VILLAGE OF DOWNERS GROVE
Report for the Village

SUBJECT: 10/20/2020	SUBMITTED BY:
Employee Benefits Renewal Contracts and Medical Plan Amendments for FY2021	Dennis Burke Director of Human Resources

SYNOPSIS

Resolutions have been prepared to authorize approval of employee benefits renewal contracts and plan amendments for FY21.

STRATEGIC PLAN ALIGNMENT

The goals for 2019-2021 include *Steward of Financial, Neighborhood and Environmental Sustainability.*

FISCAL IMPACT

The Proposed FY21 budget includes $1,650,095 in the Health Fund for claims administration, stop loss contracts and Wellness Health Initiative. The vendors and contract amounts for FY20 and FY21 are itemized below:

Vendor	Contract Item	FY2020 Amount	FY2021 Amount
Blue Cross/Blue Shield	Medical Claim Administration	$91,834	$63,386
Blue Cross/Blue Shield	Specific and Aggregate Stop Loss	$785,492	$815,961
Subtotal		**$877,326**	**$879,347**
National Insurance Services Trust	Life Insurance	$83,504	$83,504
National Insurance Services Trust	Disability Benefits	$26,746	$26,746
Humana	Medicare Insurance for Retirees Over 65	$339,361	$324,887
Delta Dental	Dental	$193,352	$193,352
Total		**$1,520,289**	**$1,507,836**

RECOMMENDATION

Approval on the October 20, 2020 Consent Agenda.

BACKGROUND

The recommended contracts provide the necessary administration and support for the Village's Health Insurance program, which has a total budget of $6.7 million as shown in the FY21 Proposed Budget. The budget also describes how the Village has positioned itself well to effectively control health insurance costs and respond to the requirements of the Patient Protection Affordable Care Act.

A summary of the 2021 employee benefits contracts is provided below:

- *Medical Claim Administration* – The Village has a self-funded medical plan and contracts with an outside vendor to provide claim administration on behalf of the Village. Claim administration includes medical and prescription drug claim adjudication, pre-certification and medical case management services. On an annual basis, staff reviews the claim administration services received from the vendor. Also reviewed is the relationship the vendor has with preferred provider organizations (PPO) to ensure the discounts received through the PPO contracts are cost effective to both the employee and the Village. The Village has contracted with Blue Cross/Blue Shield of Illinois for these services since 2011. Blue Cross has provided a renewal quote for 2021 for claims administration. Blue Cross also charges a fee to access their PPO network. The fee is offset by the significant savings the Village realizes through the Blue Cross PPO discounts. The Village made positive changes to the plan design which was recognized by Blue Cross that provided a more positive renewal cost which includes a broader increase in prescription drug credits. Total annual costs for medical claims administration for 2021, which includes the PPO access fee, are $63,386. This represents a decrease of $28,448 from the previous year.

- *Stop Loss Coverage* - The Village purchases stop loss coverage to limit its financial exposure. Stop loss coverage provides insurance for catastrophic medical claims of participants in the Village's group health care plan. There are two types of stop loss coverage, specific and aggregate. Specific stop loss insurance provides a point at which time the insurance company becomes responsible for any claims after an individual insured reaches a pre-determined limit in the contract year. As part of the annual review, staff directs the Village's consultant, the Horton Group, to recommend to the Village the most appropriate point for specific stop loss coverage. The consultant reviews specific claim data on the Village's group and determines if it is cost effective for the Village to take on additional claim exposure. For 2021 the consultant determined that the Village should remain at the current $150,000 specific stop loss level. Due to a high volume of claims that reached the $150,000 stop loss level the Village expected an increase in the Stop Loss premium. The Village does obtain alternative quotes on stop loss coverage on an annual basis. Blue Cross's quote for stop loss totals $815,961 annually. The increase of $30,469 for stop loss from last year is due to participants in the health plan exceeding the $150,000 limit. Instead of red lining these individuals at higher levels of stop loss at a higher rate, the underwriter added to the premium and kept all participants at $150,000 stop loss, which is in the best interest of the Village's Health Plan.

- *Life Insurance* - Life Insurance is offered as an employee benefit. The premium for Life Insurance for 2021 is $83,504. This premium reflects no Increase from the previous year.

- *Long Term Disability Insurance (LTD)* – LTD is a benefit for all full time employees, except sworn Police or Fire employees, who are covered through the pension plan. Premium costs for FY21 is $26,746. This premium reflects no Increase from the previous year.

- *Retiree Carve Out* - Village employees and their eligible spouses that are on the Village's Health Insurance Plan go to the Retiree Carve Out when they reach Medicare age at 65 years old. In 2012, the Village, through the Broker, found a Humana Supplement plan and this is where the coverage for these retirees is provided and are no longer on the Village's Self-Insurance Program. The Village pays the premium and invoices those premiums to the respective retirees. However, those employees that retired prior to the change in Village Ordinance on 9/9/2009 receive credit of 50% of premium. The premium for 2021 is $324,887. The decrease from the previous year is due to tax of changes decreasing premiums by $51 a month per participant.

- *Dental* – The Village provides employees a dental program administered by Delta Dental Plan of Illinois. Under this program, employees utilize PPO network providers where services are received at discounted rates and benefits are primarily paid in full. Employees also have the flexibility of going out-of-network; however, they would receive coverage that is less comprehensive. Fees for administration of the Delta Dental program for 2021 are $19,352.16. Same cost as the previous year.

ATTACHMENTS

Resolutions
Contracts

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF A RENEWAL AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND BLUE CROSS/BLUE SHIELD OF ILLINOIS FOR MEDICAL CLAIM ADMINISTRATION SERVICES

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Administrative Services and Claim Administrator Agreement Renewal (the "Renewal"), between the Village of Downers Grove (the "Employer") and Blue Cross/Blue Shield of Illinois (the "Claim Administrator"), for medical claim administration services, effective January 1, 2021 through December 31, 2021, as set forth in the form of the Renewal submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Renewal, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Renewal.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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BlueCross BlueShield of Illinois

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2021.

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

Account Number: 365058

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

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**VILLAGE OF DOWNERS GROVE ("EMPLOYER")**
By:	By:_____
Title: Vice President and Chief Underwriter	Title:_____
Date: Effective Date of Coverage noted above	Date:_____

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

RECITALS

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

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

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

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

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

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

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

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

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

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

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

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

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed.

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

2.2 **Employer's Direction as to Benefit Design.** Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in an automated benefit summary and similar documentation (collectively, "ABS") and the ASO BPA. Employer agrees that Claim Administrator shall process claims in accordance with the ABS and the ASO BPA. Employer agrees Claim Administrator may rely on the most current version of the ABS and the ASO BPA as the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

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

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

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

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

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

Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement. Employer shall obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.6 **Grandfathered Health Plans (If Applicable).** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least sixty (60) days' advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide notice thereof as required) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any

legal, tax or other ramifications related to any Plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference into and become part of this Agreement, and Employer represents and warrants that the information it submits on such Form is true, complete and accurate.

2.7 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans (If Applicable).** If Claim Administrator provides Services for any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's exempt plan status or any representation regarding any Plan's exempt plan status.

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

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

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

Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

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

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

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

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

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

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

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed and consistent with the Inter-Plan provisions of this Agreement.

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

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

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

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

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

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

the identity of Employer Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 **Business Confidential Information and Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information ("BCI"). Employer shall not use or disclose such Business Confidential Information, including this Agreement, to any third party without prior written consent of Claim Administrator. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has the opportunity to object and ensure appropriate confidentiality protections are in place. Employer will at all times remain liable for maintaining the confidentiality of this Agreement and shall ensure that any affiliated entities or third-party representatives to whom the Agreement is disclosed are bound in writing not to further disclose this Agreement without the prior written consent of Claim Administrator. Neither Party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other Party or the other Party's respective clients in advertising or promotional materials without prior written consent of the other Party; provided, however, that Claim Administrator may include Employer in its list of clients.

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

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

3.7 **Records.** For a period of one (1) year following termination of this Agreement, Claim Administrator shall, upon the request of the Employer, provide to Employer, a copy of all Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator. Such copy shall be transmitted in a form as agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. Claim Administrator shall retain all such Claim records for the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator. The failure to agree upon a retention period shall not constitute breach of this Agreement.

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

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

4.1 **Litigation.** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against one or both Parties that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either Party under the Plan and this Agreement. Employer shall undertake the defense of such action and be responsible for the costs of defense, including but not limited to attorneys' fees and costs, external claim reviews, and other expenses. Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action, in which

event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists. Some defense support by Claim Administrator, such as external claim review, may require an additional fee, the costs for which shall be Employer's responsibility.

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

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

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

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

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

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

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

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

4.3 **Third Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments and Net Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third parties' fees, as defined in the ASO BPA, associated with

such assistance and Claim Administrator's fee for its related administrative expenses to support such third party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

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

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

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

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

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

4.9 **Notice and Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such, including but not limited to initiation of Dispute Resolution under Section 4.11 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to

allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon Timely prior written notification to the other Party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

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

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

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

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

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

2. Arbitration shall be held in Chicago, Illinois.

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

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

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

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

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

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

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

SECTION 5: NON-ERISA GOVERNMENT REGULATIONS

5.1 **In Relation to the Plan.** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of Employer, Employer agrees that Claim Administrator does not and will not accept any allocation or delegation of any responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator or of the Plan.

5.3 **In Relation to Claim Administrator's Responsibilities.** Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of Employer's Plan. As such, the Parties intend for Claim Administrator to be a service provider but not a fiduciary with respect to Employer's employee benefit plan. Employer acknowledges and agrees that Claim Administrator may render advice with respect to claims and administer claims on behalf of the plan administrator of Employer's benefit plan. Claim Administrator has no other authority or responsibility with respect to Employer's employee benefit plan. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

SECTION 6: OTHER PROVISIONS

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

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

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

c. By either Party, in the event of conduct by the other Party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 4.9 above; or

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

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

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

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

The Exhibits and Addenda of this Agreement are:

a. Exhibit 1 – Claim Administrator Services

b. Exhibit 2 – Fee Schedule and Financial Terms

c. Exhibit 3 – Notices/Required Disclosures

d. Exhibit 4 – ASO Benefit Program Application ("ASO BPA")

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

f. Exhibit 6 – Recovery Litigation Authorization

g. Exhibit 7 – Pharmacy Benefit Management Services

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

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

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

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

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

6.6 **Notice of Annual Meeting.** Employer is hereby notified that it is a member of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street,

Chicago, Illinois, each year on the last Tuesday in October at 12:30 P.M. For purposes of this section, the term "member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 7: DEFINITIONS

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

7.1 **"Administrative Charge"** means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

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

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

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

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

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

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

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

7.3 **"Ambulance Transportation"** means local transportation in a specially equipped vehicle for certified ground and air transportation options from Covered Persons' home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and skilled nursing facility or from a skilled nursing facility or Hospital to a Covered Persons' home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of the Covered Person, the Covered Person's family/caregivers or Physician, or the transferring facility, is not considered medically necessary.

7.4 **"Average Discount Percentage" ("ADP")** means a percentage discount determined by Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to Covered Persons by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out–of–pocket maximums and/or any benefit maximums. The ADP will often vary from Claim to Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by Claim Administrator to be relevant to the particular Claim. The ADP reflects Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount, not to exceed fifteen percent (15%) of such estimate, to reflect related costs. (See provisions regarding "Claim Administrator's

Separate Financial Arrangements With Providers" in Exhibit 3.) In determining the ADP, Claim Administrator will take into account differences among Hospitals and other facilities, Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when the Covered Person's benefits under the Plan are secondary to Medicare and/or coverage under any other group program.

7.5 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and Blue Shield licensees through Inter-Plan Arrangements, that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence.

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

7.7 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between Claim Administrator and the particular Provider. (See provisions regarding "Claim Administrator's Separate Financial Arrangements With Providers And Other Entities" in Exhibit 3).

7.8 **"Claim Payment"** means the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge, Maximum Allowance, Prescription Drug Program Eligible Charge and/or Allowable Amount**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between Claim Administrator and the particular Provider. (See provisions regarding "Claim Administrator's Separate Financial Arrangements With Providers And Other Entities" in Exhibit 3.) The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

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

7.10 **"Contracted Provider"** means a Participating Provider and a Participating Professional Provider, collectively.

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

7.12 **"Coordinated Home Care Program"** means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. A Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of a Physician, a Physician assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. A Coordinated Home Care Program

includes physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

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

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

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

7.17 **"Custodial Care Service"** means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Covered Person's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

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

7.19 **"Eligible Charge"** means (a) in the case of a Provider, other than a professional Provider, which has a written agreement with Claim Administrator or another Blue Cross and Blue Shield Plan to provide care to Covered Persons, or is designated as a participating Provider by any Blue Cross and Blue Shield Plan, at the time Covered Services for medical benefits are rendered ("Participating Provider"), such Participating Provider's Claim Charge for Covered Services; and (b) in the case of a Provider, other than a professional Provider, which does not have a written agreement with Claim Administrator or another Blue Cross and Blue Shield Plan to provide care to Covered Persons, or is not designated as a Participating Provider by any Blue Cross and Blue Shield Plan, at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

i. the lesser of (A) the Provider's standard Claim Charges, and (B) an amount determined by Claim Administrator to be approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

ii. if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (A) the Provider's standard Claim Charges and (B) an amount determined by Claim Administrator to be one hundred and fifty percent (150%) of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

iii. if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be fifty percent (50%) of the Provider's standard Claim Charges, provided, however, that Claim Administrator may limit such amount to the lowest contracted rate that Claim Administrator has with a Participating Provider for the same or similar service based upon the type of Provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the Covered Person.

Claim Administrator will utilize the same Claim processing rules, edits or methodologies that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event Claim Administrator does not have any Claim edits, rules or methodologies, Claim Administrator may utilize the

Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Eligible Charge amount does not equate to the Non-Participating Provider's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

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

7.22 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

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

7.24 **"Hospital"** means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

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

7.26 **"Maximum Allowance"** means in the case of a professional Provider one of the following amounts in accordance with the type of medical benefits coverage elected on the most current ASO BPA:

a. For professional Providers who have a written agreement with Claim Administrator or another Blue Cross and Blue Shield Plan or is designated as a participating Provider by any Blue Cross and Blue Shield Plan to provide care to Covered Persons at the time Covered Services for medical benefits are rendered ("Participating Professional Provider"), the Maximum Allowance is the amount such Participating Professional Provider has agreed to accept as payment in full, or the reimbursement amount set by Claim Administrator or the Host Blue for Providers designated as Participating Professional Providers for a particular Covered Service. All benefit payments for Covered Services rendered by a Participating Professional Provider will be based on the Schedule of Maximum Allowances which such Provider has agreed to accept as payment in full.

b. For professional Providers who do not have a written agreement with Claim Administrator or another Blue Cross and Blue Shield Plan or is not designated as a participating Provider by any Blue Cross and Blue Shield Plan, to provide care to Covered Persons at the time Covered Services for medical benefits are rendered ("Non-Participating Professional Provider"), the Maximum Allowance is the lesser of (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

i. the Provider's Claim Charge, or;

ii. Claim Administrator's non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately one hundred percent (100%) of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services

will be fifty percent (50%) of the Non-Participating Professional Provider's standard Claim Charge for such Covered Services, (2) the non-contracting Maximum Allowance for Ambulance Transportation services provided by Providers (other than Providers that bill through a Participating Provider, which use "Eligible Charge") will be the price set forth in the ABS, and (3) the non-contracting Maximum Allowance for other unsolicited Providers will be the same as the Maximum Allowance described in (a) above. When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be one hundred percent (100%) of Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowance, then the Maximum Allowance will be twenty-five percent (25%) of Claim Charges. Claim Administrator will utilize the same Claim processing rules, edits or methodologies that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event Claim Administrator does not have any Claim edits, rules or methodologies, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

7.27 **"Net Claim Payment"** means the net benefit payment calculated by Claim Administrator, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services under this Agreement, plus any related Surcharges. All Net Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, less the ADP if applicable, irrespective of any separate financial arrangement between Claim Administrator and the particular Provider. (See provisions regarding "Claim Administrator's Separate Financial Arrangements With Providers And Other Entities" in Exhibit 3.) The term "Net Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments" in Exhibit 5.

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

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

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

7.31 **"Overpayment"** means a payment to a Provider or a Covered Person that was more than it should have been, or a payment that was made in error.

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

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

7.34 **"Prescription Drug Program Eligible Charge"** means (1) for purposes of calculating Employer Payment and Covered Persons' required deductible and Coinsurance, in the case of a Provider which has a written agreement with Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Prescription Drug Program Eligible Charge is the cost mutually agreed upon by Employer and Claim Administrator set forth in the PBM Fee Schedule Addendum to the ASO BPA, if applicable; and (2) for purposes of calculating both Employer Payment and the Covered Persons' required deductible and Coinsurance, in the case of a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by Claim Administrator to provide prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Non-Participating Prescription Drug Provider"), the Prescription Drug Program Eligible Charge is the lesser of the following charges for Covered Services:

i. the charge which the particular Non-Participating Prescription Drug Provider usually charges for Covered Services, or

ii. the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus twenty-five percent (25%) unless otherwise agreed upon by Claim Administrator and Employer.

7.35 **"Primary Care Physician"** means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in one of the recognized areas of pediatrics, obstetrics and gynecology (if applicable), internal medicine and family practice.

7.36 **"Private Duty Nursing Service"** means (T1000) Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private Duty Nursing Service is shift nursing of eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private Duty Nursing Service does not include Custodial Care Service.

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

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

7.39 **"Skilled Nursing Service"** means (T1000, S9123, S9124) those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

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

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

7.42 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within forty-eight (48) hours of notification to Employer by Claim

Administrator, monthly fees (e.g. Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

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

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

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

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

- **CLAIMS ADJUDICATION**

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

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

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

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

- **ENROLLMENT SERVICE**

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

- **DISABLED DEPENDENT VERIFICATION**

  Determine the disabled status of any dependent children of Covered Persons, for purposes of administering the Group's age limit for eligibility. Determination will be made based on Claim Administrator's review of clinical information received by Claim Administrator from the Covered Person or the dependent's medical provider(s).

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

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

- **INTERNAL APPEALS**

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

- **MEMBERSHIP**

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

- **STANDARD REPORTS**

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

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

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

- **ACTUARIAL AND UNDERWRITING**

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

- **FRAUD DETECTION AND PREVENTION**

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

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

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

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

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

- **PROVIDER NETWORK(S)**

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

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

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

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, escheat such funds to state of payee's last known address on behalf of Employer or escheat amounts pursuant to such funds to Employer, as elected by Employer, less any amount(s) owed by payee to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

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

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations such as support functions.

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **EXTERNAL REVIEW COORDINATION**

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

- **BLUE CARE CONNECTION® PROGRAM**

  Provide a program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by Employer and agreed to by Claim Administrator.

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator.

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

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

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

  Assist Employer with establishing a maximum coverage amount for specified imaging, Inpatient, and Outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

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

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

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

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates behavioral health care management, incentives for Covered Persons, maternity benefit management, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator.

EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

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

Inter-Plan Arrangement Fees:

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

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

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

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

SECTION 2: EXHIBIT DEFINITIONS

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

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

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

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

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

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

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

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the

Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

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

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

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

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

3.4 ***Service Charges upon Termination.*** In the event the Agreement is terminated in accordance with the "Term and Termination" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a termination by Employer of more than ten percent (10%) of Claim Administrator's projections of Covered Employees, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

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

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

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

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

SECTION 4: CLAIM PAYMENTS

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

4.2 ***Employer's Liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Net Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Net Claim Payment pursuant to Section 6 below titled "Claim Settlements." Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

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

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

SECTION 5: EMPLOYER PAYMENT

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

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

a. ***If Employer Payment Method is by Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.

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

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

SECTION 6: CLAIM SETTLEMENTS

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

a. All Net Claim Payments calculated on the basis of Claim Payments paid by Claim Administrator in the particular Claim Settlement Period.

b. All Net Claim Payments calculated on the basis of Claim Payments paid by Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim settlement.

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

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

6.2 ***Employer Underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within sixty (60) days from the last day of the Claim Settlement Period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer Overpayment.*** If, within the Claim Settlement Period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

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

a. Suspend Claim Payments; or

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

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

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

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

b. The maximum rate permitted by state law.

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

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, or on the date of a termination by Employer of more than ten percent (10%) of Claim Administrator's projections of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Net Claim Payments calculated on the basis of Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or termination of Covered Employees but not the Agreement, including, but not limited to, Claim Payments and/or Net Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of termination of Covered Employees but not the Agreement.

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

8.3 ***Final Settlement.*** A final settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for Overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

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

EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

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

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

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

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non–Network Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network Provider are not based upon the amount billed. The basis of the benefit payment will be determined

according to the Plan's Fee Schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance, Copayments, and deductible amounts. A Covered Person may obtain further information about the Network status of Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

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

4.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Prescription Drug Program Eligible Charge, subsection (1). All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the Prescription Drug Program Eligible Charge, subsection (2).

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

4.3 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or allowances except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the Parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts, payments and/or other allowances that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator. For the mail-order pharmacy and specialty pharmacy program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

4.4 "Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is

weighted in thirty-four (34) day supply increments so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

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

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

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

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM and Claim Administrator's own rebate contracts with pharmaceutical manufacturers. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls, and rebate arrangements between Claim Administrator and pharmaceutical manufacturers. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Claim Administrator may provide Employer with a rebate credit, the amount of which is set forth in the ASO BPA (the "Rebate Credit"). The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates provided to Claim Administrator by the PBM or pharmaceutical manufacturers. Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its Plan have no right to, or legal interest in, any portion of the rebates provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

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

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

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

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

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

SECTION 7: MEDICARE SECONDARY PAYER INFORMATION REPORTING

7.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the RRE and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

7.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding

working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute.

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

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

SECTION 8: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO Benefit Program Application ("ASO BPA")

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

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

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

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

SECTION 9: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 9.

EXHIBIT 4
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

EXHIBIT 5
BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

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

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

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

1.3 **"Alternative Provider Compensation Arrangement Payments"** means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Home payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 4.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 4.4 of this Exhibit. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 4.4 of this Exhibit). Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons. Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by Employer's Covered Persons per month. Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2: ADMINISTRATIVE SERVICES ONLY, NETWORK ONLY

Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to claims liability; and disclose the nature of the services and/or network access Claim Administrator is providing. Such disclosures must be made to Employer, Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and explanation of benefits documentation.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

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

SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 *Out-of-Area Services*

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

4.2 *BlueCard Program*

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

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

i. Covered Person Liability Calculation.

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

ii. Employer's Liability Calculation.

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

b. ***Claims Pricing***

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

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

ii. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain

payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

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

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

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

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

Claim Administrator will charge these fees as follows:

i. BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer. A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its health care provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a health care provider may bill for non-covered health care services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

ii. How the BlueCard Program Access Fee Affects Employer

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

4.3 *Negotiated Arrangements*

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue. In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom health care Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's Negotiated Arrangement(s) for national accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

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

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

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

b. ***Fees and Compensation***

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

4.4 *Special Cases: Value-Based Programs*

a. *Value-Based Programs Overview*

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

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

i. *Value-Based Programs Administration*

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

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

1. ***Actual Pricing:*** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.
2. ***Supplemental Factor:*** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g. a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

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

   a. Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
   b. Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated average or PMPM price methods, described above, are calculated. If Employer terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting

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

ii. ***Care Coordinator Fees***

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

1. PMPM billings; or

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

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

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

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

4.5 ***Return of Overpayments***

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

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

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

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

a. *Covered Person Liability Calculation*

i. In General

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

ii. Exceptions

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

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

2. the following:

a. for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences, where applicable; or

b. for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

b. *Fees and Compensation*

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

4.8 *Blue Cross Blue Shield Global® Core*

a. *General Information*

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

i. Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the

Covered Person's Claims to the service center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

ii. Outpatient Services

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

iii. Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the service center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the service center or online at bcbsglobalcore.com. If Covered Persons need assistance with their Claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day/seven days a week.

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

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

4.9 ***Modifications or Changes to Inter-Plan Arrangement Fees or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective after ninety (90) days in accordance with Section 6.1(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

EXHIBIT 6
RECOVERY LITIGATION AUTHORIZATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. If Employer should desire to participate in a class or multi–district settlement rather than defer to Claim Administrator, Employer may revoke the grant of authority established herein for that specific matter by affirmatively opting into a class settlement and by notifying Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 4.9 Notice and Satisfaction of the Agreement.

14. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 4.9 Notice and Satisfaction of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes Claim Administrator, on behalf of Employer and/or the Plan, consistent with Section 2 above, to:

a. Pursue, without advance notice to Employer, claims that Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, private lien resolution programs, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;

b. Opt out of any class action settlement or keep Employer and/or the Plan in the class, if Claim Administrator reasonably determines that it should do so;

c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.

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

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

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

EXHIBIT 7
PHARMACY BENEFIT MANAGEMENT SERVICES
(GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT)
(FOR USE ONLY FOR 151+ EMPLOYEES)

1. **Pharmacy Management:** Claim Administrator has contracted with Prime Therapeutics LLC (Prime) and/or other pharmacy benefit manager(s), mail order pharmacies, specialty pharmacies or other pharmacies to furnish certain pharmacy benefit management and other prescription drug benefit programs, including Rebate management and fee schedule management, including but not limited to MAC List management. Other services Prime will provide may include certain account management, clinical management, Drug List management, and Utilization Management services as set forth in the agreement between Prime and Claim Administrator. Claim Administrator reserves the right to contract with other pharmacy benefit managers and pharmacies directly for such services or to authorize Prime to subcontract certain services pursuant to the terms of Claim Administrator's agreement with Prime. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

   Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. Employer further understands and agrees that fees and compensation that Prime receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator, administrative fees charged by Prime to pharmacies or compensation otherwise received by Prime related to network administration, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Pharmacy Benefit Management services to be provided include Drug List management services, Rebate management services; management of the pharmacy networks for Members; Claims processing (electronic and paper); management of clinical management programs; reporting and account support services. Claim Administrator pays a fee to Prime for pharmacy benefit management services, which may be factored into the pricing set forth in the ASO BPA and the PBM Fee Schedule Addendum to the ASO BPA (the "BPA Addendum").

3. **Drug List Services:** Claim Administrator utilizes its own Drug List and Prime supports Claim Administrator in the development, maintenance and updating of such Drug List. Prime performs Drug List exception reviews in accordance with the agreement between Prime and Claim Administrator. Prime provides Drug List management services, in accordance with NCQA and URAC standards, to Claim Administrator in supporting Claim Administrator Pharmacy and Therapeutics ("P&T") and Business Committees. Employer acknowledges and agrees that Claim Administrator may, in a manner consistent with the Benefit Plan, promote the dispensing of pharmaceuticals in a manner consistent with the designated Drug List selected by Employer.

4. **Prime's Rebate and Manufacturer Administrative Fee Management:** In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers directly or through a group purchasing organization to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement.

   In addition, Prime has advised Claim Administrator that Prime receives Manufacturer Administrative Fees for bona fide administrative services provided to the Manufacturer. Claim Administrator may also negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement. Prime or Claim Administrator contracts with Manufacturers directly or indirectly, for Rebates and Manufacturer Administrative Fees on its own behalf (or Claim Administrator's behalf, as applicable) and for its own benefit (or Claim Administrator's benefit, as applicable), and not on behalf of Employer. Accordingly, Prime (or Claim Administrator, as applicable) retains all right, title and interest to any and all actual Rebates and/or Manufacturer Administrative Fees received from manufacturers. Prime has advised Claim Administrator that Rebate arrangements are based on formulary status, market share, or other similar arrangements with Manufacturers. Employer will be provided with applicable Rebate Credits

as set forth in the Agreement, the BPA, the Section of this PBM Exhibit entitled Rebates and in the PBM Fee Schedule Addendum to the BPA but otherwise shall have no right, title or interest in Rebates received by Prime, Claim Administrator under its agreement with Prime, or Claim Administrator under its agreements with Manufacturers. Employer shall have no right, title or interest in Manufacturer Administrative Fees. Prime may retain Manufacturers Administrative Fees or pass them along, in whole or in part, to Claim Administrator in accordance with Prime's agreement with Claim Administrator. As of the Effective Date, Prime has disclosed to Claim Administrator that the maximum that Prime will receive from any Manufacturer for Manufacturer Administrative Fees is five and one-half percent (5.5%) of the wholesale acquisition cost ("WAC") for all products of such Manufacturer dispensed during any given calendar year to members of Claim Administrator, as applicable; provided, however, Claim Administrator will advise Employer if such maximum has changed.

5. **Disclosures:** All other disclosures set forth in the Agreement will apply to pharmacy benefit management services.

6. **Pharmacy Network:**

a. **Network Establishment and Maintenance:** In Prime's agreement with Claim Administrator, Prime has agreed it is responsible for providing and maintaining a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. Employer acknowledges that in negotiating the Agreement and this Exhibit, it has taken into consideration that Claim Administrator and/or Prime will keep all or a portion of the discounts and/or other allowances that Claims Administrator or its pharmacy benefits manager has negotiated with the Network Participant. Prime will implement the methodology described in the Prescription Drug Program Eligible Charge when calculating the Copayment/Deductible, and Coinsurance amounts. Prime will reimburse Network Participants in accordance with the applicable Network Contract. Employer acknowledges actual network savings achieved may vary by Network Participant and plan size and/or other demographics. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member and/or the Member's Physician.

b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts to not make payments to Providers that are not licensed as required by law or that have been debarred, suspended or otherwise excluded from a federal or state program.

c. **Prime Maximum Allowable Cost ("MAC") Lists:** Prime owns and will maintain proprietary database listings of multi-source pharmaceutical drug products and supplies that also identifies a recommended maximum allowable cost for drugs or supplies within specified categories, commonly referred to as Prime's MAC Lists. Prime's MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Employer after 30 days' prior written request submitted by Employer to Claim Administrator, and subject to Employer's execution of Prime's non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. Prime's MAC List will only be made available for viewing at Prime's corporate headquarters or another secured location designated by Prime.

d. **Pharmacy Locator:** Prime will provide a means, either toll-free telephone line or electronic, to enable Members to identify Network Participants in a particular area.

e. **Mail Service:** Prime will provide or cause to be provided a mail order prescription drug service through which Members may receive Covered Prescription Drug Products and Services through the mail ("Mail Service"). Upon termination of the Agreement between Claim Administrator and Employer, Prime agrees to provide or cause to be provided mail order open refill and prior authorization files for purposes of transition to any new vendor selected by Employer at Prime's standard rate. Mail Service and specialty pharmacies may operate through an affiliate partially owned by Prime Therapeutics LLC.

f. **Pharmacy Network Audit Services:** Prime will perform or cause to be performed pharmacy Claims audits to promote Network Participant contract integrity.

g. **Audits:** In addition to the audit rights available elsewhere in the Agreement, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the

Agreement. Subject to the audit terms elsewhere in the Agreement, Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from Claim Administrator or Prime without prior written approval by Prime or Claim Administrator as applicable. Employer will bear its own cost and expenses for all such audits.

h. **Specialty Pharmacy:** Claim Administrator and Prime have contracted with specialty pharmacies and/or vendors to provide Members with access to in-network benefits for covered Specialty Drugs.

7. **Claims Processing**

a. **Adjudication of Prescription Drug Claims from Network Participants:** Prime will process Claims for Prescription Drugs Products and Services electronically submitted by Network Participants through the Claims Adjudication System, according to Benefit Plan benefit and eligibility information submitted by Claim Administrator to Prime and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Prime will also process and pay Paper Claims received from a Member at the benefit level set forth in the Benefit Plan, and based on the Prescription Drug Program Eligible Charge, in accordance with the terms of the Benefit Plan, provided that the Benefit Plan allows such reimbursement.

b. **Material Change to AWP:** If after the Effective Date: (i) changes to the formula, methodology or manner in which AWP is calculated or reported by Medi-Span take effect or (ii) Medi-Span ceases to publish AWP for the Covered Prescription Drug Services under this Exhibit, then the financial terms of this Exhibit shall be automatically adjusted at the time of such change to return the Parties to their respective economic positions as they existed under the Agreement immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Exhibit shall immediately and automatically be converted to an alternative pricing benchmark determined by Prime. Claim Administrator shall inform Employer in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services, and give Employer a reasonable opportunity to review such new benchmark. Thereafter, Employer will be deemed to have approved the designation, which will become part of this Agreement, unless Employer terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract.

c. **Statement of Account:** Prime will furnish to Claim Administrator, at least weekly, a statement of account of the amount of payments that have become due for Claims processed by Prime.

d. **NDC File:** Prime will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC.

e. **Help Desk Service:** Prime will provide help desk service for pharmacist assistance in processing a pharmacy claim.

f. **Benefit Plan Design:**

In the event Employer wishes to implement Benefit Plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the BPA Addendum may no longer be applicable. If such Benefit Plan design changes impact the existing pricing, a new BPA Addendum pricing must be negotiated. If the Parties cannot agree on the terms of the new BPA Addendum pricing, either Party shall be allowed to (a) proceed to dispute resolution, as set forth in the Agreement or (b) terminate this Exhibit with 90 days' prior written notice to the other Party. Failure to reach agreement on the new Addendum pricing shall not be a breach of contract.

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

9. **Termination**

This Exhibit may be terminated as follows:

a. By either Party at the end of any period(s) of time for which guaranteed pricing is defined in the BPA Addendum ("Guarantee Period(s)") upon ninety (90) days prior written notice to the other Party; or

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

c. By termination of the entire Agreement by either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA upon ninety (90) days prior written notice to the other Party; or

d. By either Party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Exhibit, upon written notice as provided in the "Notice and Satisfaction" section of the Agreement; or

e. By Claim Administrator, upon Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and BPA Addendum.

10. Program Pricing Terms

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

a. Pharmacy Program Claims

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

(b) Payment by Employer is subject to applicable Copayment/Deductible and/or Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers one-hundred percent (100%) of the Covered Prescription Drug Products and Services. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes. Zero balance logic is not employed.

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

b. Specialty Drug Claims

If covered under Employer Benefit Plan, notwithstanding anything to the contrary in Sections a and b above and elsewhere in the Agreement, Employer will reimburse Claim Administrator for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the pricing set forth in the BPA Addendum, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other specialty pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims under the Specialty Drug program is not included in the retail and mail pharmacy pricing described in the BPA Addendum. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes.

c. Copayments/Deductibles/Coinsurance

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

d. Rebates for Drugs Covered under the Prescription Drug Program

In connection with Rebates earned for drugs covered under the prescription drug program, Rebate Credits are paid prospectively to Employer as a credit on the monthly billing statement and shall

not continue after termination of the Prescription Drug Program or the PBM Exhibit. Additional information about rebates and Rebate Credits are included in the Agreement and the ASO BPA.

11. DEFINITIONS

Certain terms are defined in the Administrative Services Agreement, but the following terms and phrases will have the meaning set forth below, for purposes of the services described in this Exhibit.

1. **"Average Wholesale Price"** or **"AWP**" means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.
2. **"Benefit Plan"** means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.
3. **"Brand Drug"** means, except as otherwise designated in the Additional Provisions of the BPA Addendum, a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.
4. **"Claim"** or **"Claims"** means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.
5. **"Claim Administrator"** has the meaning set forth in the Agreement.
6. **"Claims Adjudication"** means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.
7. **"Compound Drug"** means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.
8. **"Coinsurance"** means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Prescription Drug Program Eligible Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member's Benefit Plan.
9. **"Copayment/Deductible"** means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member's Benefit Plan.
10. **"Covered Prescription Drug Products and Services"** means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member's Benefit Plan, subject to any Copayment/Deductible or Coinsurance.
11. **"Dispensing Fee"** means the negotiated fee for Network Participants' professional service of filling a prescription and is added to the Ingredient Cost for the prescription.
12. **"Drug Utilization Review"** or **"DUR"** means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Member's Benefit Plan. DUR can be prospective, concurrent or retrospective.
13. **"Drug List"** means a list of pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

14. **"Extended Supply Network"** or **"ESN"** means claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Eighty-Four (84) days' quantity supply of medication, provided that the Member's Benefit Plan provides for an ESN benefit.
15. **"Foreign Claim"** means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.
16. **"Generic Drug"** means, unless otherwise designated in the Additional Provisions of the BPA Addendum, a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.
17. **"Ingredient Cost"** means the negotiated rate (e.g., discount of AWP or MAC) for a prescription drug dispensed by a Network Participant and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable for the given prescription drug and the professional service of dispensing such drug.
18. **"Legend Drugs"** means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.
19. **"MAC List"** means the list of unit prices established by Prime for multi-source Covered Drugs, each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by Prime and updated from time to time in accordance with this Exhibit and the BPA Addendum.
20. **"Mail Service"** means the service through which Members may receive Covered Prescription Drug Products and Services through the mail.
21. **"Manufacturer"** means a company that manufactures, and/or distributes pharmaceutical drug products.
22. **"Manufacturer Administration Fee"** means all negotiated fees received by Prime from any given Manufacturer, directly or through a group purchasing organization, relating to administration of Rebates under a Manufacturer Agreement.
23. **"Maximum Allowable Cost"** or **"MAC"** means the unit price established by Prime for a specific multi-source drug present on the MAC List at the time of service.
24. **"Member"** or **"Members"** means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.
25. **"Network Contract"** has the meaning set forth in the definition of "Network Participant."
26. **"Network Participant"** means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with Prime or Claim Administrator ("Network Contract") to provide Covered Prescription Drug Products and Services to Members, as may be amended.
27. **"Paper Claims"** means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.
28. **"Pass-Through Price"** means the rate (inclusive of Ingredient Cost, Dispensing Fee and Provider Tax) paid by PBM to the Network Participant based on the rate set forth in the Claims Adjudication System at the time a Claim is processed.
29. **"Pricing Source"** means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which establishes and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services.
30. **"Provider Tax"** means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

31. **"Rebate(s)"** means any discount or other remuneration of any kind received or recovered by Prime, directly or through a group purchasing organization, from any Manufacturer which is directly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees which Prime is entitled to retain pursuant to the Agreement and this Exhibit unless otherwise required by law, or fees retained by a group purchasing organization for its role in securing Rebates and/or Manufacturer Administrative Fees.
32. **"Rebate Credit"** has the meaning set forth elsewhere in this Agreement.
33. **"Rebate Management Services"** means the services which Prime is obligated to provide pursuant to Section 4.
34. **"Specialty Drugs"** means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are for serious or chronic conditions, oral medications and/or that have special handling or storage requirements, or are infused medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by Prime or Claim Administrator and subject to change.
35. **"Usual and Customary"** or **"U&C"** means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.
36. **"Utilization Management"** means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members. Such services include, but are not limited to the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.
37. **"Zero Balance Due Claim"** means any Claim where the Member cost share covers one hundred percent (100%) of the Prescription Drug Program Eligible Charge for such Claim.

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as "Claim Administrator" or "BCBSIL"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 365058

Group Number(s): P65060 P65061

Section Number(s): see account structure

Legal Employer Name: Village of Downers Grove

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐ Yes
If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*:

Plan Administrator's Address:

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/Day/Year) 01 / 01 / 2021

Anniversary Date: (Month/Day/Year) 01 / 01 / 2022

Account Information ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 36-6005857

Address: 801 Burlington Ave

City: Downers Grove State: IL ZIP: 60515

Administrative Contact: Dennis Burke Title: Human Resource Director

Email Address: dburke@downers.us Phone Number: 630-434-5537 Fax Number: 630-434-5537

Wholly Owned Subsidiaries to be covered:

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

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

Blue Access for Employers (BAE) Contact: Lauren Linares

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

Email Address: llinares@downers.us Phone Number: 630-434-5538 Fax Number: 630-434-5484

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

Producer of Record Information ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Illinois, Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

Are commissions to be paid? ☐ Yes ☐ No

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

Illinois Producer#:

NPN:

Address:

City: State:

Phone: Fax:

Is Producer/Agency appointed with BCBSIL? ☐ Yes ☐ No

Commissions:

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

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

☐ Percentage of Stop Loss: %

ADDITIONAL COMMISSIONS:

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

Schedule of Eligibility ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

☒ A full-time employee of the Employer.
☐ A full-time employee of the Employer who is a member of: *(name of union)*
☐ A part-time employee of the Employer.
☐ A retiree of the *Employer*. Define criteria: _____
☒ Other: Pre 65 Retirees

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

If yes, please identify the classes and describe the exclusion: Any retiree with access to Medicare. In the event a pre 65 retiree loses access to Medicare they are able to come back and be insured under this plan.

2. Employee definitions:

Full-Time Employee means:

☒ A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.
☐ Other:

Part-Time Employee means:

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

3. **The Effective Date of termination for a person who ceases to meet the definition of Eligible Person**:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Select an effective `date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
   - ☐ The date of employment.
   - ☐ The day of employment.
   - ☒ The 1st day of the month following 1 month(s) of employment.
   - ☐ The day of the month following days of employment.
   - ☐ The day of the month following the date of employment.
   - ☐ Other:

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

   Are there multiple new hire waiting periods? ☐ Yes ☒ No
   If yes, please attach eligibility and contribution details for each section.

5. **Domestic partners covered**: ☐ Yes ☒ No
   If yes*: a domestic partner is eligible to enroll for coverage.*
   If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No
   If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No
   If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

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

6. **Civil Union Partners covered**:

   ☒ The Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, a Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Employer's Plan.

   For all other Employers: ☐ Yes ☐ No
   If yes*: A Civil Union Partner and his or her dependents are eligible to enroll for coverage.*
   If yes: Are Civil Union Partners and his or her dependents eligible for continuation of coverage? ☐ Yes ☐ No

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

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

   If Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code, this Limiting Age is extended to thirty (30) years, for unmarried eligible military personnel as described in the Employer's Plan.

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

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee? ☐ Yes ☒ No

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

9. Disabled dependent: A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse.

To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

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

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

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

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

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

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

If certification review is selected as handled by BCBSIL*, please select one option regarding forms:*
☐ The disabled dependent certification form will be utilized.
☐ A ☐ custom or ☐ other disabled dependent certification form will be utilized.

If Certification Review is selected as handled by BCBSIL*, please select allowed or not allowed below:*
A disabled dependent approved medical certification from a prior carrier is ☐ allowed ☐ not allowed.
A disabled dependent approved medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

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

☒ Yes (specify number of days below) ☐ No

Temporary Layoff: 365 days Disability:365 days Leave of Absence: 365 days

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

11. Enrollment:

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

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

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

Specify Open Enrollment Period: November 15th to December 15th for a January 1st effective date

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

Select one of the provisions below:

☐ Open Enrollment – Late applicants may only apply during Open Enrollment.
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the rules governing off-cycle enrollments.

12. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No
Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.
** Not recommended for accounts with automated eligibility.*

Lines of Business (Check all applicable services)	☐ **NO CHANGES** ☐ ***See Additional Provisions***
Medical Plan Services: ☒ Participating Provider Option (PPO) ☐ Blue Choice Select PPO ☐ Blue Choice Options **Additional Services:** ☒ Wellbeing Management ☐ Wellness Incentives ☐ Health Advocacy Solutions ☐ Mercer Health Advantage ☐ Custom Care Management Unit ☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)* ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other	**Consumer Driven Health Plan:** ☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)* ☐ HSA Eligible Health Plan (Vendor: Select Vendor) ☐ BlueEdge℠ FSA (Vendor: Select Vendor) **Prescription Drugs:** ☒ Covered under a pharmacy benefit *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)* ☐ Covered under the medical benefit or Blue Script **Pharmacy Network (Select one)**: ☐ Traditional Select Network ☒ Advantage Network ☐ Preferred Network (Not offered with Blue Script) ☐ Elite Network (Not offered with Blue Script) ☐ Network on PBM Fee Schedule Addendum ☐ Other (please specify): **PPO Drug List**: Basic Drug List Other (please specify): **PPO/HSA Preventive Drug List:** Please specify: Select Option **Other Rx programs:** Please specify: Select Program **Prescription Drug Program Clinical Programs** ☐ PCM (Retrospective) (Included with HAS) **Ancillary Services:** ☐ Dental Plan Services ☐ Vision Plan Services ☒ Stop Loss *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)* ☐ Life or Disability Insurance provided by separate carrier *(if selected, complete separate Life application)* ☐ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum to the BPA)*

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Illinois

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications ☐ NO CHANGES ☐ SEE ADDITIONALPROVISIONS

Employer Payment Method: ☐ **Online Bill Pay** ☐ **Electronic** ☐ **Auto Debit** ☒ **Check**

Employer Payment Period: ☐ **Weekly** (cannot be selected if Check is selected as payment method above)

☐ **Semi Monthly** (cannot be selected if Check is selected as payment method above)

☒ **Monthly**

Claim Settlement Period: ☒ **Monthly**

Run-Off Period: Employer Payments are to be made for **12** months following end of Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: Months

Administrative Per Employee Per Month (PEPM) Charges ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

	Medical			
Administrative Fee	**$60.24**	**$**	**$**	**$**
Dental	**$**	**$**	**$**	**$**
Limited Fiduciary Services	**$**	**$**	**$**	**$**
Health Advocacy Solutions	**$**	**$**	**$**	**$**
Wellbeing Management	**$**	**$**	**$**	**$**
Management of the Virtual Visits Program	**$.52**	**$**	**$**	**$**
Medical Rebate Credit	**$**	**$**	**$**	**$**
*Rebate Credit for the Prescription Drug Program	**$50.12**	**$**	**$**	**$**
PCM (Retrospective) **(No cost if both HAS and Prescription Drug Program are elected)**	**$**	**$**	**$**	**$**
Commissions: _____	**$**	**$**	**$**	**$**
Commissions: _____	**$**	**$**	**$**	**$**
Commissions: _____	**$**	**$**	**$**	**$**
Other: Product-Related Services List Service: BVA	**$2.50**	**$**	**$**	**$**
Other: Select Service Category List Service:	**$**	**$**	**$**	**$**
Other: Select Service Category List Service:	**$**	**$**	**$**	**$**
Other: Select Service Category List Service:	**$**	**$**	**$**	**$**
Miscellaneous:	**$**	**$**	**$**	**$**
Miscellaneous:	**$**	**$**	**$**	**$**
Total	**$13.14**	**$**	**$**	**$**

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

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

Claim Administrator Provider Access Fee(s) ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Group Number(s): P65060, P65061

☒ % of ADP Savings: **2.33**%

☐ $ per Covered Employee per month: $

☐ ***Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO plans):***
Group Number(s):

☐ % of ADP Savings: %

☐ $ per Covered Employee per month: $

BlueCard Program/Network access fees: Available upon request.

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

External Review Coordination: ☒ Yes ☐ No

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

Employer elects the following process:

☒ State of Illinois External Review Process ☐ Federal Affordable Care Act Process

Reimbursement Service: ☒ Yes ☐ No

If yes*:* It is understood and agreed that in the event Claim Administrator makes a recovery on a third-party liability claim, Claim Administrator will retain 25% of any recovered amounts other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): ☒ Yes ☐ No
Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third-Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

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

Virtual Visits Program: ☒ Yes ☐ No
If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

Termination Administrative Charge

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

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

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

Other Provisions ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. **Summary of Benefits & Coverage**:
   a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?
      ☒ Yes. Please answer question b. The SBC Addendum is attached.
      ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.
   b. Will Claim Administrator distribute the (SBC) to Covered Persons?
      ☐ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.
      ☒ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to Covered Persons as required by law, except that Claim Administrator will send the SBC in response to any request received directly from Covered Persons.
      ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to plan participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to any request received directly from a Covered Person.

2. Massachusetts Health Care Reform Act:

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

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

3. Alternative Care Management Program (applicable to the purchased medical management program):

☒ Yes ☐ No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. Prior Authorization (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No

***If no**,* Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

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

Employer elects EHBs based on the following:

1. ☒ EHBs based on a Claim Administrator state benchmark:
   ☒ Illinois ☐ Montana ☐ New Mexico ☐ Oklahoma ☐ Texas
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: ___
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Illinois benchmark plan.

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

7. Producer/Consultant Compensation:

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

Additional Provisions: Effective 01/01/2021:
-All applicable state and federal mandates apply

Wellness Credit: BCBSIL will provide a one-time wellness credit of $50,000 for the twelve-month period beginning on the Contract Effective Date, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSIL the full amount of the wellness credit.

Signature

Dee Mastro Holzkopf

Sales Representative

890 630-824-5558

District Phone & FAX Numbers

Producer Representative

The Horton Group

Producer Firm

10320 Orland Parkway, Orland Park, IL

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

36-3672171

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

PROXY

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

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

Group No.: P65060 P65061

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: Village of Downers Grove

Address: 801 Burlington Avenue

City: Downers Grove State: IL ZIP: 60515

Dated this _____ day of _____
Month Year

PBM Fee Schedule Addendum to the Benefit Program Application

Village of Downers Grove	
Term: 01/01/2021-12/31/2021	**Employees:** 400
Guaranteed Traditional Aggregate Pricing Arrangement D[1]* **Advantage Network and Basic Drug List**	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
18.75%	81.00%
DISPENSING FEE	
Brand	**Generic**
$0.55	$0.55
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
20.35%	81.40%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
21.75%	84.30%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 18.00%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	$50.12

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

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

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

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

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

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

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

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

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

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

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

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.

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

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

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

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

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

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

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

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

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

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

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

Signature of Authorized Purchaser

Print Name

Title

Date

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM
Self-Funded Accounts

This replaces and amends any existing Additional Information Form

(**Please print or type and complete the form in its entirety)**

Employer or Plan Sponsor:	**Village of Downers Grove**
BCBSIL Account number:	**365058**
BCBSIL group number(s):	**ALL**

BCBSIL's Privacy Officer: Thomas C. Lubben
Address: HCSC Privacy Office; PO Box 804836; 300 E. Randolph St., Chicago, IL 60680-4110

Primary Privacy Contact		**Additional Privacy Contact (required)**	
Name:	**David Fieldman**	Name:	**Dennis Burke**
Title:	**Village Manager**	Title:	**Director of HR**
Phone #:	**630-434-5537**	Phone #:	**630-434-5537**
FAX #:		FAX #:	
Mailing Address:	**801 Burlington Ave**	Mailing Address:	**801 Burlington Ave**
City, State, Zip:	**Downers Grove, IL 60515**	City, State, Zip:	**Downers Grove, IL 60515**
e-Mail Address:	**dfieldman@downers.us**	e-Mail Address:	**dburke@downers.us**

Authorized Signatory (Form should only be signed by authorized employee of the account.)

Name of individual completing this form:

Title of individual completing this form:

Signature: _____ Date: _____

Limitations

Please identify any limitations in any of the following documents that may affect BCBSIL's use or disclosure of PHI in the GHP's:

(List the limitation or indicate "none")

a. Notice of Privacy Practices (NoPP) **none**
b. GHP Plan Document **none**
c. Other:**none**

Responding to Individual Requests

When BCBSIL receives a request from an individual related to one of these rights under HIPAA, please identify who should respond to the member.

Please select Employer/GHP **OR** BCBSIL (not Both).

1)	Access Request:	☐ - Employer/GHP	☒ - BCBSIL
2)	Disclosure Accounting Request:	☐ - Employer/GHP	☒ - BCBSIL
3)	Amendment Request:	☐ - Employer/GHP	☒ - BCBSIL
4)	Complaint Response:	☐ - Employer/GHP	☒ - BCBSIL

Employer or Plan Sponsor:	**Village of Downers Grove**
BCBSIL Account number:	**365058**
BCBSIL group number(s):	**ALL**

Group Health Plan Authorizations
Identify the employees within your organization that work on behalf of the GHP that BCBSIL is authorized to release PHI for Plan Administration functions. Use a different line for each employee and include the following information: **JOB TITLE**, **NAME** (optional) and any **LIMITATIONS** or **RESTRICTIONS** on the data release.
Human Resources Director, Asst. HR Director, HR Administrator , Finance Staff Accountant, Asst Finance Director, Finance budget Officer
Business Associate Authorizations
Identify your Business Associates and employees at that Business Associate that BCBSIL is authorized to release PHI to on your behalf. Use a different line for each Business Associate and include the following information: **COMPANY NAME, JOB TITLE**, **NAME** (optional) and any **LIMITATIONS** or **RESTRICTIONS** on the data release.
The Horton Group: Agent, Account Executive, Account Manager, Underwriter, Reporting Specialist, Service Rep, CPA
Zywave Reporting: Decision Master Warehouse data analytics provider: AE, ITG, Programmer
RxManage Vendor: Account Executive, Account Manager, Reporting Specialist, Service Rep

Note: The GHP is responsible for notifying BCBSIL if any information listed on this form changes.