BlueCross BlueShield of Texas

ADMINISTRATIVE SERVICES AGREEMENT

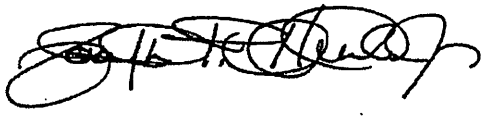
The Effective Date of this Agreement is November 1, 2018.

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

Account Number: 217766

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

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

By: 

Title: Divisional Senior Vice President

Date: Effective Date of Coverage noted above

SOUTH SAN ANTONIO ISD

By:_____

Title:_____

Date:_____

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

RECITALS

WHEREAS, as part of the Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a separate self-insured group health plan component as defined by Section 160.103 of HIPAA ("the Plan"); 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, with such ASO BPA, this Agreement and all Exhibits and Addenda described in Section 1, below, collectively referred to hereinafter as the "Agreement", unless specified otherwise; 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, as sponsor of the Plan, with respect to the Plan;

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: DEFINITIONS, EXHIBITS AND ADDENDA

Capitalized terms used in this Agreement shall have the meanings set forth in Section 24, unless otherwise provided in the Agreement. All Exhibits and addenda attached hereto and referenced herein are hereby adopted and incorporated by reference as if set out in full in the body of this Agreement.

SECTION 2: APPOINTMENT AND SERVICES

2.1 ***Appointment.*** Employer hereby retains and appoints Claim Administrator to provide Services as hereinafter defined in connection with the administration of the Plan.

2.2 ***Administrative Services.*** Claim Administrator will perform the Services set forth in Exhibit 1. 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, or any of its subsidiaries or affiliates, including any successor corporation(s), whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 3: RESPONSIBILITIES OF EMPLOYER AND CLAIM ADMINISTRATOR

3.1 ***Employer responsibility.*** Employer retains full and final authority and responsibility for the Plan and its operation. Claim Administrator is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise mutually agreed to in writing by the parties hereto.

3.2 ***Claim Administrator responsibility.*** 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 as 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. Claim Administrator shall have the responsibility for and bear the cost of

compliance with any federal, state or local laws as may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement.

3.3 ***Litigation.*** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against it or the Claim Administrator 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; provided, however, that Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, in which event the fees and expenses of those attorneys shall be the responsibility of Claim Administrator. Provided that no conflicts of interest exist, each party shall reasonably cooperate with the other party's defense of any action arising out of or related to the Services. Some defense support, such as from an external reviewer, may require an additional fee.

3.4 ***Claim overpayments.*** Employer acknowledges that unintentional administrative errors may occur. When Claim Administrator becomes aware of a Claim overpayment to a Provider or Covered Person, Claim Administrator will 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.

For purposes of this Section 3.4, an "Overpayment" is defined as a payment to a Provider or a Covered Person which was more than it should have been, or a payment that was made in error.

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 Sections (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. Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) from Other Plans, up to an amount equal to the Overpayment ("Off-Set").

(b) Cross-Plan Offsets. Claim Administrator has the right to reduce Another Plan's payment to a Provider by the amount necessary to recover the Plan's Overpayment to the same 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 Provider by the amount necessary to recover Another Plan's Overpayment to the same 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 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 equally divided between the Other Plans that overpaid the Provider.

(d) Employer Authorization for Cross-Plan Offsets. Employer authorizes and directs Claim Administrator to perform any Cross-Plan Offsets.

(e) No Independent Right of Recovery. Subject to the exception(s) set forth in this Section 3.4, 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.

3.5 ***Required Plan information.*** Employer shall furnish on a Timely basis to Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by Claim Administrator for the performance of 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 regarding Covered Persons who are to be covered under this Agreement.

It is Employer's obligation to Timely notify Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by Employer to Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by Claim Administrator to effect such changes. It is also Employer's obligation to 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 its health benefit plan are consistent with the terms of this Agreement.

3.6 ***Grandfathered Health Plans.*** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 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 timely notice thereof) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. 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 such Form is true, complete and accurate.

3.7 ***Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans.*** 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 administrative services. 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.

3.8 ***Plan eligibility errors.*** Clerical errors in keeping or reporting data relative to benefits described in this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected by Claim Administrator subject to the terms and conditions of this Agreement and Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. Employer is liable for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination.

3.9 ***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.

3.10 ***Massachusetts Health Care Reform Act.*** The Massachusetts Health Care Reform Act requires certain employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through Employer's

Plan(s) and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements. If elected on the applicable ASO BPA, Claim Administrator will provide such written statements and electronic reporting, 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.

3.11 ***Use and disclosure of Protected Health Information.*** The parties acknowledge and agree that they have entered into a Business Associate Agreement in accordance with HIPAA. The terms and conditions of the Business Associate Agreement shall govern the use and disclosure of Protected Health Information by the parties, except as otherwise provided in this Agreement.

3.12 ***Electronic exchange of information.*** In the event Employer and Claim Administrator exchange various 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. In the event Employer is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, Claim Administrator is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 4: THIRD PARTY DATA RELEASE

4.1 ***Types of data.*** In the event Employer directs Claim Administrator to provide data directly to its third party consultant and/or vendor (the "Employer's Vendor"), and Claim Administrator agrees in its sole discretion, then Employer acknowledges and agrees, and will cause Employer's Vendor to acknowledge and agree:

- **a.** That the requested documents, records and other information (for purposes of this Section 4, "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 4, 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 maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.
- **d.** 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.
- **e.** 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.
- **f.** To return or destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed 60 days thereafter.

4.2 ***Third party obligations.*** Employer's Vendor(s) shall execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator.

4.3 ***Employer obligations.*** Employer shall:

a. 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. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the Business Associate Agreement between Claim Administrator and Employer.

b. Provide Claim Administrator in writing, the appropriate authorization and specific directions with respect to the release, disclosure or exchange of data with Employer's Vendor(s) identified under 4.3.a. If Employer's Vendor(s) perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the information required in this Section will be documented in the Business Associate Agreement between Claim Administrator and Employer.

c. Indemnify, defend and hold harmless Claim Administrator and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties 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 against Claim Administrator in connection with any claim based upon Claim Administrator's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Employer Vendor(s), if consistent with Employer's directions, of any information and/or documentation or breach by Employer's Vendor(s) of any obligation described in this Agreement. In lieu of defense by Employer, Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Claim Administrator.

SECTION 5: CLAIMS/INQUIRIES

5.1 ***Claim Administrator's responsibilities.*** As provided in this Agreement, Claim Administrator will receive eligibility information, review and process properly filed Claims, respond to Covered Person's inquiries and conduct Claim reviews and appeals; however, Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan.

5.2 ***Internal Claim Administrator reviews and final internal appeal determinations.*** On occasion Claim Administrator may deny all or part of submitted Claims. Upon request of the Covered Person or the Covered Person's authorized representative, Claim Administrator will provide a review of any adverse determination of a Claim or any adverse determination of a pre-service Claim when the Covered Person would have an adverse financial impact for failing to pre-authorize the service. Certain Claims, pre-service requests for review, appeals or inquiries where there is a question as to eligibility, rescission or clarity of Employer's Plan language will be referred to Employer for review and final determination. In addition, Claim Administrator may provide other types of reviews related to the Plan.

5.3 ***External Review Coordination.*** Claim Administrator may 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.

SECTION 6: INDEMNIFICATION

6.1 The parties acknowledge and agree that (a) 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, and (b) Employer retains the ultimate responsibility for claims under or related to the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by Claim Administrator.

6.2 ***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.

6.3 ***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, and (d) 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.

SECTION 7: AUDIT RIGHTS

7.1 ***Employer audits Claim Administrator.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for any reasonable personnel time in excess of eighty (80) person-hours required to support audits conducted during the term of this Agreement. 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.

7.2 ***Claim Administrator audits Employer.*** 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 audits of Employer's membership records with respect to eligibility.

SECTION 8: TERM AND TERMINATION OF AGREEMENT

8.1 ***Term.*** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein.

8.2 ***Termination.*** 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 16 below; 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 the 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.

8.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 8, Employer agrees to notify all Covered Employees. The parties agree that Employer will give such notice because Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 9: RELATIONSHIP OF PARTIES

9.1 ***Regarding the 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.

Further, 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.

9.2 ***Regarding non–parties.*** It is understood and agreed that 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.

9.3 ***Exclusivity.*** Employer agrees not to perform or engage any other party to perform the same services as Claim Administrator's Services while this Agreement is in effect, unless Employer terminates this Agreement pursuant to its terms.

9.4 ***Assignment.*** Except as otherwise permitted by Section 2 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 to the Agreement.

SECTION 10: NON-ERISA GOVERNMENT REGULATIONS

10.1 ***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 fiduciary or non–fiduciary 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 except as set forth in this Agreement. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

10.2 ***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, except as set forth in this Agreement.

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

SECTION 11: PROPRIETARY MATERIALS

11.1 ***Business Confidential Information and Proprietary Marks.*** The parties acknowledge that Claim Administrator has developed acquired or owns certain Business Confidential Information. "Business Confidential Information" includes, 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 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. Employer shall not use or disclose Business Confidential Information to any third party without 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.

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

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

11.4 ***Disclosures in Account Contracts.*** Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding 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.

11.5 ***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 12: ELECTRONIC DOCUMENTS

Employer's consent/responsibilities. Employer consents that any documents exchanged between the parties that describe the benefits under, or the administration of, the Plan (including but not limited to benefit booklets) may be in the format of an electronic file or access to an electronic file. Employer further acknowledges and agrees that if Claim Administrator provides Employer, at Employer's request, an electronic file that describes the benefits under, or the administration of, the Plan, Employer will provide Covered Persons access, via the intranet, internet, or otherwise, to only the most current version of that electronic file. Employer also acknowledges and agrees that, in all instances, Claim Administrator may rely on the fact that the most current version of the electronic file Claim Administrator provides to Employer is the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from Employer's use or posting of the electronic file on the intranet and/or internet.

SECTION 13: RECORDS

All Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator are and shall remain the property of Employer upon termination of this Agreement. Claim Administrator shall return a copy of such property upon request in a form as agreed upon by the parties with the cost of preparing such property for transmittal to be borne by Employer. All such Claim records shall be retained by Claim Administrator until Claim Administrator receives a request from Employer for transmittal or for a period of eleven (11) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 14: APPLICABLE LAW

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

SECTION 15: ENTIRE AGREEMENT

15.1 ***Definition.*** 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, and any written amendments made pursuant to Section 15.3 (Amending) 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.

15.2 ***Components.*** The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - Recovery Litigation Authorization
- **d.** Exhibit 4 - ASO BPA

15.3 ***Amending.*** This Agreement may be amended only by mutual written agreement of the parties. Employer acknowledges and agrees that the format of such changes shall be determined by Claim Administrator in its sole discretion, including, but not limited to, the use of a new form of agreement (that replaces this Agreement in its entirety). Notwithstanding the foregoing, any amendments required by law, regulation or order ("Law") or by Claim Administrator or the Blue Cross and Blue Shield Association may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the parties shall then engage in good faith negotiations to amend the amendment. If the parties cannot agree on terms of the amendment in a satisfactory manner, either party shall be allowed to proceed to dispute resolution, as set forth in Section 18.

SECTION 16: 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 (pursuant to Section 19 Notices below) 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. 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.

SECTION 17: 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, liability (whether in contract, tort, or under any other form of liability) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited in the aggregate to the maximum benefits which should have been paid under this Agreement during the twelve (12) months preceding the incident which gave rise to the claim had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred); or, if the claim arises within the first twelve (12) months of the Agreement, the limit will be the aggregate of the total benefits which should have been paid in that first year of the

Agreement 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.

SECTION 18: DISPUTE RESOLUTION/ARBITRATION

18.1 ***Initial notice and negotiation.*** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this Section 18, which shall be the sole and exclusive procedures for the resolution of any such disputes. 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 18 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

18.2 ***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 Section 18.1, Employer or Claim Administrator may submit the dispute to confidential, binding arbitration before the American Arbitration Association ("AAA"), subject to the following:

a. 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.

b. Arbitration shall be held in Dallas, Texas.

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

d. 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.

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

f. 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.

g. 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.

h. 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.

18.3 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 19: NOTICES

All notices given under this Agreement must be in writing and 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.

SECTION 20: 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 3.3 "Responsibilities of Employer and Claim Administrator: Litigation"; Section 4 "Third Party Data Release"; Section 6 "Indemnification" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); Section 11 "Proprietary Materials"; Section 13 "Records"; Section 17 "Limitations; Limitation of Liability"; and Section 8 of Exhibit 2 "Financial Obligation Upon Agreement Termination".

SECTION 21: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the "Permitted Purposes" as defined herein). For purposes of this paragraph, "Permitted Purposes" means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and performance, including, but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, a "limited data set" has the meaning set forth in HIPAA and "de-identified" means both member de-identification (as defined by HIPAA) and Employer de-identification (unless the work is being done in connection with Employer's Plan). Solely for the Permitted Purposes, Claim Administrator may release, or authorize the release of, a limited data set or de-identified data to a third party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for access to such data. Nothing in the paragraph is intended to expand or limit the terms and conditions of the Business Associate Agreement with respect to the permitted use or disclosure of PHI (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to Claim Administrator-assigned Employer Group and Identification number.

SECTION 22: THIRD PARTY RECOVERY VENDORS AND OUTSIDE ATTORNEYS

To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies prior to Claim Payments. Third parties' fees 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.

SECTION 23: 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 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.

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 24: DEFINITIONS

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

24.2 "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.

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

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

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

ii. ***For Non-Network Providers.*** For a Provider who does not have a written agreement with Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Network Provider"), the Allowable Amount will be the lesser of: **(a)** the Non-Network Provider's Claim Charge, or; **(b)** Claim Administrator's non-contracting Allowable Amount. Except as otherwise provided in this section ii, the non-contracting Allowable Amount is developed from base Medicare reimbursements adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

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

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

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

The non-contracting Allowable Amount does not equate to the Provider's Claim Charge and Covered Persons receiving Covered Services from a Non-Network Provider will be responsible for the

difference between the non-contracting Allowable Amount and the Non-Network Provider's Claim Charge, and this difference may be considerable. To find out Claim Administrator's non-contracting Allowable Amount for a particular Covered Service, Covered Persons may call customer service at the number on the back of Claim Administrator-issued identification card.

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

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

b. ***For Prescription Drug Covered Services.*** For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Amount (1) for purposes of calculating the Employer Payment and Covered Persons' required deductible and Coinsurance shall be the cost mutually agreed upon by the Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA, attached and incorporated herein by this reference. (2) For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services for prescription drug benefits are rendered ("Non-Network Provider Pharmacies"), the Allowable Amount for purposes of calculating both the Employer Payment and the Covered Persons' required deductible and Coinsurance shall be based on the lesser of the charge which the particular Non-Network Provider Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus 20% unless otherwise agreed upon by Claim Administrator and Employer.

c. ***For Dental Covered Services.*** If dental benefits coverage is elected on the most current ASO BPA, the Allowable Amount means:

i. ***For Contracting Dentists.*** For a Provider who has a written agreement with Claim Administrator or the entity chosen by the Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Contracting Dentist"), the amount such Contracting Dentist has agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Contracting Dentists will be based on the Network Schedules which these Providers have agreed to accept as payment in full.

ii. ***For Non-Contracting Dentists.*** For a Provider who does not have a written agreement with Claim Administrator or the entity chosen by Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Non-Contracting Dentist"), the amount described in (a) or (b), below, in accordance with the type of dental benefits coverage elected by Employer:

(a) The lesser of the Non-Contracting Dentist's Claim Charge or an amount that is equal to the standard contracted fee for Contracting Dentists in the same geographic area. In the event such lesser amount does not equate to the Non-Contracting Dentist'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).

(b) The Lesser of the Non-Contracting Dentist's Claim Charge or Maximum Allowance amount which is based on data provided by a U&C service. A Usual and Customary ("U&C") service means a private or commercial source that gathers claims information from multiple insurers and builds and maintains a database and fee profiles to determine the usual and customary amount.

Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing all Participating Dentist Claims for processing Claims submitted by Non-Contracting Dentists which may also alter the Dental Maximum Allowance for a particular Covered Service. In the event that the Maximum Allowance amount does not equate to the Non-Contracting Dentist'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).

Unless otherwise stipulated by a contract between a dental Provider and Claim Administrator:

iii. ***For Covered Services performed in Texas.*** The Allowable Amount is based upon the applicable methodology for dentists with similar experience and/or skills.

iv. ***For Covered Services performed outside Texas.*** The Allowable Amount will be established by identifying dentists with similar experience or skills in order to establish the applicable amount for the Covered Service.

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

vi. ***When a less expensive professionally acceptable service, supply, or procedure is available.*** The Allowable Amount will be based upon the most economical supply, appliance, or level of dental Covered Service that is appropriate for the safe and effective treatment of the Covered Person. This is not a determination of whether a service is Dentally Necessary, but merely a contractual benefit allowance of a dental Covered Service.

The Allowable Amount for all dental Covered Services also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

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

24.5 "Alternative Provider Compensation Arrangement Payments" means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Homes payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 15.4 of Exhibit 2.

If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 24.5, 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 15.4 of Exhibit 2. 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 Members, unless an alternate calculation method is used (in the same manner as described in Section 15.4 of Exhibit 2. Expected Payment may vary from Member to Member. For purposes of this Section 24.5, 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 the 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.

24.6 "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.

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

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

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

24.10 "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.

24.11 "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.

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

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

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

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

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

24.17 "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.

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

24.19 "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.

24.20 "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.

24.21 "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.

24.22 "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").

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

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

24.25 "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.

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

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

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

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

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

24.31 "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.

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

24.33 "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.

24.34 "Physician" means a physician duly licensed to practice medicine in all of its branches.

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

24.36 "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 the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

24.37 "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.

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

24.39 "Services" means the services listed in Exhibit 1.

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

24.41 "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.

24.42 "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 and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), 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. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

24.43 "Timely" means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within 48 business hours of notification to Employer by Claim Administrator, monthly fees (e.g. administrative) 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.

24.44 "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.

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. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

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

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, 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.

- **CLIENT SERVICES AND MATERIALS**

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

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

  b. ***Standard Identification Cards.*** Provision of 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 Pre–notification Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require pre–notification, 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 pre–notification helpline 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.

- **EXTERNAL REVIEW COORDINATION (if applicable)**

  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.

- **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 settlement statements (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 policy 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 STATISTICAL**

  Determination of 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 3.

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

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

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

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying claims status, 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 including, if also applicable, Primary Care Physicians within the designated service area.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current ASO BPA)***

  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.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING (*If elected on the most current ASO BPA)***

  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 under the Agreement subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING (RBP) (*If elected on the most current ASO BPA)***
  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 *(if elected on the most current ASO BPA)***
  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) *(if elected on the most current ASO BPA)***
  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.
- **MSP INFORMATION REPORTING**
  Pursuant to Exhibit 2, Section 16 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 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, funds will escheat to state of payee's last known address on behalf of Employer 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.
- **HEALTH ADVOCACY SOLUTIONS (*If elected on the most current ASO BPA*)**
  Provide a program that may include Holistic Health Management, Member Rewards, utilization management, access to clinical and non-clinical Health Advocates, or such other features as determined by Employer and agreed to by Claim Administrator.

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

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 Exhibit. 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 Exhibit; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Exhibit; or iii) the date the Agreement is terminated (or in the case of the PBM Exhibit, the date such 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).

**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 24 AGREEMENT 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 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 Section 16 of this Exhibit 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 partial termination of Covered Employees, 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 Exhibit, 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 Exhibit, 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, 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 partial termination by Employer of more than 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);
- **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 and/or 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 Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

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

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

SECTION 5: EMPLOYER PAYMENT

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

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

- **a.** ***If Employer Payment Method is by check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If Employer Payment Method is other than check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties, of the amount due. 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 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no condition will Claim Administrator be responsible for payment of Reinsurance Contributions.

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

SECTION 6: CLAIM SETTLEMENTS

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

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

c. The Administrative 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 written notice 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 20 "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 8 of the Agreement, or on the date of a partial termination by Employer of more than 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 Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or partial termination, including, but not limited to, 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 partial termination. 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 or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

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 in accordance with Claim Administrator's established procedures and/ or the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

Employer represents that it acknowledges and has communicated the substance of the provisions stated in each of the following sections of this Exhibit 2 (Sections 10 and after) to its Covered Persons, with modifications appropriate for communications with Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***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 10.3, below. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***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.

10.3 ***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. However, 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.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing 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.

11.2 ***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 which 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.

11.3 ***If point–of–service coverage applies.*** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. ***Physician Selection.***

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

b. ***Changing Physician Selection.***

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

11.4 ***Intent of terminology.*** The use of an adjective such as but not limited to, 'Approved,' 'Administrator,' 'Participating,' 'In–Network' or 'Network' in modifying the term 'Provider' shall in no way be construed as a recommendation, referral or statement as to the ability or quality of such Provider. Conversely, the omission, non-use or non-designation of the foregoing adjectives, or, alternatively, any similar modifier, or, alternatively, the use of a term such as 'Non-Approved,' 'Non-Administrator,' 'Non-Participating,' 'Out-of-Network,' or 'Non-Network' should not be construed as carrying any statement or inference, whether negative or positive, as to the ability or quality of such Provider.

11.5 ***Provider's role.*** Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (other than as an individual Covered Person) or the Plan.

SECTION 12: 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 professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional 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 and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

13.1 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 Allowable Amount, Section 24.3.b.(1) above. 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 Allowable Amount, Section 24.3.b.(2) above.

13.2 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 discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual Network savings achieved for Covered Persons will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

13.3 Employer understands that Claim Administrator may receive such discounts during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts 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 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.

13.4 "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 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.

13.5 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. Additional information about these types of fees or the amount of these fees is available upon request.

SECTION 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

14.1 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.

14.2 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 the Claim Administrator under the PBM's agreement with Claim Administrator. This negotiation is conducted by the PBM for the benefit of Claim Administrator and not for the benefit of the 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). Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM. 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, the Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls. 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. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The Claim Administrator may provide the Employer with a Rebate Credit, the amount of which is set forth in the ASO BPA. 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. The Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM 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.

14.3 As of the Effective Date, the maximum that a Pharmacy Benefit Manager will receive from any pharmaceutical manufacturer for manufacturer administrative fees is four and one quarter percent (4.25%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to Pharmacy Benefit Manager at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed..

SECTION 15: INTER-PLAN ARRANGEMENTS

15.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim

Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator.

Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

15.2 *BlueCard® Program*

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

a. *Liability Calculation Method – In General*

(1) Covered Person Liability Calculation.

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

(2) Employer's Liability Calculation.

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

b. *Claims Pricing*

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

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

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

(3) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other

Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or an average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Covered Person and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

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

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 15.9 below.

Claim Administrator will charge these fees as follows:

(1) 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 healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

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

15.3 ***Negotiated Arrangements***

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

agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue.

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

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

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under 15.2.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 15.2.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 15.9 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.

15.4 ***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 Homes and Shared Savings arrangements.

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

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

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

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

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

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

When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

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

The Host Blue will not receive compensation resulting from how estimated average or PMPM price methods, described above, are calculated. If Employer terminates, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds in variance accounts.

Note: Covered Persons will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

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

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

a) PMPM billings; or

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

15.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

15.6 ***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 include any such surcharge, tax or other fee to Employer, which will be Employer's liability.

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

a. ***Covered Person Liability Calculation***

(1) General

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

amount that the Non-Participating Healthcare Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the 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 the Claim Administrator may make a payment based on the lesser of:

a. the amount calculated using the methodology described in Section 15.7(a)(1) above; or

b. the following:

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

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

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

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 15.9 below.

15.8 ***Blue Cross Blue Shield Global Core®***

a. ***General Information***

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

(1) Inpatient Services

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

(2) Outpatient Services

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

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

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Covered Persons need assistance with their Claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core Program are available upon request. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 15.9 below.

15.9 ***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 8.2(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.

SECTION 16: MEDICARE SECONDARY PAYER INFORMATION REPORTING

16.1 Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan ("GHP") arrangements. The parties agree that Claim Administrator as the Responsible Reporting Entity ("RRE") under Section 111 requirements is required to 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.

16.2 Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan.

16.3 Employer agrees that Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of Claim Administrator's files concerning Covered Persons and the number of individuals employed by Employer. Employer agrees to use its best efforts in responding promptly and accurately to Claim Administrator's requests for information.

16.4 Further, to assure the continuing accuracy of Claim Administrator's files, Employer agrees that it is Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer acknowledges and agrees that Claim Administrator will be using the information provided by Employer and Covered Persons to update Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

16.5 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 Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 17: REIMBURSEMENT PROVISION

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

17.1 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, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the Provider's Allowable Amount for Covered Services for which Claim Administrator has provided benefits to the Covered Person.

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.

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

SECTION 18: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. 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). As part of the overall plan of benefits that Employer offers to a Covered Person, 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 may (1) communicate directly with the Covered Persons and/or (2) provide the Host Blues whose service area covers the geographic area in which a Covered Person resides, with a Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which Employer has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

EXHIBIT 3
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 solely 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, including providing appropriate authority to communicate with Employer concerning issues pertaining to any class actions and pursuant to which Employer specifically declines representation by class litigation counsel.
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. 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.
7. 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.
8. 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.
9. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.
10. 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.
11. 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.

12. 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 19 NOTICES of the Agreement.
13. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 19 NOTICES 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.
14. 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.
15. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Exhibit.
16. 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 4
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

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

Group Status: Former HCSC Insured account converting to ASO

Employer Account Number (6-digits): 217766 Group Number(s): _____ Section Number(s): All

Legal Employer Name: South San Antonio ISD

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

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

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

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

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Select legal reason ; 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 11 /01/2018 End Date 10/31/2019 (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) 11 / 01 / 2018

Anniversary Date: (Month/Day/Year) 11 / 01 / 2019

Account Information ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 8211 Employer Identification Number (EIN): 74-6002335

Address: 5622 Ray Ellison Blvd.

City: San Antonio State: TX ZIP: 78242

Administrative Contact: Irma Paine Title: Human Resource Coordinator

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7017

☐ Mailing address is different from primary address

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Mailing Contact: Irma Paine Title: Human Resource Coordinator

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7017

☐ Billing address is different from primary address

Billing Address: _____

City: _____ State: _____ ZIP: _____

Billing Contact: Clarita Trevino Title: Accountant

Email Address: ctrevino@southsanisd.net Phone Number: 210-977-7025 Fax Number: 210-977-7017

Wholly Owned Subsidiaries: n/a

Affiliated Companies: _____

(If Affiliated Companies listed above are to be covered, a separate "Addendum to the ASO BPA Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this ASO BPA.)

Subsidiary / Affiliate Address: _____

City: _____ State: _____ ZIP: _____

Subsidiary / Affiliate Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

Blue Access for Employers (BAE) Contact: Irma Paine Title: HR Coordinator

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

Email Address: ipaine@southsanisd.net Phone Number: 210-977-7040 Fax Number: 210-977-7019

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

Producer of Record NO CHANGES SEE ADDITIONAL PROVISIONS

Effective: _____

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

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

Tax ID Number (TIN) of ☐ Producer or ☐ Agency: _____ Producer #: _____

NPN: _____

Address: _____

City: _____ State: __ ZIP: _____

Phone: _____ Fax: _____ Email: _____

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

General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

Is there a secondary Producer or Agency to whom commissions are to be paid? ☐ Yes ☐ No

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

Tax ID Number (TIN) of ☐ Producer or ☐ Agency: _____ Producer #: _____

NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

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

General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):

Producer /Agency 1: _____% Producer /Agency 2: _____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, specify location below:

_____

* 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).

** If commissions are split, please provide the information requested above on both producers/agencies. **Both** must be appointed to do business with HCSC in Texas.

Schedule of Eligibility NO CHANGES SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

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

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

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

2. Employee Definitions:

   Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 25 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 day of the month following month(s) of employment.
   ☐ The day of the month following days of employment.
   ☒ The1st 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 for coverage? ☒ Yes ☐ No

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

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

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

7. Are unmarried step-children under the limiting age eligible for coverage? ☒ Yes ☐ No

   If yes, is residency with the employee required? ☐ Yes ☒ No

8. Are unmarried grandchildren eligible for coverage?

   ☐ No ☒ Yes (answer the question below)

   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☒ Yes ☐ No

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

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

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

   ☐ Yes ☒ No

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

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

☐ Yes (specify number of days below) ☒ No

Temporary Layoff: 0 days Disability:0 days Leave of Absence: 0 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 HCSC 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 assistance under a state Medicaid or CHIP premium assistance program.

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

☒ Annual open enrollment – late applicant may apply during open enrollment and be subject to the late applicant provisions.

☐ Late applicants may apply at any time – coverage is effective first of the month following receipt of the application.

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

Specify Open Enrollment Period: August 15th - September 15th

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*

CURRENT ELIGIBILITY INFORMATION

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

Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire waiting period _____
7. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

Lines of Business (Check all applicable services)	NO CHANGES See *Additional Comments*
Medical Plan Services: ☒ PPO: Plan Name: Option 2 PPO $6000 Plan Name: Option 3 PPO $3000 Plan Name: _____ Plan Name: _____ Plan Name: _____ ☒ HMO: Plan Name: ☐ Prescription Drug Option: Select From List ☒ No Prescription Drug Option ☐ EPO: Plan Name: _____ ☐ POS: Plan Name: _____ ☐ Blue Directions (Private Exchange) (*If selected, the Blue Directions Addendum must be attached and made a part of the Agreement.)*	**Consumer Driven Health Plan (BlueEdge)** ☐ HCA, (*if selected, complete separate HCA Benefit Program Application*) ☐ HSA, (*if selected, provide HSA Administrator or trustee name:* _____) ☐ FSA (vendor: ConnectYourCare) **Traditional Coverage:** ☐ Out-of-Area (Indemnity) ☐ Benefit Offering **Prescription Drugs:** ☐ Prescription Drug Program ☐ Stand-Alone Prescription Drug Program
☐ **Dental Plan Services** Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List ☒ **Stop Loss Coverage** (*If selected, complete separate Stop Loss exhibit*) ☐ **Dearborn National Life Insurance** (*If selected, complete separate Life application*) ☐ **COBRA Administrative Services** (*If selected, complete separate COBRA Administrative Services*	☐ **Vision Plan Services** ☐ **In-Hospital Indemnity (IHI)** ☐ **Wellness Incentives** ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other

Additional Comments: South San Antonio ISD will renew moving from Fully Insured to ASO. The PPO Option 2 and Option 3 will remain. PPO Option 4 will terminate. Blue Essentials (gatekeeper) will remain the same as current benefits and will be a Gatekeeper plan with same benefits. MDLive (medical and behavioral health) included. BVA and Member

Rewards available to members on PPO plans. PBM will be ESI, we will share accums and reverse eligibility will be set up. Stop Loss will be a 12/15 contract at $200K ISL 115% attachment. Monthly ACAP included and applies to medical claims only. RX will be included in Stop Loss at year end settlement. Includes a transition credit in the amount of $15,000 and Wellness Credit in the amount of $25,000. Both Transition and Wellness credits are for the policy period 11/1/2018 through 10/31/2019. Any remaining balance will expire after 10/31/2019. HCSC agrees to provide a one (1) month net Medical & Rx Admin fee credit in the amount of $21.76 pepm. The amount of the fee credit will be worth approximately $23,436. This amount is based on the projected enrollment show on this exhibit (1,077 contracts per month), and is subject to change based on the actual enrollment of the group. If South San Antonio ISD cancels during the policy period, South
San Antonio ISD will be responsible for paying HCSC for the amount of the fee credit.

FEE SCHEDULE

Payment Specifications	NO CHANGES	SEE ADDITIONAL PROVISIONS

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** ☐ **Monthly** ☐ **Other** (please specify): _____

Claim Settlement Period: ☒ **Monthly** ☐ **Other** (please specify): _____

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

Final Settlement: Final Settlement to be made within **90** days after end of Run-Off Period.
Standard is ninety (90) days.

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

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

	11-2018	12-2018 through 10-31-2019	11-2019	11-2020
Administrative Fee	$17.83	$39.59	$38.43	$40.35
Dental	$_____	$_____	$_____	$_____
Claims Fiduciary	$_____	$_____	$_____	$_____
Outpatient Imaging Management Services	$_____	$_____	$_____	$_____
Management of the Virtual Visits Program	$_____	$_____	$_____	$_____
Commissions	$_____	$_____	$_____	$_____
Other: Other Services List Service: MD Live	$0.00	$0.00	$tbd	$tbd
Other: Other Services List Service: BVA with Member Rewards	$1.71	$1.71	$tbd	$tbd
Other: Other Services List Service: RX Shared Accums Maintenance	$.42	$.42	$tbd	$tbd
Miscellaneous: $25,000 Wellness Credit	$0.00	$0.00	$tbd	$tbd
Miscellaneous: $15,000 Transition Dollars	$0.00	$0.00	$tbd	$tbd
Total	$19.96	$41.72	$_____	$_____

Administrative Line Item Charges	Frequency	Amount

Other: Other Services List Service: Reverse Eligibility (RX carveout)	Annual If applicable, describe other: _____	$2,000
Other: Other Services List Service: Shared Accumulator Set Up (RX carveout)	One-time fee If applicable, describe other: _____	$2,000
Other: None List Service: _____	Annual 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:	$4,000

Additional Comments (Provide any additional details regarding the fee structure): _____

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

Not applicable to Grandfathered Plans

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 for external reviews to be performed under the Federal Affordable Care Act external review process.

Reimbursement Service: ☒ Yes ☐ No

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

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

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

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

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

Termination Administrative Charges

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

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

Service	11/1/2018			
Medical Run-off Administration Charge	$32.56	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	$32.56	$_____	$_____	$_____

Additional Comments:

Other Provisions — NO CHANGES — SEE ADDITIONAL PROVISIONS

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

      ☒ Yes. (Please answer question b. The SBC Addendum is attached.)
      ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

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

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

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

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

3. Case Management Program: ☒ Yes ☐ No *If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons.*

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

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

   Employer elects EHBs based on the following:

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

   ☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: _____

   ☐ 3. Other EHB, as determined by Employer.

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

6. Employer contribution:

Employer Contribution – Medical	Employer Contribution – Dental
_____ % of Employee's premium, or $HMO $342.33, PPO $355.89	_____ % of Employee's premium, or $_____
_____ % of Dependent's premium, or $_____	_____ % of Dependent's premium, or $_____

Comments: _____

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

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

Additional Provisions: Gallagher Benefit Servcies, Inc. will continue as the Consultant on this account. There is no broker.

I UNDERSTAND AND AGREE THAT:

1. **Only complete for new accounts:** Receipt by HCSC of the advance administrative fee (where applicable), in the amount of $n/a, and completed enrollment forms does not constitute approval and acceptance by the HCSC Home Office.
2. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Signature

Rae M. Bailey
Sales Representative

025 512-558-5121
District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

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 shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: South San Antonio ISD

Address: 5622 Ray Ellison Blvd.

City: San Antonio State: TX ZIP: 78242

Dated this _____ day of _____
Month Year