing records about individuals maintained by or for a covered health care provider; (2) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (3) used in part by or for the Covered Entity to make decisions about an Individual.
- c. "HIPAA Rules" shall mean the Privacy, Security, Notification, and Enforcement Rules at 45 CFR Part 150 and Part 164.
- d. "HHS Privacy Regulations" shall mean the Code of Federal Regulations ("CFR.") at Title 45, Sections 160 and 164.
- e. "Individual" shall mean the person who is the subject of the information, and has the same meaning as the term "individual" as defined by 45 CFR Section 164.501.
- f. "Parties" shall mean the Business Associate and the Covered Entity.

- g. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as amended by the HITECH Act.
- h. "Protected Health Information" shall have the same meaning as the term is defined in 45 CFR Section 160.103, but is limited to any such information created or received by the Business Associate from or on behalf of the Covered Entity.
- i. "Required by Law" has the same meaning as this term has in 45 CFR § 164.501.
- j. "Secretary" shall mean United States Department of Health and Human Services ("HHS") or his designate.
- k. "Unsecured Protected Health Information" shall mean Protected Health Information that is not secured through the use of technology or methodology specified by the Secretary in regulations or as otherwise defined in the §13402(h) of the HITECH Act.

Any term not defined in this Agreement but having a specific definition within the HHS Privacy Regulations shall have throughout this Agreement the meaning attributed to that term in the HHS Privacy Regulations. Further, any prospective amendment to the laws referenced in this definitional section prospectively amend this Agreement to incorporate said changes by congressional act or by regulation of the Secretary of HHS.

II. Relationship of the Parties.

The relationship of the Covered Entity and the Business Associate is that of independent contractors. All acts performed by the Business Associate shall be deemed to be performed in its capacity as an independent contractor.

III. Term.

The term of this Agreement shall begin **July 1, 2023** (the "Effective Date"), and shall terminate as provided in Articles VII and VIII.

IV. Limits on Use and Disclosure Established by this Agreement.

In carrying out this Agreement, the Business Associate agrees to comply with the HIPAA Rules. Therefore, the Business Associate agrees that it shall not use or disclose Protected Health Information, except as permitted or required by this Agreement or required by applicable law.

V. Permitted Disclosure by the Business Associate.

The Business Associate may use or disclose Protected Health Information for the following purpose(s):

- a. Use of Information for Management, Administration and Legal Responsibilities: The Business Associate is permitted to disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate.
- b. Sharing of Information for Management, Administration and Legal Responsibilities: The Business Associate is permitted to disclose Protected Health Information for the proper management and administration. Specifically, when the disclosure is required by law or the Business Associate obtains reasonable promises from the person to whom the Protected Health Information is disclosed that it will be kept private and used or disclosed only as required by law or for the purposes for which it was disclosed. In such a case, the person will immediately notify the Business Associate if it is discovered that the confidentiality of the information is broken.
- c. Additional Activities of Business Associate: In addition, the Business Associate may combine the Protected Health Information with the information the Business Associate received by the Business Associate in its capacity as a business associate of other covered entities if the purpose of combining the information is to provide the Covered Entity with data analysis relating to the health care operations of the Covered Entity. The Business Associate may not share Protected Health Information of one covered entity with another covered entity without proper permission.

VI. Responsibilities of the Business Associates.

- a. Proper Safeguards: The Business Associate shall maintain proper safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information in order to prevent any use or disclosure of Protected Health Information not permitted or required by this Agreement.
- b. Reports of Improper Use or Disclosure: The Business Associate shall report to Covered Entity within two (2) days of learning about any use or disclosure of Protected Health Information not permitted or required by this Agreement.
- c. Subcontractors and Agents: Business Associate agrees that any time Protected Health Information is provided or disclosed to any subcontractors or agents, the Business Associate shall enter into a subcontract with the subcontractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of Protected Health Information as in this Agreement.
- d. Right of Access to Information: The Business Associate shall provide the Covered Entity with a right of access to any Protected Health Information within five (5) days of such request. In the event an Individual requests the Business Associate provide access to Protected Health Information, then the Business Associate shall contact Covered Entity and advise Covered Entity of the request. If Covered Entity determines that the Business Associate holds Protected Health Information in a Designated Record Set and the Individual is to be granted

access to the Protected Health Information, then the Business Associate shall cooperate with the Covered Entity to provide the Individual with the Protected Health Information requested. Further, if the Designated Record Set is available electronically and the Individual requests an electronic copy, then the Business Associate must provide access to the Covered Entity in the electronic form and format requested by the Individual, if it can be readily produced in that form. The Business Associate shall take no direct action on any Individual's request for access to Protected Health Information before notifying the Covered Entity and receiving instructions from the Covered Entity.

- e. **Making and Including Changes:** The Business Associate shall amend any Protected Health Information as requested by the Covered Entity. In the event an Individual requests the Business Associate to amend Protected Health Information, then the Business Associate shall contact the Covered Entity and advise the Covered Entity of the request. If the Covered Entity determines that the Business Associate holds Protected Health Information in a Designated Record Set and the Protected Health Information regarding the Individual is to be amended, then the Business Associate shall cooperate with the Covered Entity to amend the Protected Health Information. The Business Associate shall take no direct action on any Individual's request for amendment to Protected Health Information before notifying the Covered Entity and receiving instructions from the Covered Entity.
- f. **Provide Accounting:** The Business Associate shall maintain documentation of any disclosures of Protected Health Information made by the Business Associate as may be required to facilitate the Covered Entity's response to an Individual's request for an accounting of disclosures in accordance with 45 CFR Section 164.528. The Business Associate shall, within ten (10) days of a request from the Covered Entity, provide the Covered Entity with the information collected in accordance with this paragraph.
- g. **Performance of Covered Entity's Obligations:** To the extent, the Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.
- h. **Access to Books and Records:** The Business Associate agrees to make its internal practices, books, and records relating to use or disclosure of Protected Health Information, available to the Secretary for purposes of determining the Covered Entity's compliance with the HIPAA Rules.
- i. **Procedures to Reduce Damage:** The Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to the Business Associate and that arises from a use or disclosure of Protected Health Information by the Business Associate that is contrary to the provisions of this Agreement.

- j. Property Rights: The Protected Health Information is the sole and exclusive property of the Covered Entity. The Business Associate agrees that it has no ownership rights to the Protected Health Information.
- k. Obligations in Event of a Breach: In the event, the Business Associate commits a Breach, the Business Associate must notify the Covered Entity of the Breach in writing no later than ten (10) days after discovery of the breach. For purposes of this Agreement, a Breach will be deemed to be discovered on the earlier of the date the Breach first becomes known to the Business Associate or the date the Breach would have been known if the Business Associate exercised reasonable diligence. The written notice of the Breach must include a brief description of what happened (including the dates of the breach and its discovery), the types of Unsecured Protected Information involved, and what the Business Associate is doing to mitigate losses and protect against any further breaches.

VII. Material Breach or Violation of this Agreement.

If the Covered Entity knows of a material breach or violation by the Business Associate of this Agreement, the Covered Entity shall take reasonable steps to cause the breach to be cured or the violation to end. Those reasonable steps shall include written notification to the Business Associate of the exact material breach or violation and thirty (30) days to cure the material breach or violation. If the Covered Entity is unsuccessful in its efforts to obtain a cure or stop the violation within thirty (30) days of sending written notice of the material breach or violation to the Business Associate, the Covered Entity shall terminate this Agreement. The Business Associate specifically authorizes termination of this Agreement by the Covered Entity, if the Covered Entity determines the Business Associate has violated a material term of the Agreement and the Business Associate has not cured the breach or ended the violation within thirty (30) days of receiving written notice of the material breach from the Covered Entity. If termination is not feasible, the Covered Entity must report the material breach or violation to HHS. Upon notifying HHS, the Covered Entity shall provide the Business Associate with copy of its notification. The foregoing requirements equally apply if the Business Associate knows of a material breach or violation by the Covered Entity of this Agreement.

VIII. Termination of Agreement.

- a. Either party may terminate this Agreement upon thirty (30) day written notice.
- b. The Business Associate shall return or destroy all Protected Health Information, including any Protected Health Information in the possession of subcontractors or agents to the Business Associate. The Business Associate shall retain no copies of Protected Health Information. If the Business Associate determines that returning or destroying the Protected Health Information is not feasible, then the Business Associate shall provide the Covered Entity with a notice explaining the conditions that make return or destruction infeasible. The Business Associate shall then extend all the terms of this Agreement to such Protected Health Information for so long as the Business Associate maintains such Protected Health Information and shall limit further uses of such Protected

Health Information to those purposes that make return or destruction infeasible. The obligations of the Business Associate under this Section VII (b) shall survive the termination of this Agreement.

IX. Indemnification.

The Business Associate hereby indemnifies and holds Covered Entity harmless for, from and against all claims, demands, losses, damages, expenses and costs, including, but not limited to, reasonable attorneys' fees and expenses actually incurred, arising out of or in connection with the Business Associate's failure to observe, perform and discharge the Business Associate's obligations and responsibilities under this Agreement. Similarly, the Covered Entity hereby indemnifies and holds Business Associate harmless for, from and against all claims, demands, losses, damages, expenses and costs, including, but not limited to, reasonable attorneys' fees and expenses actually incurred, arising out of or in connection with the Covered Entity's failure to observe, perform and discharge the Covered Entity's obligations and responsibilities under this Agreement.

X. Notices.

Any notice or other communication required or permitted hereunder shall be in writing, shall be marked as confidential, and shall be deemed given and effective when: (a) delivered personally or (b) three (3) days after the postmark date if mailed by certified or registered mail, postage prepaid, return receipt requested, if to the Covered Entity, addressed to it in care of the Covered Entity's signatory to this Agreement at the address stated below his signature hereto, and if to the Business Associate, addressed to it at the address stated below its signature, or to such other address as such party may designate from time to time in a written notice to the other party or parties in accordance with the provisions of this Article X.

XI. Entire Agreement.

This Agreement constitutes the entire agreement between the Parties hereto relating to the disclosure and protection of Protected Health Information and Unsecured Protected Health Information and supersedes all prior oral and written agreements, negotiations, commitments and understandings of the Parties with respect to the contractual relationship between the parties.

XII. Amendment.

This Agreement may not be changed or amended except by writing executed by all the Parties.

XIII. Binding Effect, Assignment and Third Party Beneficiaries.

This Agreement shall be binding upon and injure to the benefit of the Parties and their heirs, legal representatives, successors and assigns (to the extent this Agreement is assignable). The Business Associate may not assign this Agreement or delegate any duties hereunder without the prior written consent of the Covered Entity. The Covered Entity may assign any of its rights

or benefits under this Agreement, in its sole discretion, to any affiliate, assignee or successor in interest, and such persons and entities shall have the same rights and assume the obligations of the Covered Entity hereunder. The Parties do not intend this Agreement to create any third party beneficiaries, including individuals who are subject of Protected Health Information.

XIV. Choice of Law.

This Agreement shall be governed by and construed in accordance with the laws of the State of Arizona, but without regard to those provisions in the law which construes ambiguities against the drafter and without regard to conflict of laws rules.

XV. Jurisdiction and Venue.

The Parties stipulate that jurisdiction shall lie exclusively in the Superior Court of Maricopa County, Arizona for any action arising from this Agreement including, but not limited to issues involving the validity, interpretation or enforcement of the Agreement. They expressly consent to the jurisdiction and venue of such Court.

XVI. Proceeding Expenses.

In any controversy, claim or dispute arising out of, or relating to, this Agreement the prevailing, party, as determined by the court (or as applicable the mediator, arbitrator, etc.), shall be entitled to and shall award, in addition to any other relief, proceeding expenses. If neither party wholly prevails, the party that substantially prevails, as determined by the court (or as applicable the mediator, arbitrator, etc.), shall be awarded proceeding expenses. In determining the award of proceeding expenses, attorneys' fees, proceeding costs, costs of investigation and other reasonable expenses shall be included. For the purposes of this provision, the term "proceeding," shall include mediation, arbitration, administrative, bankruptcy and judicial proceedings, including appeals therefrom.

XVII. Severability.

If any one or more of the provisions of this Agreement shall be held invalid, unenforceable or void, the remainder of this Agreement shall remain in full force and effect.

XVIII. Counterparts.

This Agreement may be executed and delivered in one or more counterparts, each of which when executed and delivered shall be an original, and all of which when executed shall constitute one and the same instrument. The exchange of copies of this Agreement and of signature pages by facsimile or other electronic transmission shall constitute effective execution and delivery of this Agreement as to the Parties and may be used in lieu of the original Agreement for all purposes. Signatures of the Parties transmitted by facsimile or other electronic means shall be deemed to be their original signatures for all purposes.

EXECUTED as of the date first set forth above.

"Covered Entity"

City of San Luis

By: _____

Print Name: _____

Title: _____

Address: 1090 East Union Street

San Luis, AZ 85349

"Business Associate"

MATRIX Risk Management Services, LLC

By: _____ 

Print Name: Timothy J. Paradis

Title: Chief Financial Officer

Address: 190 U.S. Route One, PMB 365

Falmouth, ME 04105

DISCLOSURE STATEMENT

GROUP NAME: City of San Luis

Participant(s) shall include active employees, COBRA beneficiaries, retirees and their dependents.

1. Please list any **Participant** who has paid or pending claims equal to or greater than \$10,000 (for specific deductible levels up to \$50,000) or equal to or greater than 50% of the specific deductible (for specific deductible levels in excess of \$50,000) during the past 12 months or could reasonably be expected to have claims in excess of this amount in the next 12 months.

<u>Participant</u>	<u>Diagnosis</u>	<u>Amount Paid/Pended/Expected</u>	<u>Prognosis/Status</u>
---------------------------	-------------------------	---	--------------------------------

See the attached report(s):

2. Other than those **Participants** listed above, regardless of amount paid and/or pended, please list any **Participant** known to have multiple hospital admissions with the same diagnosis or any "serious condition", including but not limited to, Cardiovascular Conditions; Chronic Respiratory Conditions; AIDS and AIDS related Conditions; Neurological Conditions (including, but not limited to, ALS, Idiopathic Polyneuropathy, Guillain Barre, Multiple Sclerosis (MS), Cystic Fibrosis, Rey's Syndrome, Meningitis, or Encephalitis); Newborns with complications; Congenital Defects; Cerebral Vascular Accident; Renal Problems (Kidney); Hepatitis C; Cancer or history of Cancer; Accidents which may lead to the following: Amputations, Brain Injuries, Burns causing hospital confinement, Multiple Crushing or Fractures, Spinal Cord Injuries; or known to have or scheduled to have Organ Transplants, including Bone Marrow Transplants.

<u>Participant</u>	<u>Diagnosis</u>	<u>Amount Paid/Pended/Expected</u>	<u>Prognosis/Status</u>
---------------------------	-------------------------	---	--------------------------------

See item 1 above

3. Other than those **Participants** already listed above, please list any **Participant** who is disabled or hospital confined.

<u>Participant</u>	<u>Diagnosis</u>	<u>Date of Disability/ Admission/Expected Discharge</u>	<u>Prognosis/Status</u>
---------------------------	-------------------------	--	--------------------------------

See item 1 above

4. Are expected benefits available from the prior insurer for presently disabled **Participants**? YES NO
5. Will any former **Participant** be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? YES NO

Please explain any "YES" answers to questions 4 and 5:

Individuals who are continuing coverage under any Federal, State or local program are subject to and included in the disclosure information listed in item 1 above.

After a thorough review of the records maintained by the Employer, the Employer's Claims Payor/TPA and the Employer's utilization review, pre-certification and large case management vendors, we represent that the above information is complete and accurate to the best of our knowledge and belief. We understand that if the information is not complete and accurate, the Excess Loss coverage proposed may be reevaluated, rerated, rescinded or declined and **Participants** not disclosed may be denied coverage or individually underwritten retroactively to the Effective Date.

Plan Sponsor/Employer: City of San Luis

Claims MGA/Administrator: Healthcomp, LLC

Officer's Signature: _____

Signature: _____

Name & Title: _____

Name & Title: _____

Date: _____

Date: _____



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. C.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the approval of Run-Out Claims Process by 90 Degrees. **(Susan Posada, Broker and Consultant)**

SUMMARY:

Due to the Third-Party Administrator change, a Run-Out Claims Process is required. The run-out period refers to the period of time, immediately following termination, during which time all claims incurred prior to the termination date are being paid. Timely claims submission, determination of medical necessity, clarification of issues, and claims processing all contribute to the run-out period. 90 Degree Benefits offers 12 months of run-out claims processing for an amount equivalent to six months of current administration fees. It is recommended to have 90 Degrees to process the run-out claims since they have the accumulation of deductibles and out-of-pocket maximums.

The administrative fees for processing 12 months of run-out claims are as follows:

- \$43,299.00 for medical claims.
- \$5,058.00 for dental claims.
- \$300 for HIPAA Certificates for City Employees.
- \$2,500 run-out claims reports which includes census, deductible, and out-of-pocket reports, and benefit maximum report.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE RUN-OUT CLAIMS PROCESS BY 90 DEGREE BENEFITS, ALONG WITH ASSOCIATED FEES AS PRESENTED, AND DIRECT THE EXECUTIVE ADVISORS TO TAKE ALL STEPS TO FURTHER SUCH PROCESSING.

Fiscal Impact

Fiscal Impact:

Total fees will be \$51,157 for processing run-out claims for a period of 12 months.

Attachments

RUN-OUT CLAIMS REQUEST



7020 North Port Washington Rd.
Glendale, WI 53217
800.558.7798
90DegreeBenefits.com

April 17, 2023

Tadeo De La Hoya
City of San Luis
1090 E. Union Street
San Luis, AZ 85349

RE: City of San Luis termination of services effective July 1, 2023

Dear Tadeo

90 Degree Benefits has received notice to terminate administrative services effective July 1, 2023. We need the following information confirmed to process this request.

Run-out claims are defined as claims incurred during the plan year that have not been received and processed until after the termination date. Per the 90 Degree Benefits' service agreement, we offer 12 months of run-out for 6 months of current administration fees to process those claims. Claims that have been incurred within the plan year but are not received in this office within the run-out period will not be processed. 90 Degree Benefits will use the census count as of April 1, 2023, which is **283 medical / 281 dental**.

1. The administrative service fee to process 12 months of run-out medical claims is **\$43,299.00**.
($283 \times \$25.50 = \$7,216.50 \times 6 = \$43,299.00$).

2. The administrative service fee to process 12 months of run-out dental claims is **\$5,058.00**.
($281 \times \$3.00 = \$843.00 \times 6 = \$5,058.00$).

3. If HIPAA certificates need to be provided by 90 Degree Benefits for your employees, there will be an additional fee of **\$300.00**. The certificates will be forwarded to the City of San Luis for distribution to your employees.

4. Additional fees may apply. These additional fees may include, Multiplan wrap and any out of network claims programs. These fees will be billed separately.

5. There will be a fee of **\$2,500.00** for runout reports which includes census (already provided), deductible and out-of-pocket reports, and benefit maximum report. Additional fees may apply if IT programming is required. Month end reports will be provided for no additional charge during the run-out period.

Please note – Blue Cross Blue Shield of Arizona requires the claims account remain open for 24 months after term for any adjustments that may apply.

Below is a recap of 90 Degree Benefits Service Agreement regarding closing dates for claims processing:

Accounting Books/Closing Date/Specific Reimbursement Deductible

(a) The monthly closing Date of 90 Degree Benefits' accounting books shall be (5) business days prior to the last calendar day of the month, unless 90 Degree Benefits notifies Employer otherwise.

Please be advised that upon completion of any elected run-out period, 90 Degree Benefits will refer all calls relating to your plan back to City of San Luis. If run-out is not elected, this will occur immediately.

We will need the attached election form completed and returned to our office as soon as possible. We thank you for the opportunity to have served your organization. If we can be of further help to you, do not hesitate to contact our office.

Sincerely,
Paula Hennen
Paula Hennen – Manager of Account Executives

City of San Luis Group #: SLS001

90 Degree Benefits must receive this signed authorization as well as the elected run-out fees (if elected) prior to May 31, 2023. The amount due is \$43,299.00 for medical, \$5,058.00 for dental, \$300.00 for HIPAA certificates and \$2,500.00 for the reporting package.

If we do not receive your authorization prior to May 31, 2023, it will be assumed that 90 Degree Benefits will not be handling runout claim administration for your plan and all vendors will be notified.

City of San Luis does hereby authorize 90 Degree Benefits to process medical run-out claims for a period of 12 months for a fee totaling \$43,299.00. (283 x \$25.50 = \$7,216.50 x 6 = \$43,299.00).

City of San Luis does hereby authorize 90 Degree Benefits to process dental run-out claims for a period of 12 months for a fee totaling \$5,058.00. (281 x \$3.00 = \$843.00 x 6 = \$5,058.00)

City of San Luis requests that HIPAA certificates be provided by 90 Degree Benefits for your employees for a fee of \$300.00. The certificates will be forwarded to City of San Luis for distribution to your employees.

City of San Luis requests run out reports for an additional \$2,500.00 fee. Our standard report package includes census, deductible and out-of-pocket report, and benefit maximum report. Additional fees may apply if IT programming is required.

Processing of run-out claims is not authorized.

Please select below how run-out fees will be paid:

City of San Luis authorizes 90 Degree Benefits to add the fees selected above to their next weekly funding request.

City of San Luis will pay by check any fees selected above. Check should be made payable to 90 Degree Benefits, Inc.

Mail to - 90 Degree Benefits, Inc.
Attention: Corporate Accounting
2145 Ford Parkway, Suite 300
St. Paul, MN 55116-1912

Authorized signature

Date

cc: Susan Posada - broker



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. D.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the Service Agreement for HealthComp as the Third-Party Administrator. **(Susan Posada, Benefits Consultant).**

SUMMARY:

During the Employee Benefit Trust meeting held on April 5, 2023, the Board of Trustees approved the change of Third-Party Administrator (TPA). In addition, it was recommended to select HealthComp as the new TPA due to the extensive experience they have in administering benefits and optimizing savings.

Below is HealthComp's Claim Fee Schedule:

Administrative fees

Medical Claims Administration - \$25.00 Per Employee Per Month (PEPM)

Dental Claims Administration - \$2.50 PEPM

Plan Renewal - \$2,000 Annual fee

Implementation - \$4,000 One-time fee

Network Fees

PCHS Wrap network (out-of-state provider) - 25% of Gross Savings

SIARMED network - Medical \$3.00 PEPM and Dental \$1.50 PEPM

Care Management

Utilization review - \$3.16 PEPM

Large Case Manager - \$160.00 per hour

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE SERVICE AGREEMENT WITH HEALTHCOMP EFFECTIVE JULY 1, 2023 AS PRESENTED.

Fiscal Impact

Fiscal Impact:

Fiscal impact as shown in the summary and in the attachment.

Attachments



Your Workforce is Unique.
Your Benefits Should Be Too.



City of San Luis Employee Benefit Trust July 1, 2023 Third-Party Administration Contract

This Third-Party Administration Contract (“the Agreement”) is made by and between City of San Luis Employee Benefit Trust as Plan Sponsor and Plan Administrator (“Plan Sponsor”) and HealthComp Holding Company, LLC, and its subsidiaries including HealthComp Integrated Solutions, LLC and Gilsbar, L.L.C., 621 Santa Fe, Fresno, CA 93721 (“HEALTHCOMP”) with respect to the Benefit Plan issued by the Plan Sponsor to the eligible covered employees and dependents. This Agreement is to be in effect as of July 1, 2023 and shall continue until terminated as herein provided.

WHEREAS, Plan Sponsor has established a self-funded employee welfare benefit plan pursuant to ~~the Employee Retirement Income Security Act of 1974 as amended~~, (the “Plan”) for certain employees of Plan Sponsor and for certain dependents of such employees (“Participants”); and

WHEREAS, HEALTHCOMP is in the business of providing administrative services in conjunction with such Plans, and Plan Sponsor desires to engage HEALTHCOMP to perform the services enumerated herein below:

NOW, THEREFORE, in consideration of the premises and of the mutual promises and covenants contained therein, the parties agree as follows:

I. PLAN

1.1 Plan Document. All services to be provided by HEALTHCOMP hereunder shall be performed pursuant to the provisions of the Plan Documents, as amended by Plan Sponsor. A copy of the Plan Documents and any amendments thereto shall be deemed to form part of this Agreement for such purpose.

1.2 Interpretation of the Plan. Plan Sponsor shall be the final arbiter as to the interpretations of the Plan and as to the payment of benefits thereunder. HEALTHCOMP shall consult with Plan Sponsor in the event extraordinary benefit matters arise. In the event an exception is to be made, Plan Sponsor shall notify HEALTHCOMP in writing of such exception.

II. SCOPE OF RELATIONSHIP

2.1 Parties. This Agreement is between HEALTHCOMP and the Plan Sponsor, and does not create any rights or legal relationships between HEALTHCOMP and any of the Participants or Beneficiaries under the Plan, or to any other third party. In the event that the Plan Sponsor fails to comply with any federal or state law, mandatory filings, or the terms of the Plan, HEALTHCOMP shall not be liable in any action brought in regard thereto. HEALTHCOMP’s relationship with the Plan Sponsor shall be that of an independent contractor, and nothing in this Agreement shall be construed as creating the relationship of employer and employee, partnership, or joint venture between the parties. Plan Sponsor also acknowledges that HEALTHCOMP may not be a party to any contract entered into on behalf of Plan Sponsor for the purpose of obtaining discounts, network access, or other purposes which are intended primarily to benefit the Plan. Plan Sponsor assumes all contractual and financial obligations related thereto unless otherwise specified in writing in one of those contracts.

2.2 Fiduciary. HEALTHCOMP shall not be deemed to be a fiduciary of the Plan, nor shall HEALTHCOMP be considered to be the “Plan Administrator,” ~~for purposes of ERISA.~~ Rather, the duties of HEALTHCOMP hereunder are ministerial in nature, and this Agreement shall not be deemed to confer or delegate to HEALTHCOMP any discretionary authority or discretionary responsibility in the administration of the Plan. HEALTHCOMP shall exercise its obligations under the Agreement in accordance with and by applying industry-accepted (or commonly-accepted) standards and practices regarding the ordinary interpretation, definition, and application of the Plan Document provisions.

2.3 Communications. HEALTHCOMP shall be entitled to rely, without question, upon any written or oral communication from the Plan Sponsor or Plan Sponsor’s Representatives.

2.4 Plan Sponsor’s Representatives. Plan Sponsor, wherever referenced in the Agreement, includes its directors, officers, employees, human resource and benefit personnel, other authorized employees, agents/brokers and others retained to or acting on Plan Sponsor’s behalf.

2.5 HEALTHCOMP’s Representatives. HEALTHCOMP, wherever referenced in the Agreement, includes its directors, officers, employees, agents and others retained to or acting on HEALTHCOMP’s behalf.

III. DUTIES OF HEALTHCOMP

3.1 Documentation. HEALTHCOMP shall review the existing Plan Document, and assist in the review of any Plan Booklets describing the benefits of the Plan. Plan Sponsor understands that ~~ERISA requires that~~ its employee welfare benefit plan be established and be maintained pursuant to a written instrument(s), including plan and/or trust instruments. Plan Sponsor agrees that HEALTHCOMP shall have no responsibility with respect to such instrument(s) or with respect to the preparation, amendment or validity of such instrument(s).

3.2 Claims Services. HEALTHCOMP agrees to perform the following services with respect to the processing and payment of claims under the Plan:

- a) provide claim forms to Plan Sponsor for submission of claims to HEALTHCOMP;
- b) receive claims and claims documentation;
- c) correspond with the Participants and providers of services if additional information is deemed by HEALTHCOMP to be necessary to complete the processing of claims;
- d) coordinate benefits payable under the Plan with any other benefit plans;
- e) prepare disbursement checks for the amount of benefits determined to be payable under the Plan;
- f) provide notice to Participants as to the reason(s) for denial of benefits and provide for the review of denied claims including appeals in accordance with the terms of the Plan.

Such review shall be advisory to Plan Sponsor and shall not be deemed to be an exercise of discretion by HEALTHCOMP. HEALTHCOMP shall not be authorized or required to render legal advice to Plan Sponsor regarding the validity of any claim or denial of benefits under the Plan;

- g) use its commercially reasonable efforts in the normal course of its services hereunder to identify claims for which there is the potential for collection of amounts paid to, or on behalf of, Participants through subrogation of rights of Participants, except for those amounts paid prior to the Effective Date of this Agreement;
- h) use its commercially reasonable efforts in the normal course of its services hereunder to identify claims that may be subject to reimbursement based upon the existence of any Stop-Loss Policy. In no event shall HEALTHCOMP be held liable for any claims not covered by the Stop-Loss Carrier, irrespective of the reasons or bases provided as reason for the denial of those claims;
- i) use its commercially reasonable efforts in the normal course of its services hereunder to identify claims that contain fraudulent charges. In no event shall HEALTHCOMP be held liable for claims which are later determined to contain fraudulent charges.

3.3 Administrative Services. HEALTHCOMP agrees to perform the following services with respect to the administration of the Plan:

- a) maintain member enrollment for eligibility for payment of claims and census data;
- b) provide bookkeeping details of all billing and collections;
- c) maintain reinsurance reporting;
- d) provide experience reporting for coverages;
- e) provide enrollment forms and identification cards to the Plan Sponsor;
- f) provide any ancillary medical claim services selected by Plan Sponsor. In order to provide such services, HEALTHCOMP may enter into subcontracts with other service providers to perform all or some of the services. With respect to any separately stated fee charged to the Plan Sponsor for an ancillary medical claim service, HEALTHCOMP may retain a portion of such fee for discharging its duties and obligations, with the remainder paid to the ancillary medical claim service provider pursuant to the subcontract between HEALTHCOMP and the ancillary medical claim service provider. More information about the types of administrative and ancillary service fees retained by HEALTHCOMP is included in the Fee Schedule. HEALTHCOMP may also receive fees from various subcontractors for performance of services to assist the subcontractor perform their services.

- g) Obtain professional reviews, independent medical evaluations, and audits of hospital or other health care provider costs, expenses and credit balances in accordance with group health industry standards and practices to determine if hospital and physician charges are accurate, appropriate and necessary. The Plan Sponsor authorizes HEALTHCOMP to obtain such professional reviews, independent medical evaluations, and audits and Plan Sponsor shall be responsible for all fees or expenses, if any, of third parties in connection with such reviews, evaluations and audits. Further, Plan Sponsor will be responsible for all fees of medical, vocational, and dental consultants and any consulting attorney who may be consulted to assist in a determination of whether benefits are payable under the Plan.
- h) provide Enhanced Cost Containment for the Plan Sponsor. HealthComp or its retained professional may, on behalf of the Plan Sponsor, negotiate with providers, perform medical chart audits, pursue subrogation liens, reprice claims, participate in required arbitrations and negotiate settlements to obtain discounts, reductions or reimbursements on claims filed with and otherwise paid/payable by the Plan, and recovery of any overpayments made other than as a result of the sole negligence of HEALTHCOMP. As compensation for these services, HEALTHCOMP shall receive the fee set forth in the Fee Schedule of any discount, reduction, or reimbursement realized by the Plan as a result of these services. If the discount, reduction, or reimbursement, or any portion thereof, is subsequently changed by request of the Plan Sponsor or by any required arbitration process, HEALTHCOMP shall not be required to reimburse all or any portion of HealthComp's fee.
- i) provide a Dialysis Claims Management Program to the Plan Sponsor. HEALTHCOMP will provide the Plan amendment for HEALTHCOMP's Dialysis Claims Management program. On behalf of the Plan Sponsor, HEALTHCOMP will manage members dialysis claims; assist members with Medicare enrollment; determine the Medicare allowable for each claim; determine the payable Plan benefit at a defined percentage; and handle all appeals from providers. As compensation for these services HEALTHCOMP shall receive the fee set forth in the Fee Schedule of the savings realized by the Plan Sponsor.
- j) provide those additional services as selected by the Plan Sponsor in the Fee Schedule.

3.4 Records and Files. HEALTHCOMP shall establish and maintain a record keeping system concerning the services to be performed hereunder. All such records, including an accumulator report and member eligibility listing of such, and all hard copy files shall be the property of Plan Sponsor and shall be delivered to Plan Sponsor upon termination of the Agreement, subject to the right of HEALTHCOMP to copy and retain all or any of such records as it may be required by law to retain. All such records shall be available for inspection by Plan Sponsor upon reasonable prior written notice, and at any time during HEALTHCOMP's normal business hours.

3.5 Reports. HEALTHCOMP shall provide the following to Plan Sponsor:

- a) check register;
- b) report of claims paid identified as to Participants;
- c) statement of account;
- d) reports of claims incurred but not reported; and
- e) annual report of Plan's operation.

If HEALTHCOMP is not providing run-out services upon termination of this Agreement, HEALTHCOMP will charge \$2,500 for our Standard Termination Reporting Package.

3.6 Recovery of Payments. The parties will cooperate to make reasonable efforts to recover overpayments of benefits under the Plan. In the event that payment is made to or on behalf of an ineligible Participant or that a payment is made in excess of the amount properly payable, HEALTHCOMP will make a demand to the payee with respect to the Participant in writing for the return of such payment or overpayment. If that effort is unsuccessful in obtaining recovery, HEALTHCOMP may use an outside vendor, collection agency or attorney to pursue recovery. Overpayment recoveries made through third party recovery vendors, collection agencies or attorneys are credited to Plan Sponsor net of fees charged by them. HEALTHCOMP shall have no further obligation with respect to any such payment or overpayment, except that HEALTHCOMP is hereby authorized to offset such payment against any unpaid claim of such payee for any employee Participant or covered dependent unless advised otherwise by the Plan Sponsor.

3.7 Forms 5500. HEALTHCOMP shall not be responsible for the preparation of the annual Forms 5500 unless HEALTHCOMP contracts with Plan Sponsor in writing to perform that function. Filing of the Forms 5500 shall remain the responsibility of Plan Sponsor.

3.8 Confidentiality of Personal Information. HEALTHCOMP maintains a Privacy Policy. HEALTHCOMP shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the Plan, except in the following instances:

- a) in response to a court order;
- b) for an examination conducted by the Commissioner of Insurance;
- c) for an audit or investigation conducted [under the ERISA by any governmental entity](#);
- d) to, or at the request of, Plan Sponsor or its stop-loss/reinsurance carrier; or
- e) with the written consent of the individual identified by the information, or his or her legal representative.

Nothing in this section is to be inconsistent with any Mutual Business Associate Agreement executed by and between Plan Sponsor and HEALTHCOMP, attached hereto as Exhibit A.

3.9 Run-Out Services. If requested, HEALTHCOMP will provide services under this Agreement for a “run-out period” not to exceed twelve months (12) following the date of termination (“Run-Out Services”). HEALTHCOMP shall provide the charge for Run-Out Services after receipt of termination with a Run-Out Services Agreement. All applicable provisions of this Agreement shall remain in effect with respect to the Run-Out Services notwithstanding the termination of this Agreement. Separate Run-Out Service fees may be charged from PPO vendors to utilize their services for discounts on claims or by other vendors to continue their services.

IV. DUTIES OF PLAN SPONSOR

4.1 Service Fee. Plan Sponsor agrees to pay to HEALTHCOMP the Service Fees as set forth in Exhibit B within fifteen (15) days of invoicing from HEALTHCOMP.

4.1.1 Change of Service Fees. HEALTHCOMP reserves the right to change the Service Fees applicable to the Agreement at any time, provided (a) that the then-current Service Fees have been applicable for a period of twelve (12) months, and provided that written notice of such change is furnished to the Plan Sponsor at least thirty (30) days prior to the effective date for the new Service Fees; or (b) any time there are changes to this Agreement or the Plan, which affect the Service Fees, and provided that written notice of such change is furnished to the Plan Sponsor at least thirty (30) days prior to the effective date for the new Service Fees; or (c) when there are changes in laws or regulations which affect, change or increase the Services HEALTHCOMP is providing or will be required to provide, and provided that written notice of such change is furnished to the Plan Sponsor at least thirty (30) days prior to the effective date for the new Service Fees .

4.1.2 Audit Fees. HEALTHCOMP recognizes that from time to time Plan Sponsor may wish to perform (or have performed) an audit for purposes of financial statements, performance standards, claims payment, or other purposes. Plan Sponsor shall provide reasonable written notice to HEALTHCOMP prior to such audits, and HEALTHCOMP shall make all requested information available to Plan Sponsor or their designated auditor within a reasonable time frame. Plan Sponsor agrees to pay HEALTHCOMP the Service Fee set forth in the Fee Schedule for services not previously listed for any HEALTHCOMP staff time required by such an audit. Plan Sponsor also agrees that HEALTHCOMP will have the right to submit written responses to any audit findings, and that such written responses will be included in any audit report which is prepared.

4.2 Liability for Benefits. It is understood and agreed that payment of benefits under the Plan is the sole liability of Plan Sponsor, and that HEALTHCOMP shall not have any liability for such benefits. Plan Sponsor shall be responsible for any damages, losses, liabilities, or expenses incurred by HEALTHCOMP which are related to claims by any Participant or a provider of health care services for benefits under the Plan. Both parties recognize that this includes claims or liabilities to which either Party is determined to be obligated either contractually or statutorily, regardless of whether such claims are allowed under the Plan Document, and specifically includes Medicare Secondary Payer Claims and contractual obligations under provider network agreements.

4.3 Taxes and Other Assessments. Plan Sponsor shall pay HEALTHCOMP within a reasonable time after assessment, any tax or charge assessed against HEALTHCOMP which may be incurred by reason of (a) a ruling or other determination by an Insurance Department or other governmental authority to the effect that any fees charged or payable under Section 4.1 or the amount of claim payments made in accordance with the Plan and Section III of this Agreement is an insurance premium and subject to the premium tax provisions of the applicable statutes, including any retroactive assessment; or (b) any sales tax imposed on or related to HealthComp's Services; or (c) a change in any charges relating to this Agreement and imposed on HEALTHCOMP by any public body exclusive of Federal or State Income Taxes.

4.3.1 Tax Collection. Plan Sponsor shall promptly pay to HEALTHCOMP all state and local taxes which may be imposed on Plan Sponsor or HEALTHCOMP as a result of the Agreement. HEALTHCOMP agrees to remit these to the proper authorities in a timely fashion.

4.3.2 Tax Liability. It is agreed that nothing in this Agreement shall be deemed to confer on HEALTHCOMP any responsibility for any federal, state or local tax liability, (excluding its own income and payroll taxes), which may be imposed upon HEALTHCOMP, Plan Sponsor, Trust, Administrator, Fiduciary or any Participant or Beneficiary of the Plan.

4.4 Plan Documents and Amendments. Plan Sponsor shall provide HEALTHCOMP with all Plan Documents at least thirty (30) days prior to the Effective Date of this Agreement. Plan Sponsor shall also notify HEALTHCOMP in writing of any changes in the Plan Documents at least thirty (30) days prior to the effective date of such changes. HEALTHCOMP shall have thirty (30) days following receipt of such notice of change to inform Plan Sponsor whether they can and will administer such proposed changes. HEALTHCOMP shall not be held responsible for any delay or errors in claims administration caused by Plan Sponsor's failure to timely provide Plan Documents or notice of changes to Plan Documents.

4.5 Census. Plan Sponsor agrees to promptly furnish HEALTHCOMP such information in writing as may be necessary or required by HEALTHCOMP from time to time to maintain adequate records for eligibility of Plan Sponsor's Participants.

4.6 Access to Online Service. Subject to Plan Sponsor's continuing compliance with the terms and conditions of this Agreement, Plan Sponsor may, on non-exclusive basis and during the term of this Agreement, access and use the Hosted Service solution ("Hosted Service") provided by HEALTHCOMP (the "**Hosted Service**"), solely for Plan Sponsor's internal business purposes as follows:

- a) Plan Sponsor will only permit the maximum number of individuals agreed upon in writing between the parties, if any, to utilize a user name and password ("**Account Information**"). Plan Sponsor will ensure the security and Confidentiality of its Account Information and is responsible for all activities

performed in the Hosted Service with its Account Information;

- b) Plan Sponsor will not (and Plan Sponsor will not permit any third party to): (i) make the Hosted Service available to any third party (via a services arrangement, service bureau, lease, sale, resale, or otherwise); (ii) modify, adapt, or otherwise create a derivative work of the Hosted Service; (iii) circumvent any usage or access limits on the use of the Hosted Service; (iv) damage, disable, overburden, impair, or disrupt the Hosted Service or attempt to gain unauthorized access to any systems or networks that connect thereto or otherwise interfere with the operation of the Hosted Service or in any way with the use or enjoyment of the Hosted Service by others; or, (v) use the Hosted Service in any unlawful manner or for any unlawful purpose or in any jurisdiction where any such use is illegal;
- c) Plan Sponsor will immediately notify HEALTHCOMP in writing of any unauthorized use of any Account Information or the Hosted Service, in each case, that comes to Plan Sponsor's attention. In the event of any such unauthorized use by any third party that obtained access to the Hosted Service through Plan Sponsor, Plan Sponsor will take all steps necessary to terminate such unauthorized use. Plan Sponsor will provide HealthComp with such cooperation and assistance related to any such unauthorized use as HEALTHCOMP may reasonably request;
- d) As between the parties, HEALTHCOMP owns all right, title and interest in the Hosted Service. Plan Sponsor hereby assigns to HEALTHCOMP all right, title and interest in and to any feedback, recommendations or ideas for improvements or enhancements to the Hosted Service submitted to HEALTHCOMP by Plan Sponsor or its personnel. Plan Sponsor will execute and deliver all documents and take other actions reasonable requested by HEALTHCOMP, to confirm, protect or defend the foregoing ownership rights at no additional cost to HEALTHCOMP. All rights not expressly granted to Plan Sponsor in this Agreement are hereby expressly reserved and retained by HEALTHCOMP and its licensors.

V. FUNDING OF MEDICAL BENEFIT PAYMENTS

5.1 Claims Funding. Plan Sponsor shall establish a Plan Sponsor Medical Claims Fund Account. The Plan Sponsor agrees to maintain a positive balance in such account at all times, to provide funds to cover all outstanding claims payments within one (1) business day of notice, and to:

- i. Deposit into the account on a weekly basis an amount sufficient to enable HEALTHCOMP to release all checks drawn on the account for payment of medical claims that week;
- ii. Institute check tracing for missing checks. The Plan Sponsor shall request from its financial institution a stop payment order for any outstanding check that is missing, and notify HEALTHCOMP of such a stop payment so that it may issue a replacement; and
- iii. Reconcile the account on a monthly basis.

VI. MEDICAL STOP LOSS INSURANCE SERVICES

6.01 Submission of Claims to Stop-Loss. HEALTHCOMP agrees to submit claims to and attempt to obtain reimbursement from the Plan Sponsor's medical stop-loss insurer.

6.02 Disclaimer – Not a Guarantee of Payment. Plan Sponsor acknowledges that HEALTHCOMP shall have no obligation to reimburse Plan Sponsor for any losses not covered by the medical stop-loss insurer. Plan Sponsor shall not be entitled to seek any damages or recovery against HEALTHCOMP resulting from, or relating to, any denial of reimbursement under any medical stop-loss insurance policy regardless of the reason for such denial (including but not limited to conflicting language between the Plan Document and the stop-loss policy concerning conditions or exclusions of benefits, or conflicting language between the Plan Document and the terms of any contract with a third-party vendor or service provider such as network provider agreements), with the sole exception being for denials based solely upon the reason that such reimbursement request was not timely submitted to the medical stop-loss insurer, and where HEALTHCOMP had possession of the claim and all documentation and information needed to process and submit the claim (including but not limited to network pricing, medical reviews, and medical records) at least fifteen (15) business days prior to the deadline for submitting claims to the stop-loss insurer under the then-applicable policy.

VII. GENERAL PROVISIONS

7.1 Entire Contract. This Agreement, together with any Exhibits, Attachments and Amendments appended hereto, constitutes the entire Agreement between the parties. No representation, understanding, or agreement which is not expressly contained herein shall be binding or enforceable. No modification of the terms or provisions of the Agreement shall be effective unless evidenced by written amendment signed by an authorized officer of both Plan Sponsor and HEALTHCOMP.

7.2 Choice of Law and Attorney's Fees. This Agreement shall ~~be deemed to have been made and entered into in the State of California, and shall be~~ construed and enforced according to the ~~internal~~ laws of the State of ~~California~~Arizona, ~~applicable to contracts entered into and performed solely within that state.~~ In the event suit is brought to enforce or interpret any part of this contract, the

prevailing party shall be entitled to recover reasonable attorney's fees as an element of their costs of suit. The "prevailing party" shall be the party who is entitled to recover costs of suit, whether or not the suit ends with a final judgment.

7.3 Fair Reading and Joint Construction. The Agreement is a result of negotiations between the parties, and will not be construed strictly against or in favor of any party hereto, but shall be considered to have been jointly drafted by the parties. The parties intend that the Agreement will be given a fair reading and reasonable construction in accordance with the intentions of the parties and without regard to, or aid of, §1654 of the California Civil Code.

7.4 Section Headings. The paragraph, section and article headings used in the Agreement are intended solely for convenience and reference and shall not in any manner amend, limit, modify or otherwise be used in the interpretation of any of the provisions of the Agreement.

7.5 No Waiver. No waiver of any breach of any term or provision of the Agreement shall be construed to be, or shall be, a waiver of any other breach of this the Agreement. No waiver shall be binding unless in writing and signed by the Party or Parties waiving the breach.

7.6 Severability. If any term or provision of the Agreement is determined to be illegal, unenforceable, or invalid in whole or in part for any reason, such illegal, unenforceable, or invalid provisions or part thereof shall be stricken from this Agreement and such provision shall not affect the legality, enforceability, or validity of the remainder of this Agreement. If any provision or part thereof of the Agreement is stricken in accordance with the provisions of this section, then this stricken provision shall be replaced, to the extent possible, with a legal, enforceable, and valid provision that is as similar in tenor to the stricken provision as is legally possible.

7.7 Successors. This Agreement shall inure to the benefit of each party hereto, its predecessors, successors, subsidiaries, affiliates, representatives, assigns, agents, officers, directors, employees and personal representatives, past, present and future.

7.8 Warranty of Authority. The parties signing below warrant they are authorized to enter into this Agreement on behalf of their designated party, and do so with that party's full consent and knowledge.

7.9 Indemnification of Plan Sponsor. In the event of any claim or cause of action against Plan Sponsor, HEALTHCOMP agrees to indemnify Plan Sponsor and hold it harmless from and against any and all resultant liabilities, damages and expenses incurred by Plan Sponsor, including court costs and attorneys' fees, to the extent that liabilities, damages or expenses arise as a result of the gross negligence of HEALTHCOMP or HEALTHCOMP's intentional, willful, or reckless acts or omissions in the performance of its duties under this Agreement.

7.10 Indemnification of HEALTHCOMP. In the event of any claim or cause of action against HEALTHCOMP by any Plan member, health care provider, or network claiming benefits or right to

payment under the Plan, Plan Sponsor agrees to indemnify HEALTHCOMP and hold it harmless from and against any and all resultant liabilities, damages and expenses incurred by HEALTHCOMP, including court costs and attorneys' fees, to the extent that liabilities, damages or expenses arise other than as a result of the gross negligence of HEALTHCOMP or HEALTHCOMP's reckless acts or omissions in the performance of its duties under this Agreement. Provided further, nothing in this Section or any other provision of this Agreement shall entitle HEALTHCOMP to be indemnified, reimbursed, or held harmless for any grossly negligent or wrongful acts or omissions of HEALTHCOMP, its employees, officers, directors, affiliates, or subcontractors.

7.11 Limitation of Liability. Any liability of HEALTHCOMP to Plan Sponsor for purposes of indemnification or other losses shall be limited to the greater of the previous twelve (12) months of claims administration fees as determined by the fees paid in the immediate twelve (12) months preceding the date of the act giving rise to the liability or the amount of its available insurance coverage, but not to exceed the limits of coverage available.

7.12 Statute of Limitations. Either party seeking indemnification or any other damages under the terms of the Agreements or the failure to properly perform services under this Agreement must ~~commence comply with the statutes of limitations of claims for the State of Arizona, not to exceed litigation within~~ twenty-four (24) months of the date of the act or acts giving rise to such liability ~~or when the party knew or should have known of the ,irrespective of when the Party learns~~ of such acts, or such litigation will be deemed barred as untimely. ~~This section does not apply to any willful misconduct or fraudulent activity committed by either party, such actions instead being controlled for statute of limitations purposes under then-current law in the state of California.~~

7.13 Notices. All written notices required by this Agreement shall be sent to HEALTHCOMP or Plan Sponsor as follows:

If to HealthComp:	With Copy To:	If to Plan Sponsor:
CEO	General Counsel	Director of Human Resources
HealthComp Holding Company, LLC	HealthComp Holding Company, LLC	City of San Luis Employee Benefit Trust
621 Santa Fe Avenue	621 Santa Fe Avenue	1090 East Union Street
Fresno, California 93721	Fresno, California 93721	San Luis, Arizona 85349 PO Box 1170
		San Luis, Arizona 85349

VIII. TERM OF AGREEMENT

8.1 Term. This Agreement shall commence on July 1, 2023 and shall remain effective for *thirty-six (36) months*, and shall remain in effect for subsequent twelve (12) month renewal periods unless written notice is provided by either party at least one hundred twenty (120) days prior to the next twelve (12) month renewal period, or unless otherwise terminated as provided herein.

8.1.1 Failure to Provide Required Notice. If Plan Sponsor fails to provide at least one hundred twenty (120) days' notice, it will be obligated to pay Late Termination Service fees for the equivalent of one hundred twenty (120) days and all Run-Out fees for a period of twelve months from the Notice of termination. The Late Termination Service fees shall be the current Claims Administration fee multiplied by four (4) months multiplied by the average number of Covered Employees on the first day of each month for the last (6) months of Services prior to the termination date. The Late Termination Service fees and Run-Out Service fees are not duplicative of the other. The Late Termination Service fees shall be due thirty (30) days from the Notice of Termination.

8.1.2 Early Termination Fees. If Plan Sponsor provides notice of a termination date prior to the end of the then current term it shall pay an Early Termination Service fee of the current Claims Administration fee multiplied by the remaining months of the current term multiplied by the average number of Covered Employees on the first day of each month for the last (6) months of Services prior to the termination date. The Early Termination Service fees shall be due thirty (30) days from the Notice of Termination.

8.2 Termination By Default. Should either party default in the performance of any of the terms or conditions of the Agreement, the other party shall deliver (personally or by certified mail) to the defaulting party written notice thereof specifying the matters in default. The defaulting party shall have ten (10) calendar days after its receipt of the written notice to cure such default. If the defaulting party fails to cure the default within such ten-day period, this Agreement shall terminate at 11:59 p.m. on the tenth day after the receipt of the notice by the defaulting party.

8.3 Termination By Law. If any state or federal law or regulation is enacted or promulgated which prohibits the performance of any of the duties hereunder, or if any law is interpreted by a court of competent jurisdiction or any governmental agency or instrumentality to prohibit such performance, this Agreement shall automatically terminate as of the effective date of such prohibition.

8.4 Termination via Bankruptcy. This Agreement shall automatically and immediately terminate if either party: (1) becomes insolvent, seeks bankruptcy protection, or is adjudicated as a bankrupt entity; (2) if their business or operations come into possession of or under the control of any trustee in bankruptcy; (3) a receiver is appointed for the party's business or operations; or (4) it makes a general assignment for the benefit of creditors. But this provision may be waived if the other party affirmatively elects in writing to waive said termination.

8.5 Effect of Termination. As of the effective date of termination of this Agreement, HEALTHCOMP shall have no further duties of performance hereunder. This period between notice of termination and the effective date of termination shall be used to facilitate an orderly transfer of records and funds, if any, from HEALTHCOMP to the Plan Sponsor or to such person as Plan Sponsor may designate in writing. Any record transfer shall be completed within fifteen (15) calendar days of

the termination date. HEALTHCOMP's obligation under Section 7.9 and Plan Sponsor's obligation under Section 7.10 and all payment obligations shall survive the termination of this Agreement.

City of San Luis Employee Benefit Trust

Name _____

Title _____

Signature _____

Date _____

HealthComp Holding Company, LLC

Name _____

Title _____

Signature _____

Date _____

EXHIBIT A
MUTUAL BUSINESS ASSOCIATE AGREEMENT

This Agreement is made between City of San Luis Employee Benefit Trust, and HealthComp Holding Company, LLC dba HealthComp, LLC. This Agreement is for the purpose of addressing the measures that the Parties will take to protect the confidentiality of certain health information that either Party may deliver to the other, or that one Party may receive on behalf of the other. This Agreement is to be in effect as of July 1, 2023, or the first day applicable data was exchanged or obtained, and shall continue until terminated as herein provided.

Whereas, the disclosure of certain health-related information is regulated by the provisions of 45 U.S.C. §§1171 et seq., enacted by (i) the *Health Insurance Portability and Accountability Act of 1996* and the regulations promulgated thereunder (collectively referred to as “HIPAA Implementing Regulations”); (ii) Title XIII of the *American Recovery and Reinvestment Act of 2009* (ARRA) entitled *Health Information Technology for Economic and Clinical Health Act* (“HITECH”) 42 U.S.C. §§17921, et seq.; and (iii) the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013, 75 Fed Reg 5566, (“the Final Regulations”). The Implementing Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Agreement as “the HIPAA Requirements”.

Whereas, in performance of their contractual obligations to each other, or to other third parties, the Parties may exchange Protected Health Information (“PHI”, as that term is defined by the HIPAA Requirements) in connection with health benefit plans for which HealthComp provides third party administration services;

Whereas, one Party may receive or disclose PHI on behalf of the other Party in connection with those contractual obligations;

Whereas, the Parties desire that this Agreement accurately reflect the requirements of the HIPAA Requirements as they apply to the disclosure and breach of PHI; and

Whereas, the Parties agree to incorporate into this Agreement any regulations issued by the U.S. Department of Health & Human Services (“DHHS”) with respect to the HIPAA Requirements that relate to the obligations of either Party and that are required to be reflected in a Business Associate Agreement. The Parties recognize that they are obligated by law to meet the applicable HIPAA Requirements and that each Party has direct liability for any violation of the HIPAA Requirements.

Now, Therefore, the Parties agree as follows:

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Requirements: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (“PHI”), Electronic Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

- (a) Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean both Parties, individually and jointly.
- (b) Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean both Parties, individually and jointly.
- (c) HIPAA Requirements. “HIPAA Requirements” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Parties

Parties agree to:

- (a) Not use or disclose PHI other than as permitted or required by the Agreement or as required by law;
- (b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;
- (c) Report to the other Party any known use or disclosure of PHI not permitted under the Agreement, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware;
- (d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors or service suppliers that create, receive, maintain, or transmit PHI on behalf of the Party agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information and execute a written Business Associate Agreement reflecting same;
- (e) Make PHI available in a designated record set to the other Party or to the “individual or the individual’s designee” as necessary to satisfy either Party’s obligations under 45 CFR 164.524;
- (f) Make any amendment(s) to PHI in a designated record set as directed or agreed to by the other Party pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the other Party’s obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the other Party or “individual” as necessary to satisfy either Party’s obligations under 45 CFR 164.528; and

(h) To the extent either Party is to carry out one or more of the other Party’s obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the other Party in the performance of such obligation(s).

Permitted Uses and Disclosures by Business Associate

(a) Each Party may use or disclose PHI only for any lawful purpose and as required for the performance of that Party’s obligations under any contract or agreement related the administration of or providing of services to, a health care plan, and only if the disclosure is in compliance with the HIPAA Requirements.

Except as otherwise limited in this Agreement, the Parties may disclose PHI to either Party’s other Business Associates or vendor of personal health records, provided that such use or disclosure would not violate any Privacy Rule and that the other entity has executed a written Business Associate Agreement with the Party.

(b) The Parties may use or disclose PHI as required by law.

(c) The Parties agree to make uses and disclosures and requests for PHI consistent with the other Party’s minimum necessary policies and procedures.

(d) Neither Party may use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the other Party.

(e) Either Party may use PHI for the proper management and administration of that Party or to carry out the legal responsibilities of that Party.

(f) Each Party may disclose PHI for the proper management and administration of that Party or to carry out the legal responsibilities of that Party, provided the disclosures are required by law, or the Party obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Party of any instances of which it is aware in which the confidentiality of the information has been breached.

Provisions for Party to Inform Other Party of Privacy Practices and Restrictions

(a) Each Party shall notify the other Party of any limitation(s) in the notice of privacy practices of that Party under 45 CFR 164.520, to the extent that such limitation may affect the other Party’s use or disclosure of PHI.

(b) Each Party shall notify the other Party of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect that Party's use or disclosure of PHI.

(c) Each Party shall notify the other Party of any restriction on the use or disclosure of PHI that the Party has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect the Party's use or disclosure of PHI.

Permissible Requests by Parties

Neither Party shall request the other Party to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 (or any other HIPAA Requirements) if done by covered entity.

Investigations

The Parties shall make their internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the United States Department of Health and Human Services (the "Secretary") for purposes of determining the Parties' compliance with applicable law. A Party shall immediately notify the other Party in the event they receive or are otherwise notified of any request by the Secretary to conduct an investigation of the use or disclosure of PHI.

Audit Rights

- A. Right to Audit.** Either Party, or its representative, shall be entitled after ten (10) business days' prior written notice to the other Party, to audit that Party to verify their compliance with the terms of this Agreement. The auditing Party shall be entitled and enabled to inspect the records and other information relevant to the audited Party's compliance with the terms of this Agreement. The auditing Party shall conduct its review during the normal business hours of the audited Party, and shall have the right to conduct the audit in any reasonable manner which does not unreasonably interfere with the audited Party's normal operations.
- B. Obligation to Maintain Records.** The Parties shall produce and maintain accurate and complete records of all receipts, transmissions, uses, and disclosures of PHI subject to HIPAA and HITECH reporting standards, throughout the term of any contracts between the Parties, or for such longer period as may be Required By Law. The Parties shall maintain all records and other information in a safe and secure environment and in compliance with applicable laws. The Parties shall maintain all records and other information with a system of audit trails and controls sufficient to allow either Party to confirm the other Party's compliance with any requirements or regulations enforced by the Secretary.

Term and Termination

(a) Term. The Term of this Agreement shall terminate when all PHI exchanged between the Parties, or received by one Party on behalf of the other Party, is destroyed. Or, if it is not reasonably feasible

to destroy the PHI, all protections created by this Agreement shall be extended to that PHI, or the date either Party terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Either Party may terminate this Agreement if that Party determines that the other Party has violated a material term of the Agreement

(c) Obligations of Parties Upon Termination.

Upon termination of this Agreement for any reason, each Party shall return to the other Party all PHI received from that Party, or created, maintained, or received by the Party on behalf of the other Party that the Party still maintains in any form. The Party shall retain no copies of the PHI.

Upon termination of this Agreement for any reason, each Party, with respect to PHI received from the other Party, or created, maintained, or received by the Party on behalf of the other Party, shall:

1. Retain only that PHI which is necessary for the Party to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to the other Party the remaining PHI that the Party still maintains in any form;
3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as the Party retains the PHI;
4. Not use or disclose the PHI retained by the Party other than for the purposes for which such PHI was retained and subject to the same conditions which applied prior to termination; and
5. Return to the other Party the PHI retained by the Party when it is no longer needed by the Party for proper management and administration or to carry out its legal responsibilities.

(d) Survival. The obligations of both Parties under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Requirements means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement as is necessary to allow the Parties to meet their contractual obligations to comply with the requirements of the Privacy Rule or any other HIPAA Requirement. In the event of any amendment to HIPAA or HITECH or any other Privacy-related Rule, this Agreement will be deemed by all Parties to concurrently adopt such amendments and incorporate them in this Agreement as necessary to comply with such regulation or amendment. Such modifications to this Agreement will immediately be effective without the necessity of a signed amendment.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Requirements.

Indemnification

In the event a Party negligently allows the improper or unauthorized use, disclosure or breach of PHI, that Party agrees to defend and indemnify the other Party and hold it harmless from and against any and all claims, causes of action, losses, liabilities, damages and expenses, including court cost and attorneys' fees, to the extent that such claims, causes of action, losses, liabilities, damages and expenses which arise from such improper or unauthorized use or disclosure.

Obligations of Party's Subcontractors, Vendors and Other Third Parties

The Parties agree that as required by the HIPAA Requirements, each Party will enter into written Business Associate Agreements with all other Business Associates, or vendors or other third parties with access to PHI, that requires them to comply with Privacy and Security Rule provisions of this Agreement in the same manner as required of Parties, and notifies that Business Associate that they will incur liability under the HIPAA Requirements for non-compliance with such provisions. The Parties will assure that all other Business Associates provide written agreement to the same privacy and security restrictions, conditions and requirements that apply to the Parties regarding PHI.

Warranty of Authority

The Parties signing below warrant they are authorized to enter into this Agreement on behalf of their designated Party, and do so with that Party's full consent and knowledge.

City of San Luis Employee Benefit Trust

Name _____
Title _____
Signature _____
Date _____

HealthComp Holding Company, LLC

Name _____
Title _____
Signature _____
Date _____

EXHIBIT B
FEE SCHEDULE
City of San Luis Employee Benefit Trust
EFFECTIVE: July 1, 2023

All fees listed below are Per Employee, Retiree and COBRA participant Per Month unless stated otherwise.

Administrative Fees	
	Fee
Medical Claims Administration Enhanced Cost Containment Services – <i>30% of Savings</i> HIPAA administration included at no additional charge Appeals – includes external appeal review, independent review for medical necessity and federal external reviews, as necessary, and will be billed at cost	\$25.00*
Dental Claims Administration	\$2.50
COBRA Administration	\$1.50
Plan Renewal To be assessed beginning 7/1/2024	\$2,000 Annual Fee
Implementation To be assessed one-time 7/1/2023	\$4,000 One-time fee

Network Fees	
	Current
PHCS Wrap Network, when applicable, For Blue Cross Blue Shield of Arizona members receiving covered services outside of Arizona. (PHCS will receive 25% of which 5% will be paid to HealthComp for coordination and processing)	25% of Gross Savings

Network Fees	
	Current
SiarMed Network, when applicable,	
For members receiving covered services in Mexico.	
Medical	\$3.00
Dental	\$1.50

Care Management Services	
	Current
Utilization Review	\$3.16
Large Case Management	\$160 per hour

Other Administrative Services	
	Current
Hourly Rate for Services - Changes	\$200 per hour
Any changes to the TPA's standard processing methods	
Hourly Rate for Services - Requests	\$100 per hour
Any and all requests for services not specified in the Agreement	
Hourly Rate for Physician Review	\$150 per hour
Subrogation Recovery Services	33.33%
Amount recovered by the subrogation recovery firm in addition to all costs of litigation, excluding attorney's fees, is paid as compensation if the filing of suit and continued litigation is required to recover funds	

Other Administrative Services	
	Current
Consolidated Appropriations Act (CAA), No Surprises Act (NSA), and Transparency in Coverage Compliance Fees <ul style="list-style-type: none"> • Hosting of in-network machine-readable files • Creation and hosting of out-of-network allowed amount machine-readable files • Price transparency tool • Associated services related to continuity of care • Formatting of compliant ID cards • Provider directory maintenance (if necessary) 	Included in Medical Claims Administration Fee**

Plan Sponsor Broker Fees	
	Current
Broker Fee for medical plan participants	\$35.00

* The Medical Claims Administration fee of \$25.00 PEPM is effective July 1, 2023, through June 30, 2025. The Medical Claims Administration Fee will increase up to a maximum of 3% on July 1, 2025.

**The Consolidated Appropriations Act (CAA), No Surprises Act (NSA), and Transparency in Coverage Compliance Fees are billed at the current HealthComp rate of \$1.70 PEPM.

EXHIBIT C

DISCLAIMER

City of San Luis Employee Benefit Trust

EFFECTIVE: July 1, 2023

Plan Sponsor acknowledges that HEALTHCOMP has not been contracted by the Plan Sponsor to procure Stop Loss coverage. HEALTHCOMP therefore disclaims any losses related to that Stop Loss coverage and desires to be indemnified from any losses related to that Stop Loss coverage. Plan Sponsor shall assume all liability related to procurement and operation of any Stop Loss Coverage related to the Plan.

The parties therefore agree:

Plan Sponsor shall indemnify, hold harmless, and defend HEALTHCOMP (and their respective subsidiaries, officers, partners, employees, and agents, collectively “HEALTHCOMP’s Indemnitees”) from and against any and all claims or losses (including attorney’s fees and costs); obligations; actions; or any causes of action whatsoever, which arise from any acts, failure to act, or the manner of performance of acts related to the Plan’s Stop Loss coverage. The foregoing indemnity and hold harmless obligations of Plan Sponsor include and apply—without limitation—to any damages to HEALTHCOMP, HEALTHCOMP’s Indemnitees, Plan Participants, or any other third party.

Plan Sponsor shall not seek to recover from HEALTHCOMP and will hold HEALTHCOMP harmless for any losses, expenses, or liabilities incurred by Plan Sponsor which are related to denial of reimbursement under any Stop Loss coverage and which arises from either: (1) conflicting language between the Plan Document and any Stop Loss Policy regarding conditions or exclusions of benefits; or (2) conflicting language between the Plan Document and the terms and conditions of any contract with a third-party vendor or service provider, including network pricing agreements.

Notwithstanding anything in the foregoing to the contrary, this disclaimer shall not apply to claims which are denied by the stop-loss carrier solely on the basis of untimely submission and where HEALTHCOMP had possession of the clean claim and all documentation and information needed to process and submit the claim (including but not limited to network pricing, medical reviews and medical records) at least fifteen (15) business days prior to the deadline for submitting claims to the stop-loss insurer under the then-applicable stop-loss policy, in which case Plan Sponsor may seek to recover from HEALTHCOMP in accordance with the applicable provisions of the Agreement.

Balance of this page intentionally left blank

City of San Luis Employee Benefit Trust

Name

Title

Signature

Date



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. E.

Meeting Date: 05/04/2023

Department Head: Kay Macuil, City Attorney, Attorney's Office

Submitted By: Kay Macuil, City Attorney, Attorney's Office

ITEM:

Discussion and possible action on any and all matters regarding the Southern Scripts Pharmacy Products and Services Administration Agreement. **(Susan Posada, Broker and Consultant)**

SUMMARY:

Attached to this agenda item is the Southern Scripts Pharmacy Products and Services Administration Agreement. Southern Scripts provides prescription management services. The contract is for 3 years, starting July 1, 2023. The Financial Terms are shown on Exhibit B, attached to this agenda item. The basic administration fee plus the coordination fee is \$9.00 per claim paid.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE SOUTHER SCRIPTS PHARMACY PRODUCTS AND SERVICES ADMINISTRATION AGREEMENT AS PRESENTED.

Attachments

Exhibit B - Fees

SS Agreement

“EXHIBIT B”

FINANCIAL TERMS

I. ADMINISTRATIVE EXPENSES:

A. Administrative Fee*:	\$8.00 per Paid Claim
B. Monthly Minimum:	N/A
C. Rebates:	100% Rebates Passed-Through to Customer
D. TPA Coordination Fee:	\$1.00 per Paid Claim

II. ELECTIVE EXPENSES:

A. Ancillary Services (if utilized)	
i. Explanation of Benefits:	\$3.00 plus postage, shipping, and handling
ii. Coverage Determination Notices:	\$3.00 plus postage, shipping, and handling
iii. Mailed Welcome Materials:	Cost plus postage, shipping, and handling
iv. Non-standard Member Materials:	Cost plus postage, shipping, and handling
v. Coverage Redetermination Appeals:	Cost
vi. Third Party Override Coordination Fee:	\$50 per override
vii. Disengagement Assistance Services	
a. Additional Files	\$1,500 per additional file
b. Custom Formatting for Additional Files	\$150 per hour
c. Not Otherwise Specified	\$150 per hour
viii. Compliance Services	TBD
ix. Other Unspecified:	TBD
B. Elective Services (if utilized)	Cost
i. Retiree Drug Subsidy	
ii. Employer Group Waiver Plan Administration	
iii. Medication Therapy Management	
iv. Independent Medical Reviews or Coverage Redeterminations	
v. Third Party Audit Services	
vi. Pharmacy Benefit Consulting	
vii. Other Ancillary Services	
viii. Consolidated Appropriations Act Reporting	TBD

**There will be an adjustment to any fee in the event that Customer's actual Plan participation decreases below ninety-percent (90%) of the expected Plan participation which, as of the Effective Date of the Agreement, is 380 Members.*

X*Contract Execution Reminders*

Before signing/returning the PBM contract to Southern Scripts for final execution, please ensure that you have filled in the following fields of the contract:

- Pharmacy Products and Services Administration Agreement (PPSAA)
 - Proper legal entity name of Plan Sponsor (first paragraph of first page)
 - Selection of chosen payment timing/methodology (Section 3.5)
 - Address/information for notices to Plan Sponsor (Section 6.4)
 - Signature page information

- Business Associate Agreement (BAA)
 - List of vendors to whom PHI disclosure is permitted (Section 3.1.2(B))

If you have any additional questions related to the contract, please reach out to the Legal Department at legal@southernscripts.net.



PHARMACY PRODUCTS AND SERVICES ADMINISTRATION AGREEMENT

This Pharmacy Products and Services Administration Agreement (“PPSAA”) is made and entered into as of 07/01/2023 (the “Effective Date”) by and between Southern Scripts, LLC, a Delaware limited liability company, (“Southern Scripts”) and City of San Luis Employee Benefit Trust, an Arizona governmental entity (“Customer”). Customer and Southern Scripts are referred to herein individually as a “party” and collectively as the “parties”.

RECITALS

WHEREAS, Southern Scripts has developed the Pharmacy Benefit Management Program, which provides for the coordination and selling of pharmacy benefit management;

WHEREAS, Southern Scripts is a fully transparent pharmacy benefit manager;

WHEREAS, Customer is the sponsor of a health benefit plan or plans that offers pharmacy product and services administration and benefits to employees, insureds, beneficiaries or eligible members exempted from state regulation by the Employee Retirement Income Security Act (ERISA);

WHEREAS, Customer desires to utilize Southern Scripts in connection with the delivery of pharmacy products and services to employees, insureds, beneficiaries or eligible members of the health benefit plan(s); and

WHEREAS, Southern Scripts desires to contract with Customer to make Southern Scripts and other service provider benefits available in connection with the delivery of pharmacy products and services to employees, insureds, beneficiaries or eligible members of the Customer’s health benefit plan(s).

NOW, THEREFORE, in consideration of the foregoing, and in consideration of the covenants and agreements set forth herein, the parties agree as follows:

ARTICLE I – DEFINITIONS

For purposes of the Agreement, the following terms shall have meanings as follows:

- 1.1 **Administrative Expenses** shall mean and refer to all fees as designated in Section I of Exhibit B associated with the processing of each Claim by Southern Scripts.
- 1.2 **Administrative Fee** means the amount Southern Scripts charges the Customer for the Administrative Services provided under this Agreement.
- 1.3 **Administrative Services** shall mean all of the services described in Section 2.4 of this Agreement, which are included in the Administrative Fee.
- 1.4 **Agreement** shall mean this Pharmacy Products and Services Administration Agreement (PPSAA).
- 1.5 **Ancillary Services** means those additional services listed in Section II of Exhibit B that may be provided by Southern Scripts upon request by Customer. Fees/costs for such services are not included in the Administrative Fee are only billed for if utilized as an Elective Expense.
- 1.6 **Applicable Plan Formulary** shall mean and refer to a standard listing of Covered Products developed by and periodically revised by Southern Scripts and/or Customer.
- 1.7 **Average Wholesale Price or “AWP”** shall mean the Average Wholesale Price for a given Prescription Legend Drug or other pharmaceutical product as published by MediSpan and as updated on a weekly basis. In the rare instance where MediSpan does not have a published AWP for a particular prescription drug on the date that a pharmacy is submitting the claim, Southern Scripts will use its best efforts to identify a fair compensation to the pharmacy based upon WAC; the amount billed to the Customer will be exact amount reimbursed to the pharmacy.
- 1.8 **Brand Drug Product** shall mean a Covered Product with a proprietary name or trademark that has been determined a Covered “brand” Product by Southern Scripts using MediSpan MultiSource Indicators of M, N, and O.
- 1.9 **Claim** shall mean and refer to Pharmacy’s billing or invoice for a single prescription for Covered Prescription Products and services dispensed to a Member enrolled in a Plan.
- 1.10 **Claims Adjudication System** means Southern Scripts online computerized claims processing system.
- 1.11 **Compound Drug Product** shall mean a Covered Product that consists of two or more ingredients, which the primary active ingredient must be a formulary Federal Legend Drug that is weighed, measured, prepared, or mixed according to the prescription order and which the pharmacy has adjudicated the Claim with the qualifier of “02” in the NCPDP field 406-D6 COMPOUND CODE.
- 1.12 **Contracted Rate** shall mean the reimbursement rate that a specific pharmacy or pharmacy chain contractually agrees to accept for processing prescription drug Claims on behalf of Southern Scripts.

- 1.13 **Co-payment or Cost Share** shall mean the applicable co-payment, access fee, co-insurance, deductible, or other amount required by the Plan’s benefit design due from the Member requesting the Pharmacy Product and Service to a Network Pharmacy under the Member’s Plan for a Covered Pharmacy Product and Service.
- 1.14 **Covered Pharmacy Products and Services** shall mean any Pharmacy Products and Services that a Member requests and which are covered under the terms of the Member’s Plan as communicated to Southern Scripts by the Customer. The terms “Covered Products” and “Covered Services” may also be used.
- 1.15 **Designated Plans** shall mean the Plans subject to this Agreement.
- 1.16 **Dispensing Fee** shall mean the component of pharmacy reimbursement added to the Ingredient Cost and associated with the delivery of Covered Products.
- 1.17 **Effective Rate** shall mean the blended performance rate of discount for the AWP, accounting for difference in reimbursement rate among individual pharmacies and the net effect of drugs that process at a customary level.
- 1.18 **Elective Expenses** shall mean all expenses for Elective and Ancillary Services as designated in Section II of Exhibit B, none of which are included in the Administrative Fee.
- 1.19 **Elective Services** shall mean any non-standard, optional services chosen by the Customer that are not provided for in this Agreement and which are not included in the Administrative Fee. Expenses associated with such Elective Services are outlined in Section II of Exhibit B. Separate additional Exhibits, Amendments, and Addendums may be used to further itemize any associated costs or charges if necessary.
- 1.20 **Eligibility File** means the electronic communication supplied to Southern Scripts by the Customer or the Customer’s agent which identifies the Members covered under the Designated Plan, along with other eligibility information, such as effective dates and termination dates, necessary for Southern Scripts to provide Administrative Services.
- 1.21 **Generic Drug Product** means a drug identified by its chemical or non-proprietary name considered to be bioequivalent to the Brand Drug Product that has been determined to be a Covered “generic” Product by Southern Scripts using MediSpan MultiSource Indicator of Y.
- 1.22 **Ingredient Cost** shall mean the component of pharmacy reimbursement associated with the reimbursement of the Covered Product dispensed.
- 1.23 **Mail Service Pharmacy** means a duly licensed pharmacy where prescriptions are filled and delivered to Members via mail delivery service.
- 1.24 **Maximum Allowable Cost or “MAC”** shall mean the unit price that has been established by Southern Scripts for a drug included on the MAC drug list, which list may be amended from time to time by Southern Scripts.

- 1.25 **Member** shall mean any eligible participant of a Designated Plan or eligible dependent who is participating and is entitled to receive Pharmacy Products and Services under the Designated Plan of the Customer. The term “Member” shall be synonymous with the term “Plan Participant” under this Agreement.
- 1.26 **Member Identification Card** shall mean the identification card provided by Southern Scripts or the Customer that identifies an individual as a Member covered under a Designated Plan.
- 1.27 **NCPDP** shall mean National Council of Prescription Drug Programs.
- 1.28 **Network** shall mean one of Southern Scripts nationwide networks of Network Pharmacies.
- 1.29 **Network Pharmacy or Pharmacies** shall mean a pharmacy which has executed an agreement to provide Covered Drugs to Members and is included in the list maintained in accordance with Section 2.1 of this Agreement.
- 1.30 **Network Pharmacy Payment Schedule** shall mean the schedule for reimbursement to Network Pharmacies.
- 1.31 **Pass-Through** shall mean the method of charging Customer no more than the actual amount paid by Southern Scripts to a Network Pharmacy including all discounts, Professional Fees, taxes and Dispensing Fees and is applicable to all participating Network Pharmacies. Regarding Rebates, Pass-Through shall mean all Rebate earnings received by Southern Scripts from manufacturers or Rebate Aggregators, including administrative fees, will be retained by the Customer.
- 1.32 **Pharmacy Products and Services** shall mean Prescription Legend Drugs and other products, services and / or supplies normally provided by the Network Pharmacy to the general public in the ordinary course of pharmacy business.
- 1.33 **Physician or Prescriber** shall mean a doctor of medicine, osteopathy, dental surgery, or other health care professional who is legally licensed to prescribe medications within the scope of that license.
- 1.34 **Plan** shall mean a Customer’s group insurance policy, health care plan or retail program that provides a Pharmacy Products and Services benefit, among other covered services to Members.
- 1.35 **Plan Liabilities** shall mean, in the event that the reimbursement of any benefits to Member in connection with this Agreement is subject to tax reporting requirements, Customer is responsible for complying with these requirements and for paying any taxes or assessments associated with such reporting.
- 1.36 **Plan Payment Schedules** shall mean the payment schedules for Covered Pharmacy Products and Services referenced in Section 3.4.

- 1.37 **Plan Setup Document** means the forms (including electronic forms) or supporting documents, as modified from time to time, that are completed or provided by Customer that specify the terms and provisions of the Plan and the configuration of the Claims Adjudication System, which, illustratively, includes specifically but not exclusively Covered Pharmacy Products and Services, any limitations or exclusions, the benefit design and Cost Share structure, and any conditions associated with the specific services to be rendered by Southern Scripts under this Agreement.
- 1.38 **Plan Sponsor or Customer** shall mean the entity such as an employer, health maintenance organization, self-funded plan, medical savings plan, insurance carrier, purchaser, or trust fund that provides a Plan to Members and who has financial responsibility for Pharmacy Products and Services provided pursuant to a Plan and are bound by this Agreement. The Customer has ultimate responsibility for determining the rules by which the Plan is to be administered; and is financially responsible for the payment of Administrative Fees, fees for Ancillary/Elective Services, and Claims for Covered Pharmacy Products and Services.
- 1.39 **Prescription Legend Drug** shall mean any medicinal agent the label of which is required to bear the legend warning “Caution: Federal Law Prohibits Dispensing Without Prescription Under the Federal Food Drug and Cosmetic Act.”
- 1.40 **Professional Fee** shall mean the component of pharmacy reimbursement added to the Ingredient Cost and Dispensing Fee associated with professional services of a pharmacist including, but not limited to, a vaccine administration fee or a compounding level of effort fee.
- 1.41 **Rebate(s)** shall mean any and all manufacturer derived revenue such as rebates, discounts, administrative fees, and any other revenue earned by Customer as provided for through the Rebate Aggregator for a particular pharmaceutical product provided by the drug manufacturer for placement of the manufacturer’s pharmaceutical product on the Applicable Plan Formulary. Rebates shall not include any percentage or amount retained by the Rebate Aggregator to pay for rebate administration services and/or to fund audit fees for contract compliance and oversight.
- 1.42 **Rebate Aggregator** shall mean a vendor contracted with Southern Scripts to provide rebate management and administrative services as set forth in the rebate agreement between such vendor and Southern Scripts.
- 1.43 **Single Source Generic** shall mean a Product that only has one or two manufacturers and is considered a reference product.
- 1.44 **Specialty Drugs** shall mean those scientifically engineered Covered Products deemed specialty by Southern Scripts available at a contracted specialty Network Pharmacy used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Notwithstanding the foregoing, for purposes of Rebates, Specialty Drugs shall have the meaning assigned thereto by the applicable Rebate Aggregator.
- 1.45 **Third Party Administrator (TPA)** shall be any person or entity acting on behalf of the Customer that has been delegated certain aspects of the Designated Plan’s administration

and claims processing. Customer shall ensure any person or entity acting on their behalf shall perform all delegated responsibilities of the Customer in accordance with this Agreement and shall ensure all processes and technology platforms of the TPA are up-to-date and in line with industry standards. Modifications to the Southern Scripts System to accommodate a specific TPA shall be subject to additional charges.

- 1.46 **Usual and Customary Charge or “U&C”** shall mean the charge for Pharmacy Products and Services that a Network Pharmacy would have charged a Member receiving benefits if such Member was not covered by a Plan.
- 1.47 **Wholesale Acquisition Cost or “WAC”** shall mean the manufacturers’ published catalog or list price for a drug product to wholesalers, as established and updated by MediSpan or other pricing reference. Pricing shall be honored based on the accurate pricing from such national drug database as of the date dispensed.

ARTICLE II – SOUTHERN SCRIPTS ADMINISTRATIVE AND OTHER SERVICES PURSUANT TO THIS PPSAA

Southern Scripts shall perform the following pharmacy administration services. Unless otherwise noted, the services specified below are included in the Administrative Fee.

- 2.1 Establishment Networks of Pharmacies.** Southern Scripts shall establish and maintain a network(s) of pharmacies (“Network Pharmacies”) to provide Covered Pharmacy Products and Services to Members and shall maintain, update (on no less than a weekly basis), and make available to Customer a list of the Network Pharmacies upon request. Southern Scripts maintains multiple networks. Customer agrees that Network Pharmacies may elect to participate or not participate in a Network on a Plan-by-Plan basis and that Members shall utilize only contracted Network Pharmacies. Customer acknowledges that the pharmacies participating in a Network may change from time to time.
- 2.2 Delivery of Covered Pharmacy Products and Services.** Southern Scripts shall make arrangements for Network Pharmacies to provide Covered Pharmacy Products and Services to Members of a Designated Plan upon a Member’s presentation of a Member Identification Card which has not been terminated. Customer acknowledges the availability of drugs is subject to market conditions and that Southern Scripts cannot and does not assure the availability of any drug from any Network Pharmacy.
- 2.3 Pricing of Covered Pharmacy Products and Services.**
- A. Full Pass-Through Pricing. Southern Scripts will charge Customer the exact price and no more than the actual amount paid to a Network Pharmacy including all discounts, fees, taxes, and Dispensing Fees.
- B. MAC Pricing. Southern Scripts will maintain a listing of Covered Products that may be reimbursed to participating pharmacies based on MAC. Products subject to MAC pricing may include single-source and multi-source generic products in an effort to

control differentials in Ingredient Cost of these products. Southern Scripts will add and remove products based on wholesaler data, acquisition cost data, and industry standards. Generic products represented on the MAC list are established at a class level to establish a consistent price regardless of manufacturer. Southern Scripts exercises reasonable diligence in surveying the market for price changes, performing timely and regular updates to the generic pricing program, and validating product availability through pharmacy and wholesaler communications. Customer may request a current listing of MAC prices. Customer shall not disclose Southern Scripts MAC pricing without written consent.

- C. Pricing of Single Source Generics. Single Source Generics will be priced as negotiated with individual pharmacy providers either using generic MAC pricing, AWP generic discount, or the AWP brand discount rate. Regardless of what pricing is remitted to a pharmacy, claims will be aggregated in accordance with the definitions provided in Section 1 of this Agreement.

2.4 Administrative Services.

- A. Southern Scripts shall verify a Member's eligibility to receive Covered Pharmacy Products and Services upon a Member's request for Pharmacy Products and Services presented to a Network Pharmacy.
- B. Southern Scripts shall require Network Pharmacies to provide Covered Pharmacy Products and Services to Members in accordance with the Applicable Plan Formulary, Plan Setup Document, and Network Pharmacy Payment Schedules.
- C. Southern Scripts shall require Network Pharmacies to collect required Co-payments for Covered Pharmacy Products and Services provided to Members.
- D. Southern Scripts shall coordinate the delivery to Customer of Claim reimbursement requests by Network Pharmacies for Covered Pharmacy Products and Services in accordance with the Plan Setup Document and Plan Payment Schedules.
- E. If not provided by TPA and upon request by Customer, Southern Scripts shall provide Member Identifications Cards. Member Identification Cards must conform to Southern Scripts' standard card layout, NCPDP specifications, and state and federal law. Any modifications to the standard card layout or changes related to comply with any legal or regulatory requirements may be subject to a change fee. The Member Identification Card shall be proofed by the Plan Sponsor before Member Identification Cards are processed and issued. Once the Plan Sponsor has provided final approval, any further changes will incur an additional charge to be paid by the Plan Sponsor. Southern Scripts will only produce and issue cards after receiving the approval of the card design and layout which must be received twenty-one (21) business days prior to the date set for the initial mailing of the Member Identification Cards. Southern Scripts shall issue or terminate Member Identification Cards to eligible Members of a Designated Plan upon written request by Plan Sponsor. Member Identification Cards shall be issued

- and terminated not more than fourteen (14) business days following Southern Scripts' receipt of a request from Plan Sponsor or Designated Plan. Plan Sponsor will be notified in writing whenever there is an exception. Once initial Member Identification Cards have been issued, requested changes in the Plan's overall Identification Cards, including Member identification numbers, phone numbers, logos, and/or group numbers by the Plan Sponsor will be subject to additional charges to cover the cost of reprinting, shipping, and handling. Each cardholder may be issued up to four (4) Member Identification Cards during a calendar year free of charge. Any additional cards will be charged to the Plan and/or Member depending on Plan's setup. Cards that are reissued to correct errors in information provided to Southern Scripts will be subject to additional charges to include the cost of reprinting, shipping, and handling.
- F. Member Identifications Cards shall be provided to Members in accordance with the Eligibility Files remitted by Customer or Customer's agent.
 - G. If requested by Customer, Southern Scripts shall provide initial standard welcome materials to Members of the Designated Plan. Standard welcome materials will be provided in an electronic format and disseminated through email or online directly to the Customer. Standard welcome materials that are mailed directly to the Customer may be subject to an additional charge. Any requested materials that are non-standard will be provided as elected by the Customer and may be subject to an additional charge.
 - H. Southern Scripts shall require Network Pharmacies to maintain appropriate documentation to support Claims for Covered Pharmacy Products and Services.
 - I. Southern Scripts shall provide detailed Claims information with every billing cycle. Direct access may be through a web-based platform.
 - J. Southern Scripts may provide Claims Adjudication System edits. The Claims Adjudication System will determine the manner in which Claims are adjudicated. Notice by Southern Script of revisions or re-statement of the Claims Adjudication System may be made by Southern Scripts in a manner which Southern Scripts, in its sole and undisturbed discretion, deems meet and proper. Thereafter, Southern Scripts will provide the dispensing Network Pharmacy with the appropriate messaging to advise the pharmacy of the applicable limitation, program, rule, or override. At its own discretion, Southern Scripts may automatically apply and periodically update standard Claims Adjudication System edits to the Plan. Upon request and/or periodically, Southern Scripts shall provide a listing of edits to the Plan Sponsor. The Plan Sponsor shall review such edits as the edit pertains to the Plan's benefit design and execution and may request modifications, including removal, of certain edits.
 - a. Administrative Edits. Southern Scripts may apply administrative edits that include but are not limited to coverage limitations or exclusions, drug utilization management techniques (such as tablet splitting, or reference pricing), application of dispensed as written codes (DAW), and other administrative overrides or prior authorizations to authorize the dispensing of

Covered Pharmacy Products and Services in certain circumstances (such as dose changes, vacation overrides).

- b. Clinical Edits. Southern Scripts may apply clinical edits that include but are not limited to drug utilization management techniques, therapeutic duplications, overutilization, drug interactions, inappropriate dosing, age limitations, and maximum costs, and other clinical overrides or prior authorizations to authorize the dispensing of Covered Pharmacy Products and Services in qualified circumstances.
- c. Initial Coverage Determinations. All initial coverage determinations for Administrative or Clinical overrides and prior authorizations requests shall be provided by Southern Scripts as a standard service at no additional charge. In determining whether to authorize coverage, Southern Scripts may rely upon information about the Member and the diagnosis of the Member's condition provided to it from the Prescriber, Network Pharmacy, or Member. Any subsequent appeals or redeterminations shall be performed by an external independent review organization, medical review officer, or other designated third party as provided for in the Plan's policy for handling appeals. Any external prior authorization review, including appeals, redeterminations, or other third party reviews, will be subject to the fees charged by the external vendor or contractor plus a coordination fee to be paid to Southern Scripts.
- d. Prior Authorization Requests. Southern Scripts shall respond timely to all prior authorization requests. Customer shall ensure that any person or entity acting on their behalf shall not impede or obfuscate the ability of Southern Scripts to provide timely initial coverage decisions. Southern Scripts shall make coverage decisions in a reasonable and prudent manner, exercising a reasonable interpretation of the Plan, which Southern Scripts shall do in its sole and undisturbed discretion. Any Claims granted prior authorization or an override, as determined by Southern Scripts at the sole discretion of clinical staff, shall be payable by Customer until the expiration of the authorization or override.
- e. Customer Acknowledgement. Customer acknowledges that it has the sole authority to control and administer the Plan and has contracted with Southern Scripts for assistance in administering Claims. Customer grants to Southern Scripts the authority to make coverage determinations pursuant to the Plan. Customer has the ultimate authority and responsibility to define eligibility and coverage criteria under the Plan. Southern Scripts shall have no responsibility or liability for the terms, provisions, definitions, coverages or validity of the Customer's Plan. Customer acknowledges that it is also solely responsible for disclosing or reporting information regarding the Plan to governmental agencies or Members as may be required by law.

- K. Southern Scripts shall maintain and operate a customer service center with toll-free customer service numbers and adequately staffed with trained personnel for the use of Customer, Members, Prescribers, and Network Pharmacies. The customer service center shall provide after-hours coverage.
- L. Southern Scripts shall facilitate the provision of specialty pharmaceutical products and services, to include the Variable Copay, through our Variable Copay Network Pharmacies which include CRX Specialty Pharmacy (“CRX”), a wholly-owned subsidiary of Southern Scripts’ parent company Southern Scripts Intermediate II LLC. CRX services are included in the Administrative Fee and will be provided unless Customer opts out. The use of CRX Pharmacy which include the Variable Copay Program is completely voluntary; Customer has the unconditional option to opt out of the programs altogether. CRX uses its best efforts to deploy various strategies to control costs related to high-cost and/or Specialty Drugs and will coordinate and manage the high cost and/or Specialty Drug needs of Customer’s Members.
- a. CRX Services. Services to be provided by CRX include the following:
- i. Review historical drug Claim data to identify and recommended strategies for Variable Copay to Customer;
 - ii. Implement, provide and coordinate approved strategies to include Variable Copay;
 - iii. Determine the most appropriate strategies to be applied to a specific specialty therapy and/or on an individual case-by-case basis;
 - iv. Execute strategies and coordinate the provision of a high-cost and/or Specialty Drug for the Member, their Prescriber, and the applicable Specialty Pharmacy;
 - v. Provide Call Center support for Members, their Prescribers, and pharmacy providers; and
 - vi. Report impact of strategies and savings (Plan and Member) over time.
- b. Independent Contractor Status. CRX shall perform the services provided herein only as an independent contractor. As it relates to the Variable Copay (“the Program”), Customer shall be responsible for disclosure, reporting, and actuarial equivalency requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Patient Protection and Affordable Care Act (ACA), and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), as amended, and all regulations issued thereunder. Such obligations include, but are not limited to, updating any related Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) to include language for utilization of the Program as necessary to accommodate the Program and providing such documents. Sample language for compliance with Plan’s obligations under ERISA is attached hereto as Exhibit D. Additionally, it is the responsibility of the Customer to properly disclose the Program when

(a) seeking to certify satisfaction of the minimum value requirement under the ACA, (b) determining whether coverage is creditable under MMA, and (c) reporting to CMS Allowable Retiree Costs as part of a Retiree Drug Subsidy program under Medicare Part D Rules. Furthermore, Customer hereby certifies its understanding that the impact of Variable Copay Program on Rebates is unknown and may cause certain Claims to no longer be eligible for Rebates under the terms and conditions of the Rebate Agreement.

- c. Disclosure. Like Southern Scripts, CRX Specialty Solutions Pharmacy, LLC (“CRX Specialty Pharmacy”) is an independent and wholly owned operating unit of Southern Scripts Intermediate II LLC. CRX Specialty Pharmacy and Southern Scripts are, therefore, subsidiaries of the same parent company. Southern Scripts contracts with pharmacy vendors for the provision of Pharmacy Products and Services to Plan Participants of Customers pursuant to the Variable Copay Program. CRX Specialty Pharmacy is one of the pharmacy vendors engaged by Southern Scripts to provide such service. Like all pharmacy vendors providing this service to Southern Scripts, CRX Specialty Pharmacy, will generate revenue from its provision of pharmaceutical products under the Variable Copay Program. Such revenue is based upon volume and overall profitability of business or other related factors. Information regarding such additional revenue insofar as it relates to the Plan will be made available upon request. By entering into this Pharmacy Products and Services Administration Agreement, Customer hereby acknowledges that Southern Scripts has fully disclosed its relationship with CRX Specialty Pharmacy as a sister company, and understands that CRX Specialty Pharmacy will generate revenue from its provision of Pharmacy Products and Services to Plan Participants of Southern Scripts Customers. Southern Scripts receives no revenue or compensation of any kind from CRX Specialty Pharmacy or in connection with the service provided thereby.

2.5 Elective Services. Elective Services are any non-standard, optional services chosen by the Customer that are not provided for in this Agreement and which are not included in the Administrative Fee. Elective Services may be provided by Southern Scripts, a subcontractor vendor engaged by Southern Scripts, or a subcontractor vendor engaged directly by Customer. Expenses associated with such Elective Services provided by Southern Scripts or a subcontractor vendor engaged by Southern Scripts are outlined in Section II of Exhibit B and shall be paid to Southern Scripts by Customer in accordance with the usual payment schedule or as otherwise agreed upon by the parties. Separate additional Exhibits, Amendments, and Addendums may be used to further itemize any associated costs or charges if necessary. Customer acknowledges and agrees that, with respect to subcontractor vendors with whom Customer has contracted for services, Customer has full responsibility to pay (i) any charges for such services that are billed to Southern Scripts at the direction of Customer, and (ii) any fees associated with Southern Scripts’ integration with such subcontractor vendor. Elective Services that may be provided

by Southern Scripts, a subcontractor vendor engaged by Southern Scripts, or a subcontractor vendor engaged by Customer include, but are not limited to, the following:

- A. Retiree Drug Subsidy Administration
- B. Employer Group Waiver Plan Administration
- C. Medication Therapy Management
- D. Independent Medical Reviews or Coverage Redeterminations
- E. Third Party Audit Services
- F. Pharmacy Benefit Consulting
- G. Compliance Services
- H. RxCompass Services
- I. Other Ancillary Services

2.6 Full Transparency. Southern Scripts will fully disclose Contracted Rates with Network Pharmacies for branded and generic products, including MAC pricing, upon request from Customer. Pursuant to its Full-Pass-Through Pricing philosophy, Southern Scripts will charge Customer the price and no more than the amount paid to Network Pharmacies, including all discounts and Dispensing Fees.

2.7 Rebates.

A. Establishment of Rebate Agreements. Southern Scripts shall, on behalf of all Customers in general, establish and maintain agreements with Rebate Aggregators for the provision of rebate management and administrative services as set forth in the rebate agreement between such Rebate Aggregators and Southern Scripts. Southern Scripts shall provide Customer with the relevant information about the Rebate Aggregators, including (i) available formulary options and (ii) disruption analysis, as necessary for Customer to determine, in its sole discretion, which Rebate Aggregator it would like utilized. Customer understands and agrees that it is subject to the remedies available to the Rebate Aggregator for recovery from the Customer if necessary as provided in the rebate agreement between Southern Scripts and the applicable Rebate Aggregator. At any time during the term of this Agreement and upon Customer's request, Southern Scripts may disclose portions of the rebate agreement between Southern Scripts and the applicable Rebate Aggregator.

B. Payment of Rebates. Rebates will be deemed 'payable' to Customer by Southern Scripts approximately 210 days after the end of each calendar quarter unless withheld or set-off as provided in Section 3.8(A). Rebate payments shall be made to Customer only upon execution of this PPSAA providing for Rebates and upon payment of such Rebates by the applicable Rebate Aggregator. Customer hereby acknowledges that such Rebate payments shall be subject to the terms and conditions as provided by in the Rebate Agreement between Southern Scripts and the applicable Rebate Aggregator. Southern Scripts shall have the right to use any funds held until payment of Rebate amounts are deemed payable to Customer. In the event that Customer directs Southern Scripts to pay Rebates to its TPA or other third party rather than directly to Customer, Southern Scripts makes no warranty of full Pass-Through of such Rebates by that TPA

or other third party and shall not be in any way responsible for the disposition of such Rebates thereafter. Payment of Rebates by means other than ACH may be subject to a processing fee.

- C. Rebate Exclusivity. Customer represents and warrants to Southern Scripts during the initial or any extended term of this PPSAA, i.) Customer shall not receive Rebates or manufacturer derived revenue, directly or indirectly, other than through Southern Scripts for Claims processed by Southern Scripts pursuant to this Agreement, ii.) Customer shall not submit Claims to another pharmacy benefit manager or carrier or other third party which have been transmitted to Southern Scripts for the collection of Rebates or manufacturer derived revenue or cause a manufacturer to decline Rebate payments to Southern Scripts. Southern Scripts reserves the right to recover from Customer, and Customer shall refund to Southern Scripts, any Rebates or manufacturer derived revenue, including any related penalties and fees.

2.8 Pharmacy Audits. In the event Customer or Southern Scripts suspects non-compliance with Plan, Network Pharmacy agreement, or fraudulent activity of a Network Pharmacy, Southern Scripts may perform audits. In the event that an audit results in a recovery of funds from the Network Pharmacy, all recovered monies will be refunded to the Customer. Any recovery(ies) shall be reduced by the actual costs and expenses incurred by Southern Scripts to conduct said audit.

2.9 Record Retention. Southern Scripts shall maintain such business records as may be required by applicable law or regulation, or as may be necessary to properly document the delivery of, and payment for, Covered Pharmacy Products and Services. Southern Scripts shall maintain data and processing information pertaining to Claims for Covered Pharmacy Products and Services for a period of no less than two (2) years from the date on which the Claim for Covered Pharmacy Products and Services is submitted to Southern Scripts by a Network Pharmacy.

2.10 Sole Source of Revenue Warranty. As a fully transparent pharmacy benefit manager, Southern Scripts hereby warrants that its sole source of revenue for Claims processed under this Agreement is the Administrative Fee as stated in the Financial Terms attached to this Agreement as Exhibit B.

ARTICLE III – CUSTOMER DUTIES AND OBLIGATIONS

3.1 Plan Setup Document.

- A. Customer shall provide Southern Scripts with an executed Plan Setup Document and other requested supportive Plan documents and historical data as reasonably necessary for Southern Scripts to set up the Claims Adjudication System and commence the provision of Pharmacy Administrative Services. Such documents and data includes, without limitation, prior drug utilization and pharmacy utilization reports, Member eligibility, and any Summary Plan Documents and Plan Documents. Customer

understands and agrees that Southern Scripts shall rely on the terms and provisions provided by Customer on the Plan Setup Document. Modifications to the Customer's Plan or Plan Setup Document shall be submitted to Southern Scripts in writing at least thirty (30) days prior to the effective date of any modification of the Plan. Customer shall have sole authority to determine the terms of the Plan and the coverage of benefits thereunder. Customer shall be solely responsible for ensuring that all programs administered by Southern Scripts and/or its affiliates are properly documented and disclosed in any legal Plan Documents. Customer shall also be solely responsible for independently verifying and complying with any local, state, or federal laws related to any programs administered by Southern Scripts and/or its affiliates to include, but not limited to, formulary management, benefit structures, utilization management, prior authorization, clinical management, and specialty programs. Customer shall inform Southern Scripts of any such regulatory requirements in which their health plan must comply with for local, state, or federal regulators.

- B. Customer is responsible to provide Southern Scripts with a copy of Customer's Summary of Benefits and Coverage and Summary Plan Document. Southern Scripts will not provide templates or assist in the drafting of Customer's Summary of Benefits and Coverage and Summary Plan Document. Customer shall have sole authority to determine the terms of the Plan and the coverage of benefits thereunder. Customer shall be solely responsible for ensuring that all programs administered by Southern Scripts and/or its affiliates are properly documented and disclosed in any legal Plan Documents. Customer shall also be solely responsible for independently verifying and complying with any local, state, or federal laws related to any programs administered by Southern Scripts and/or its affiliates to include, but not limited to, formulary management, benefit structures, utilization management, prior authorization, clinical management, and specialty programs.

3.2 Member Eligibility Information.

- A. Customer shall deliver to Southern Scripts a list of Members under each Designated Plan, which list shall include information sufficient for Southern Scripts to issue Member Identification Cards to Members and process Claims under this Agreement. Such Member listing shall be in an electronic format as designated by Southern Scripts and delivered in a secure manner. Customer is responsible that the file is correctly transmitted and received by Southern Scripts; and the file is a clean file, free from errors, and meets the designated data file specifications set forth by Southern Scripts. Customer shall notify Southern Scripts of any additional Members of a Designated Plan or the termination of any Member from a Designated Plan in an electronic or written format as from time to time designated by Southern Scripts. Notwithstanding the termination of a Member from a Designated Plan, Customer acknowledges that it remains responsible for all Claims submitted by Network Pharmacies for Covered Pharmacy Products and Services before Southern Scripts' database is updated. A clean eligibility file will be updated within twenty-four (24) business hours. A corrupt file may take up to five (5) business days following Southern Script's actual receipt of a notice of a Member's termination from participation in a Designated Plan. Southern

Scripts does not and will not activate termination by absence logic for eligibility until the Customer requests the same and a Termination by Absence Election Addendum is signed by Customer.

- B. The Customer shall be responsible for establishing criteria for eligibility, providing a data file of eligible Members and eligibility criteria, and the accuracy of data provided to Southern Scripts. The Customer is responsible for monthly reconciliation of the eligible membership and each Member's status contained in the Claims Adjudication System, including new enrollments and disenrollments, by comparison to the Customer's own internal records. The Customer shall provide written notification to Southern Scripts of any material data conflicts within ten (10) business days and Southern Scripts will correctly identify material data conflicts within ten (10) business days of actual receipt. Southern Scripts is not financially or otherwise responsible for any mistaken coverage, Claim payment or denial determination if such mistake is due to a change in a Member's eligibility status that was not communicated to Southern Scripts. Southern Scripts shall not be financially or otherwise responsible for any mistaken coverage resulting from any manual updates to eligibility that are made by Southern Scripts at Customer's direction. Retroactive termination or disenrollment of a group or Member shall not release Customer of its obligation to pay Claims incurred, at any time, or Administrative Fees due during any period for which services were rendered based on the then current eligibility. Any overall changes in the Customer's Member Identification and/or group numbering system will be subject to additional charges.

3.3 Plan Formularies. Customer shall use the Southern Scripts formulary for each Designated Plan, which is referred to herein as the Applicable Plan Formulary. The Applicable Plan Formulary may be modified or updated from time to time by Southern Scripts or by Customer. The Applicable Plan Formulary shall be made available to the Customer online or upon request. Customer may request customization of the Applicable Plan Formulary for Designated Plans and acknowledges that such customizations may negatively impact Rebates.

3.4 Payment Schedule & Financial Terms. Customer shall use the Plan Payment Schedule, attached to this Agreement, for each Plan. Customer hereby accepts the fees and rates as specified in the Plan Payment Schedule, which may be modified or updated from time to time by Southern Scripts. Customer hereby accepts and agrees to the fees for the services provided under this Agreement as specified in the Financial Terms, attached to this Agreement as Exhibit B.

3.5 Processing and Payment of Claims/Fees. Southern Scripts will invoice Customer or its designee not less frequently than weekly or bi-monthly as hereinafter provided. Customer or its designee shall reimburse and pay Southern Scripts in accordance with the selections made by Customer below (the "Due Date") for those sums invoiced for Claims, Administrative Fees and Fees for Ancillary/Elective Services, and for any services rendered, together with all applicable provider, sales, use, taxes, and penalties for failure to make prompt payment to Network Pharmacies. Customer shall be liable for payment of

all Claims for Pharmacy Services and Products submitted by Southern Scripts to Customer with regard to Customer's Members, whether by Network Pharmacies or Members. Southern Scripts will invoice Customer for Claims in the amount Southern Scripts pays for the Claims. Customer shall not withhold payment for disputed Claims and shall not unreasonably dispute any Claims for Covered Pharmacy Products and Services, and the parties will negotiate in good faith to resolve any disputed Claims as quickly as possible.

- A. Timing of Payment. Customer selects the following payment timing option (Customer initial one of the following options):

(_____) *Advance Payment Option.*

Under this option, Customer agrees to advance to, and maintain with, Southern Scripts an amount equal to the sum of one (1) month's estimated Claims for Covered Pharmacy Products and Services and one (1) month's estimated Administrative Fees not later than five (5) days prior to the Effective Date of the Agreement. Invoices will be submitted between one (1) and three (3) days after the end of each invoice cycle, and payment in full will be due ten (10) calendar days from the date of the invoice.

(_____) *Prompt Payment Option.*

Under this option, Southern Scripts shall invoice Customer for Claims weekly. Customer shall pay and/or reimburse Southern Scripts for all Claims, fees for Administrative Expenses, and fees for Ancillary Expenses invoiced via ACH transfer within two (2) business days of receipt of the invoice.

(X) *Customer/TPA/Vendor Option.*

Under this option, Southern Scripts shall invoice Customer, or TPA/Vendor at Customer's direction, for Claims weekly or biweekly. Customer, or TPA/Vendor at Customer's direction, shall pay and/or reimburse Southern Scripts for all Claims, fees for Administrative Expenses, and fees for Ancillary Expenses invoiced via ACH transfer within five (5) business days of receipt of the invoice or timeframe of applicable prompt payment state law. While self-funded employer-sponsored health benefit plans governed by ERISA may not be subject to state prompt pay laws, Customer nonetheless assumes any and all liabilities associated with any applicable state laws/regulations for failure to make payments to Network Pharmacies in accordance with the law by selection this option rather than the Advance Payment Option or the Prompt Payment Option.

- B. Payment Methodology. Customer selects the following payment methodology option (Customer initial one of the following options):

(X) *Southern Scripts Initiated ACH.*

Under this option, Customer shall maintain a bank Customer custodial account from which Southern Scripts will initiate ACH transfers in order to satisfy Customer's obligations hereunder. Customer shall be solely responsible for

depositing funds and verifying that the Account has sufficient funds to pay Covered Product Claims and Southern Scripts' administrative charges.

(_____) *Customer/TPA/Vendor Initiated ACH.*

Under this option, Customer, or TPA/Vendor at Customer's direction, shall initiate ACH transfers from Customer's bank account to Southern Scripts' bank Customer custodial account in order to pay all amounts when due hereunder.

- C. Custodial Account Funds. Customer acknowledges and agrees that Southern Scripts' Customer custodial account(s) into which funds from Customer's bank account is transferred will contain money from one or more other Southern Scripts' Customers that have engaged Southern Scripts to provide Administrative Services and further agrees that upon payment by Customer to Southern Scripts, the funds paid shall not be considered assets of the Plan.
- D. Past Due Interest. Customer agrees to pay interest at a rate of one and one-half percent per month on any balance due at the time of the next billing in addition to any interest assessed by a Network Pharmacy; however, in no event shall such interest rate be greater than the rate permitted by law. If any portion of any Claims or Fees is overdue and placed with an attorney or other third party for collection, Customer will reimburse Southern Scripts for its collection expenses including, without limitation, reasonable attorney's fees and expenses. Customer shall be and remain responsible for the payment of all invoices for Claims, Administrative Fees, and fees for Ancillary/Elective Services.
- E. Claim Finality. The Parties to this PPSAA agree that the amount of a Claim, Administrative Fees, and fees for Ancillary/Elective Services shall be deemed final sixty (60) days from the receipt by Customer of each invoice and thereafter shall not be subject to dispute.

3.6 Manual Claims. If it is necessary for Southern Scripts to process a Claim manually, the Claim will be processed in the Claims Adjudication System within seven (7) to ten (10) business days of receipt. Once processed, the Claim will be added to the Customer's next invoice based on the Customer's usual payment schedule as selected Section 3.5. Upon Southern Scripts receipt of payment in full of the Claim by Customer, the necessary reimbursement amount is distributed to the Member within thirty (30) business days. The fee associated with processing a Claim manually will be either (a) the standard Administrative Fee, or (b) an amount separately agreed upon by Customer and Southern Scripts as stated in the Financial Terms attached to this PPSAA as Exhibit B.

3.7 Payment of Taxes and Fees. If any government authority imposes any taxes, assessments, fines, or similar fees, Customer is responsible for reimbursing Network Pharmacy any sales tax on the Network Pharmacy's provision of Covered Product and Services to any Member. Pharmacy is responsible for timely and accurately remitting the applicable sales tax to the appropriate taxing authority. In no event shall Southern Scripts be liable for any taxes or

fees. Customer is solely responsible for any Affordable Care Act reporting, excise taxes and fees, or penalties, as applicable.

3.8 Default and Remedies - Collection of Fees or Claims Payments. Customer shall be in default if Customer fails to timely pay a Claim, Administrative Fees, and/or fees for Ancillary/Elective Services pursuant to the terms of this PPSAA. In the event of a default in payment of a Claim by Customer, Southern Scripts shall have the right to immediately terminate this PPSAA upon giving Customer written notice of its intent to do so, not sooner than seven (7) days prior to the effective date of the termination. As additional remedies of default in timely payments:

- A. Southern Scripts is herewith granted the right by Customer to set-off or withhold from Rebates the amount of any unpaid Claims, Administrative Fees, fees for Elective/Ancillary Services, fees associated with termination as provided in Section 4.3, or any other amounts owed under this PPSAA;
- B. Southern Scripts may assign to any Pharmacy Provider any right(s) of action against the Customer that Southern Scripts may otherwise have regarding any late payment or non-payment by Customer; and
- C. Southern Scripts shall have the right in its sole discretion, to suspend Customer or individual Members for any services pursuant to this PPSAA for the failure to pay Claims or Administrative Fees, or other charges. Southern Scripts may provide notice of such suspension or termination of Customer to Network Pharmacies and Members but is not obligated to do so. If Southern Scripts suspends the provision of services to Customer pursuant to this Section 3.8(C), Customer understands and accepts that Members will be required to pay 100% of the costs associated with that pharmacy as outlined in the Plan Payment Schedule, attached to this Agreement as Exhibit A.

3.9 Payment Responsibility. Customer shall pay the Claims to Southern Scripts as a condition precedent to the payment by Southern Scripts to Network Pharmacies. Customer acknowledges, ratifies and confirms that Southern Scripts is an intermediary between the Customer and Network Pharmacies with respect to Claims. Payment of Claims is the sole and exclusive responsibility of the Customer.

3.10 Right to Audit. At its sole expense, Customer may audit Southern Scripts' Claims data, contracts with Network Pharmacies, rebate agreements, formulary-decision making records, and financial records related to the adjudication of Claims by Southern Scripts. Southern Scripts shall make financial records available for such audit as reasonably necessary for verification that the Financial Terms as outlined in Exhibit B to this Agreement have been met. Audits may be for the past twelve (12) months and not occur more frequently than annually. No subcontractor or third party representative of the Customer may be allowed to conduct an audit without an executed nondisclosure agreement prior to the date of the audit, ensuring the confidentiality of Southern Scripts' confidential information and to comply with non-disclosure provisions contained in Southern Scripts' agreements with Network Pharmacies and other subcontractor vendors.

Customer agrees to not use as its auditors, any person or entity which, in the sole discretion of Southern Scripts, is a competitor of Southern Scripts, a pharmaceutical manufacturer representative, or any other person or entity which has a conflict of interest with Southern Scripts. Audits shall only be made during normal business hours following thirty (30) days written notice, be conducted without undue interference to Southern Scripts' business activity, and in accordance with reasonable audit practices. Customer's auditor may inspect contracts with Network Pharmacies and Rebate Aggregators at Southern Scripts' offices only, and no copies of such contracts may be removed from Southern Scripts' offices. Southern Scripts cannot accommodate audit requests during the months of November, December or January.

- 3.11 Pharmacy Grievance Process.** Disputes between a Network Pharmacy and Southern Scripts shall be resolved, exclusively, in the manner set forth in the Agreements between these parties.
- 3.12 Third Party Administrator Integration.** Customer acknowledges, ratifies and confirms that any implementations or changes involving a TPA shall be the responsibility of the TPA. Southern Scripts shall cooperate to the extent reasonable and necessary during such TPA implementation or transition. Furthermore, Customer acknowledges, ratifies and confirms that the sole responsibility to effectuate a transition of a TPA is the exclusive responsibility of the TPA, selected by Customer and not Southern Scripts. In the event the Customer changes its TPA, Customer shall provide Southern Scripts notice of such change not less than forty-five (45) days from the effective date. A TPA change fee of \$5.00 per Member shall be paid to Southern Scripts to cover the additional administrative costs associated with such a change and shall be due before work commences. In the event that integration between the new TPA and Southern Scripts is not operationally possible, it shall not be deemed a default of this Agreement by Southern Scripts and Customer shall not have the right to terminate this Agreement early as a result.
- 3.13 Miscellaneous Plan Services.** Customer shall be responsible for providing any and all other Plan services required by the Plan then in effect which are not specifically delegated to Southern Scripts by this Agreement.
- 3.14 Cooperation.** Customer acknowledges, ratifies and confirms, i.) TPA, or other designee shall promptly provide to Southern Scripts all information in a manner agreeable to the Parties reasonably necessary for Southern Scripts to complete its obligations hereunder; ii.) Any information required to Southern Scripts by a TPA or other designee to perform a service or provide a product under this Agreement shall be deemed to be untimely if not received by Southern Scripts on its due date; and, iii.) Customer, TPA, or other designee shall not obfuscate, delay, impede or otherwise fail to cooperate with Southern Scripts.
- 3.15 Disclosure of TPA Coordination Fee and Other Third Party Payments.**
- A. TPA Coordination Fee. TPA may provide coordination services to Southern Scripts in connection with the delivery of pharmacy benefit management services to Designated Plans under this Agreement. Such coordination services include reasonable general

administrative and management services, oversight, and resources as necessary for coordination with Southern Scripts to enable Southern Scripts to effectively meet its obligations under this Agreement. If such services are provided by the TPA, Southern Scripts shall pay TPA a Coordination Fee in consideration for the provision of such services. The Designated Plan will be billed this fee as forth in Exhibit B of this Agreement.

- B. Other Third Party Payments. Southern Scripts may engage third parties for various services in connection with this Agreement, such as consultative or marketing services. If such services are provided in connection with this Agreement, Southern Scripts hereby discloses that such arrangement may involve payment of a fee for such services by Southern Scripts to such third party that may or may not be included in the Administrative Fee.
- C. General Agent Fee. Southern Scripts may make payments to a general agent(s) in connection with the delivery of pharmacy benefit management services to Designated Plans under this Agreement. Southern Scripts hereby discloses that such arrangement may involve payment of a fee for general agent services by Southern Scripts to such third parties that may or may not be included in the Administrative Fee.

3.16 Exclusivity. Customer acknowledges and agrees that Southern Scripts shall be the exclusive provider of Pharmacy Products and Services for Customer during the initial or any extended term of this PPSAA.

ARTICLE IV – TERM OF AGREEMENT

4.1 Term and Renewal. The term of this Agreement shall commence on the Effective Date and shall continue for an initial term of three (3) years. Unless one Party terminates this PPSAA in accordance with this Article 4 or as otherwise provided in this Agreement, this PPSAA shall be extended for consecutive one (1) year terms. In the event of an extension of this PPSAA, Southern Scripts reserves the right to automatically increase its Administrative Fee to align with the Consumer Price Index, as provided by the U.S. Department of Labor for that year. Any further modification to services and/or fees associated with this Agreement shall be provided by ninety (90) days prior written notice thereof.

4.2 Termination for Cause/Default. In addition to the provisions of default provided in Section 3.8, if Southern Scripts or Customer fails to perform any of the material terms, conditions or covenants of this Agreement for more than thirty (30) days after written notice, either Party may terminate this Agreement for cause. The notice must state the failure(s) to perform any of the material terms, conditions or covenants and must be actually delivered in accordance to Section 6.4 to the party in default and an opportunity to cure to the reasonable satisfaction of the parties has been given, the non-defaulting party, in addition to other remedies it may have, shall have the right to terminate this Agreement immediately, provided, however, that the termination of this Agreement shall not relieve

the parties of their duties and obligations which have accrued through the date of termination.

4.3 Termination Without Cause.

- A. During Initial Term. During the initial term, either party may terminate this Agreement without cause by providing the other party not less than ninety (90) calendar days advance written notice. Customer agrees that if it terminates under this section and complies with the notice requirement, it shall pay, in addition to any and all amounts already owed, an early termination fee in the amount of the Administrative Fees that would have been owed during the remainder of the initial term calculated using the highest monthly Administrative Fees incurred thus far as determined by Southern Scripts and subject to the monthly minimum, if applicable. If Customer fails to comply with the notice requirement, it shall pay, in addition to all amounts owed as well as the above early termination fee, Administrative Fees for an additional three (3) months calculated using the highest monthly Administrative Fees incurred thus far as determined by Southern Scripts and subject to the monthly minimum, if applicable. In consideration of the fact that Southern Scripts does not charge any initial implementation fees, Customer agrees that if it terminates during the first year of the initial term it shall pay a first year termination fee in the amount of seven (\$7.00) dollars per Member.
- B. During Subsequent Terms. After the initial term, either party may terminate this Agreement without cause by providing the other party with not less than ninety (90) calendar days advance written notice. Customer agrees that if it terminates under this section and complies with the notice requirement, it shall pay, in addition to any and all amounts already owed, an early termination fee in the amount of the Administrative Fees that would have been owed during the remainder of the subsequent term then in effect, calculated using the highest monthly Administrative Fees incurred thus far as determined by Southern Scripts and subject to the monthly minimum, if applicable. Customer agrees that if it terminates the Agreement under this section and fails to comply with the ninety (90) calendar day notice requirement, it shall pay, in addition to all amounts owed as well as the above early termination fee, Administrative Fees for an additional three (3) months calculated using the highest monthly Administrative Fees incurred thus far as determined by Southern Scripts and subject to the monthly minimum, if applicable.
- C. Rebates Set-off. If Customer terminates without cause pursuant to this section, Southern Scripts reserves the right to set-off Rebates payable to Customer against any amounts owed to Southern Scripts under this Agreement.

4.4 Termination Upon Insolvency.

- A. Either party may terminate this Agreement upon the filing by or against the other party of a petition in bankruptcy under the Federal Bankruptcy Act if such filing is not dismissed within thirty (30) days, or if the other party affirmatively seeks relief under

any other law or act regarding insolvency, reorganization, or arrangement or extension for the relief of debtors, including an assignment of assets for the benefit of creditors, or if there is an appointment of a receiver or trustee for transfer or sale of a material portion of the other party's assets.

- B. Without notice, Southern Scripts reserves the right to require pre-funding of anticipated Claims or suspend processing of Claims, upon the Customer (i) becoming insolvent or admitting in writing that the party is insolvent, (ii) upon the institution of receivership or bankruptcy proceedings or any other proceedings for the settlement of Customer's debts, or (iii) upon Customer making an assignment for the benefit of creditors.

4.5 Termination Resulting from Change in Laws/Regulations. In the sole and undisturbed discretion of Southern Scripts, it may terminate this PPSAA in the event Southern Scripts' obligation required under this Agreement are materially changed due to amendments, modifications or changes in federal, state or local laws, regulations or rules during the term of this Agreement. In such event, Southern Scripts shall deliver written notice to Customer termination thirty (30) days prior to the effective date.

4.6 Notice of Termination. All notices required under this Article 4 shall be reasonably specific concerning the cause for termination and shall specify the requested effective date of termination.

4.7 Obligations upon Termination.

- A. Effect of Termination. In the event of termination of this Agreement, such termination shall not relieve either party from the performance of duties and obligations prior to the effective date of termination, including, without limitation, the responsibility of Customer for the reimbursement of Claims and Administrative Fees to Southern Scripts.
- B. Obligation to Notify Southern Scripts of Request for Proposals. In the event that Customer intends to send out a request for proposals at the expiration of the then-current term of this Agreement, Customer shall provide no less than ninety (90) days-notice to Southern Scripts of such intention. During such period, Southern Scripts shall be afforded the right to negotiate any opportunity to renew this Agreement outside of the request for proposals process.
- C. Disengagement Assistance Services. Upon written notice of termination of this Agreement, Customer shall have the option to request Southern Scripts to provide some or all of the disengagement services and/or disengagement assistance items listed below ("Disengagement Assistance Services"). Southern Scripts will provide industry-standard files to Customer upon request. The nature and extent of the Disengagement Assistance Services shall include those services as are reasonably determined by the mutual agreement of Customer and Southern Scripts. Notwithstanding the foregoing, upon Customer's request as part of the Disengagement Assistance Services, Southern Scripts shall take all reasonable steps necessary for Customer to transfer the Services

to another vendor or to Customer provided that Customer has not become insolvent. Customer agrees to pay or reimburse Southern Scripts for any costs charged by a vendor or pharmacy related to the transfer of files to or from such vendor or pharmacy at any time during the initial or any subsequent term of this Agreement or in connection with the termination of this Agreement. Notwithstanding anything in this Agreement to the contrary, Southern Scripts shall not be obligated to provide post-disengagement services following the transition to the successor pharmacy benefit manager and conclusion of the period in which Customer has requested Southern Scripts to provide the Disengagement Assistance Services, including, but not limited to the provision of continued data reporting, reporting, consultation, or analysis.

a. Disengagement Assistance Services provided at no additional charge:

i. Historical Claims File

1. One time file in Southern Scripts' standard format capturing all claims data from the current plan year to be delivered approximately thirty (30) days prior to the Customer's effective date with the new pharmacy benefit manager. Customer must request this file not less than thirty (30) business days prior to date needed.
2. One time lag file in Southern Scripts' standard format capturing all claims data not included in the original file for the current plan year to be delivered approximately fifteen (15) days after the Customer's effective date with new pharmacy benefit manager. Customer must request this file not less than thirty (30) business days prior to date needed.
3. Files will include all member information available to Southern Scripts, as well as Specialty and Non-Specialty claims.

ii. Prior Authorization File

1. One time file in Southern Scripts' standard format capturing all open Prior Authorizations. Customer must request this file not less than thirty (30) business days prior to date needed.
2. One time lag file in Southern Scripts' standard format capturing all open Prior Authorizations not included in original file. Customer must request this file not less than (30) business days prior to date needed.

iii. Member Census File

1. One time file in Southern Scripts' standard format capturing all active members.

b. Disengagement Assistance Services subject to additional charges:

i. Open Refill Transfer File

1. Southern Scripts utilizes Network Pharmacies for mail and specialty prescriptions. Southern Scripts will assist with coordinating the Open Refill Transfer file from the current pharmacy provider (sender) to the new specified pharmacy provider (receiver). Customer will be responsible for any

and all fees charged by either the sending and/or the receiving pharmacy provider.

- ii. Additional Files
 - 1. Customer will be charged \$1,500 per additional file plus \$150 per hour for custom formatting of files.
- iii. Any other Disengagement Services, requested by Customer will be charged at a rate of \$150 per hour.

D. Run-out Claims Processing. Following termination of this Agreement, Customer acknowledges its obligation and agreement to pay any run-out Claims processed by Southern Scripts for a period of twelve (12) months following termination. The fee associated with processing such Claims shall be the Administrative Fee as stated in the Financial Terms, attached to this Agreement as Exhibit B. During the post-termination run-out period, any monthly minimum stated in the Financial Terms shall not apply.

ARTICLE V – INDEMNIFICATION, LIABILITY AND INSURANCE

5.1 Indemnification.

- A. Southern Scripts does not insure or underwrite the liability of Customer under the Plan and Customer acknowledges ratifies and confirms that Southern Scripts shall have no liability for designing the Plan or the benefits to be provided thereunder. Customer shall retain the ultimate responsibility and all liabilities and obligations for Claims under the Plan and all expenses incident to the Plan. Customer agrees to indemnify, defend, save and hold harmless Southern Scripts, its affiliates, and their respective owners, directors, officers, agents, attorneys, and employees from and against any and all claims, suits, actions, liabilities, Plan Liabilities, losses, fines, penalties, damages, and expenses of any kind, including court costs, defense costs, arbitration costs, and attorneys' fees (collectively, "damages") asserted against or incurred by Southern Scripts, its affiliates, and their respective owners, directors, officers, agents, attorneys, and employees, to the extent that such damages are caused by, arise from or are based on:
- i. Customer's negligence, acts, omissions, willful misconduct, or violation of any common law, statute, governmental law or regulation in the performance of its duties under this Agreement or in the administration of the Plan;
 - ii. A release of Claims data by Southern Scripts to the Customer, or to any other person or entity upon Customer's request and/or at Customer's direction;
 - iii. An interpretation of the Plan, a decision concerning eligibility, coverage or benefits payable under the Plan, or a determination of an appeal;
 - iv. Any breach of this Agreement by Customer;
 - v. Any claim for benefits under the Plan;
 - vi. Any claim by any pharmacy or health care provider related to payment or reimbursement for services provided to a current or former participant,

including but not limited to Claims under network provider agreements, or for forfeiture of Network discounts, “prompt pay” penalties, or interest;

- vii. Any losses or expenses resulting from any inaccuracy in or omission from any information or data supplied to Southern Scripts on Customer’s behalf in connection with the services provided under this Agreement.
 - viii. Any actions taken by Southern Scripts upon instruction from or at the direction of any of the following:
 - 1. Customer, its directors, officers, and employees;
 - 2. TPA, or its designated representative; or
 - 3. Members, or Member’s personal representative
 - 4. Any third party vendor utilized or engaged by Customer
- B. No civil action shall be brought by Customer or an agent/representative thereof to recover under this agreement after the expiration of two (2) years from the date the cause of action accrued.
- C. Subject to the limitations of Section 5.3, Southern Scripts hereby agrees to indemnify and hold harmless the Customer and its directors, officers, and employees against any damages asserted against or incurred by Customer, to the extent that such damages are caused by, arise from or are based on Southern Scripts’ gross negligence, willful misconduct, or criminal conduct. Provided however, any such indemnification shall exclude any damages caused by any act or omission, including any negligent act or omission, of Customer, directors, officers, and employees.
- D. All parties agree that the party seeking indemnification (“indemnified party”) will provide the other party (“indemnifying party”) written notice within thirty (30) days of receiving notice of a claim potentially giving rise to indemnification hereunder and will provide the other party an opportunity to defend any such claim; provided, however, that the failure to notify the indemnifying party will not relieve the indemnifying party of any liability that it may have to any indemnified party, except to the extent that the indemnifying party demonstrates that the defense of such action is prejudiced by the indemnified party’s failure to give such notice. Notwithstanding the foregoing, the indemnifying party shall not make any settlement of any claim on behalf of the indemnified party without the prior written consent of the indemnified party, which consent shall not be unreasonably withheld or delayed.

5.2 Disclaimer of Warranties. Southern Scripts does not make and hereby disclaims any and all express or implied warranties of any kind whatsoever with respect to its nature, capacity, or functions including without any limitation the implied warranty of merchantability or fitness for a particular purpose of any service provided under this Agreement or with respect to Pharmacy Products and Services provided by Network Pharmacies. Southern Scripts does not warrant that any services will be uninterrupted or error free.

5.3 LIMITATION OF LIABILITY.

- A. THE CUMULATIVE LIABILITY OF SOUTHERN SCRIPTS FOR ANY ACTUAL OR ALLEGED LOSSES, CLAIMS, SUITS, CONTROVERSIES, BREACHES, ATTORNEYS' FEES, OR DAMAGES FOR ANY CAUSE WHATSOEVER ARISING OUT OF, BASED ON OR RELATING TO THIS AGREEMENT, WHETHER BASED UPON BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), WARRANTY, INDEMNITY OR ANY OTHER LEGAL THEORY, SHALL NOT EXCEED THE TOTAL AMOUNT OF THE FEES ACTUALLY PAID UNDER THIS AGREEMENT BY CUSTOMER TO SOUTHERN SCRIPTS DURING THE TWELVE MONTHS IMMEDIATELY PRECEDING CUSTOMER'S CLAIM; PROVIDED THAT NOTHING IN THE PRECEDING SENTENCE SHALL LIMIT SOUTHERN SCRIPTS' LIABILITY FOR ITS GROSS NEGLIGENCE, CRIMINAL CONDUCT, OR FRAUD.
- B. NOTWITHSTANDING ANY PROVISION CONTAINED HEREIN TO THE CONTRARY, IN NO EVENT SHALL SOUTHERN SCRIPTS, ITS AFFILIATES, THEIR RESPECTIVE OWNERS, DIRECTORS, OFFICERS, AGENTS, ATTORNEYS, OR EMPLOYEES BE LIABLE TO CUSTOMER FOR ANY INDIRECT, INCIDENTAL, SPECIAL, PUNITIVE, EXEMPLARY, OR CONSEQUENTIAL DAMAGES OF ANY KIND (INCLUDING, WITHOUT LIMITATION, LOSS OF INCOME, LOSS OF PROFITS, OR OTHER PECUNIARY LOSS) EVEN IF SUCH DAMAGES WERE FORESEEABLE OR SOUTHERN SCRIPTS HAS BEEN ADVISED OF THE POSSIBILITY THEREOF.
- C. THE SERVICES PROVIDED BY SOUTHERN SCRIPTS HEREIN ARE NOT INTENDED TO SUBSTITUTE FOR OR SUPPLEMENT THE KNOWLEDGE, EXPERTISE, SKILL, AND JUDGMENT OF PHYSICIANS, PHARMACISTS, OR OTHER HEALTH CARE PROFESSIONALS IN PRESCRIBING OR SUGGESTING PRODUCTS. THE ABSENCE OF A WARNING FOR A GIVEN DRUG, DRUG DOSAGE, OR DRUG COMBINATION SHALL NOT BE CONSTRUED TO INDICATE THAT THE DRUG, DRUG DOSAGE, OR DRUG COMBINATION IS SAFE, APPROPRIATE, OR EFFECTIVE FOR ANY MEMBER. SOUTHERN SCRIPTS SHALL NOT BE LIABLE OR RESPONSIBLE FOR INJURY, INCLUDING DEATH, SUFFERED BY ANY MEMBER OR OTHER CONSUMER OF ANY PHARMACEUTICAL OR ANY OTHER PRODUCT DISPENSED OR DISTRIBUTED BY ANY NETWORK PHARMACY, NON-NETWORK PHARMACY, OR PERSON OR ENTITY, OR FOR ANY AIDE EFFECTS OR OTHER CONSEQUENTIAL OR INCIDENTAL DAMAGES OF ANY KIND OR DESCRIPTION WHATSOEVER FROM THE USE OF ANY SUCH PRODUCT, IT BEING EXPRESSLY UNDERSTOOD THAT SUCH LIABILITY AND RESPONSIBILITY RESTS ENTIRELY UPON THE PHARMACIST, THE PRESCRIBER, OR OTHER PROFESSIONAL INVOLVED IN THE TRANSACTION. CUSTOMER AGREES THAT SOUTHERN SCRIPTS SHALL NOT BE LIABLE TO THE CUSTOMER OR ANY MEMBER FOR LOSSES, COSTS, CLAIMS, LAWSUITS, SETTLEMENTS, JUDGMENTS, OR EXPENSES,

INCLUDING ATTORNEYS' FEES, ARISING AS A RESULT OF THE SALE, COMPOUNDING, DISPENSING, MANUFACTURING, OR USE OF ANY PRESCRIPTION DRUG, PRODUCT OR SERVICE DISPENSED BY A NETWORK PHARMACY OR A NON-NETWORK PHARMACY WHOSE CLAIMS ARE PROCESSED HEREUNDER, OR FOR ANY VIOLATION BY SUCH PHARMACY OF ANY APPLICABLE STANDARD OF CARE OR APPLICABLE LAW, INCLUDING WITHOUT LIMITATION, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA") OR THE REGULATIONS PROMULGATED THEREUNDER.

- D. SOUTHERN SCRIPTS SHALL NOT BE LIABLE OR RESPONSIBLE FOR ANY CLAIM, INJURY, DEMAND, OR JUDGMENT BASED ON CONTRACT, TORT, OR ANY OTHER THEORY OF LAW, STATUTE OR REGULATION ARISING DIRECTLY OR INDIRECTLY OUT OF THE PAYMENT OF FRAUDULENT CLAIMS OR FILLING OF FRAUDULENT PRESCRIPTION IF THE FRAUD IS COMMITTED BY ANY THIRD PARTY INCLUDING BUT NOT LIMITED TO PRESCRIBERS, PHARMACIES, MEMBERS, NON-MEMBERS, EMPLOYER, OR EMPLOYEES. "FRAUDULENT CLAIMS" SHALL INCLUDE THE UNAUTHORIZED, ILLEGAL, OR WRONGFUL USE OF ANY IDENTIFICATION CARD ISSUED TO MEMBER.
- E. SOUTHERN SCRIPTS SHALL NOT BE LIABLE IN ANY MANNER FOR DAMAGES THAT RESULT EITHER DIRECTLY OR INDIRECTLY DUE TO ANY DELAY IN PERFORMANCE OF ITS OBLIGATIONS HEREUNDER BEYOND SUCH PARTY'S REASONABLE CONTROL, INCLUDING, BUT NOT LIMITED TO, ANY DELAY OR FAILURE DUE TO STRIKES, LABOR DISPUTES, RIOTS, PANDEMIC, EPIDEMIC, EARTHQUAKES, STORMS, FLOODS, OR OTHER EXTREME WEATHER CONDITIONS, FIRES, EXPLOSIONS, ACTS OF GOD, EMBARGOES, TERRORIST ACTS, WAR OR OTHER OUTBREAK OF HOSTILITIES, GOVERNMENT ACTS OR REGULATIONS, OR THE FAILURE OR INABILITY OF CARRIERS, SUPPLIERS, DELIVERY SERVICES OR COMMUNICATION PROVIDERS TO PROVIDE SERVICES NECESSARY TO ENABLE A PARTY TO PERFORM ITS OBLIGATIONS HEREUNDER.
- F. WHILE SOUTHERN SCRIPTS AGREES TO WORK WITH THIRD PARTY VENDORS ENGAGED BY CUSTOMER OR MEMBER VOLUNTARILY, SOUTHERN SCRIPTS SHALL NOT BE LIABLE IN ANY MANNER FOR DAMAGES THAT RESULT EITHER DIRECTLY OR INDIRECTLY FROM THE SERVICES PROVIDED THEREBY IN RELATION TO THE PLAN.
- G. SOUTHERN SCRIPTS SHALL NOT BE LIABLE FOR ANY DIRECT OR INDIRECT INSTRUCTION PROVIDED BY CUSTOMER, CUSTOMER'S AGENT, TPA, OR VENDOR TO OVERRIDE ANY DRUGS THAT HAVE BEEN EXCLUDED OR RESTRICTED BY CUSTOMER'S PLAN. FURTHERMORE, SOUTHERN SCRIPTS SHALL NOT BE LIABLE FOR ANY UNCLEAR OR

AMBIGUOUS INSTRUCTION PROVIDED BY CUSTOMER, CUSTOMER'S AGENT, TPA OR VENDOR TO SOUTHERN SCRIPTS REGARDING RESTRICTED OR EXCLUDED DRUGS OR ANY EXCEPTIONS AND/OR RESTRICTIONS MADE TO COVERED DRUGS. CUSTOMER ACKNOWLEDGES AND ACCEPTS THAT A DRUG DESIGNATED AS RESTRICTED, ALLOWS FOR GREATER OVERRIDE EXPEDIENCIES BUT ALSO MAY RESULT IN A GREATER RISK FOR INADVERTENT OR UNINTENDED OVERRIDES. CUSTOMER ACKNOWLEDGES AND ACCEPTS THAT A DESIGNATION OF A RESTRICTED DRUG CREATES A POTENTIAL RISK FOR A CLAIM TO BE OVERRIDDEN. CUSTOMER SHALL REMAIN LIABLE FOR ANY COST OF CLAIMS OR FEES ASSOCIATED WITH DRUGS THAT HAVE BEEN EXCLUDED OR RESTRICTED.

5.4 Insurance.

- A. Southern Scripts shall procure by the Effective Date and shall maintain, at its own expense insurance relating to the operation of its business and its obligations under the Agreement in amounts Southern Scripts determines to be appropriate for its business activities. Southern Scripts agrees to provide a certificate of insurance to Customer upon written request.
- B. Customer agrees to maintain adequate insurance related to the operation of its business and its obligations under the Agreement. Customer agrees to provide a certificate of insurance to Southern Scripts upon written request.

ARTICLE VI – MISCELLANEOUS

6.1 Customer Representations.

- A. Customer represents and warrants that the execution, delivery, and performance of this Agreement are within its corporate power. All requisite authority necessary to enter into this Agreement has been obtained from Customer for Plans, and Customer has duly and validly executed and delivered this Agreement.
- B. Customer represents and warrants that it is not, by entering into this Agreement with Southern Scripts for pharmacy benefit management services, violating any other agreement, and that it has no undisclosed conflicts of interest.
- C. Customer represents and warrants that it has and shall continue to maintain throughout the term of this Agreement any and all licenses, governmental authority, or other authorization required to operate an entity of its type.

6.2 Acceptance of Offer. Notwithstanding anything herein to the contrary, this Agreement shall not be binding upon the parties hereto unless and until this Agreement is signed and executed by a duly authorized agent of each of the parties. Customer acknowledges that its

signing of this Agreement constitutes an offer only until the same has been accepted by Southern Scripts as evidenced by its execution of this Agreement.

6.3 Relationship of the Parties.

- A. This Agreement shall not be deemed to create a partnership, association, joint venture, or other similar arrangement with Southern Scripts or Customers. The intent of this Agreement will be that Southern Scripts and Customer shall be and shall remain independent contractors for purposes of the performance of their respective obligations under this Agreement.

- B. Nothing in this Agreement shall be construed to create a fiduciary relationship between Southern Scripts and the Customer or its Plan. Customer acknowledges and agrees that it is the Customer, Plan Administrator, and fiduciary for purposes of required actions and disclosures under ERISA. Customer further acknowledges and agrees that Southern Scripts does not have any discretionary authority or control over the Plan's prescription benefit program. Customer acknowledges that all such discretionary authority and control with respect to the management of the Plan and Plan assets is retained by the Customer. Customer acknowledges that it has the sole responsibility for ensuring its Plan Document, Summary Plan Document, and any other documents are in compliance with applicable law and is routinely updated and maintained in accordance with any stop loss requirements. Southern Scripts shall not be responsible financially or otherwise for any conflict between the Summary Plan Document and the operation of the Plan design, including but not limited to conflicts which cause an issue with stop loss claims.

6.4 Notices. Any notice, designation, consent or approval required or permitted hereunder shall be made in writing and delivered personally or mailed by certified mail, return receipt requested, addressed to the parties as hereinafter specified. Any notice forwarded by mail in accordance with the terms of this section shall be deemed to have been received, delivered, or given to the other party three (3) business days following the date of mailing. Addresses, for purposes of this Agreement, unless otherwise designated in a subsequent written notice, are as follows:

SOUTHERN SCRIPTS:

**Southern Scripts, LLC
Attn: LeAnn C. Boyd, CEO
411 Bienville Street
Natchitoches, LA 71457
legal@southernscripts.net**

CUSTOMER:

**City of San Luis Employee Benefit Trust
Attn: _____
1090 East Union Street
San Luis, AZ 85349
Email: _____**

6.5 Proprietary Rights.

- A. Customer acknowledges that Southern Scripts is the owner of the exclusive right to managed care and retail programs and / or any other program name or names used or developed by Southern Scripts in conjunction with the Southern Scripts System, together with any distinctive trademark and / or any service mark that may hereafter be adopted, and to any trade secrets and other information of any kind with respect to the Southern Scripts System including, but not limited to, operating procedures, manuals, forms, plan data sheets, computer software, marketing materials (“Proprietary Property”). Customer agrees that the Southern Scripts System names, marks and information, are proprietary to Southern Scripts and shall not be used by Customer or its owners or employees, or otherwise disclosed in any way to third parties, without the prior written consent of Southern Scripts first having been obtained. Any new product developments, forms or improvements of the Southern Scripts System during the term of this Agreement shall be the property of Southern Scripts and shall be deemed part of the Southern Scripts System, names, marks and information. Upon termination of this Agreement, Customer will immediately return to Southern Scripts all copies of manuals, forms, Plan data sheets, Plan Payment Schedules, MAC Pricing, Plan Formularies, marketing materials and other documentation which is the property of Southern Scripts. This provision shall survive the termination of the term of this Agreement.
- B. Customer acknowledges and agrees that Customer’s covenants and agreements contained herein regarding Proprietary Property are of a special, unique and extraordinary character, the breach of which by Customer will cause Southern Scripts irreparable harm, injury and damages. Consequently, Customer expressly agrees that in the event of a breach of this Agreement by Customer, Southern Scripts shall be entitled to a temporary and permanent restraining order, injunction, and/or other equitable relief, including the remedy of specific performance, without any requirement of posting a bond or showing irreparable harm or inadequacy of monetary damages, in order to secure the full enforcement of Customer’s covenants and agreements herein, in addition to, and not exclusive of, any other right or remedy otherwise available to Southern Scripts hereunder, or at law or in equity.

- 6.6 Confidentiality.** Except as otherwise specifically provided in this Agreement, parties to this Agreement each covenant that they shall keep the information and data generated during the course of this Agreement, and the terms and conditions of this Agreement strictly confidential and shall not distribute copies of this Agreement or disclose the terms and conditions of this Agreement to any person or entity. As an exception to the foregoing, and to the extent not prohibited by applicable federal and state laws, rules or regulations, including without limitation medical record confidentiality regulations adopted under HIPAA, Customer hereby grants Southern Scripts the unrestricted and irrevocable right to use and distribute all data generated during the term of this Agreement for any purpose such as drug utilization review, population health management, benchmarking, business purposes to illustrate cost efficacy, research and development, and as may be necessary or appropriate to secure Rebates or reimbursements from drug manufacturers in managing

formulary programs. As a further limited exception to the foregoing, either party may distribute copies of this Agreement or disclose the terms and conditions of this Agreement, including MAC Pricing, under the conditions set forth:

- A. This Agreement and the terms and conditions of this Agreement may be disclosed to the parties' legal and tax advisors;
- B. This Agreement and the terms and conditions of this Agreement may be disclosed to the Customer and Plan fiduciaries designated under this Agreement;
- C. This Agreement and the terms and conditions of this Agreement may be disclosed as may be necessary or appropriate to enforce the terms of this Agreement;
- D. This Agreement and the terms and conditions of this Agreement may be disclosed by binding court order or subpoena, but the disclosing party shall notify the other party of court order or subpoena so that the other party may, at its discretion, seek a protective order.
- E. This Agreement and the terms and conditions of this Agreement may be disclosed per the written consent of all parties to the Agreement, which shall be evidenced in writing and signed by an authorized agent of each respective party to the Agreement.

The confidentiality and nondisclosure obligations of the parties shall survive the termination of this Agreement.

- 6.7 Force Majeure.** The duties and obligation of each party to this Agreement are limited in the event of circumstances beyond their control, such as a major disaster, riots, pandemic, epidemic, war, complete or partial destruction of facilities, disability of a significant number of personnel, significant labor dispute, and acts of God. In such an event, the parties hereto agree to use their best efforts under the circumstances to fulfill their duties and obligations under this Agreement by whatever reasonable means are available.
- 6.8 Assignment.** This Agreement is personal to the parties and may not be assigned by either party except by written agreement signed by the parties. Any attempt to assign, transfer, pledge, or hypothecate, or make any other disposition of this Agreement, or any of the rights, obligations, or benefits contrary to the foregoing shall be null and void and without effect. Subject to the restrictions against unauthorized assignment or transfer set forth herein, the provisions of this Agreement shall inure to the benefit of and be binding upon each of the parties and their respective successors and assigns. Notwithstanding anything in this Agreement to the contrary, Southern Scripts, shall have the absolute right to assign this Agreement to any parent or subsidiary corporation or to any entity which, by way of merger, acquisition by purchase and sale of substantially all of the assets of Southern Scripts, or other similar transaction, succeeds to the rights of either party.
- 6.9 Entire Agreement; Amendment.** This Agreement and Schedules hereto contains the entire agreement between the parties and supersedes all prior negotiations, representations

or agreements, either written or oral; and unless otherwise provided in this Agreement may only be amended or modified by written instrument signed by the parties.

6.10 Severability. The partial invalidity of any provisions of this Agreement shall not invalidate or affect the validity of the remaining provisions of this Agreement. If any provision of this Agreement is deemed invalid or unenforceable, this Agreement shall remain in full force and effect as if such invalid or unenforceable provision were omitted.

6.11 Waiver. No failure by either party to require the performance by the other party of any of the terms of this Agreement shall in any way affect such party's rights to enforce such terms, nor shall any waiver on any one occasion be deemed a waiver of any other term hereof, or subsequent breach thereof. No right under this Agreement may be waived and no modification or amendments to this Agreement may be made except by written agreement executed by the parties.

6.12 Survival of Obligations. Provisions of this Agreement that are not fully performed or capable of being performed on the effective date of this Agreement, including but not limited to audits, insurance, indemnification, limitation of damages, and confidentiality provisions, will survive termination or expiration of this Agreement regardless of the cause giving rise to the termination and shall be effective thereafter until fully performed.

6.13 Dispute Resolution.

A. Good Faith Dispute Resolution Negotiations. Except as provided in Section 3.8, if Customer has a controversy, claim or dispute ("Dispute") with or against Southern Scripts arising out of or relating to this Agreement, the parties shall attempt to resolve the Dispute through negotiations between designated representatives of the parties who have authority to settle.

B. Arbitration. If the Dispute has not been resolved within sixty (60) days of the party's request for negotiation, the Dispute shall be decided by arbitration in accordance with the rules of the American Arbitration Association, unless the parties mutually agree otherwise. Either party may commence arbitration against the other party by serving on such party or its legal counsel, if known, a document (a "Demand") signed by an authorized representative of the party and including the following: (a) a description of the Dispute(s) as to which arbitration is sought; (b) a statement of the amount(s) and type(s) (e.g. as compensation, as punitive damages) of monetary or other relief sought; and (c) a statement that the party wishes to pursue arbitration under this Section 6.13(B). A Demand shall be deemed to have been made, for purposes of any statute of limitations or other purpose as to which the date of institution of arbitration may be relevant, on the date such Demand is signed and served. The scope of discovery includes only those facts directly relevant to the claims and defenses in the case. The prevailing party in such arbitration and any ensuing legal action shall be reimbursed by the party who does not prevail, for the reasonable attorneys, accountants, and expert fees and the costs of such actions.

6.14 Applicable Law. This Agreement shall be construed, interpreted, and governed by the laws of the State of Delaware, without regard to conflict of law principles.

6.15 Compliance. Customer agrees to comply with all laws applicable to its prescription drug benefit plan. Customer acknowledges that Southern Scripts shall have no responsibility to advise Customer regarding Customer's compliance with any applicable law including, without limitation, ERISA. Southern Scripts makes no representation or warranty that the plan design selected by Customer shall be in compliance with applicable law. Customer acknowledges and agrees that it is responsible for disclosing to Members all benefit information legally required to be disclosed, including information related to the calculation of Coinsurance, Co-payments, Deductibles, coverage and exclusions and eligibility requirements it receives in connection with this Agreement. Customer shall be required to submit any reporting under applicable state or federal law. Upon request, Southern Scripts may provide any necessary data required to comply with the applicable state or federal law.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK; SIGNATURES TO FOLLOW]

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date and year first above written.

Southern Scripts, LLC

Name: LeAnn C. Boyd

Title: Chief Executive Officer

Signature: _____

Date: _____

City of San Luis Employee Benefit Trust

Name: _____

Title: _____

Signature: _____

Date: _____

“EXHIBIT A”

PLAN PAYMENT SCHEDULE

PLAN SPONSOR’S PRICE CHARGED PER PRESCRIPTION LEGEND DRUG

PRICE PER PRESCRIPTION WILL BE THE PASSED-THROUGH PRICE FOR PRESCRIPTION LEGEND DRUGS DISPENSED FROM THE NETWORK PHARMACY PLUS A PASSED-THROUGH DISPENSING FEE FOR PRESCRIPTION LEGEND DRUG DISPENSED. THERE WILL BE NO MARGIN PRICING. NETWORK PHARMACY CONTRACTED RATES MAY VARY. THE PHARMACY REIMBURSEMENT MAY BE THE LOWER OF NETWORK PHARMACY CONTRACTED RATES OR U&C. RATES AND DISPENSING FEES ARE SUBJECT TO CHANGE BUT WILL ALWAYS EQUAL THE CONTRACTED PHARMACY RATE.

ANTICIPATED EFFECTIVE RATES FOR NETWORK PHARMACIES’ REIMBURSEMENT PER PRESCRIPTION LEGEND DRUG

	2023	2024	2025
Retail Pricing			
30 Day Supply			
Brand	AWP – 18%	AWP – 18%	AWP – 18%
Generic	AWP – 83.75%	AWP – 84%	AWP – 84.25%
Average Dispensing Fee	\$1.25	\$1.25	\$1.25
90-Day Supply			
Brand	AWP – 21%	AWP – 21%	AWP – 21%
Generic	AWP – 84.75%	AWP – 85%	AWP – 85.25%
Average Dispensing Fee	\$0.75	\$0.75	\$0.75
Mail Pricing			
Brand	AWP – 24.5%	AWP – 24.5%	AWP – 24.5%
Generic	AWP – 88%	AWP – 88%	AWP – 88%
Dispensing Fee	\$0.00	\$0.00	\$0.00
Specialty Pricing			
Non-Variable Copay™	AWP – 18%	AWP – 18%	AWP – 18%
Variable Copay™	AWP - 26%	AWP - 26%	AWP - 26%
Dispensing Fee	\$1.50	\$1.50	\$1.50
Based on overall performance rates of the Southern Scripts block of business. Does not include regional differences or most-favored nations rates (i.e. AK, GA, HI, MA, PR, WV). Price per prescription will be the passed-through price plus any associated taxes less the member’s contribution. There will be no margin or spread pricing. The rate paid to the participating retail pharmacy will be equal to the amount billed to plan sponsor.			

SPECIALTY PRICING DOES NOT INCLUDE LIMITED DISTRIBUTION SPECIALTY PRODUCTS. DOES NOT INCLUDE PROFESSIONAL FEES SUCH AS VACCINE ADMINISTRATION AND COMPOUNDS. GENERIC PRICING ALSO USES MAC PRICING AT RETAIL AND MAIL. GENERIC PRICING INCLUDES ALL GENERICS EXCEPT FOR COMPOUNDS AND SPECIALTY.

COMPOUNDS: COST PLUS 10% + Level of Effort Adjusted Dispensing Fee

VACCINES: Applicable Reimbursement Rate + Vaccine Administration Fee

“EXHIBIT B”

FINANCIAL TERMS

I. ADMINISTRATIVE EXPENSES:

A. Administrative Fee*:	\$8.00 per Paid Claim
B. Monthly Minimum:	N/A
C. Rebates:	100% Rebates Passed-Through to Customer
D. TPA Coordination Fee:	\$1.00 per Paid Claim

II. ELECTIVE EXPENSES:

A. Ancillary Services (if utilized)	
i. Explanation of Benefits:	\$3.00 plus postage, shipping, and handling
ii. Coverage Determination Notices:	\$3.00 plus postage, shipping, and handling
iii. Mailed Welcome Materials:	Cost plus postage, shipping, and handling
iv. Non-standard Member Materials:	Cost plus postage, shipping, and handling
v. Coverage Redetermination Appeals:	Cost
vi. Third Party Override Coordination Fee:	\$50 per override
vii. Disengagement Assistance Services	
a. Additional Files	\$1,500 per additional file
b. Custom Formatting for Additional Files	\$150 per hour
c. Not Otherwise Specified	\$150 per hour
viii. Compliance Services	TBD
ix. Other Unspecified:	TBD
B. Elective Services (if utilized)	Cost
i. Retiree Drug Subsidy	
ii. Employer Group Waiver Plan Administration	
iii. Medication Therapy Management	
iv. Independent Medical Reviews or Coverage Redeterminations	
v. Third Party Audit Services	
vi. Pharmacy Benefit Consulting	
vii. Other Ancillary Services	
viii. Consolidated Appropriations Act Reporting	TBD

**There will be an adjustment to any fee in the event that Customer’s actual Plan participation decreases below ninety-percent (90%) of the expected Plan participation which, as of the Effective Date of the Agreement, is 380 Members.*

“EXHIBIT C”

BUSINESS ASSOCIATE AGREEMENT ADDENDUM

1.0 General Provisions

The terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms or provisions of the Pharmacy Products and Services Administration Agreement to which this Addendum is attached, including all riders, exhibits or other attachments thereto and all documents incorporated therein by reference (the “Agreement”).

Southern Scripts, LLC (hereinafter in this Addendum referred to as “Business Associate”) and the Plan (hereinafter in this Addendum referred to as “Covered Entity”) (each of Business Associate and Covered Entity are sometimes individually referred to herein as a “Party” and are collectively referred to herein as the “Parties”) intend to protect the privacy and provide for the security of any Protected Health Information (“PHI”) (defined below) which Business Associate may create, receive, maintain or transmit from, or on behalf of, Covered Entity pursuant to the Agreement, and any Electronic Protected Health Information (“EPHI”) (defined below) that either Party may create, receive, maintain or transmit pursuant to the Agreement (PHI and EPHI are collectively referred to herein as PHI or Protected Health Information; EPHI will be used when only EPHI is being referenced), in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 (“HIPAA”), and the implementing regulations at 45 C.F.R. Parts 160, 162, and 164 promulgated by the United States Department of Health and Human Services (the “HIPAA Regulations”), along with any guidance or regulations issued by the U. S. Department of Health and Human Services (“DHHS”), and other applicable state and federal laws.

This Addendum is intended to meet the provisions of the HIPAA Regulations, which require Business Associate to enter into a contract containing specific provisions intended to preserve the confidentiality and security of PHI obtained by Business Associate in the course of its business relationship with Covered Entity (defined below) prior to any disclosure of PHI to Business Associate. The specific provisions are set forth in, but not limited to, Title 45, Sections 164.306, 164.308(b), 164.314(a) and (b), 164.502(e) and 164.504(3) of the Code of Federal Regulations and are applicable to this Addendum.

This Addendum is also intended to meet the requirements of all other applicable federal and state laws for the protection of personal information and the reporting of security breach incidents.

2.0 Definitions

As used in this Addendum, the following terms shall have the indicated meaning. Capitalized terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Regulations, or for Personal Information, the definition found in the applicable federal or state laws. The definitions below which set forth a reference to the Code of Federal Regulations are defined HIPAA terms, and such definitions are incorporated herein as though set forth in full. A change to the HIPAA Regulations which modifies any defined term, or which alters the regulatory citation for the definition, shall be deemed incorporated into this Addendum.

- 2.1 **Agreement** means the Administrative Service Agreement between Covered Entity and Business Associate, whereby Business Associate provides or will provide certain services to Covered Entity and, in providing those services, may have access to PHI.

- 2.2 **Authorization** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.508.
- 2.3 **Breach** shall have the same meaning as the term “breach” in 45 C.F.R. Section 164.402 and shall include the unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of such information. For purposes of Personal Information, the term “Breach of Security” shall have the meaning given in the applicable federal and state laws.
- 2.4 **Business Associate** shall mean Southern Scripts, LLC. Where the term “business associate” appears without initial capital letters, it shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103.
- 2.5 **Covered Entity** shall mean the Plan, as defined. It shall also have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103.
- 2.6 **Data Aggregation** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.501.
- 2.7 **Designated Record Set** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.501.
- 2.8 **Electronic Protected Health Information (“EPHI”)** shall have the meaning given to the term Electronic Protected Health Care Information under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103.
- 2.9 **Encrypt or Encryption** means the transformation of data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, unless a higher standard is defined by the appropriate regulatory body under the applicable federal and state laws.
- 2.10 **Health Care Operations** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.501.
- 2.11 **Individual** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103. It shall also include a person who qualifies as a personal representative in accordance with 45 C.F.R. Section 164.502(g).
- 2.12 **Privacy and Security Rule** shall mean the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information that is codified at 45 C.F.R. parts 160 and 164.
- 2.13 **Protected Health Information (“PHI”)** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual, and shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 160.103.
- 2.14 **Required by Law** shall have the meaning given to the term under the HIPAA Regulations, including, but not limited to, 45 C.F.R. Section 164.512(a).

- 2.15 **Security Incident** shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of EPHI, or interference with system operations in an information system.
- 2.16 **Security Standards** shall mean those security standards promulgated or to be promulgated pursuant to HIPAA and other applicable federal or state regulations or statutes.
- 2.17 **Unsecured Protected Health Information or Unsecured PHI** shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in 45 C.F.R. Section 164.402.

3.0 **Obligations of Business Associate**

3.1 **Permitted Use and Disclosure of Protected Health Information.**

- 3.1.1 Business Associate may use and disclose PHI only as required to satisfy its obligations under the Agreement or this Addendum, as permitted herein, as allowed by HIPAA and the HIPAA Regulations, or as Required by Law, but shall not otherwise use or disclose any PHI. Business Associate shall not, and shall ensure that its directors, officers, employees, contractors and agents do not, use or disclose PHI in any manner that would constitute a violation of the HIPAA Regulations if done by the Covered Entity, except that Business Associate may use PHI if necessary (i) for the proper management and administration of Business Associate, (ii) to carry out the legal responsibilities of Business Associate, or (iii) to provide Data Aggregation services relating to the Health Care Operations of the Covered Entity. Business Associate further represents that, to the extent it requests Covered Entity to disclose PHI to Business Associate, such request will only be for the minimum PHI necessary for the accomplishment of Business Associate's purpose.
- 3.1.2 In addition to the uses/disclosures permitted under section 3.1 of this Addendum, the following specific uses/disclosures by Business Associate are permitted under this Addendum:
- A. Uses of PHI by Business Associate for the following business purposes:
 - i. Illustrate cost efficacy (e.g. benchmarking)
 - ii. Internal research and development for new programs/initiatives or updates to existing programs/initiatives

 - B. Disclosures of PHI by Business Associate to the following third party vendors engaged by Covered Entity for various purposes related to plan administration (e.g. medical management consultant, claims administrator, etc.):
 - i. HealthComp Holding Company, LLC and subsidiaries
 - ii. Susan Posada Agency, Inc.
 - iii. Grenz & Company, Inc.
 - iv. _____

 - C. Disclosure of PHI by Business Associate to the following third party vendors for various purposes related to plan administration is authorized if and only if engaged by Covered Entity:
 - i. RxCompass, LLC

- 3.2 **Safeguarding PHI and Personal Information.** Business Associate shall use any and all appropriate safeguards to prevent use or disclosure of PHI and/or Personal Information other than as permitted by this Addendum. Business Associate further agrees to use appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of any PHI and/or Personal Information that Business Associate creates, receives, maintains or transmits on behalf of Covered Entity, in accordance with the HIPAA Regulations and for Personal Information, the applicable federal and state laws in states in which Business Associate receives Personal Information. More specifically, to comply with the HIPAA Security Standards for PHI and to applicable federal and state laws protecting Personal Information, Business Associate agrees that it shall: (i) Develop and implement policies and procedures that meet the Security Standards documentation requirements of HIPAA; (ii) As also provided for in Section 3.5 below, ensure that any agent, including a subcontractor, to whom it provides such PHI or Personal Information agrees to implement reasonable and appropriate safeguards to protect it; (iii) Report to Covered Entity, any Security Incidents or Breaches of Security of which Business Associate becomes aware that result in the unauthorized access, use, disclosure, modification or destruction of the Covered Entity's PHI or Personal Information (hereinafter referred to as "Successful Security Incidents"). Business Associate shall report Successful Security Incidents to Covered Entity as specified in Section 3.4.3, and upon Covered Entity's request, shall provide access to and copies of documentation regarding Business Associate's safeguards for PHI; (iv) Report to Individuals and the media any Successful Security Incidents as specified in Section 3.4.4; (v) For any other Security Incidents that do not result in unauthorized access, use, disclosure, modification or destruction of PHI (hereinafter "Unsuccessful Security Incidents"), Business Associate shall, upon Covered Entity's written request, report to the Covered Entity in accordance with the reporting requirements identified in Section 3.4.3; (vi) Encrypt all PHI and/or Personal Information stored on laptops or other personal devices, encrypt all transmitted records and files containing PHI and/or Personal Information that will travel across public networks, and encrypt all PHI and/or Personal Information to be transmitted wirelessly; and (vii) Business Associate agrees that this Addendum constitutes its representation that it has a written, comprehensive information security program that meets its obligation to safeguard Personal Information in its possession as required by the applicable federal and state laws.
- 3.3 **Mitigation of Harmful Effects.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or Personal Information by Business Associate in violation of the requirements of this Addendum.
- 3.4 **Breach of Privacy or Security Obligations.**
- 3.4.1 **Notice and Reporting of Violations.** Business Associate shall notify and report to Covered Entity, applicable state authorities, Individuals and the media, if required, in the manner described herein any use or disclosure of PHI or Personal Information in violation of this Addendum by Business Associate or any of its officers, directors, employees, contractors or agents.
- 3.4.2 **Notice to Covered Entity.** Business Associate will notify Covered Entity without unreasonable delay following discovery, but in no event later than ten (10) business days following its discovery of a Breach of Unsecured Protected Health Information as such terms are defined by the HIPAA Regulations or any Breach of Security under the applicable federal or state laws. Business Associate shall

cooperate with Covered Entity in investigating the Breach and in meeting Covered Entity's obligations under HIPAA and any other security breach notification laws. Business Associate shall follow its notification to the Covered Entity with a report that meets the requirements outlined immediately below.

3.4.3 **Reporting to Covered Entity.** (i) For Successful Security Incidents and any other use or disclosure of PHI or Personal Information, where it has been determined that Business Associate was the sole cause for such incident, use or disclosure, and that is not permitted by this Addendum, the Agreement, by applicable law or without the prior written approval of the Covered Entity, Business Associate, without unreasonable delay, but in no event later than twenty (20) business days after Business Associate learns of such Successful Security Incident or non-permitted use or disclosure, shall provide Covered Entity with a report that will: (a) Identify, if known, each individual whose Unsecured Protected Health Information or Personal Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during such Breach; (b) Identify the nature of the non-permitted access, use, or disclosure, including the date of the incident and the date of discovery; (c) Identify the PHI or Personal Information accessed, used or disclosed (e.g., name; social security number, date of birth); (d) Identify who made the non-permitted access, use or received the non-permitted disclosure; (e) Identify what corrective action Business Associate took or will take to prevent further non-permitted access, use or disclosure; (f) Identify what Business Associate did or will do to mitigate any harmful effect of the non-permitted access, use or disclosure; and (g) Provide such other information, including a written report, as the Covered Entity may reasonably request; and (ii) For Unsuccessful Security Incidents, Business Associate shall provide Covered Entity no less than quarterly, upon its written request, a report that: (a) identifies the categories of Unsuccessful Security Incidents as described in Section 3.2; (b) indicates whether Business Associate believes its current defensive security measures are adequate to address all Unsuccessful Security Incidents given the scope and nature of such attempts; and (c) if the security measures are not adequate, the measures Business Associate will implement to address the security inadequacies.

3.4.4 **Reporting to Individuals and Media.** For any Breach of Unsecured Protected Health Information and any other use or disclosure of PHI, that is caused by Business Associate and that is not permitted by this Addendum, the Agreement, or by applicable law, it is hereby understood and agreed that Business Associate shall be responsible for providing any legally required notifications to Individuals on behalf of Covered Entity. Business Associate shall also, in collaboration with Covered Entity, for any Breach caused by Business Associate, notify the media on behalf of Covered Entity. Business Associate shall provide these notifications in accordance with the HIPAA Regulations and shall pay for the reasonable and actual costs associated with such notifications, not to exceed the total amount of fees actually paid under this Agreement by Covered Entity to Business Associate during the twelve (12) months immediately preceding a Breach of Unsecured Protected Health Information. Business Associate shall also provide Covered Entity with the information necessary for Covered Entity to comply with DHHS reporting requirements, as applicable, under the HIPAA Regulations. Notwithstanding the foregoing, if Covered Entity desires to provide the reporting to Individuals as described in this subsection 3.4.4, Covered Entity shall notify

Business Associate within five (5) business days of receipt of Business Associate's notice provided under subsection 3.4.2.

3.4.5 **Reporting by Covered Entity.** Where a Breach relates to PHI, if Covered Entity determines pursuant to Section 5.2 of this Addendum that termination of this Addendum is not feasible, in Covered Entity's sole discretion, then Covered Entity shall have the right to report Business Associate's Breach to the Secretary of the Department of Health and Human Services.

3.4.6 **Reporting by Business Associate.** Where a Breach of Security relates to Personal Information, Business Associate shall report promptly such Breach of Security to Covered Entity as required by applicable federal and state laws.

3.5 **Agreements by Third Parties.** Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides or transmits PHI and/or Personal Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to substantially similar restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.

3.6 **Access to Information.** Business Associate agrees, at the request of Covered Entity, to provide Covered Entity access to PHI about an Individual contained in a Designated Record Set in a prompt commercially reasonable manner in order to enable Covered Entity to meet the requirements of 45 C.F.R. Section 164.524, and where applicable, any other requirements of the HIPAA Regulations. In the event any Individual requests access to his or her PHI directly from Business Associate, Business Associate shall forward the PHI directly to the Individual, or make the PHI available to the Individual at a reasonable time and at a reasonable location in accordance with 45 C.F.R. Section 164.524.

3.7 **Availability of Protected Health Information for Amendment.** Business Associate agrees to make any amendment of an Individual's PHI or a record regarding an Individual contained in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. Section 164.526 at the request of Covered Entity or an Individual, in a prompt and commercially reasonable manner.

3.8 **Accounting of Disclosures.** To the extent applicable to Business Associate, Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. Section 164.528 or the HIPAA Regulations. In addition, Business Associate agrees to provide to Covered Entity or an Individual, in a prompt commercially reasonable manner, information collected in accordance with this Addendum to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. Section 164.528 or the HIPAA Regulations.

3.9 **Auditing, Inspections and Enforcement.** Upon reasonable notice, Business Associate agrees to make its internal practices, books and records relating to the use or disclosure of PHI available to the Secretary of the Department of Health and Human Services, or the Secretary's designee, in a prompt commercially reasonable manner for purposes of determining Covered Entity's compliance with the HIPAA Regulations.

4.0 Covered Entity's Obligations.

- 4.1 **Notice of Limitations and Restrictions.** Covered Entity shall notify Business Associate of any limitations or restrictions in Business Associate's ability to use or disclose Covered Entity's PHI to the extent that such limitations or restrictions may affect Business Associate's use or disclosure of PHI, within a reasonable period of time after Covered Entity becomes aware of or agrees to such limitations or restrictions.
- 4.2 **Revocation of Authorization by Individual.** Covered Entity agrees to inform Business Associate of any change to, or revocation of, an Individual's Authorization to use or disclose PHI to the extent that such change may affect Business Associate's use or disclosure of PHI, within a reasonable period of time after Covered Entity becomes aware of such change.
- 4.3 **Restrictions on Use and Disclosure.** Covered Entity agrees to notify Business Associate of any restrictions to the use or disclosure of PHI agreed to by Covered Entity in accordance with 45 C.F.R. Section 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
- 4.4 **Permissible Requests.** Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Regulations if done by Covered Entity. Requests by Covered Entity for Business Associate to disclose PHI to a third party will be in writing and will specify whether or not the third party is also a business associate of Covered Entity. Business Associate shall require that a separate privacy and security agreement and/or a Nondisclosure and Confidentiality Agreement ("NDA") be signed by the third party prior to disclosure. In the event that third party will not enter into a separate privacy and security agreement and/or an NDA with Business Associate, Covered Entity shall indemnify Business Associate against any Breach of Unsecured Protected Health Information committed by third party in accordance with the indemnification provisions of the Agreement.
- 4.5 **Safeguards.** Covered Entity shall use appropriate safeguards in accordance with 45 C.F.R. Sections 164.306, 164.308, 164.310 and 164.312 to ensure the security of PHI provided to Business Associate pursuant to the Agreement and this Addendum, until such PHI is received by Business Associate.

5.0 Termination of Addendum

- 5.1 **Term.** The term of this Addendum shall end upon termination of the underlying Agreement, subject, however, to the requirements of this Section 5.0 for return or destruction of all PHI.
- 5.2 **Termination Upon Breach of Provisions Applicable to Protected Health Information or Personal Information.** Any other provision of this Addendum notwithstanding, this Addendum may be terminated by the non-breaching Party (without penalty) upon ten (10) days' prior written notice to the other Party in the event that such other Party materially breaches any obligation of this Addendum and fails to cure the Breach within such ten (10) day period.
- 5.3 **Return or Destruction of Protected Health Information and Personal Information Upon Termination.** Upon termination of this Addendum and the Agreement, Business Associate shall either return to Covered Entity or destroy all PHI and Personal Information in Business Associate's possession and in the possession of its agents or subcontractors. Business Associate shall not retain any copies of PHI or Personal Information. Notwithstanding the foregoing, if Business Associate determines that returning or destroying PHI and/or Personal

Information is infeasible, Business Associate shall extend the protections of this Addendum to such PHI and/or Personal Information and limit further uses and disclosures of such PHI to those purposes that make return or destruction infeasible, for so long as Business Associate maintains such PHI and/or Personal Information. If Business Associate elects to destroy all PHI and/or Personal Information, it shall certify in writing to Covered Entity that such PHI and/or Personal Information has been destroyed.

6.0 **Miscellaneous**

- 6.1 **Ownership of Protected Health Information and Personal Information.** As between Business Associate and Covered Entity, the PHI and Personal Information and any related information created for or received from or on behalf of Covered Entity is, and will remain, the property of Covered Entity, including any and all forms thereof developed by Business Associate in the course of fulfilling its obligations pursuant to the Agreement. Business Associate agrees that it acquires no ownership rights in or title to PHI or Personal Information or any related information. Notwithstanding the foregoing, if Business Associate determines that returning or destroying PHI is infeasible, and that a copy must be kept, then Section 5.3 of this Addendum shall govern Business Associate's retention of a copy of such PHI or Personal Information.
- 6.2 **Amendment to Comply With Law.** Business Associate and Covered Entity agree to amend this Addendum to the extent necessary to allow either Party to comply with the standards and requirements of HIPAA, the HIPAA Regulations and other applicable state and federal laws relating to the security or confidentiality of PHI and/or Personal Information. Business Associate and Covered Entity will comply fully with all applicable standards and requirements of such federal or state regulations or statutes. To the extent that any amendment of such laws requires changes to this Addendum, Business Associate shall provide written notice to Covered Entity of such changes and this Addendum shall be automatically amended to incorporate the changes set forth in the written notice provided by Business Associate to Covered Entity unless the Covered Entity objects to such changes in writing within fifteen (15) days of receipt of such notice. If Covered Entity objects in a timely manner to such amendment, the Parties shall work in good faith to reach agreement on a change to the Addendum that complies with the amendment of such laws. If the Parties are unable to reach agreement on a change to the Addendum within thirty (30) days of the date that Business Associate receives written objection from Covered Entity, then either Party may terminate this Addendum upon written notice of such termination.
- 6.3 **Other Amendments.** Any other amendment to this Addendum unrelated to compliance with applicable law and regulations shall be effective only upon execution of a written agreement between the Parties.
- 6.4 **Survival.** The respective rights and obligations of Business Associate under Section 5.3 of this Addendum shall survive the termination of this Addendum and the underlying Agreement.
- 6.5 **Effect on Agreement.** The provisions of this Addendum shall prevail over any provisions of the Agreement that conflict with or are inconsistent with any provision of this Addendum. All other terms of the Agreement shall remain in full force and effect.
- 6.6 **Interpretation.** This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with the HIPAA Regulations. The Parties agree that any

ambiguity in this Addendum or the Agreement shall be resolved in favor of a meaning that complies with and is consistent with the HIPAA Regulations.

“EXHIBIT D”

SAMPLE LANGUAGE FOR VARIABLE COPAY PROGRAM UTILIZATION AND DRUG-SPECIFIC COST SHARING DESIGN

The language suggested below is sample* language that Plan may incorporate into its Summary Plan Description (SPD) and Summary of Benefits Coverage (SBC) documents to comply with its content obligations to Plan Participants under ERISA for utilization of the Variable Copay Program. Alternative language may also be satisfactory. Plan Sponsor, or other designated administrator of the Plan, should have its own attorney or other qualified advisor review this sample language if used to ensure compliance with the applicable law. **Please note, however, that for Plan Sponsors seeking to utilize a drug-specific cost-sharing obligation with respect to drugs no longer eligible for the Variable Copay Program, we recommend that Plan Sponsors amend their plans and/or SPDs, as applicable, to include the highlighted language below or equivalent language.**

I. Summary Plan Description (SPD). This language should be modified by Plan Sponsor, or other designated administrator of the Plan, as necessary to reflect the terms of the Designated Plan and must be incorporated in a manner that satisfies the requirements of 29 C.F.R. §2520(B) and related guidance.

A. Sample language to include for Variable Copay Program generally:

The Plan has adopted the Southern Scripts Variable Copay™ Program to help Members who utilize manufacturer copay programs save money on prescription drugs. Under the Variable Copay™ Program, your out-of-pocket cost for prescription drugs may be reduced or eliminated by a drug manufacturer’s copay subsidy. If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug. **Note: Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.** If you are not eligible to receive a manufacturer copay subsidy, your copay obligation will be the copay amount listed for the drug in the standard formulary under the Plan. **Note: If you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation—and the out-of-pocket cost you may be required to pay—will be the maximum manufacturer copay subsidy for that drug.**

Manufacturer eligibility requirements are subject to change without notice. As a result, **in certain instances, drugs may no longer be available under the Variable Copay Program (“Excepted Drug”).** Effective as of [DATE], the Plan has a drug-specific cost-sharing obligation with respect to each Excepted Drug. **This cost-sharing obligation is solely your responsibility and is fixed regardless of whether you are eligible for or receive third party cost-sharing assistance. While the Excepted Drug is no longer eligible under the Plan’s Variable Copay Program, cost-sharing assistance may be available to you from a third party (such as a drug manufacturer). Please note that any cost-sharing assistance you receive with respect to an Excepted Drug will accumulate against your deductible or maximum-out-of-pocket limit, subject to you having satisfied your statutory minimum deductible for purposes of the federal tax rules governing Health Savings Account (HSA) eligibility if you are enrolled in an HSA-qualifying high-deductible health plan. For information on the Excepted Drugs subject to a drug-specific cost-sharing obligation under the Plan, and for more information on the specific cost-sharing that applies each Excepted Drug, please visit variablecopay.com or you may call (833) 439-9617.**

II. Summary of Benefit Coverage (SBC). The below SBC template produced by the Department of Labor, Internal Revenue Service, and Department of Health and Human Services includes sample language to satisfy the requirements of 26 C.F.R. §54, 29 C.F.R. §2590, and 45 C.F.R. §147. The language must be incorporated in a manner that satisfies the formatting requirements of the associated guidance for group coverage. The sample template below contains the necessary language for the Variable Copay Program.

Common Medical Event	Services You May Need	What You Will Pay*		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage under the Variable Copay™ Program is available at www.variablecopay.com .	Generic drugs	\$_____	\$_____	None
	Preferred brand drugs	\$_____	___% <u>coinsurance</u>	If you are eligible to receive a subsidy through a manufacturer copay program, your <u>copayment</u> under the Variable Copay™ Program will be equal to the maximum subsidy available through that manufacturer copay program. Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.
	Non-preferred brand drugs	\$_____	___% <u>coinsurance</u>	
	Specialty Drugs	\$_____	___% <u>coinsurance</u>	On occasion, a drug may become ineligible for the Variable Copay Program. If this occurs, the drug is subject to a specific cost-sharing obligation that is fixed and is solely your responsibility regardless of whether you utilize third party copay assistance or otherwise. For information on drugs subject to a specific cost-sharing obligation under your Plan and the amount of such cost-sharing obligation, visit variablecopay.com

*The cost-sharing chart must show copayments and coinsurance after the deductible has been met (i.e., if subject to deductible and then covered at 100%, this column must state “no charge”). If the deductible does not apply, the phrase “does not apply” should appear in the chart.

DISCLAIMER: PLAN HAS ULTIMATE AUTHORITY AND RESPONSIBILITY TO ENSURE THAT ITS PLAN DOCUMENTS ARE IN COMPLIANCE WITH ERISA. PLAN MAY NOT RELY ON THIS SAMPLE LANGUAGE TO ASSERT ANY CLAIM AGAINST SOUTHERN SCRIPTS BASED ON OR ARISING OUT OF SUCH RELIANCE. SOUTHERN SCRIPTS WILL NOT BE LIABLE FOR ANY CLAIM FOR DAMAGE THAT RESULTS EITHER DIRECTLY OR INDIRECTLY FROM RELIANCE ON THIS SAMPLE LANGUAGE.



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. F.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding newly hired employees' benefits eligibility date. **(Mary Barajas, Human Resources Coordinator)**

SUMMARY:

The City of San Luis has established the City of San Luis Employee Benefit Trust in order to provide comprehensive healthcare benefits for employees and their eligible dependents.

In our current benefit plan, the initial enrollment is defined as follows:

- For benefits-eligible City employees, coverage becomes effective the 1st of the month following the date of hire.
- Coverage of enrolled spouse and/or dependents becomes effective the 1st of the month following the employee's effective date.

Having different eligibility dates for Employees and their dependents on initial enrollment of benefits is not the usual practice. Since systems do not support the automation of different dates, this practice requires manual intervention on the TPA side, which may lead to errors in our enrollment system.

After conducting research with other municipalities, we have found that the common practice is to allow new employees and dependents to be eligible for coverage on the same date, which is usually the **1st of the month following one month of employment.**

This change does not have an impact on current employees as it only applies to the initial enrollment of new hires. By approving this change in our Plan, we can minimize any human errors and optimize the enrollment process.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE BENEFITS COVERAGE ELIGIBILITY DATE TO BECOME EFFECTIVE THE FIRST OF THE MONTH FOLLOWING ONE MONTH OF EMPLOYMENT FOR NEW EMPLOYEES AND THEIR DEPENDENTS.

Fiscal Impact

Fiscal Impact:

The fiscal impact may save the trust a minimal amount delaying the newly hired employees' enrollment date to the first of the month following the date of hire.



AGENDA ITEM REVIEW FORM

Special Employee Benefit Trust Board Meeting

3. G.

Meeting Date: 05/04/2023

Department Head: Adela Cortez, Director Human Resources, Human Resources Department

Submitted By: Maria Barajas Gutierrez, Human Resources Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding benefit trust fund reserves. **(Monica Castro, Director of Finance)**

SUMMARY:

The Employee Benefit Trust Fund is composed of ongoing contributions (insurance premiums) made by the City and Employees to pay health-related claims. Distributions from the Fund are made throughout the fiscal year to pay medical and dental claims. Claims are not always the same. There are years when claims are high, and most of the contributions are used. There are other years when the claims are low, and all contributions are not used, thus building reserves in the Fund. It is customary to maintain reserves of approximately six (6) months of the total annual contributions, which according to our annual claims, would be equivalent to approximately 1.9 million. The Fund currently has 4 million in reserves.

The cost of health insurance increases every year. During the last three (3) years, the City of San Luis has not increased the employer or the employee premiums. Due to a number of high claims this year, we anticipate that 3.9 million will be required to cover claims for FY 2024. Employer and employee contributions will not cover the estimated expenses. City of San Luis Administration has decided to use reserve funds to cover any difference between the total contributions and the estimated expenses.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE UTILIZATION OF THE EMPLOYEES BENEFITS TRUST FUND RESERVES TO COVER THE INCREASE OF HEALTH INSURANCE PREMIUMS.
