BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

GROUP NAME: Madison County BOS

EFFECTIVE DATE: October 1, 2017

ADMINISTRATIVE SERVICES (Per Employee Per Month)	$ 40.00
Broker/Consultant Fee	$
Optional Services	$ 0.00 (Risk Pool)
Total	$ 40.00

Networks
- Participating Hospital
- Key Physician
- Diagnostic Imaging Centers
- Comprehensive Outpatient Rehabilitation
- Durable Medical Equipment
- Home Infusion Therapy
- Chiropractor
- Podiatry
- Renal Dialysis Facilities
- Psychiatric/CDU
- Pharmacy Network
- Ambulatory Surgical Facilities
- Physical/Occupational Therapy
- Optometrist
- Nurse Practitioner

Services
- Creditable Coverage Certificates
- Standard Blue Cross & Blue Shield of Mississippi ID Cards
- Prescription Drug Management Program
- Furnish Explanation of Benefits
- Online Access to Reporting
- Other Party Liability Program
- Employee Booklets(Summary Plan Descriptions)
- Annual Renewal
- Electronic Claims Processing
- Appeals
- Utilization Management
- Reinsurance Monitoring
- Local Customer Service
- Online Access to Claims Viewing

BLUECARD PROGRAM FEES:

Administrative Fees – An out-of-state Blue Cross and Blue Shield Plan may charge an administrative fee for each original claim filed with that plan. These fees will be passed to the group as a claims expense.

Network Access Fees – Certain Blue Cross and Blue Shield Plans charge a network access fee for use of their networks and access to their savings. These fees will be passed to the group as a claims expense.

ENROLLMENT REQUIREMENTS:

- Electronic Enrollment
- Bank Draft Authorization for Claims and Premiums

OPTIONAL ADMINISTRATIVE SERVICES:

Dental – Basic (Not Part of the Health Plan) $ _____

Administrative Services, Reinsurance & Assignment of Benefits Confirmation

☐ **New Group** ☒ **Renewal**

1. Effective Date: 10/1/2017
2. Medical Administrative Fee Per Employee Per Month: $40.00
3. Dental Administrative Fee Per Employee Per Month: $_____
4. Agent/Broker Commission Per Employee Per Month: $_____
5. Optional Services: (Risk Pool _____) $0.00
6. Specific Stop-Loss Reinsurance Carrier (if applicable): _____
   A. Specific Stop-Loss Deductible: $_____
   B. Aggregating Specific Deductible: $_____
   C. Specific Stop-Loss Rates: Single $_____ Family $_____ Composite $_____
   D. Claims Basis: (Paid, 15/12 etc.) _____
   E. Lasered Deductible – Member Name: _____ Amount: _____
   F. Lasered Deductible – Member Name: _____ Amount: _____
   G. Lasered Deductible – Member Name: _____ Amount: _____
7. Aggregate Stop Loss: ☐ Yes ☐ No Aggregate Rate: _____ Basis: _____
   Aggregate Monthly Factor: $_____ Annualized Attachment point: $_____

Group Name: Madison County BOS **By:** _____

Date: _____ **Title:** _____

Assignment of Benefits
Amending
Reinsurer Excess Risk Insurance Policy with Policyholder

☒ **Applicable** ☐ **Not Applicable**

This Agreement is made by and between, Madison County BOS, the Policyholder and Blue Cross & Blue Shield of Mississippi, a Mutual Insurance Company. This Amended Assignment of Benefits will become effective on 10/1/2017.

In consideration of the fact that Blue Cross & Blue Shield of Mississippi has agreed to advance to the Policyholder any and all benefit payments due under the terms of the policy between _____ (Reinsurance Carrier) and Policyholder, Policyholder acknowledges and agrees, that by affixing an authorized signature to this form, that all benefits due under the terms of said policy, a copy of which is attached and made a part hereto, are hereby assigned to Blue Cross & Blue Shield of Mississippi.

_____ (Reinsurance Carrier) and Madison County BOS (Policyholder) explicitly agree that any and all provisions directing payment of benefits to Policyholder and/or preventing assignment of such benefits are hereby amended to reflect that benefits will be paid to Blue Cross & Blue Shield of Mississippi.

IN WITNESS WHEREOF, the parties hereto have caused this Assignment to be executed by their respective officers who have been duly authorized to execute this Assignment.

_____ (Reinsurance Carrier)	Madison County BOS (Policyholder)	Blue Cross & Blue Shield of Mississippi
By: _____	By: _____	By: _____
Title: _____	Title: _____	Title: _____
Date: _____	Date: _____	Date: _____

ADMINISTRATIVE SERVICES CONTRACT

between

Blue Cross & Blue Shield of Mississippi, a Mutual Insurance Company,

Madison County Board of Supervisors,

and

Employee Health Protection Plan for Madison County Board of Supervisors

October 1, 2017

(the "Effective Date" of this agreement)

ADMINISTRATIVE SERVICES ONLY AGREEMENT

This Administrative Services Agreement is ("Agreement") between Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company (hereinafter "Claim Administrator") and Madison County Board of Supervisors (hereinafter the "Employer") and Employee Health Protection Plan for Madison County Board of Supervisors (hereinafter "GHP") is entered into as of October 1, 2017 (the "Effective Date"). The term of the Agreement is for a 12 month period, running October 1, 2017 to September 30, 2018. In consideration of the premises, the mutual understanding of the Claim Administrator, Employer, and GHP, as reflected in this Agreement, the Parties agree to be bound by the following terms and conditions.

WITNESSETH AS FOLLOWS:

WHEREAS, Employer has established and maintains GHP as an employee welfare benefit plan as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 and the regulations promulgated thereunder ("ERISA"); and

WHEREAS, the benefit plans offered by GHP, and sponsored by Employer, for eligible employees and their eligible dependents include a comprehensive major medical program; and

WHEREAS, Employer and GHP desire to retain Claim Administrator to provide certain administrative services with respect to the Benefit Plan; and

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements set forth below, Employer, GHP and Claim Administrator agree as follows:

PART 1 - DEFINITIONS

Terms with capital letters appearing in this Agreement shall have the meaning given to them in the Benefit Plan, as well as applicable state and Federal laws or shall have the following meanings. To the extent terms below are defined in the Benefit Plan, the Benefit Plan definition prevails, as the terms used in this Agreement may be abbreviated.

A. **"Accountable Care Organization (ACO)"** – 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.

B. **"Benefit Plan"** - the employee booklet outlining the comprehensive major medical program adopted by GHP. The Benefit Plan is identified as follows: Employee Health Protection Plan for Madison County Board of Supervisors, Contract Type C615.

C. **"BlueCard Program"** - A reciprocal agreement between Claim Administrator and other Blue Cross and Blue Shield Plans that provides the opportunity to utilize local Blue Cross and Blue Shield Provider agreements in other states.

D. **"Care Coordination"** – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

E. **"Care Coordinator"** - An individual within a Provider organization who facilitates Care Coordination for patients.

F. **"Care Coordinator Fee"** - A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to Providers periodically for Care Coordination under a Value-Based Program. Care Coordinator Fees are negotiated amounts paid to Providers on a per member per month basis. These fees reimburse Providers for the additional care coordination services provided to Members and are not intended to reflect performance incentives.

G. **"Claim"** - means notification in a form acceptable to Claim Administrator that service has been rendered or furnished to a Covered Person.

H. **"Covered Employee"** - means the person to whom coverage under the Benefit Plan has been extended by GHP and to whom Claim Administrator has directly or indirectly issued an identification card bearing GHP's Number. For purposes of providing benefits under the Benefit Plan, Covered Employee does not mean a person who has selected Medicare as primary coverage.

I. **"Covered Person" or "Member"** - means the Covered Employee and the Covered Employee's legal spouse and/or dependent children as specified in the Benefit Plan.

J. **"EnrollBlue"** –Claim Administrator's electronic system with allows GHP to enroll Covered Persons and complete maintenance to the GHP's membership.

K. **"Global Payment/Total Cost of Care"** - 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.

L. **"Medical Policy"** – A set of formal written guidelines developed by Claim Administrator to assist Claim Administrator in reaching decisions on matters of: 1) Medical Necessity; 2) Covered Services as defined in the Benefit Plan; 3) appropriate adjudication of Claims; 4) Care Management, and 5) quality assessment programs.

M. **"*my*Blue Group"** – A secure internet portal that provides access to GHP information including, but not limited to, benefits, Payment and billing, and enrollment along with various health and wellness information.

N. **"Negotiated Arrangement"** - An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

O. **"Network Provider"** – A Hospital, Physician, or Allied Provider who has a Network Agreement with Claim Administrator pertaining to Covered Services rendered to a Member.

P. **"Payment"** means any of the following activities of a health plan, such as GHP, as relates to a Covered Person (*see* 45 Code of Federal Regulations § 164.501):

1. Obtaining premium payments;
2. Determining or fulfilling responsibility for coverage and provision of benefits under the health plan;
3. Determining an enrollee's eligibility or coverage;
4. Coordinating benefits, determining cost sharing amounts, adjudicating or subrogating health benefit claims;
5. Adjusting risk amounts due based on enrollee health status or demographic characteristics;
6. Engaging in billing, claims management, issuance of explanations of benefits, collection activities, and related health care data processing;
7. Obtaining payment under a contract of reinsurance (including stop-loss insurance and excess of loss insurance);
8. Reviewing health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
9. Conducting utilization review, precertification and preauthorization of services, and concurrent and retrospective review of services; and
10. Disclosure to consumer reporting agencies not more than the demographic data permitted by 45 Code of Federal Regulations § 164.501 ("Payment" ¶ 2(vi)).

Q. **"Patient-Centered Medical Home (PCMH)"** - 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.

R. **"Provider Agreement"** – An agreement between Claim Administrator and a Network Provider.

S. **"Provider Incentive"** - 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 agreed-upon procedural and/or outcome measures for a particular population of Covered Persons.

T. **"Protected Health Information"** - means Individually Identifiable Health Information that is transmitted or maintained electronically, on paper, orally or in any other form or medium.

U. **"Shared Savings"** - A payment mechanism in which the Provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk. Providers that improve the quality of care and reduce total healthcare spending based upon defined quality and cost targets may receive Provider Incentives.

V. **"Value-Based Program (VBP)"** - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

PART 2—CLAIM ADMINISTRATOR'S RESPONSIBILITIES

I. SERVICES PROVIDED BY CLAIM ADMINISTRATOR

A. During the term of this Agreement, the Claim Administrator agrees to handle the administrative function involved with filing, processing, and Payment of claims incurred on or after the Effective Date in accordance with the Benefit Plan. Claim Administrator's responsibilities under this Agreement are limited to administering claims on behalf of GHP. As such, Claim Administrator is a service provider, and not a fiduciary with respect to GHP or the Benefit Plan. Further, Claims Administrator does not assume any financial risk or obligation with respect to Claims administered on behalf of GHP. Pursuant to this function the Claim Administrator will perform the following acts:

1. Prepare a standard electronic Benefit Plan utilizing the finalized Benefit Confirmation Report, Administrative Confirmation Report, and any important documentation attached to Claim Administrator's Blue Form. Claim Administrator will prepare an electronic copy of the initial Benefit Plan and revisions to the Benefit Plan at the time of the Group's renewal. Any future changes must be made at the next renewal date. This will be a part of the standard administrative fee. Any printed books or additional changes, including revisions to benefits or eligibility requirements requested by the Employer to the Benefit Plan after the initial Benefit Plan or outside of the GHP's renewal date must be approved by Claim Administrator in writing and will result in additional fees. Retroactive benefit and eligibility changes will not be allowed except where approved by Claim Administrator or otherwise required by law. Benefit Plan will comply with all of the statutory and regulatory requirements applicable to the Summary Plan Description provided for under ERISA, if applicable, the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care Education and Reconciliation Act of 2010 and the implementing regulations (collectively "PPACA"), and any other applicable laws and regulations.

2. Prepare a Summary of Benefits and Coverage in accordance with PPACA and maintain the same in an electronic format located on *my*Blue Group and *my*Blue.

3. Provide suitable facilities, personnel, procedures, forms and instructions for the administration of Claims under the Benefit Plan.

4. Receive, review, process and determine, in accordance with the Benefit Plan and Claim Administrator's Medical Policy, the qualification for Payment of Claims submitted and make such investigation regarding Claims as may be necessary.

5. Make Payment of amounts due with respect to Claims which qualify for Payment under the Benefit Plan.

6. Provide access to customer service representatives.

7. Provide administrative advice on disputed Claims.

8. Provide notices of Payment of benefits and denial of Claims for non-covered services.

9. Coordinate benefits as outlined in the Coordination of Benefits section of the Benefit Plan.

10. Determine, in accordance with the Benefit Plan and based on information from GHP, the eligibility of employees and dependents for coverage under the Benefit Plan.

11. Identify, investigate and administer Claims which may involve third party liability and for which there is a potential for collection under the terms of the Benefit Plan of amounts paid to, or on behalf of, Covered Persons through subrogation of their rights of reimbursement in connection with a claim for Covered Services. Claims Administrator will not be required to initiate court proceedings for the recovery of the third party liability. In the event this Agreement is terminated, Claim Administrator will discontinue this service. Upon notification by the GHP of the name and address of the new claim administrator, Claim Administrator will forward a copy of any subrogation files to the new claim administrator.

12. Utilize the "Pay and Pursue" method when administering Claims which involve a subrogation lien. The "Pay and Pursue" method is subject to exceptions when, for example, Claim Administrator conducts investigations prior to Payment for filed Claims related to motor vehicle accidents or work related injuries.

13. Provide initial and electronic standard identification cards for Covered Persons. Any additional cards may be subject to additional cost.

14. Make every reasonable effort to recover any overpayment or mistaken Payment of Claims, but Claim Administrator will not be required to initiate court proceedings for such recovery or defend on GHP's behalf.

15. Provide annually, upon the request of GHP:

    a. an estimate of the Benefit Plan's incurred benefit costs, and

    b. an analysis of Benefit Plan benefits and desirability of Benefit Plan modification.

16. Make available for inspection by GHP or GHP's auditor for any three (3) years during the continuance of this Agreement and for three (3) years thereafter, the Claim Administrator's books and records that may have a bearing on this Agreement; provided, however, that any examination of individual benefit Payment records will be conducted in a manner agreed to by GHP and the Claim Administrator to protect the confidentiality of Claim Administrator's proprietary information and the individual's Protected Health Information.

17. Provide notification and tender the defense of any litigation where GHP is the real party in interest. GHP shall provide reasonable assistance and cooperation to remove Claim Administrator from any litigation where it is not a proper party.

18. Fund all Claims over the individual specific stop-loss deductible amount as defined in GHP's excess risk insurance policy (hereinafter "Reinsurance"). This Section applies only when GHP has elected to have Claim Administrator fund all Claims over the individual specific stop-loss deductible amount as defined in GHP's Reinsurance.

19. File aggregate and specific stop-loss claims with the Reinsurance carrier. This Section applies only when GHP has elected to have Claim Administrator file aggregate and specific stop-loss claims with the Reinsurance carrier. GHP and Employer acknowledge that while Claim Administrator will make reasonable efforts to file all specific stop-loss claims with the Reinsurance carrier prior to the end of the plan year, Claim Administrator cannot and does not guarantee that all aggregate and specific stop-loss claims will be filed with the Reinsurance carrier prior to the end of the plan year. GHP and Employer will hold Claim Administrator harmless for any damages, costs or expenses caused by aggregate and specific stop-loss claim not being filed by the end of the plan year.

20. Provide in a timely manner to GHP the Claim Administrator's standard electronic reporting package. The standard reporting package consists of those reports available on *my*Blue Group. These reports shall be provided exclusively on *my*Blue Group. Any non-standard or ad hoc reports are subject to approval of Claims Administrator and additional cost.

21. Provide a process for individual benefit determinations and appeal procedures in accordance with standards established by Claim Administrator and any applicable statutory or regulatory requirements. In the event GHP initiates an independent appeals process from the one established by the Claim Administrator, GHP assumes full responsibility for the process. GHP will also indemnify and hold harmless Claim Administrator from any damages, lawsuits, judgments or attorney fees incurred by Claim Administrator as a result of GHP's appeal decisions.

22. Claim Administrator will not intentionally manipulate the Payment of Claims or their application to deductibles or other limits in order to create a Claim.

B. Claim Administrator agrees to provide Care Management programs to ensure cost effective health care in the most appropriate setting. These programs include the following:

1. **Utilization Management**

   a. **Pre-admission Certification** is performed to determine the Medical Necessity and most appropriate setting for a Covered Person's admission to a non-delegated facility. Certification must be performed within one business day of receipt of the information necessary to complete the review process.

   b. **Prior Authorization** to determine that services, procedures, supplies, equipment, or prescription drugs are Medically Necessary and that the medical setting, such as the level of care and place of treatment, is clinically appropriate.

   c. **Continued Stay Review** to determine the Medical Necessity of continued hospitalization beyond the initially approved length of stay.

   d. **Case Management** involving ongoing case reviews to identify the appropriateness of more cost-effective, but quality alternative care of high risk, high cost, and/or catastrophic cases. Alternative services include, but are not limited to, home infusion therapy, home health care and hospice care.

   e. **Discharge Planning** on and during admission to promote timely discharge and help prevent unnecessary readmissions.

   f. **Medical Necessity Review** is performed to determine what services, treatments, procedures, equipment, drugs, devices, or supplies furnished by a covered Provider are Medically Necessary.

2. **Network Providers**

   a. A program based on an agreement between Claim Administrator and contracted Providers designed to assist in securing affordable health care services.

   b. Network Providers agree to file claims on behalf of the patient and to accept Claim Administrator's Payment, plus any applicable Deductible and/or Coinsurance/Co-payment, as Payment in full for Covered Services, support Claim Administrator's Care Management programs, and agree to hold the patient harmless for charges in excess of the Allowable.

3. **Prescription Drug Management Program**

   a. **Community PLUS Pharmacy Network** - a network of independent and chain retail pharmacies that have entered into an agreement with Claim Administrator, or an affiliate of Claim Administrator, for the purpose of more effectively managing prescription drug costs. Pharmacies participating in the network have agreed to a negotiated price which will be charged at the point of sale for prescription drug purchases.

   b. **Disease Specific Pharmacy Network (if elected by GHP)** – a network of Disease Specific Pharmacies which have expertise in disease states as well as the drugs used to treat disease states. Disease Specific Pharmacies have entered into

an agreement with Claim Administrator for the purpose of more effectively managing prescription drug costs. Pharmacies participating in the network have agreed to a negotiated price which will be charged at the point of sale for Disease Specific Drug purchases.

c. **Prescription Drug Rebate Program** - Claim Administrator maintains a prescription drug formulary (the "Formulary") listing preferred medications by categories chosen for their therapeutic and cost-effective advantages. The Formulary coverage of medications is determined by Claim Administrator's Pharmacy and Therapeutics Committee process. The benefit Payment for any medication is not determined by the presence or absence of the medication in the Formulary. Certain manufacturers offer volume discounts in return for inclusion of their products in the Formulary. These discounts or rebates are passed on to GHP.

d. **Prescription Drug Utilization Program** – a Care Management program, which determines the Medical Necessity of prescription drugs and through which reviews for clinical appropriateness and drug interactions are conducted.

4. **Color Me Healthy!**

If the GHP offers Color Me Healthy! (CMH!), which is a Disease Management Benefit focusing on the treatment and control of metabolic health risks and diseases, the cost of CMH! Care Coordination will be reflected monthly on an invoice summary as well as with an accompanying roster of claims.

5. **Blue Primary Care Home**

GHPs choosing to participate in Blue Primary Care Home will also participate in the Shared Savings Program. The Shared Savings Program establishes quality, outcome, and other performance measurements for Blue Primary Care Home Network Providers designed to improve health outcomes while reducing or minimizing healthcare costs. The Blue Primary Care Home Network Providers participate in savings reimbursed to them through the Shared Savings Program. If the requirements are not met, there are no savings distributed. The GHP will participate in the Shared Savings Program with other self-insured and insured plans, not independently. The Shared Savings Program impact will be reflected on a monthly claim billing invoice after the first year, and may be adjusted quarterly thereafter following the initial year of participation.

II. PAYMENT OF BENEFITS

A. Payment by Claim Administrator of any Claims under the Benefit Plan shall be in accordance with Claim Administrator's standard practice and in accordance with applicable state and federal statutes and regulations.

B. Claim Administrator shall send an electronic Claims Billing Summary Report to GHP on a three-time-per-month billing cycle. The Claims Billing Summary Report will indicate:

1. the amount of reimbursement for Claim Administrator funds used in the Payment of GHP's Claims, and

2. the amount of the administrative and access fees for the BlueCard Program (see Article IV).

C. Payment of the total amount specified on the Claims Billing Summary Report will be made three times a month to Claim Administrator on the 7th calendar day of the month following the billing cycle (if the 7th falls on a non-banking day, then payment will be initiated on the first banking day following the 7th). Payment will be made to Claim Administrator via ACH Direct Program from the GHP's bank account initiated by Claim Administrator.

D. GHP will be drafted the total amount specified on the Claims Billing Summary Report without regard to Reinsurance funding. Any Reinsurance issues shall be resolved by GHP and shall not impact or be grounds for adjustment to the Payment of Claims billings. Any short Payment of Claims

billings will result in the suspension of all services provided by Claim Administrator as outlined in Section II(E) below.

E. Should the GHP fail to have the funds, as billed, available for Payment on the 7th Calendar day following each billing cycle, the Claim Administrator may take the following action prior to the next billing cycle:

1. Claim Administrator may suspend all administrative services and Utilization Management programs outlined in Article I.
2. If the funds are not available by the 15th calendar day of the month following the billing cycle (if the 15th falls on a non-banking day, then funds must be available on the first banking day following the 15th), the Agreement will automatically terminate and GHP will be notified.
3. Should the administrative services be suspended more than once in any twelve month period, the Claim Administrator has the discretion to terminate the Agreement. The Agreement will not be reinstated.
4. The failure of Claim Administrator to suspend services or to terminate the Agreement due to GHP's failure to have the funds available in their bank account does not preclude the future suspension of services or the termination of the Agreement.

III. HOSPITAL SAVINGS

A. GHP Benefits

GHP shall be entitled to benefits from: (1) any Participating Hospital Agreement applicable to administrative services groups, and (2) any BlueCard Program between Claim Administrator and a Blue Cross and Blue Shield Plan (see Article IV).

B. Calculation of Savings

Claim Administrator will calculate the total savings received by GHP on Covered Services rendered to any Covered Person by any hospital that has signed a Participating Hospital Agreement with Claim Administrator. Of these savings, 100 percent will be passed on to GHP.

IV. ACCESS TO OUT-OF-STATE HOSPITAL SAVINGS THROUGH THE BLUECARD PROGRAM

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 Blue Cross Blue Shield Association ("Association"). Whenever Members 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.

Typically, when accessing care outside the geographic area Claim Administrator serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. Claim Administrator remains responsible for fulfilling its contractual obligations to you. Claim Administrator 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 Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area Claim Administrator serves, 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.

1. **Liability Calculation Method Per Claim – In General**

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

b. GHP's Liability Calculation

The calculation of the GHP'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 be greater for a given service or services than 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, the GHP may be liable for the excess amount even when the Member'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.

2. **Claims Pricing**

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

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

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

(iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its 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 average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the GHP 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 Member and the GHP 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 the GHP will be adjusted in a following year, as necessary, to account for over- or underestimation 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 the GHP. If the GHP terminates, you 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 settled over time. The timeframe for their 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. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

GHP understands and agrees to reimburse Claim Administrator for certain fees and compensation which it is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to GHP are set forth in Exhibit I. BlueCard Program Fees and compensation may be revised from time to time as described in section IV.F below.

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

GHP's Members 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.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon quality/cost goals in the following ways:

The Host Blue may pass these provider payments to Claim Administrator, which Claim Administrator will pass directly on to GHP as 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 the Host Blue:

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

(ii) 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 follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements and/or Care Coordination Fees to accounts are outside of the claim system. Claim Administrator will pass these Host Blue charges directly through to GHP as a separately identified amount on the group billings. When amounts are billed separately from claims, the group billings may include Care Coordination Fees with supporting documentation and/or Shared Savings.

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:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- 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 GHP terminates, you 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 settled over time. The timeframe for their 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. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members 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.

Care Coordinator Fees

Host Blues may also bill Claim Administrator for Care Coordinator Fees for provider services which are invoiced to GHP as follows:

1. Individual Claim billings reflecting a per member per month fee for those Members enrolled in a Value-Based Program.

As part of this Agreement, Claim Administrator and GHP will not impose Member cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

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

C. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating 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. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Claim Administrator they will be credited to GHP's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to GHP as a percentage of the recovery.

D. Nonparticipating Providers Outside Claim Administrator's Service Area

1. Member Liability Calculation

a. In General

When Covered Services are provided outside of Claim Administrator's service area by nonparticipating providers, the amount(s) a Member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, Claim Administrator may pay Claims from nonparticipating healthcare providers outside of Claim Administrator's service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by Claim Administrator or by applicable state law. In other exception cases, Claim Administrator may pay such Claims based on the payment Claim Administrator would make if Claim Administrator were paying a nonparticipating provider inside of Claim Administrator's service area. This may occur where the Host Blue's corresponding payment would be more than Claim Administrator's in-service area nonparticipating provider payment. Claim Administrator may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Members may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

2. Fees and Compensation

GHP understands and agrees to reimburse Claim Administrator for certain fees and compensation which it 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 GHP are set forth in Exhibit I. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section IV(F) below.

E. Blue Cross Blue Shield Global Core

2. General Information

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not serviced by a Host Blue.

- **Inpatient Services**

  In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their deductibles, coinsurance, etc. In such cases, the hospital will submit Member Claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services. **Members must contact Claim Administrator to obtain precertification for non-emergency inpatient services.**

3. Blue Cross Blue Shield Global Core Related Fees

GHP understands and agrees to reimburse Claim Administrator for certain fees and compensation which we are 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 GHP under Blue Cross Blue Shield Global Core are set forth in Exhibit I if charged separately from the general administrative fee. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section IV(F) below.

F. 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 GHP 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 GHP's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If GHP fails to respond to the notice and does not terminate this Agreement during the notice period, GHP will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

PART 3—GROUP HEALTH PLAN'S RESPONSIBILITIES

V. RESPONSIBILITIES OF GHP

A. GHP agrees to furnish any information required by the Claim Administrator as a result of state or federal law.

B. GHP accepts full responsibility and liability for granting any appeal rights to a denied claimant beyond those appeal rights provided for under the Benefit Plan.

C. GHP has full discretionary authority to determine eligibility for benefits and/or to construe the terms of the Benefit Plan. If the GHP's determination is not supported by the language of the Benefit Plan, GHP will indemnify and hold harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims and for any damages, lawsuits, judgments, expenses and attorney fees incurred by Claim Administrator as a result of such determination.

D. GHP acknowledges Claim Administrator will process and administer Claims in accordance with GHP's Benefit Plan and Claim Administrator's Medical Policy. In the event GHP instructs Claim Administrator to provide benefits which are outside the scope of GHP's Benefit Plan or in conflict with Claims Administrator's Medical Policy, GHP agrees in writing to accept full responsibility for the decision and to provide Claim Administrator with a written request for benefits outside of the scope of the Benefit Plan or in conflict with Claim Administrator's Medical Policy. Additionally, GHP agrees to indemnify and hold harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims and for any damages, lawsuits, judgments, expenses and attorney fees which arise from GHP's decision on such benefits.

E. In the event GHP retroactively cancels the coverage of an employee or dependent after Claims have been processed for the individual, GHP agrees to provide funds for the Payment of the Claims. GHP agrees to indemnify and hold harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims and for any damages, lawsuits, judgments, expenses and attorney fees which arise from GHP's retroactive cancellation or rescission of coverage.

F. GHP acknowledges the retroactive addition of an employee or dependent to coverage may cause coverage issues with the GHP's reinsurer. Claim Administrator assumes no liability or responsibility for these coverage issues caused by retroactive additions.

G. GHP shall enter into an "Assignment of Benefits" agreement wherein GHP will assign individual specific stop-loss benefits to Claim Administrator for reimbursement of Claim Administrator funds utilized for claims over GHP's individual specific stop-loss amount.

H. GHP accepts full responsibility for providing information requested by the Reinsurance carrier in a timely fashion. Claim Administrator shall not be responsible for any loss of Reinsurance funding caused by the GHP's failure to provide information requested by the Reinsurance carrier. GHP accepts full responsibility for securing Reinsurance. GHP shall provide Claim Administrator a copy of the Reinsurance policy within 30 days after the Effective Date of this Agreement.

I. GHP acknowledges that any decisions on its part to pay benefits that are not covered under GHP's Benefit Plan may result in reinsurance issues with its respective reinsurance carriers. GHP accepts full responsibility for these decisions.

J. GHP acknowledges that Claim Administrator is not a party to the Reinsurance policy and is not aware of the terms of the Reinsurance policy. GHP further acknowledges it is solely responsible for ensuring no conflict exists between the terms of the Reinsurance policy and the Benefit Plan. Additionally, GHP agrees to indemnify and hold harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims and for any damages, lawsuits, judgments, expenses and attorney fees which arise from any such conflict.

K. Employer is solely responsible for ensuring that the GHP is in compliance with Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employer's Plan Administrator (who is not Claim Administrator) is responsible for administering the GHP in accordance with COBRA provisions, providing any notices required by COBRA provisions, and making any and all coverage decisions with regard to the administration of COBRA benefits. GHP agrees to hold indemnify and harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims and any damages, lawsuits, judgments, expenses and attorney fees arising from GHP's administration of COBRA.

L. GHP accepts full responsibility for the distribution of Summaries of Benefits and Coverage to Employer's employees and their dependents under the Benefit Plan in accordance with PPACA

and/or guidelines and regulations set forth by the U.S. Department of Labor, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury.

M. GHP agrees that it will provide Claim Administrator with the reinsurance terms and contingencies, as agreed to between GHP and its reinsurance carrier, no later than the effective date of the reinsurance agreement. If GHP fails to furnish the reinsurance terms and contingencies to Claim Administrator by the effective date of the reinsurance agreement, all administrative services listed in Part 2 may be suspended by Claim Administrator.

PART 4—EMPLOYER'S RESPONSIBILITIES

VI. EMPLOYER'S OBLIGATIONS

A. Employer to Control GHP

Employer retains full and final authority and responsibility for GHP and its operation. Claim Administrator is empowered to act on behalf of GHP only as stated in this Agreement, or as mutually agreed in writing by Employer and Claim Administrator.

Employer will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations, including any licensing, filing, reporting, and disclosure requirement, that may apply to GHP. Claim Administrator will have no responsibility for or liability with respect to GHP's compliance or non-compliance with any applicable federal, state, or local law, rule, or regulation.

Employer's obligation includes, but is not limited to, compliance with all provisions of ERISA, if applicable. This includes those fiduciary responsibilities of administering its GHP and maintaining adequate funding to support the GHP.

B. Underwriting and Benefits Determinations

Employer retains the ultimate responsibility for Claims under the GHP and all expenses incident to GHP, except as Claim Administrator has specifically undertaken in this Agreement. Claim Administrator does not insure or underwrite the liability of Employer or GHP, and has no responsibility for determining the terms of or the benefits to be provided under the GHP.

C. Enrollment Information

Employer is solely responsible for furnishing the information that is required by Claim Administrator. This includes, but is not limited to, any information that is necessary to enroll employees and their dependents under the Benefit Plan, process terminations, and effect changes in family and membership status. Employer acknowledges and agrees that such information may be collected and transmitted electronically, including internet transmission.

D. Information Required by Law

Employer agrees to furnish any information required by the Claim Administrator as a result of state or federal law.

E. Membership Notification

All notification of membership or coverage changes must be through electronic transmission, approved by Claim Administrator and include all information required by Claim Administrator to effect changes.

F. Accuracy of Information

Employer warrants the accuracy of the information transmitted to Claim Administrator and understands that Claim Administrator will rely on this information. Employer agrees to supply or allow inspection of personnel records to verify eligibility as requested by Claim Administrator.

G. **Indemnification for Untimely or Inaccurate Information**

Employer further agrees to indemnify Claim Administrator for all expenses it incurs, if any, as a result of Employer's failure to transmit the information, failure to transmit it in the time period required by Claim Administrator, or failure of correct information being transmitted to Claim Administrator.

H. **Summary of Benefits and Coverage**

Employer acknowledges and agrees that GHP will furnish and distribute Summaries of Benefits and Coverage to Employer's employees and their dependents under the Benefit Plan in accordance with PPACA and/or guidelines and regulations set forth by the U.S. Department of Labor, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury.

VII. DIRECT PAYMENT TO MEMBER AND PARTICIPATION IN FAVORABLE REIMBURSEMENT AGREEMENTS

GHP agrees that unless otherwise required by law, all benefits payable under the Plan are not assignable, in whole or in part, by the Covered Persons. Claim Administrator will make payment for Covered Services directly to Network Providers, or to Non-Network provider(s) only if the Member provides written direction that benefits for Covered Services are to be paid directly to such Non-Network provider(s). In the absence of such a Network Agreement or the Member's written direction of payment to a Non-Network provider, all benefits will be payable to the Covered Person and any assignment of such benefits will not be honored.

PART 5—CLAIM ADMINISTRATOR'S COMPENSATION

VIII. COMPENSATION FOR CLAIM ADMINISTRATION

A. During the term of this Agreement, GHP agrees to pay Claim Administrator a monthly administrative services fee. Claim Administrator's compensation shall be based on GHP's enrollment as of the date the final bill preparation is completed by Claim Administrator. Note: The aforementioned fees are for Claims processing and other services performed in that month only.

1. The monthly administrative service fee is $40.00 for each employee covered in the Benefit Plan on or after October 1, 2017. The fee includes the services specified in Article I. The due date of the monthly administrative services fee is the first day of each month.

2. If GHP chooses the bank draft as billed option, on the 7th calendar day of the month (if the 7th falls on a non-banking day, then the payment will be initiated on the first banking day following the 7th) payment will be made to the Claim Administrator via ACH Direct Payment from the GHP's bank account initiated by Claim Administrator. If funds are not available on the 7th calendar day of the month, all administrative services listed in Article I may be suspended by the Claim Administrator.

3. If the Funds are still not available in the GHP's bank account by the 15th calendar day of the month (if the 15th day falls on a non-banking day, then payment will be initiated on the first banking day following the 15th) the Administrative Services Contract may be terminated immediately by the Claim Administrator.

4. If the GHP chooses the bank draft as reconciled option, then the GHP has the availability to initiate payment approximately 10 days prior to the due date and 10 days after the due date via the *my*Blue Group website.

B. GHP will provide electronic payment of the total monthly administrative fee as referenced on the electronic invoice received by GHP. Any adjustments to the administrative fee due to changes in coverage (e.g. additions, deletions, etc.) will be adjusted on GHP's electronic invoice for the following month.

C. GHP will pay the total monthly administrative fee as referenced on the invoice received by GHP. Any adjustments to the administrative fee due to changes in coverage (e.g. additions, deletions, etc.) will be adjusted on GHP's invoice for the following month.

D. Should the expense of administrative services increase due to benefit changes or other mutually agreed upon changes in services or procedures provided under this Agreement, the Claim Administrator may adjust the administrative fee accordingly, such adjustment to be effective on the date the changes take effect, subject to prior approval from GHP. Changes in administrative services and procedures will not be implemented until GHP agrees to the adjustment in the administrative fees. GHP will not unreasonably withhold approval for the adjustment of the administrative fee. In the event GHP fails to approve the increase in the administrative fee within thirty (30) days after receipt of a notice to increase from the Claim Administrator, Claim Administrator, at its discretion, may immediately terminate the Agreement without any additional notice to GHP; provided, however, that the Claim Administrator shall give written notice of any such termination to GHP immediately thereafter.

IX. REINSURANCE PREMIUMS

A. Timely payment of the reinsurance premiums is the responsibility of the GHP. Claim Administrator will collect the reinsurance premiums from the GHP and distribute the premiums to the reinsurance carrier in a timely manner; however the responsibility of timely payment of the premiums belongs to the GHP. Claim Administrator will not be held responsible for GHP's failure to pay the reinsurance premium in a timely manner. GHP acknowledges that Claim Administrator is not a party to the Reinsurance arrangement that exists between the GHP and its reinsurer and has no obligations with regard to same aside from those specifically provided for herein. This Section only applies when GHP has elected to have Claim Administrator collect the reinsurance premiums and distribute them to the reinsurance carrier.

B. The due date of the monthly premium is the first day of each month.

1. If the GHP chooses the bank draft as billed option, then on the 7th calendar day of the month (if the 7th falls on a non-banking day, then payment will be initiated on the first banking day following the 7th); payment will be made to Claim Administrator via ACH Direct Payment from the GHP's bank account initialized by Claim Administrator. If funds are not available on the 7th day of the month for which the premiums are due, all administrative services listed in Article I may be suspended by the Claim Administrator.

2. If the GHP chooses the bank draft as reconciled option, then the GHP has the availability to initiate Payment approximately 10 days prior to the due date and 10 days after the due date via the *my*Blue Group website.

3. If the Funds are still not available by the 15th calendar day of the month (if the 15th day falls on a non-banking day, then the activity will be initiated on the first banking day following the 15th), Claim Administrator may not be able to distribute the premiums to the reinsurance carrier in the allowed time period. GHP's reinsurance may be terminated for non-payment.

4. Should the reinsurance premiums change, Claim Administrator will adjust the billing accordingly, such adjustment to be effective on the date of the change.

PART 6—MISCELLANEOUS

X. TERMINATION

A. Termination With or Without Cause

Any Party may terminate this Agreement, with or without cause, upon thirty (30) days prior written notice. This provision does not supersede Claim Administrator's rights to automatically terminate this Agreement for the GHP's failure to remit funds as outlined in Section II.D, above.

B. GHP Benefit Plan Termination

Claim Administrator may terminate this Agreement on the date GHP's Benefit Plan is terminated.

C. **Automatic Termination by Claim Administrator**

Notwithstanding the provisions of Section A above, this Agreement will terminate automatically upon the occurrence of any of the following events, as determined by Claim Administrator:

1. GHP's failure to remit fees, funds or late Payments as outlined in Sections VII, VIII and IX above;

2. GHP's Benefit Plan is terminated;

3. The Claim Administrator reasonably believes that GHP does not have the financial ability to adequately fund the Benefit Plan, and GHP has failed to immediately provide adequate assurances of such ability to Claim Administrator.

4. GHP or Employer otherwise materially breaches this Agreement.

D. **Payment of Fees Upon Termination**

1. Termination of this Agreement for any of the reasons provided for herein does not relieve GHP from its obligations to reimburse Claims Payments, and pay any and all fees accrued through the date of termination.

E. **Run-out Agreement**

Upon termination of this Agreement, Claim Administrator may, at Claim Administrator's sole discretion, continue to perform services with respect to any Claims incurred prior to the effective date of termination for 60 days following termination of the Agreement. The administrative fee for these services will be determined at the time of the termination of this Agreement and be set forth in a separate run-out agreement. Moreover, Claim Administrator will cooperate with Employer to develop, as promptly as possible, a comprehensive plan for transferring services back to Employer or to another service provider designated by Employer. To the extent permitted by law, Claim Administrator will assist Employer in transferring the Claim Administrator's responsibilities in an expeditious manner in order to minimize the possibility of discontinuity or disruption to Employer. If there is commencement of a bankruptcy proceeding by or against the GHP or Employer under the United States Bankruptcy Code, run-out shall not be available.

XI. LIABILITY AND INDEMNITY

A. GHP is contracting with the Claim Administrator only for the administrative services specifically listed in Article I of this Agreement. GHP retains the final authority for the Payment of Claims filed under the Benefit Plan, it being understood that Claim Administrator functions in an administrative capacity only subject to the direction of GHP. The Parties agree that Claim Administrator does not underwrite or insure the participants in the Benefit Plan and that Claim Administrator is subject to the direction of GHP with respect to any questions regarding eligibility for Payment, the amount of Payment, and any controversy involving employees and dependents with respect to the Plan. GHP also retains the ultimate responsibility for all expenses incident to the Benefit Plan and for compliance with all federal and state laws except as specifically assumed in this Agreement by the Claim Administrator.

B. GHP agrees to defend, indemnify and hold harmless Claim Administrator, its affiliates and/or subsidiaries and their respective directors, officers and employees against all claims for premium taxes on Benefit Plan payments if any, and for any damages, lawsuits, judgments, expenses and attorneys' fees incurred by Claim Administrator, as a result of the performance of its duties under this Agreement except where the liability therefor is the direct result of gross negligence, dishonesty, fraud or criminal conduct on the part of Claim Administrator, its employees, officers or directors.

C. Claim Administrator agrees to defend, indemnify and hold harmless GHP for any damages, lawsuits, judgments, expenses and attorney fees resulting from or arising out of dishonesty, fraud, criminal conduct or gross negligence with respect to this Agreement on the part of Claim Administrator, its employees, officers or directors.

XII. LAW AND VENUE

This Agreement shall be construed and interpreted under the laws of the State of Mississippi except where preempted by federal law. GHP and Employer consent to the jurisdiction and venue of the federal and state courts located in Rankin County, Mississippi.

XIII. ATTORNEY FEES

If Claim Administrator incurs any attorney fees, court costs or expenses of any kind due to GHP's or Employer's breach of any provision of this Agreement, GHP or Employer shall be liable for such costs and shall reimburse Claim Administrator for such costs.

XIV. AMENDMENTS TO THIS AGREEMENT

This Agreement may be amended by written agreement between Claim Administrator, Employer, and GHP except as otherwise permitted by automatic operation under this Agreement.

XV. MULTIPLE ORIGINALS

This Agreement has been executed in multiple originals, any one of which may be used for any purpose without the necessity of accounting for the others.

XVI. INDEPENDENT CORPORATION

GHP and Employer each on behalf of itself and its participants hereby expressly acknowledge their understanding that this Agreement constitutes a contract solely between GHP, Employer, and Blue Cross & Blue Shield of Mississippi, as Claim Administrator. Claim Administrator is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Claim Administrator to use the Blue Cross and Blue Shield Service Marks in the State of Mississippi, and that Claim Administrator is not contracting as the agent of the Association. GHP and Employer further acknowledge and agree that they have not entered into this Agreement based upon the 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 GHP or Employer for any of Claim Administrator's obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

XVII. TRADEMARKS AND TRADENAMES

Each Party to this Agreement reserves the right to the control and use of its name, symbols, trademarks, tradenames, service marks, and copyrights presently existing or later established. No Party to this Agreement shall use another Party's name, symbols, trademarks, tradenames, or service marks in advertising, promotional materials, or otherwise, without the prior written consent of such other Party. Any permitted use shall terminate upon the termination of such consent or upon termination of this Agreement, whichever first occurs.

XVIII. AGREEMENT

This Agreement and any referenced attachments (attached hereto and incorporated by reference herein) contain the entire agreement between the Parties relating to the subjects addressed herein. Any prior agreement, promise, negotiation, or representation, either oral or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement shall be of no force or effect.

XIX. SEVERABILITY

If any provision of this Agreement is rendered invalid or unenforceable by the decision of any court of competent jurisdiction, that invalid or unenforceable provision shall be severed from this Agreement and all other provisions of this Agreement shall remain in full force and effect.

XX. WAIVER OF BREACH

Waiver of breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

XXI. DISCLOSURE OF CONFIDENTIAL CLAIMS DATA

During the term of this Agreement, either GHP or Employer may request that Claim Administrator provide Protected Health Information or data to GHP, Employer and/or their designated representatives. The Parties agree that Claim Administrator will provide Protected Health Information only as permitted under the terms of this Agreement and as permitted by law.

GHP and Employer each agrees that they will maintain any and all such information or data provided by Claim Administrator that constitutes Protected Health Information in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rules and any other applicable state or Federal law. GHP and Employer each agrees to use such information solely for legally permissible purposes pursuant to the requirements of various federal and state laws and regulations, whether now existing or hereafter enacted. GHP and Employer represent that they and/or their designated representatives have specific legally permissible purposes for requesting any information from Claim Administrator. GHP and Employer warrant that they and/or their designated representatives have in effect internal procedures to prevent the unauthorized and/or legally impermissible disclosure and/or use of such Claims data.

GHP and Employer agree to defend, indemnify and hold harmless the Claim Administrator, its officers, directors, employees and agents against any and all claims, lawsuits, judgments, attorney fees, costs and expenses of whatever kind and nature arising out of or resulting from Claim Administrator's release of this information containing medical or other data of a confidential nature to GHP, Employer and/or their designated representatives.

XXII. NOTICES

Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, to Claim Administrator at Post Office Box 1043, Jackson, MS 39215-1043, and to GHP at P.O. Box 608, Canton, MS 39046. Notice shall be effective on the date indicated on the return receipt.

XXIII. GENERAL CONFIDENTIALITY

This Agreement and the information provided pursuant to the same is confidential information. This confidential information includes, but is not limited to reimbursement information and marketing information. Said confidential information shall be treated as confidential, proprietary, or trade secret information. This obligation of confidentiality shall not apply to (a) Information that at the time of the disclosure is in the public domain; (b) Information that, after disclosure, becomes part of the public domain by publication or otherwise, except by breach of this Agreement; (c) Information that the disclosing Party can establish by reasonable proof was in the disclosing Party's possession at the time of original disclosure; or (d) Information that the disclosing Party receives from a third party who has a right to disclose it to the disclosing Party.

XXIV. AGENT DISCLOSURE OF COMMISSION

GHP and Employer acknowledge that their agent has disclosed to them in writing the existence of all compensation.

SIGNATURES

In witness whereof, the Parties hereto have caused this Agreement to be executed by their respective Officer who has been duly authorized to execute this Agreement.

CLAIM ADMINISTRATOR:

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A MUTUAL INSURANCE COMPANY

BY: _____

Title: _____

Date: _____

EMPLOYER:

MADISON COUNTY BOARD OF SUPERVISORS

BY: _____

Title: _____

Date: _____

GROUP HEALTH PLAN:

EMPLOYEE HEALTH PROTECTION PLAN FOR MADISON COUNTY BOARD OF SUPERVISORS

By: _____

Title: _____

Date: _____

EXHIBIT I

Only the BlueCard Program Access Fee and the BlueCard Program Administrative Expense Allowance (AEA) fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in the Administrative Charges.

The Access Fee is charged by the Host Blue to Claim Administrator for making the applicable Host Blue's provider network available to GHP's Members. The Access Fee will not apply if the provider does not participate in the applicable Host Blue's network. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential Claim Administrator receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged, Claim Administrator passes the Access Fee directly on to GHP.

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 directly to GHP as stated above even though GHP paid little or had no claim liability.

The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Claim Administrator for administrative services that the Host Blue provides in processing claims for GHP's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, Claim Administrator passes the AEA Fee directly on to GHP.

See the Fee Listing section of this Exhibit for the BlueCard Program Access Fee and AEA Fee and for Claim Administrator's General Administrative Fee. The General Administrative Fee includes all other fees relative to the BlueCard Program. These fees include the Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee, PPO Provider Directory Fee and Blue Cross Blue Shield Global Core Fees, if applicable.

A General Administrative Fee encompasses fees Claim Administrator charges to GHP for administering GHP's Benefit Plan. They may include both local within Claim Administrator's service area and Inter-Plan fees. For purposes of this Agreement, they include the following BlueCard Program-related fees other than the BlueCard Program Access Fee and AEA Fee: namely, Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee, PPO Provider Directory Fee and Blue Cross Blue Shield Global Core Fees, if applicable.

Group Name: Madison County Board of Supervisors
Group Numbers: 48887A and 48888A
Effective Date: October 1, 2017 through September 30, 2018

Inter-Plan Arrangements Fees:	
BlueCard Program Fees	
Access Fees:	4.79% of network savings, capped at $2,000.00 per claim in 2017. 4.30% of network savings, capped at $2,000.00 per claim in 2018.
Administrative Expense Allowances (AEAs):	$5.00 per claim professional and $11.00 per claim institutional (for fewer than 1,000 PPO or traditional enrolled Blue contracts).
General Administrative Fee:	$40.00 per employee per month
Nonparticipating Provider Claims Processing Fee:	$3.00 per claim for out-of-network claims.

Blue Cross & Blue Shield of Mississippi (BCBSMS) Patient Protection and Affordable Care Act (PPACA) - Healthcare Reform Checklist Confirmation

As part of our continuing PPACA compliance process, BCBSMS is offering the following informational updates for your review, and in certain cases, options you must make with regard to the administration of your Benefit Plan.

Grandfathered Status:

If your Plan is grandfathered, details regarding pertinent provisions of PPACA that you should keep in mind when making benefit decisions/changes are set out below.

A Plan can obtain and maintain Grandfathered status if at least one individual was enrolled in the Plan on March 23, 2010. However, there can be issues with making changes to your plan that may impact Grandfathered status.

- **Changes that will NOT cause a loss of Grandfathered Status:**
  - Change to premiums;
  - Changes required to comply with federal or state law;
  - Changes to increase benefits to comply with PPACA;
  - Changes to the pharmacy formulary;
  - Changes to provider networks; and
  - Changes to an existing group due to newly acquired mergers and acquisitions.

- **Changes that WILL cause a loss of Grandfathered Status (this is not an all-inclusive list):**
  - Cannot significantly cut or reduce benefits;
  - Cannot decrease co-insurance percentage paid by the group or carrier;
  - Cannot significantly raise co-payment charges. Grandfather plans will be able to increase those co-pays by no more than the greater of $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points over the life of the product beginning March 23, 2010. This includes prescription drug changes increasing co-payment amounts across any tier in excess of $5.00;
  - Cannot significantly raise deductibles or out-of-pocket amounts. Grandfathered plans can only increase these deductibles or out-of-pockets by a percentage equal to medical inflation plus 15 percentage points over the life of the product beginning March 23, 2010;
  - Cannot significantly lower employer contributions. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points;
  - Cannot add or tighten an annual limit on what the insurer pays;

- Groups that define eligibility to include all full-time employee moves to a Management carve-out arrangement (i.e. custom eligibility arrangement) or a custom eligibility group that redefines their eligibility to exclude a currently covered class.

If you choose to forego your Grandfathered Status, BCBSMS will make the appropriate changes to your plan to bring it into compliance with PPACA.

Please indicate below whether you want to maintain Grandfathered Status for your Plan.

☐ **Our Plan is claiming Grandfathered Status.**

☐ **Our Plan does not claim Grandfathered Status.**

Women's Preventative Services:

- Non-Exempt Non-Grandfathered plans must provide certain women's preventative services, including contraceptives, to Plan Members with no cost sharing. Grandfathered and Exempt Plans may choose to provide these benefits. Please advise if you would like to do so at this time.

  ☐ **Yes, provide all required women's preventative services at no cost sharing.**

  ☐ **No, maintain the current benefits related to women's preventative services (only Grandfathered Plans may choose this option).**

Tobacco Cessation Preventive Services:

- Non-Grandfathered plans are required to cover tobacco cessation counseling and interventions at no cost-sharing as part of the requirement to cover preventive services. BCBSMS' Be Tobacco Free program satisfies this requirement and is automatically available to members of non-grandfathered groups. If your group health plan is grandfathered, your plan is not required to provide this coverage, but may do so voluntarily. If your group health plan is Grandfathered, please advise if you will provide access to the Be Tobacco Free program to members of your plan.

  ☐ **Yes, our Grandfathered group health plan will provide access to the Be Tobacco Free program.**

  ☐ **No, our Grandfathered group health plan will not provide access to the Be Tobacco Free program.**

Transitional Reinsurance Fee:

- All Plans must make reinsurance contributions in accordance with the Transitional Reinsurance Program. This fee is determined based upon an annual enrollment count of the number of covered lives under a Plan. Self-funded Plans must report enrollment counts and make reinsurance contributions to the United States Department of Health and Human Services (HHS). BCBSMS will not be reporting enrollment counts or making reinsurance contributions on behalf of Self-Funded Plans. Please consult your Plan's accountant and/or legal counsel for guidance. The uniform contribution rate for the 2016 benefit year is $27 per Member per year. If paid in two installments, the contribution amounts are $21.60 and $5.40, respectively.

Patient Centered Outcome Research Institute Fee:

- Blue Cross & Blue Shield of Mississippi will not be calculating or submitting your Plan's required Patient Centered Outcome Research Institute fee. Please consult your Plan's accountant and/or legal counsel for guidance.

Out-of-Pocket Maximum:

- For plan years beginning on or after January 1, 2017, non-grandfathered plans are subject to the ACA Maximum Out-of-Pocket of $7,150 for individual coverage and $14,300 for family coverage. Out-of-pockets include network deductibles, co-payments, coinsurance and similar charges but do not include premiums or contributions, amounts incurred for non-covered services, non-network cost-sharing, or balance billed amounts charged by out-of-network providers.

- For High Deductible Health Plans, the following amounts apply for plan years beginning on or after January 1, 2017:

  Minimum Annual Deductibles:

  - $1,300 for self-only coverage
  - $2,600 for family coverage

  Maximum Out-of-Pockets:

  - $6,550 for self-only coverage
  - $13,100 for family coverage

  Note: A non-grandfathered plan – including an HSA-qualified high deductible health plan - with a family out-of-pocket maximum or a family deductible higher than the ACA Maximum Out-of-Pocket for self-only coverage must nonetheless limit cost-sharing for any one enrolled individual to the ACA Maximum Out-of-Pocket, even if the family deductible has not been met.

Summary of Benefits and Coverage:

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  - Included with written application materials that are distributed for enrollment or on the first day a Member is eligible to enroll if no enrollment materials are distributed.
  - On the first day of the plan year as each Group renews;
  - On the first day of open enrollment;
  - Within 90 days of Enrollment for a HIPAA Special Enrollee;
  - Within 7 days of a request by a Member; and,
  - 60 days prior to mid-year modifications[1].

A statement must be included on the Summary of Benefits and Coverage which indicates whether or not your Plan meets the required Minimum Values.

☐ **Yes, the Group agrees that BCBSMS will produce and electronically deliver an SBC for each of our Group's Benefit Plans. The Group further agrees that it is the Group's responsibility to deliver the SBC to its Members at the appropriate time.**

☐ **No, the Group will produce its own SBC to be delivered to its Members. The Group acknowledges that that the requirement to produce and deliver the SBC falls solely upon the Group and that BCBSMS does not bear any responsibility for the same.**

By signing the Attestation below, the Group acknowledges that all obligations to timely deliver the SBC to its Members in accordance with PPACA are the responsibility of the Group. The Group further acknowledges that the SBC must be delivered to its Members in accordance with PPACA, as summarized above. The Group understands that, as an added benefit, BCBSMS will produce and electronically deliver an SBC for each of the Group's Benefit Plans in a non-editable format. Furthermore, the Group agrees that all obligations to determine that the SBC is accurate and complies with PPACA remain the responsibility of the Group.

Large Employer Mandate:

- For the purposes of compliance with PPACA, we are aware of our Company's requirement to meet the following for full-time employees and their dependent children effective on our Plan:

[1] The 60 days notice requirement for material modifications can be satisfied by providing a separate notice of material modification and the SBC can be updated when the modification takes effect.

- Provide ACCESS to coverage (95% or greater)
- Provide ADEQUATE coverage (60% or greater Minimum Value)
- Provide AFFORDABLE coverage (i.e., for plan years beginning in 2017, employee's required contribution for lowest cost self-only option is no more than 9.69% of the employee's household income or satisfaction of a safe harbor)

Removal of Autism Spectrum Disorder Exclusion:

- Effective January 1, 2015, BCBSMS removed the exclusion for coverage of autism spectrum disorder and developed medical policy for coverage of autism spectrum disorder. Please advise if your group health plan will remove the exclusion for coverage of autism spectrum disorder.

  ☐ **Yes, remove the autism spectrum disorder exclusion.**

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  ☐ Yes, the Group wishes to include the Primary Care Program as part of its Group Health Plan.

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Additional Comments:

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Attestation:

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Group: _____

Group #:_____

By: _____

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Please return this document no later than 60 days prior to your renewal. be healthy!
Revised 8/17/2016

Blue Cross & Blue Shield of Mississippi (BCBSMS) Patient Protection and Affordable Care Act (PPACA) - Healthcare Reform Checklist Confirmation

As part of our continuing PPACA compliance process, BCBSMS is offering the following informational updates for your review, and in certain cases, options you must make with regard to the administration of your Benefit Plan.

Grandfathered Status:

If your Plan is grandfathered, details regarding pertinent provisions of PPACA that you should keep in mind when making benefit decisions/changes are set out below.

A Plan can obtain and maintain Grandfathered status if at least one individual was enrolled in the Plan on March 23, 2010. However, there can be issues with making changes to your plan that may impact Grandfathered status.

- **Changes that will NOT cause a loss of Grandfathered Status:**
  - Change to premiums;
  - Changes required to comply with federal or state law;
  - Changes to increase benefits to comply with PPACA;
  - Changes to the pharmacy formulary;
  - Changes to provider networks; and
  - Changes to an existing group due to newly acquired mergers and acquisitions.

- **Changes that WILL cause a loss of Grandfathered Status (this is not an all-inclusive list):**
  - Cannot significantly cut or reduce benefits;
  - Cannot decrease co-insurance percentage paid by the group or carrier;
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