ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement"), which, as of the effective date stated herein, replaces the Agreement that was effective as of January 1, 2019 is entered into by and between Augusta-Richmond County ("Employer") and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. dba Anthem Blue Cross and Blue Shield ("Anthem") and is effective as of January 1, 2023 upon the following terms and conditions:

1. Employer is the sponsor of a self-funded Group Health Plan (as defined below) providing, among other things, health care benefits to certain eligible employees and their qualified dependents.

2. Employer desires to retain Anthem as an independent contractor to administer certain elements of Employer's Group Health Plan.

3. Anthem desires to administer certain elements of Employer's Group Health Plan pursuant to the terms of this Agreement.

In consideration of the promises and the mutual covenants contained in this Agreement, Anthem and Employer (the "Party" or "Parties" as appropriate) agree as follows:

ARTICLE 1 - DEFINITIONS

For purposes of this Agreement and any amendments, attachments or schedules to this Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent:

ADMINISTRATIVE SERVICES FEES. The amount payable to Anthem in consideration of its administrative services and operating expenses as indicated in Section 3 of Schedule A, excluding any cost for stop loss insurance coverage or any other policy of insurance, if applicable. All additional charges not included in the Administrative Services Fees are specified elsewhere in this Agreement.

AGREEMENT PERIOD. The period of time indicated in Section 1 of Schedule A.

ANTHEM AFFILIATE. An entity controlling, under common control with or controlled by Anthem.

BENEFITS BOOKLET. A description of the portion of the health care benefits provided under the Plan that is administered by Anthem.

BILLED CHARGES. The amount that appears on a Member's Claim form (or other written notification acceptable to Anthem that Covered Services have been provided) as the Provider's charge for the services rendered to a Member, without any adjustment or reduction and irrespective of any applicable reimbursement arrangement with the Provider.

BLUE CROSS BLUE SHIELD ASSOCIATION ("BCBSA"). An association of independent Blue Cross and Blue Shield companies.

CLAIM. Written or electronic notice of a request for reimbursement of any health care service or supply on a form acceptable to Anthem.

CLAIMS RUNOUT SERVICES. Processing and payment of Claims that are incurred but unreported and/or unpaid as of the date this Agreement terminates.

CONSOLIDATED APPROPRIATIONS ACT ("CAA"). The Consolidated Appropriations Act of 2021 (42 USC 300gg, et seq. and 29 USC 1185, et seq.), as amended, and regulations promulgated thereunder.

COVERED SERVICE. Any health care service or supply rendered to Members for which benefits are eligible for reimbursement pursuant to the terms of the applicable Benefits Booklet.

EMPLOYER AFFILIATES. Companies affiliated with Employer that are participating in the Plan and which, along with the Employer constitute a single "control group" as that term is used in the Internal Revenue Code.

GROUP HEALTH PLAN OR PLAN. An employee welfare benefit plan established by the Employer, in effect as of the Effective Date, as described in the Plan Documents, as they may be amended from time to time.

INTER-PLAN ARRANGEMENTS. Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.

INVOICE DUE DATE. The date on the invoice provided to Employer indicating when payment is due. For self-billing, the Invoice Due Date is the date on which payment is due.

MEMBER. The individuals, including the Subscriber and his/her dependents, as defined in the Benefits Booklet, who have satisfied the Plan eligibility requirements of Employer, applied for coverage, and been enrolled for Plan benefits.

NETWORK PROVIDER. A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with Anthem to provide Covered Services to Members through negotiated reimbursement arrangements.

PAID CLAIM. The amount charged to Employer for Covered Services or services provided during the term of this Agreement and any Claims Runout Period. Paid Claims may also include any applicable surcharges assessed by a state or government agency and any applicable interest paid. In addition, Paid Claims shall be determined as follows:

1. Provider and Vendor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount Anthem actually pays the Provider or Vendor without regard to: (i) whether Anthem reimburses such Provider or Vendor on a percentage of charges basis, a fixed payment basis, a global fee basis, single case rate, or other reimbursement methodology; (ii) whether such amount is more or less than the Provider's or Vendor's actual Billed Charges for a particular service or supply; or (iii) whether such payments are increased or decreased by the Provider's or Vendor's achievement of, or failure to achieve, certain specified goals, outcomes or standards adopted by Anthem.

2. This provision is intentionally removed.

3. Payment Innovation Programs. If a Provider or Vendor participates in any Anthem payment innovation program, excluding any programs described in paragraph 1 of this provision, in which performance incentives, rewards or bonuses are paid based on the achievement of cost, quality, efficiency, or service standards or metrics adopted by Anthem ("Payment Innovation Programs"), Paid Claims shall also include the amount of such payments to Providers or Vendors for these Payment Innovation Programs. Such payments may be charged to Employer on a per Claim, lump sum, per Subscriber, or per Member basis and shall be based on Anthem's predetermined methodology for such Payment Innovation Program, as may be amended from time to time. The total monies charged in advance to fund a Payment Innovation Program shall be actuarially determined as the amount necessary to fund the expected payments attributable to the Payment Innovation Program. Prior to its implementation, Anthem shall provide Employer with a description of the Payment Innovation Program, the methodology that will be utilized to charge the Employer, and any reconciliation process performed in connection with such program. Payments to Providers or Vendors under these Payment Innovation Programs shall not impact Member cost shares.

4. Fees Paid To Manage And/Or Coordinate Care Or Costs. Paid Claims may also include fees paid to Providers or Vendors for managing and/or coordinating the care or cost of care for designated Members.

5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of dispute resolution procedures. Any Claims paid pursuant to this provision will count towards any stop loss accumulators under a stop loss agreement with Anthem.

6. Claims Payment Pursuant To Inter-Plan Arrangements And Other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Arrangements or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about Inter-Plan Arrangements is found in the Inter-Plan Arrangements Schedule of this Agreement.

7. Claims Payment Pursuant To A Consumer Directed Health Plan Account. If applicable to Plan benefits and as indicated on Schedule A or B of this Agreement, Paid Claims shall include any amount actually paid by Anthem from a consumer directed health plan account, such as a health reimbursement account or a health incentive account.

PLAN DOCUMENTS. The documents that set forth the terms of the Plan, and which include the Benefits Booklet.

PROPRIETARY INFORMATION AND CONFIDENTIAL INFORMATION. Employer's Proprietary Information is information about the systems, procedures, methodologies and practices used by Employer to run its operations and the Plan and other non-public information about Employer. Anthem's Proprietary Information is non-public, trade secret, commercially valuable, or competitively sensitive information, or other material and information relating to the products, business, or activities of Anthem or an Anthem Affiliate, including but not limited to: (1) information about Anthem's Provider networks, Provider negotiated fees, Provider discounts, and Provider contract terms; (2) information about the systems, procedures, methodologies, and practices used by Anthem and Anthem Affiliates in performing their services such as underwriting, Claims processing, Claims payment, and health care management activities; and (3) combinations of data elements that could enable information of this kind to be derived or calculated. Anthem's Confidential Information is information that Anthem or an Anthem Affiliate is obligated by law or contract to protect, including but not limited to: (1) Social Security numbers; (2) Provider tax identification numbers (TINs); (3) National Provider Identification Numbers (NPIs); (4) Provider names, Provider addresses, and other identifying information about Providers; and (5) drug enforcement administration (DEA) numbers, pharmacy numbers, and other identifying information about pharmacies.

PROVIDER. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Benefits Booklet.

SUBSCRIBER. An employee or retiree of Employer or other eligible person (other than a dependent) who is enrolled in the Plan.

VENDOR. A person or entity other than a Provider, including an Anthem Affiliate, that provides services or supplies pursuant to a contract with Anthem.

ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY ANTHEM

a. Anthem shall process the enrollment of eligible individuals and termination of Members as directed by the Employer subject to the provisions of this Agreement. Anthem shall, with the assistance of Employer, respond to direct routine inquiries made to it by employees and other persons concerning eligibility in the Plan.

b. Anthem shall perform the following Claims administrative services:

    1. Process Claims with a Claims Incurred Date indicated in Section 1 of Schedule A and provide customer service, including investigating and reviewing such Claims to determine what amount, if any, is due and payable according to the terms and conditions of the Benefits Booklet and this Agreement. Anthem shall perform coordination of benefits ("COB") with other payors, including Medicare. In processing Claims, Anthem shall utilize Anthem's medical policies and medical policy exception process, its definition of medical necessity, its precertification and/or preauthorization policies, Provider contract requirements and applicable Claim timely filing limits.

    2. Disburse to the applicable individuals or entities (including Providers and Vendors) payments that it determines to be due according to the provisions of the Benefits Booklet.

    3. Provide notice in writing when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Benefits Booklet and shall otherwise satisfy applicable regulatory requirements governing the notice of a denied Claim.

    4. Administration of independent dispute resolution processes for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the Consolidated Appropriations Act if listed in Schedule A for the fee set forth in Section 3.C of Schedule A. Employer agrees to promptly notify Anthem if an independent dispute resolution request is received. Failure to promptly notify Anthem may impact independent dispute resolution processes.

c. Employer delegates to Anthem fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary to determine appeals of any adverse benefit determinations under the Plan. Anthem shall administer complaints, appeals and requests for independent review according to Anthem's complaint and appeals policy, and any applicable law or regulation unless otherwise provided in the Benefits Booklet. In carrying out this authority, Anthem is delegated full discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. Anthem shall be deemed to have properly exercised such authority unless a Member proves that Anthem has abused its discretion or that its decision is arbitrary and capricious. Anthem is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement and only to the extent that its performance of such actions constitutes fiduciary action. Anthem shall have no fiduciary responsibility in connection with any other element of the administration of the Plan. Anthem shall not act as the administrator of the Plan nor shall it have any fiduciary responsibility in connection with any other element of the administration of the Plan. Anthem shall charge Employer the fee described in Section 3.C of Schedule A for any independent review conducted pursuant to this provision.

d. Anthem shall have the authority, in its discretion, to institute from time to time, utilization management, case management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare services. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the applicable Benefits Booklet, unless otherwise agreed to by the Employer. Anthem reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

e. Anthem shall perform Claims prepayment analysis and recovery services as provided in Articles 4 and 13.

f. Anthem shall issue identification cards to Subscribers and/or Members, as applicable, and the content and design of the identification cards shall comply with BCBSA regulations.

g. Employer authorizes Anthem to use relevant Employer Claims and eligibility data to offer Medicare products as a replacement of Employer's Group Health Plan for Members.

h. Anthem shall provide Members and potential Members access to an online directory of Providers contracted with Anthem ("Provider Directories"). Members may also contact customer service for a listing of applicable Network Providers. Additionally, if applicable to Plan benefits, Anthem shall ensure that Members and potential Members have access to the BlueCard directory of Providers via a website sponsored by BCBSA.

i. Anthem reserves the right to make benefit payments to either Providers or Members at its discretion. Employer agrees that the terms of the Plan will include provisions for supporting such discretion in determining the direction of payment including, but not limited to, a provision prohibiting Members from assigning their rights to receive benefit payments, unless otherwise prohibited by applicable law.

j. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem may provide or arrange for the provision of the following managed care services:

    1. Conduct medical necessity review, utilization review, and a referral process, which may include, but is not limited to: (a) preadmission review to evaluate and determine the medical necessity of an admission or procedure and the appropriate level of care, and for an inpatient admission, to authorize an initial length of stay; (b) concurrent review throughout the course of the inpatient admission for authorization of additional days of care as warranted by the patient's medical condition; (c) retrospective review; and (d) authorizing a referral to a non-Network Provider. Anthem shall have the authority to waive a requirement if, in Anthem's discretion, such exception is in the best interest of the Member or the Plan, or is in furtherance of the provision of cost effective services under this Agreement.

    2. Perform case management to identify short and long term treatment programs in cases of severe or chronic illness or injury.

    3. Provide access to a specialty network of Providers if the Plan includes a specialty network. Anthem reserves the right to establish specialty networks for certain specialty or referral care.

    4. Provide any other managed care services incident to or necessary for the performance of the services set forth in this Article 2.

k. If applicable to the Plan benefits and as indicated in Schedule A or B of this Agreement, Anthem shall offer wellness programs and other programs to help Employer effectively manage the cost of care, and Employer shall pay fees for the programs selected by Employer only if such fees are indicated in Section 3(B) of Schedule A. Employer shall abide by all applicable policies and procedures of the programs selected, which may require Employer to provide requested information prior to Anthem initiating the service.

l. On behalf of Employer, Anthem shall produce and maintain a master copy of the Benefits Booklet and make changes and amendments to the master copy of the Benefits Booklet and incorporate any approved changes or amendments pursuant to Article 18(a) of this Agreement. Employer shall determine, in its sole discretion, whether Anthem has accurately produced the Benefits Booklet and has fully implemented the approved changes or amendments. Until Employer has approved the Benefits Booklet, Anthem will administer the quoted benefits according to Anthem's most similar standard Benefits Booklet language.

m. Anthem will provide Employer with Plan data and assistance necessary for preparation of the Plan's information returns and forms required by federal or state laws. Anthem shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers.

n. Anthem shall administer unclaimed funds associated with Paid Claims that are not processed through Inter-Plan Arrangements pursuant to unclaimed property or escheat laws and shall make any required payment and file any required reports under such laws. Inter-Plan Arrangement Paid Claims are processed according to the Host Blue's procedures and may be escheated to the state.

o. Unless otherwise agreed to by the Parties and specified in the Benefits Booklet, Anthem's standard policies and procedures, as well as Provider contracts, as they may be amended from time to time, will be used in the provision of services specified in this Agreement. In the event of any conflict between this Agreement and any of Anthem's policies and procedures, this Agreement will govern. In the event of any conflict between this Agreement and the Provider contracts, the Provider contracts will govern the rights and obligations as between the Parties and Providers.

p. This provision is intentionally omitted.

q. Select state laws require Employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After Employer completes any applicable forms, Anthem shall make all assessment and/or surcharge payments on behalf of Employer to the appropriate pools administered by the respective states, based primarily upon Anthem's Paid Claims information and Member information provided to Anthem by Employer. Examples of such assessments and surcharges include, but are not limited to, the Massachusetts Health Safety Net Trust Fund, the New York Health Care Reform Act and the Michigan Health Insurance Claims Assessment Act.

r. Anthem shall provide required notices describing Member's rights under the Women's Health and Cancer Rights Act (WHCRA) upon a Member's enrollment and at least annually thereafter.

s. Anthem shall have the authority, in its sole discretion, to build and maintain its Provider network on its own behalf. In building and maintaining its Provider network, Anthem is not acting on behalf of or as an agent for any employer or member. Nothing in this Agreement shall be interpreted to require Anthem to maintain negotiated fees or reimbursement arrangements or other relationships with certain Providers or Vendors or to negotiate on behalf of or for the benefit of Employer or Employer's Members. Anthem will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider inquiries, negotiating contract language and negotiating rates with Providers or auditing Providers, and Employer agrees that it will be governed by the terms and conditions of these agreements.

t. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with Anthem's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, Anthem shall have the right, without first seeking consent from Employer, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, Anthem shall report its actions to Employer. Employer shall reimburse Anthem for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.

u. Anthem shall submit any claim that is required to be filed under any stop loss policy issued by Anthem or an Anthem Affiliate. Anthem shall have no obligation to prepare or file any claim for excess risk or stop loss coverage under a policy not issued by Anthem or an Anthem Affiliate. Anthem shall provide Employer with Claims data pursuant to Article 11 of this Agreement if Employer chooses to file a claim under a stop loss policy issued by an entity other than Anthem or an Anthem Affiliate. Anthem shall assume no liability or responsibility to Employer if an unaffiliated stop loss carrier determines that a stop loss claim is not covered for any reason.

v. This provision is intentionally omitted.

w. If a Member is a Massachusetts resident, Anthem shall mail the Member any notices required by the Massachusetts Health Care Reform Act ("HCRA") reflecting coverage during the current and prior Agreement Period. If a Member works in Massachusetts for Employer, but resides in another State, Anthem will only provide such notices if Employer notifies Anthem at least 60 days prior to any notice deadline imposed by HCRA that such Member requires the HCRA notices.

x. Anthem is the responsible reporting entity ("RRE") for the Plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, Anthem requires information from the Employer, including, but not limited to, Member Social Security Numbers. Employer shall cooperate with Anthem and timely respond to any request for information made by Anthem.

y. Anthem will provide Employer with Plan information and assistance necessary for the preparation of the Plan's Summary of Benefits and Coverage ("SBC") related to the elements of the Plan that Anthem administers. Employer is solely responsible for ensuring that the SBC accurately reflects the benefits Employer will offer and for finalizing and distributing the SBC to Subscribers. Notwithstanding the provisions in Article 18(a), if Employer's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, Employer agrees to provide Anthem with any changes to the benefits Anthem administers at least 60 days prior to the start of the open enrollment period.

z. Anthem generally receives Member telephone numbers from Employer through enrollment files or the online employer access portal. Telephone numbers are provided directly to Employer by Members with the understanding that Anthem may contact them, and Employer does not obtain telephone numbers through a service or a third party. Anthem may contact Members by telephone for clinical purposes, benefit related issues or to perform services under the Agreement. Telephone numbers may be updated periodically by Members, and Anthem will honor do not call requests. With regard to Anthem's use of Member telephone numbers, Employer agrees to retain Member enrollment records for a period of at least 4 years or as otherwise set forth in the Telephone Consumer Protection Act and, upon request, will provide such records to Anthem in a timely manner.

aa. Anthem shall provide reporting as indicated in Schedule B to assist with compliance under the Consolidated Appropriations Act.

ARTICLE 3 - OBLIGATIONS OF EMPLOYER

a. Employer shall furnish to Anthem initial eligibility information regarding Members. Employer is responsible for determining eligibility of individuals and advising Anthem in a timely manner, through a method agreed upon by the Parties, as to which employees, dependents, and other individuals are to be enrolled Members. Anthem reserves the right to limit the effective date of retroactive enrollment as indicated in Schedule A. Such retroactive enrollments shall be subject to Anthem's receipt of any applicable fees as indicated in Section 3 of Schedule A. Employer shall keep such records and furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting COBRA coverage elections, effecting changes in single or family coverage status, effecting changes due to a Member becoming eligible or ineligible for Medicare, effecting changes due to a leave of absence, or for any other purpose reasonably related to the administration of eligibility under this Agreement. Employer acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely, accurate, and efficient processing of Claims.

Employer shall notify Anthem on at least a monthly basis of the Subscribers, dependents, or other individuals that will be or have become ineligible for benefits under the Plan. Upon receipt of such notice, Anthem shall terminate coverage in accordance with the Benefits Booklet. Employer shall give Anthem advance notice, if possible, of any Member's expected termination and/or retirement. Anthem reserves the right to limit retroactive terminations as indicated in Schedule A. Anthem shall credit Employer applicable fee for such retroactive terminations as indicated in Section 3 of Schedule A.

If Anthem has paid Claims for persons no longer eligible, then Employer shall reimburse Anthem for all unrecovered Paid Claim amounts to the extent that the amounts have not already been paid by Employer and to the extent recoupment of such amounts has not been obtained by Anthem.

b. Employer has all discretionary authority and control over the management of the Plan, and all discretionary authority and responsibility for the administration of the Plan except as delegated to Anthem in Article 2(c) of this Agreement. Employer retains all final authority and responsibility for the Plan and its operation and Anthem is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise agreed to by the Parties in writing. Employer shall provide Anthem with timely, accurate and complete information necessary for any services administered by Anthem. Employer or its designee shall provide Anthem with timely, accurate and complete information necessary for any Anthem obligation under the Agreement.

c. It is understood and agreed that the provision of any notice, election form, or communication and the collection of any applicable premium or fees required by or associated with Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage, shall be the sole responsibility of Employer and not Anthem, except as otherwise agreed to in a written agreement between the Parties.

d. Employer is solely responsible for compliance with the Family and Medical Leave Act ("FMLA") and, to the extent applicable to Employers' wellness program(s), for compliance with the Americans with Disabilities Act, the Internal Revenue Code, federal and state nondiscrimination laws, and other federal and state laws and regulations governing wellness programs.

e. Employer agrees to and shall collect those contributions from Subscribers that are required by Employer for participation in the Plan. If Employer elects Anthem's stop loss coverage, Employer shall abide by Anthem's participation and contribution guidelines.

f. Unless otherwise agreed to by the Parties in writing, Employer shall prepare and distribute all notices or summaries of changes or material modifications to the Plan. Employer shall ensure that if it creates any documents that refer to benefits offered under the Plan, the documents will accurately reflect the terms of the Benefits Booklet.

g. To the extent that Medicare, Medicaid, the Veterans Administration or any other federal or state agency or entity asserts a reimbursement right against Employer, the Plan, or Anthem pursuant to that agency's or entity's rights under applicable law with respect to Claims processed by Anthem under this Agreement, the Employer shall be responsible for reimbursing Anthem any such amounts determined to be owed.

h. Employer shall give notice to Anthem of the expected occurrence of any of the following events (including a description of the event), with such notice to be given at least 30 days prior to the effective date of the event, unless such advance notice is prohibited by law or contract in which case, notice will be provided as soon as practicable:

    1. Change of Employer's name; or

    2. The sale or other transfer of all or substantially all of the assets of either Employer or any Employer Affiliates or the sale or other transfer of the equity of Employer or any Employer Affiliates, or;

    3. Any bankruptcy, receivership, insolvency or inability of Employer to pay its debts as they become due.

i. The Employer shall have the sole responsibility, in accordance with state or federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order. The Employer shall provide notice to Anthem once it has made such determination.

j. The Employer may request Anthem, on an exception basis, to process and pay Claims that were denied by Anthem or take other actions with respect to the Plan that are not specifically set forth in this Agreement or the Benefits Booklet. In such cases, any payments shall not count toward the stop loss accumulators under a stop loss agreement issued by Anthem, unless otherwise agreed to by Anthem. Anthem may charge Employer a processing fee that has been mutually agreed to by the Parties prior to the processing of the Claim. Anthem shall not be responsible for any liability associated with any act or omission undertaken at the direction of, or in accordance with, instructions received from the Employer under this provision.

ARTICLE 4 - CLAIMS PAYMENT METHOD

a. Employer shall pay or fund Paid Claims according to the Claims payment method described in Section 4 of Schedule A. Employer shall pay or fund such amounts by the Invoice Due Date. In addition, from time to time, the Parties acknowledge that Employer may request a review of the appropriateness of a Claim payment and, during the review period, Employer shall pay or fund such Claim.

b. The Parties acknowledge that, from time to time, a Claims adjustment may be necessary as a result of coordination of benefits, subrogation, workers' compensation, other third party recoveries, payment errors and the like, and that the adjustment will take the form of a debit (for an additional amount paid by Anthem) or a credit (for an amount refunded to Employer). The Parties agree that such Claims adjustment shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim in the billing period in which it was initially reported as paid. Any Claims credit may be reduced by a fee as indicated in Schedule A of this Agreement. In addition, a credit shall not be provided to Employer for a recovery related to a Claim that was covered under stop loss coverage provided by Anthem.

c. Employer acknowledges and directs Anthem to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that members will be held harmless. Offsetting is the practice of Anthem recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of Anthem recovering overpayments made to a Network Provider for one member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another member, who receives benefits under a different group health plan for which Anthem pays the Claims on behalf of a different employer.

ARTICLE 5 - ADMINISTRATIVE SERVICES FEES

During the term of this Agreement, Employer shall pay Anthem the Administrative Services Fees, described in Section 3 of Schedule A. Employer shall pay the Administrative Services Fees and other fees authorized under this Agreement by the applicable Invoice Due Date according to the payment method described in Section 5 of Schedule A.

ARTICLE 6 - RENEWAL SCHEDULES

If Anthem offers to renew this Agreement at the end of an Agreement Period, then Anthem shall provide Employer with the terms and conditions of the proposed renewal in writing within the time period provided in Section 1 of Schedule A. Employer shall notify Anthem in writing of its selection from the renewal options by indicating its selection and signing Anthem's designated renewal form. If Anthem does not receive a signed acceptance of the renewal from Employer prior to the start of the next Agreement Period, Employer's payment of the amounts set forth in the renewal shall constitute Employer's acceptance of the terms. Anthem shall provide a revised Schedule A that will become part of this Agreement without the necessity of securing Employer's signature.

ARTICLE 7 - CLAIMS RUNOUT SERVICES

a. Claims Runout Services shall be provided for the period of time provided in Section 6 of Schedule A (the "Claims Runout Period"), except such Claims Runout services shall not be provided in the event that termination is due to non-payment pursuant to Article 19(a) of this Agreement. During the Claims Runout Period, the terms of this Agreement shall continue to apply. Anthem shall have no obligation to process or pay any Claims or forward Claims to Employer beyond the Claims Runout Period. Any amounts recovered beyond the Claims Runout Period shall be retained by Anthem as reasonable compensation for services under this Agreement. Anthem shall, however, return any recoveries for which Anthem had received monies, but had not processed the recovery prior to the end of the Claims Runout Period. In addition, Employer shall have no obligation to reimburse Anthem for any amounts paid by Anthem due to adjustments to Claims after the end of the Claims Runout Period.

b. The fee for providing Claims Runout Services during the Claims Runout Period, if applicable, is provided in Section 6 of Schedule A. Paid Claims and the fee for providing Claims Runout Services shall be invoiced and paid in the same manner as provided in Sections 4 and 5 of Schedule A, unless otherwise provided or agreed to in writing by the Parties.

ARTICLE 8 - LATE PAYMENT PENALTY

This Article is intentionally omitted.

ARTICLE 9 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

a. Anthem's duties and responsibilities in connection with the requirements imposed by the Health Insurance Portability and Accountability Act ("HIPAA") and the Privacy, Security, Breach Notification and Standard Transactions regulations promulgated thereunder will be set forth in a separate Business Associate Agreement between the Parties. Business Associate is defined as a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a Covered Entity, as defined under 45 CFR 160.103. Business Associate Agreement (BAA) is defined as a legal contract that describes how Anthem, as a Business Associate, and Plan, as a Covered Entity, may use or disclose protected health information so that the Plan may comply with the applicable requirements of HIPAA and its regulations. Any reference in this Agreement to Business Associate or to Business Associate Agreement shall be considered to be capitalized.

b. In the event the Plan submits Claims or eligibility inquiries or any other HIPAA covered transaction as defined in 45 CFR Part 160 and 162 to Anthem through electronic means, the Plan and Anthem shall comply with all applicable requirements of HIPAA and the Plan and Anthem shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

ARTICLE 10 - PROPRIETARY AND CONFIDENTIAL INFORMATION

a. Each Party retains ownership of its Proprietary Information and Confidential Information (collectively "Information") and neither conveys ownership rights in its Information nor acquires ownership rights in the other Party's Information by entering into this Agreement or performing its obligations hereunder. Nothing in this Agreement shall impair or limit a Party's right to use and disclose its Information for its own lawful business purposes.

b. Each Party shall maintain the other Party's Information in strict confidence, and shall institute commercially reasonable safeguards to protect it.

c. Employer shall use and disclose Anthem's Information solely for the purpose of administering the Plan. Employer shall not, without Anthem's advance written consent, (1) use or disclose Anthem's Information, or reports or summaries thereof, for any purpose other than administering the Plan; (2) combine Anthem's Information with other data to create or add to an aggregated database that will or could be made available to any third party; (3) combine Anthem's Information provided for a particular purpose with Anthem's Information provided for another purpose; or (4) sell or disclose Anthem's Information to any other person or entity except as expressly permitted by this Article 10.

d. Employer may disclose the minimum amount of Anthem's Information necessary to Employer's stop loss carriers, consultants, auditors, and other third parties engaged by Employer (each a "Plan Contractor"), provided that: (i) each such third party needs to know such Information in order to provide services to Employer; (ii) the restrictions set forth in subsection c. of this Article 10 shall apply to each such third party as well as to Employer; and (iii) prior to such disclosure, each such third party shall enter into the confidentiality agreement attached hereto which shall be provided to third party by Employer for signature and returned to Anthem for countersignature by Anthem prior to the planned disclosure.

e. Upon termination of this Agreement, each Party shall return or destroy the other Party's Information or retain the Information in accordance with its reasonable record retention policies and procedures; provided; however that each Party shall continue to comply with the provisions of this Article 10 for as long as it retains the other Party's Information.

f. This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; or, (4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party.

ARTICLE 11 - DATA REPORTS

a. Upon Employer's request and only as permitted by the business associate agreement entered into between the Parties, Anthem will provide Anthem's standard account reporting package. Prior to Anthem providing data or reports to Employer, the Parties must mutually agree to the types, format, content and purpose of the reports requested. If Employer requests from Anthem information that is not part of Anthem's standard account reporting package, and such request is approved by Anthem, Employer agrees to pay a mutually agreed upon charge to Anthem for such additional reports.

b. If Employer requests Anthem to provide a data extract or report to any Plan Contractor for use on Employer's behalf and Anthem agrees to do so: (i) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, Anthem's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by Employer's applicable business associate agreements with Anthem and the Plan Contractor; and (ii) to the extent such data or report includes Anthem's Proprietary Information and/or Anthem's Confidential Information, Employer acknowledges and agrees that Plan Contractor shall be subject to the requirements set forth in Article 10 of this Agreement.

c. Employer agrees not to contact, or to engage or permit a Plan Contractor to contact on Employer's behalf, any health care Provider concerning the information in any reports or data extracts provided by Anthem unless the contact is coordinated by Anthem.

d. In addition to their unlimited rights to use Anthem's Proprietary Information and Confidential Information, Anthem and Anthem Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the Parties, so long as: (1) PHI is de-identified in a manner consistent with the requirements of HIPAA; or (2) the data is used or disclosed for research, health oversight activities, or other purposes permitted by law; or (3) a Member has consented to the release of his or her PHI. The data used or disclosed shall be used for a variety of lawful purposes including, but not limited to, research, monitoring, benchmarking and analysis of industry and health care trends. Anthem may receive remuneration for PHI only if permitted by HIPAA.

ARTICLE 12 - CLAIMS AUDIT

a. At Employer's expense, Employer shall have the right to audit Claims on Anthem's premises, during regular business hours and in accordance with Anthem's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to Employer upon request.

b. If Employer elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and Anthem's audit policy, such auditor must be mutually acceptable to Employer and Anthem. Anthem will only approve auditors that are independent and objective and will not approve auditors paid on a contingency fee or other similar basis. Anthem reserves the right to charge a fee to Employer for expenditure of time by Anthem's employees in completing any audit. An auditor or consultant must execute a confidentiality and indemnification agreement with Anthem pertaining to Anthem's Proprietary and Confidential Information prior to conducting an audit.

c. Employer may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither Employer nor anyone acting on Employer's or the Plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit.

d. Employer shall provide to Anthem copies of all drafts, interim and/or final audit reports at such time as they are made available by the auditor or consultants to Employer. Any errors identified as the result of the audit shall be subject to Anthem's review and acceptance prior to initiating any recoveries of Paid Claims pursuant to Article 13 of this Agreement. Anthem reserves the right to terminate any audit being performed by or for Employer if Anthem determines that the confidentiality of its information is not properly being maintained or if Anthem determines that Employer or auditor is not following Anthem audit policy.

e. An audit performed pursuant to this Agreement shall be the final audit for the Audit Period and for any prior Audit Period unless otherwise agreed to in writing by the Parties; however, Claims may be re-audited if Employer is required to conduct the audit by a government agency with which it has a contractual arrangement.

ARTICLE 13 - RECOVERY AND PREPAYMENT ANALYSIS SERVICES

a. Pursuant to the provisions of this Article 13(a), Anthem shall conduct recovery activities including review of Paid Claims processed under this Agreement (including during any Claims Runout Period) and audits of Provider and Vendor contracts. The purpose of these services is to determine whether Paid Claims processed under this Agreement have been paid accurately and identify recoveries that can be pursued. Anthem shall not be obligated to retain outside counsel or other third parties if Anthem's recovery efforts are not successful. If Anthem makes a recovery as a result of the services described in this Article 13(a), then Anthem shall receive a fee provided in Schedule A as compensation for its services and Employer will receive the remaining recovery amount.

   Anthem shall also engage in various Claims prepayment analysis activities. These activities analyze Claims after services are rendered by a Provider or Vendor but prior to Claims payment to determine whether the billing and Claims submission are accurate and are intended to prevent inaccurate payments from being made. If the amount charged to Employer as a Paid Claim is less than the amount that would have been charged to Employer absent the services described in this Article 13(a), then Anthem shall be entitled to receive the fee provided in Schedule A as compensation for its services. This fee shall only be charged where the prepayment analysis activities relate to a specific Claim(s).

b. Anthem may become aware of additional recovery opportunities by means other than those described in Article 13(a). Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to pursue the recovery such as filing a proof of claim in a class action settlement, adjusting Claims by offsetting or cross-plan offsetting as described in Article 4, commencing litigation, opting out of or objecting to a proposed settlement, and/or engaging in settlement negotiations; (2) select and retain outside counsel when needed; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery; and (4) implement or effect any settlement of the Employer's and Plan's rights by, among other things, executing a release waiving the Employer's and Plan's rights to take any action inconsistent with the settlement.

c. During the term of this Agreement and any applicable Claims Runout Period, Anthem may pursue payments to Members by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services ("Subrogation Services"). Anthem shall charge Employer a fee provided in Schedule A to this Agreement ("Subrogation Fee"). Any subrogation recoveries shall be net of the Subrogation Fee. Subrogation Fees will not be assessed on subrogation recoveries until they are received by Anthem and credited to Employer.

d. This provision is intentionally omitted.

e. In exercising its authority pursuant to this Article 13, Anthem shall determine which recoveries it will pursue or Claims that it will review prior to payment, and in no event will Anthem pursue a recovery if it reasonably believes that the cost of the collection is likely to exceed the recovery amount or if the recovery is prohibited by law or an agreement with a Provider or Vendor. Anthem will not be liable for any amounts it does not successfully recover or prevent from being paid based on Claims prepayment analysis activities. Anthem shall retain any recoveries it obtains as a result of its recovery services or audits if the cost to administer the refund is likely to exceed the amount of the refund. Employer further understands and agrees that Anthem shall have authority to enter into a settlement or compromise on behalf of the Employer and Plan regarding these recovery, subrogation and audit services, including, but not limited to, the right to reduce future reimbursement to Provider or Vendor in lieu of a lump sum settlement. Anthem may have contracts with Network Providers or Vendors or there may be judgments, orders, settlements, applicable laws or regulations that limit, under certain circumstances, Anthem's right to make recoveries or engage in Claims prepayment analysis activities. Anthem may, but is not required to, readjudicate Claims or adjust Members' cost share payments related to the recoveries made from a Provider or a Vendor. Anthem shall credit Employer net recovery amounts after deduction of fees and costs as set forth in this Article 13 not later than 150 days following the receipt of the total recovery amount. If Anthem does not credit Employer within 150 days of its receipt of the total recovery amount, Anthem shall pay Employer interest calculated at the Federal Reserve Funds Rate in effect at the time of the payment. In no event, however, will Anthem be liable to credit Employer for any recovery after the termination date of this Agreement and any Claims Runout Period, and Employer acknowledges and agrees that such sums shall be retained by Anthem as reasonable compensation for recovery services provided by Anthem.

ARTICLE 14 - PHARMACY BENEFITS AND SERVICES

This Article is intentionally omitted.

ARTICLE 15 - INTER-PLAN ARRANGEMENTS

This Article is intentionally omitted and replaced by the Inter-Plan Arrangements Schedule.

ARTICLE 16 - CLAIMS LITIGATION

a. For purposes of Articles 16 and 17 of this Agreement, "Claims Litigation" means a demand asserted or litigation, proceedings, or arbitration commenced, by a Member, Plan beneficiary or Network or non-Network Provider, or any individual or entity working on any of their behalf ("Claimant(s)"), regardless of how pled or how asserted, where the Claimant seeks to recover monetary damages (including but not limited to actual, compensatory, punitive or other damages), equitable relief, declaratory relief, attorneys' fees, costs, expenses, or other relief, in connection with Anthem's alleged failure to properly handle a request for Covered Services or to pay for all or any portion of Covered Services, including any allegations related to the sufficiency of the amount paid for all or any portion of a Covered Service. References to "Employer" in this Article 16 shall mean Employer or Plan or both as appropriate given the context.

b. Anthem shall direct the defense of any Claims Litigation brought against Anthem. If Employer (in addition to Anthem) is also a named party in the Claims Litigation, Anthem shall direct the defense of the Claims Litigation and the Employer will cooperate in defending against the Claims Litigation. Employer will direct the defense of the Claims Litigation where Anthem is not a named party. Unless there is a conflict that is not waived, in any of the above scenarios, if Anthem requests, Anthem and the Employer will enter a common interest and/or joint defense agreement to address the sharing of information and any other matters the Parties deem appropriate. Whether there is such a conflict or not, all other provisions of this Article 16 will continue to apply. Anthem shall provide notice of Claims Litigation to the Employer as soon as practicable; provided, however, that this notice obligation shall not apply to Claims Litigation brought by any Provider or to any Claims Litigation to which Employer is a named party.

c. For any Claims Litigation to which Anthem is a named party, Anthem will select and retain counsel for itself and, if Employer is also named, for the representation of Anthem and Employer contemplated by Article 16(b). If, at the outset or during such Claims Litigation, Employer and Anthem have a conflict of interest, the selected counsel shall represent Anthem only. Employer shall waive any conflict for such representation and retain separate counsel for Employer. Subject to Article 16(d), Employer will assume liability for payment of all reasonable attorneys' fees and costs incurred by Anthem and/or Employer in the defense of Claims Litigation.

d. If it is determined by the third-party decision maker in the Claims Litigation that Anthem failed to perform its responsibility to review and determine Claims for benefits under the Plan in a manner that is consistent with the standard of care in Article 17 of this Agreement, Anthem will assume liability for payment of its legal fees and costs.

e. Anthem is authorized to settle or compromise any Claims Litigation with the approval of Employer, which approval shall not be unreasonably withheld. Notwithstanding the above, settlements of reimbursement disputes brought by Providers do not require the approval of Employer.

f. Anthem is not an insurer of benefits under the Plan nor does it underwrite the risk or otherwise assume any risk for the payment of benefits under the Plan. Under all circumstances, Employer shall be liable to pay Plan benefits awarded or paid by settlement, judgment, or otherwise.

ARTICLE 17 - INDEMNIFICATION

This Article is intentionally omitted.

ARTICLE 18 - CHANGES IN BENEFITS BOOKLET AND AGREEMENT

a. Either Party reserves the right to propose changes to the provisions described in the Benefits Booklet by giving written notice to the other Party not less than 90 days prior to the start of an Agreement Period and such changes will be made to the Benefits Booklet as mutually agreed to in writing by the Parties. Either Party may also propose changes to the Benefits Booklet at a time other than the start of an Agreement Period and such changes will be made to the Benefits Booklet if mutually agreed to in writing by the Parties. Anthem's incorporation of the requested changes into the Benefits Booklet shall constitute Anthem's acceptance of the Employer's requested changes. If Anthem initiates the proposed changes and does not receive written notice from Employer prior to the effective date of the proposed changes that such changes are unacceptable, the changes shall be deemed approved by Employer and Anthem shall incorporate such changes into the Benefits Booklet.

b. If changes to the provisions of the Benefits Booklet are mandated as a result of a change to any applicable state or federal law, Anthem shall have the right to make such changes to the Benefits Booklet to comply with the law and shall provide written notice to Employer at least 30 days prior to the effective date of the change, unless the effective date specified in the law is earlier.

c. Anthem also reserves the right to change the Base Administrative Services Fee provided in Section 3(A) of Schedule A at a time other than the start of an Agreement Period upon the occurrence of one or more of the following events: (1) a change to the Plan benefits initiated by Employer that results in a substantial change in the services to be provided by Anthem; (2) a change in ownership as described in Article 3(h) of this Agreement; (3) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Base Administrative Services Fee was last modified; (4) a change in Employer contribution as described in Article 3(e) of this Agreement; (5) a change in nature of Employer's business resulting in a change in its designated Standard Industrial Classification ("SIC") code; or (6) a change in applicable law that results in an increase in the cost or amount of administrative services from those currently being provided by Anthem under this Agreement. Anthem shall provide notice to Employer of the change in the Base Administrative Services Fee at least 30 days prior to the effective date of such change. If such change is unacceptable to Employer, either Party shall have the right to terminate this Agreement by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Base Administrative Services Fee, Anthem shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Employer's signature on the Schedule.

d. In the event any action of any department, branch or bureau of the federal, state or local government is initiated or taken ("Action") against a Party to this Agreement and such Action materially and adversely affects that Party's performance of the obligations under this Agreement, the affected Party shall notify the other Party of the nature of the Action and provide copies of pertinent documents supporting the reason(s) for the Action. If a modification to the Agreement is needed as a result of the Action, the Parties shall meet within 30 days of the notice by the affected Party to the other Party and shall, in good faith, attempt to negotiate a modification to this Agreement that minimizes or eliminates the impact of the Action. If the Parties are unable to minimize or eliminate the impact of the Action, then either Party may terminate this Agreement by giving at least 90 days notice of termination. This Agreement may be terminated sooner if agreed to by the Parties or required by the government entity initiating or taking the Action.

e. No modification or change in any provision of this Agreement shall be effective unless and until approved in writing by an authorized representative of Anthem and evidenced by an amendment or new Schedule attached to this Agreement. If Anthem proposes such a modification or change, Anthem shall provide written notice to Employer at least thirty (30) days prior to the effective date of such change. The modification or change will be deemed accepted by Employer unless Anthem receives written notice from Employer prior to the effective date that such change is unacceptable. If Employer does not accept the proposed change, the Parties will meet and confer to reach agreement prior to implementation of such change.

ARTICLE 19 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

a. Notwithstanding any other provision of this Article, this Agreement automatically terminates, without further notice or action, if Employer fails to pay or fund any amount due under this Agreement within 7 days of the date of Anthem's notice to the Employer of a delinquent amount owed. Such termination shall be effective as of the last period for which full payment was made. In addition, this Agreement automatically terminates, without further notice or action, at the end of each Agreement Period unless Anthem offers to renew this Agreement and Employer accepts such offer of renewal pursuant to Article 6 of this Agreement. Upon termination of this Agreement, Employer shall remain liable for all payments due to Anthem under the terms of this Agreement. Notwithstanding the above, Anthem has the right to suspend performance of its obligations under this Agreement if full payment is not made by the Invoice Due Date. Anthem shall have no obligation to pay any Claims under the Agreement until all required payments have been paid in full.

b. If either Party fails to comply with any material duties and obligations under this Agreement other than payment of amounts due under this Agreement, the other Party shall have the right to: (1) terminate this Agreement by giving the non-compliant Party at least 60 days prior written notice of termination; or (2) upon written notice to the other Party, suspend performance of its obligations under this Agreement. Employer acknowledges and agrees that in the event it is the non-compliant Party, Anthem shall have no liability to any Member. Either Party, at its option, may allow the non-compliant Party to cure a breach of this Agreement and, upon acceptance in writing by that Party that a breach is cured, this Agreement may be reinstated retroactive to the date of the breach or suspension of performance. Notwithstanding any other provision of this Agreement, a Party may seek injunctive or other equitable relief from a court of competent jurisdiction should there be any unauthorized use or disclosure of Proprietary Information or Confidential Information by the other Party.

c. If there shall occur any change in the condition (financial or otherwise) of Employer or an Employer Affiliate that, in the reasonable opinion of Anthem, has a material adverse effect upon the validity, performance, or enforceability of this Agreement, on the financial condition or business operation of Employer (or Employer Affiliate), or on the ability of Employer to fulfill its obligations under this Agreement, then Anthem shall have the right to require Employer to provide adequate assurance of future performance, which may include a payment of a cash deposit, letter of credit, or other method of assurance acceptable to Anthem. Examples of such a change could include, but would not be limited to the actual, or Anthem's reasonable anticipation of: (1) any voluntary or involuntary case or proceedings under bankruptcy law with respect to Employer or an Employer Affiliate; (2) any receivership, liquidation, dissolution, reorganization or other similar case or proceeding with respect to Employer or an Employer Affiliate; (3) any appointment of a receiver, trustee, custodian, assignee, conservator or similar entity or official for Employer or an Employer Affiliate; or (4) any assignment for the benefit of creditors or sale of all or substantially all of Employer's assets or a key Employer Affiliate's assets.

   Any deposit amount shall be paid to Anthem within 30 days of the request or in such shorter time as agreed to by the Parties. The deposit amount shall not be paid with Plan assets, shall not be funded in any part by Member contributions, and shall not be paid from any segregated fund or from funds in which the Plan or any Member has a beneficial interest. The deposit amount shall be the property of Anthem, may be held in Anthem's general account, may be subject to satisfy the claims of Anthem's general creditors, and does not govern or limit the benefits available under the terms of the Plan. At the termination of this Agreement and designated Claims Runout Period, if any, the deposit amount, net of any outstanding fees or Claims amounts payable to Anthem, shall be returned to Employer. Any deposit amount returned to Employer under this Article 19(c) shall not include interest. Neither Employer, the Plan, nor any Member shall have any beneficial or legal ownership interest in any deposit amount paid pursuant to this Section.

   If such further assurance is required by Anthem, Anthem may, at any time after the date of notice to Employer of such requirement, suspend performance of its obligations under this Agreement until the date of receipt by Anthem of such adequate assurance without being liable to the Employer, the Plan or any Member for such suspension. If such adequate assurance is not received within 30 days of the request, Anthem may terminate this Agreement.

d. Subject to the provisions of Article 7 of this Agreement, if this Agreement terminates and Anthem makes payment of any Claim that would otherwise have been payable under the terms of this Agreement after the termination date, Employer shall be liable to reimburse Anthem for such Claim to the extent that the amounts have not already been paid by Employer. Employer also agrees to cooperate fully with Anthem in the coordination of pharmacy Claims with any successor pharmacy benefit manager.

e. Employer may terminate this Agreement at any time other than at the end of an Agreement Period by giving Anthem 90 days written notice of its intent to terminate.

f. In connection with the termination of this Agreement and upon Employer's request, Anthem shall provide reports that are part of Anthem's standard account reporting package at no extra charge. In no event shall Anthem be obligated to produce more than two sets of reports following the termination date of this Agreement. However Anthem shall have no obligation to provide the reports after the termination date of this Agreement if such termination is due to non-payment pursuant to Article 19(a) of this Agreement. In addition, Anthem shall also provide data extract files upon Employer's request for an additional fee mutually agreed to by the Parties.

ARTICLE 20 - LIMITATION ON ACTIONS AND GOVERNING LAW

a. No action by either Party alleging a breach of this Agreement may be commenced after the expiration of 3 years from the date on which the claim arose.

b. This Agreement shall be governed by, and shall be construed in accordance with the laws of Georgia but without giving effect to that state's rules governing conflict of laws.

ARTICLE 21 - NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation herein, and, no course of dealing between Employer and Anthem, shall operate as a waiver of such right or obligation or be construed as or constitute a waiver of the right to enforce or insist upon compliance with such right or obligation in the future. Any single or partial exercise of any right or failure to enforce any obligation shall not preclude any other or further exercise, or the right to exercise any other right or enforce any other obligation.

ARTICLE 22 - ASSIGNMENT AND SUBCONTRACTING

a. Unless it has first obtained the written consent of an officer of the other Party, neither Party may assign this Agreement to any other person. Notwithstanding the foregoing, Anthem may, with advance written notice to Employer, assign or otherwise transfer its rights and obligations hereunder, in whole or in part, to: (i) any affiliate of Anthem; or (ii) any entity surviving a transaction involving the merger, acquisition, consolidation, or reorganization of Anthem, or in which all or substantially all of Anthem's assets are sold. Additionally, Employer may, with advance written notice to Anthem, assign, delegate, or otherwise transfer its rights and obligations hereunder, in whole, to (i) any affiliate of Employer; or (ii) any entity surviving a transaction involving the merger, acquisition, consolidation or reorganization of Employer, or in which all or substantially all of Employer's assets are sold, provided that such affiliate or other assignee presents, in Anthem's opinion, an equivalent or better financial status and credit risk. Either Party is required to provide advance written notice under this provision only to the extent permissible under applicable law and the reasonable terms of the agreement(s) governing such merger, acquisition, consolidation, reorganization, or asset sale. If advance written notice is not allowed, notice shall be provided as soon as practicable. Upon receipt of notice of an assignment of this Agreement, the other Party may terminate this Agreement by providing the assigning Party with 30 days advance written notice of termination. Any assignee of rights or benefits under this Agreement shall be subject to all of the terms and provisions of this Agreement.

b. Either Party may subcontract any of its duties under this Agreement without the prior written consent of other Party; however, the Party subcontracting the services shall remain responsible for fulfilling its obligations under this Agreement.

ARTICLE 23 - NOTICES

a. Any notice or demand pursuant to Articles 19 and 22 of this Agreement shall be deemed sufficient when made in writing as follows: to Employer, by first class mail, personal delivery, or electronic mail or overnight delivery with confirmation capability, to its principal office shown upon the records of Anthem; to Anthem, by first class mail, personal delivery, electronic mail or overnight delivery with confirmation capability, to the designated Anthem sales representative.

b. A notice or demand shall be deemed to have been given as of the date of deposit in the United States mail with postage prepaid or, in the case of delivery other than by mail, on the date of actual delivery at the appropriate address.

c. Employer shall be obligated to provide all notices to Members as may be necessary to effectuate any change in or termination of the Agreement.

ARTICLE 24 - ADMINISTRATION

a. Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Anthem, that Anthem is an independent corporation operating under a license with BCBSA permitting Anthem to use the Blue Cross and Blue Shield Service Marks in Georgia and that Anthem is not contracting as the agent of BCBSA. Employer further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to it for any of Anthem's obligations to Employer created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this Agreement.

b. Anthem is providing administrative services only with respect to the portion of the Plan described in the Benefits Booklet. Anthem has only the authority granted it pursuant to this Agreement. Anthem is not the insurer or underwriter of any portion of the Plan. Anthem has no responsibility or liability for funding benefits provided by the Plan, notwithstanding any advances that might be made by Anthem. Employer retains the ultimate responsibility and liability for all benefits and expenses incident to the Plan, including but not limited to, any applicable taxes that might be imposed relating to the Plan.

c. This provision has been intentionally deleted in its entirety.

d. Employer shall ensure that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fees, and other fees or charges.

ARTICLE 25 - ENTIRE AGREEMENT

a. The following documents will constitute the entire Agreement between the Parties: this Agreement, including any amendments and Schedules thereto, and the Benefits Booklet.

b. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. In the event that Employer has not signed the Agreement within 90 days of Employer's receipt of the Agreement, payment of Administrative Services Fees by Employer will be considered confirmation of acceptance of the terms.

c. This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter contained in this Agreement.

d. If any provision of this Agreement is held to be invalid, illegal or unenforceable in any respect under applicable law, order, judgment or settlement, such provision shall be excluded from the Agreement and the balance of this Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

ARTICLE 26 - THIS ARTICLE IS INTENTIONALLY OMITTED

ARTICLE 27 – MISCELLANEOUS

a. Employer and Anthem are separate legal entities. Anthem is strictly an independent contractor. Nothing contained in this Agreement shall cause either Party to be deemed a partner, member, agent or representative of the other Party, nor shall either Party have the expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other Party through its actions, omissions or representations.

b. Except as may be explicitly set forth in this Agreement, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names, or other intellectual property. Neither Party shall use the name, trademarks, domain names, or any other name or mark of the other Party in any press release, printed form, advertising or promotional materials or otherwise, without the prior written consent of the other Party. In addition, Employer has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Employer to use the Brands. Any references to the Brands made by Employer in its own materials are subject to prior review and approval by Anthem.

c. Nothing contained herein shall cause either Party to be deemed an agent for service of legal process for the other Party.

d. Anthem or an Anthem Affiliate may enter into business arrangements with certain Network Providers and Anthem may have financial interest in such Network Providers through direct ownership, partnership, joint venture or other arrangements. The business arrangements may provide practice management or other services to Network Providers that are designed to promote a more effective and cost-efficient health care delivery system that emphasizes continuous improvement and increased patient access to high quality, cost-effective health care. Because of its ownership or financial interests in Network Providers, Anthem may share in the Network Provider's profits or other revenue. Any revenue received by Anthem in connection with these business arrangements shall be retained by Anthem.

e. The Parties acknowledge that Anthem, in making decisions regarding the scope of coverage of services under the Benefits Booklet, is not engaged in the practice of medicine. Providers are not restricted in exercising their independent medical judgment by contract or otherwise and do not act on behalf of, or as agents for, Anthem or the Plan.

f. In addition to any other provision providing for survival upon termination of this Agreement, the Parties' rights and obligations under Articles 10, 11, 12, 13, 16, 17, 19, 24, 25(a) and 25(c) shall survive the termination of this Agreement for any reason.

g. Each Party shall comply with all laws and regulations applicable to their respective duties and obligations assumed under this Agreement.

h. Anthem and Employer agree to the performance standards set forth in Schedule C and EXHIBIT C - PERFORMANCE GUARANTEES OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by affixing the signatures of duly authorized officers.

Augusta-Richmond County	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. dba Anthem Blue Cross and Blue Shield
By: _____	By: Robert Tan
Title: _____	Title: Vice President, Sales and Client Management
Date: _____	Date: October 9, 2023

INTER-PLAN ARRANGEMENTS SCHEDULE
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Inter-Plan Arrangement Schedule supplements and amends the Administrative Services Agreement and is effective as of January 1, 2023. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Out-of-Area Services

Overview

Anthem 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 BCBSA. Whenever Members access healthcare services outside the geographic area Anthem serves (the "Anthem Service Area"), 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 Anthem Service Area, 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 ("Non-Participating Providers") with the Host Blue. Anthem remains responsible for fulfilling its contractual obligations to Employer. Anthem'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 Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of Anthem's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Plan will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Anthem Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

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 or the negotiated price made available to Anthem by the Host Blue.

b. Employer Liability Calculation

The calculation of Employer liability on Claims for Covered Services will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, Employer 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 Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to Anthem 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 in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating 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 Employer pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be 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. Upon termination, 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 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 at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Anthem may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Anthem and one or more Host Blues for any group health plan that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Anthem and Employer agree 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 Anthem's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for Employer, the Plan or Members.

Member Liability Calculation

If Anthem has entered into a Negotiated Arrangement with a Host Blue, the calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Anthem and that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Anthem's service area.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of 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.
2. **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.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **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.
6. **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.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **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.

Value-Based Programs Overview

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 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 Anthem, which Anthem will pass directly on to Employer 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 Employer 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 using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Anthem will pass these Host Blue charges directly through to Employer as a separately identified amount on the Employer 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:

- 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 the Agreement 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 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, and interest is earned at the federal funds or similar rate. 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 Anthem for Care Coordinator Fees for Provider services which Anthem will pass on to Employer as follows:

1. PMPM billings; or

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

Anthem and Employer will not impose Member cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside Anthem's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Plan, when Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, which may occur at Employer's direction, Anthem may use other pricing methods, such as Billed Charges, the pricing Anthem would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core®

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of Blue Cross Blue Shield Global Core® when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core 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 Anthem to obtain precertification for non-emergency inpatient services.

Outpatient Services

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

F. Recoveries

Host Blues may conduct: (i) prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits and (ii) recoveries of overpayments including, but not limited to, anti-fraud and abuse reviews, audits/healthcare Provider/hospital bill audits, credit balance audits, and utilization review refunds (collectively, for (i) and (ii), "Recoveries"). Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If Recoveries are passed on a Claim-by-Claim basis from a Host Blue to Anthem, they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification related to Recoveries, including collection of overpayments. Employer may be charged a fee for Recoveries as described in Schedule A.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Anthem will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. 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, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by Employer, Anthem 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 right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. 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 Anthem will then allow such modifications to become part of this Agreement.

H. Fees and Compensation

Employer understands and agrees to reimburse Anthem for certain fees and compensation which Anthem is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement related services. The specific Inter-Plan Arrangement fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and Blue Cross Blue Shield Global Core are charged to Employer are set forth in Section 7 of Schedule A to the Agreement. The various Inter-Plan Arrangement Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

Access Fee: The Access Fee is charged by the Host Blue to Anthem for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Anthem receives from the applicable Host Blue subject to a maximum of $2,000 per Claim. When charged, Anthem passes the Access Fee directly on to Employer.

Instances may occur in which the Claim payment is zero or Anthem 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, Anthem will pay the Host Blue's Access Fee and pass it along directly to Employer as stated above even though Employer paid little or had no Claim liability.

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer'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 group enrollment. When charged, Anthem passes the AEA Fee directly on to Employer.

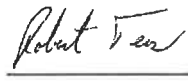
Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The PSPM dollar amount is charged on a per Subscriber per month basis by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount can also be based on the size of group enrollment. When charged, Anthem passes the PSPM Fee directly on to Employer.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. When charged, Anthem passes the Non-Standard AEA Fee directly on to Employer.

Central Financial Agency (CFA) Fee: The CFA Fee is a fixed dollar amount per payment notice and is paid by Anthem to the BCBSA. This fee applies each time Anthem receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Anthem's behalf and requesting that Anthem either approve or deny payment. When charged, Anthem passes the CFA Fee directly on to Employer. The CFA Fee supports ongoing operations of BCBSA programs and services, including but not limited to Blue Cross Blue Shield AXIS® Data Services, network solutions, and BlueCard Program-related applications.

Inter-Plan Teleprocessing System (ITS) Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Anthem and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Anthem electronically. Anthem then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA Fee and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Anthem via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to the BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim. When charged, Anthem passes the ITS Transaction Fee directly on to Employer.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: 

Title: Vice President, Sales and Client Management

Date: October 9, 2023

SCHEDULE A
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Schedule A shall govern the Agreement Period from January 1, 2023 through December 31, 2023. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

Section 1. Effective Date and Renewal Notice

This Agreement Period shall be from 12:01 a.m. January 1, 2023 to the end of the day of December 31, 2023.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

- Incurred from 01/01/2013 through 12/31/2023 and
- Paid from 01/01/2023 through 12/31/2023.

Anthem shall provide any offer to renew this Agreement at least 60 days prior to the end of an Agreement Period.

Section 2. Broker or Consultant Base Compensation

Medical

Broker or Consultant Fee is included in the Base Administrative Services Fee described in Section 3(A) of this Schedule A. Upon receipt of payment from Employer, Anthem shall remit payment to the broker or consultant designated by Employer.

Section 3. Administrative Services Fees

Change to Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Administrative Services Fees provided in this Section 3 of Schedule A during the Agreement Period based upon the occurrence of any of the following events:

- Employer's Member to Subscriber ratio is not within +/-5% of 2.03;
- Anthem is not the sole administrator for medical and pharmacy benefits under Employer's Plan;
- Employer's enrollment is not within +/-10% of 2,255 Subscribers;
- Employer moves any of the Plan benefits administered under this Agreement to another administrator or to a public or private exchange;
- A material reduction in Provider billed or published charges that results in a decrease in Anthem's discount of 10% or more;
- A change in law or regulation that materially impacts underwriting assumptions made at the time of the offer or renewal.

If Employer terminates the Pharmacy Services Schedule with PBM at any time, then Anthem shall have the right to amend the Administrative Services Fees indicated in Section 3 of Schedule A of this Agreement.

A. **Base Administrative Services Fee**

HMO

Base Administrative Services Fee:	$50.15	per Subscriber per month
Less Pharmacy Rebate Offset from Exhibit A to the Pharmacy Schedule:	($40.00)	per Subscriber per month
Total Administrative Services Fee After Offset:	**$10.15**	per Subscriber per month

Upon offer and acceptance of renewal, the Base Administrative Services Fee will be:

$50.15 per Subscriber per month from January 1, 2024 through December 31, 2024

$50.15 per Subscriber per month from January 1, 2025 through December 31, 2025

$51.62 per Subscriber per month from January 1, 2026 through December 31, 2026

Upon offer and acceptance of renewal, the Pharmacy Rebate Offset will be:

($40.00) per Subscriber per month from January 1, 2024 through December 31, 2024

($40.00) per Subscriber per month from January 1, 2025 through December 31, 2025

($40.00) per Subscriber per month from January 1, 2026 through December 31, 2026

POS

Base Administrative Services Fee:	$33.70	per Subscriber per month
Less Pharmacy Rebate Offset from Exhibit A to the Pharmacy Schedule:	($23.55)	per Subscriber per month
Total Administrative Services Fee After Offset:	**$10.15**	per Subscriber per month

Upon offer and acceptance of renewal, the Base Administrative Services Fee will be:

$33.70 per Subscriber per month from January 1, 2024 through December 31, 2024

$33.70 per Subscriber per month from January 1, 2025 through December 31, 2025

$34.55 per Subscriber per month from January 1, 2026 through December 31, 2026

Upon offer and acceptance of renewal, the Pharmacy Rebate Offset will be:

($23.55) per Subscriber per month from January 1, 2024 through December 31, 2024

($23.55) per Subscriber per month from January 1, 2025 through December 31, 2025

($23.55) per Subscriber per month from January 1, 2026 through December 31, 2026

Article 3(a) Retroactivity.

Notwithstanding anything to the contrary in the Agreement, Anthem reserves the right to limit the effective date of retroactive enrollment to a date not earlier than 60 days prior to the date the notice is received and Anthem reserves the right to limit retroactive terminations to a maximum of 60 days prior to the date the notice is received. Anthem reserves the right to not process Claims for retroactive additions beyond 60 days and to not pursue recovery of Claims for retroactive terminations beyond 60 days. Additionally, Anthem is not required to initiate recovery services if the Provider agreement or any law or regulation precludes recovery. Anthem shall credit per Subscriber per month and per Member per month Administrative Services Fees for each retroactive deletion up to a maximum of 60 days and shall charge Administrative Services Fees for each retroactive addition up to a maximum of 60 days.

B. Health and Wellness Program Fees

Enhanced Wellbeing Solutions Foundational Program: Included in Base Administrative Services Fee

Upon offer and acceptance of renewal, this fee will be:

Included in Base Administrative Services Fee from January 1, 2024 through December 31, 2024

Included in Base Administrative Services Fee from January 1, 2025 through December 31, 2025

Included in Base Administrative Services Fee from January 1, 2026 through December 31, 2026

C. Other Fees or Credits

Fee for Subrogation Services. The charge to Employer is 25% of gross subrogation recovery.

Fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities. The charge to Employer is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and vendor activity to identify overpayments and (ii) the difference between the amount Employer would have been charged absent prevention or prepayment analysis activities and the amount that was charged to Employer following performance of prevention or prepayment analysis activities. This includes, but is not limited to, COB, Host Blue activities, contract compliance, and eligibility. The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim.

Fee for Independent Claims Review: $500.00 per independent review.

Fees and Costs for Independent Dispute Resolution. Notwithstanding anything to the contrary in the Agreement, Employer shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by Anthem as part of independent dispute resolution processes.

Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member per month amount charged to Employer for the Provider performance bonus portion of the Enhanced Personal Health Care program. These charges are included in Paid Claims on the invoice and may accumulate towards any stop loss policy amounts.

Capitation Fee. A capitation fee shall be charged for Anthem's oversight and care coordination of designated Members. Such fee shall be 20% of the capitated Provider payment. These charges are included in Paid Claims on the invoice and may accumulate towards any stop loss policy amounts.

Discount Share. Employer agrees to pay an additional amount based on the difference between Billed Charges for Covered Services and the Negotiated Amount. The "Negotiated Amount" is the amount Anthem, an Anthem Affiliate and/or Host Blue is contractually obligated to pay a Network Provider under a negotiated reimbursement arrangement, before application of Member cost-share amounts, such as deductibles, copayments and coinsurance. Prescription Drug Claims, Payment Innovation Program payments and Claims paid on a capitated basis are all excluded from the fee calculation. In addition, Claims paid at the out-of-network level of benefits using the Traditional Network fee schedule are excluded from the fee calculation. The Discount Share is equal to: 2% per Claim, up to $5,000.00 per Claim. These charges are included in Paid Claims as claim related charges on the invoice and may not accumulate towards any stop loss policy amounts.

Non-Network Savings Fee. If Anthem or its Vendor negotiates with a non-Network Provider for Covered Services from the non-Network Provider, Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using a pricing tool. In the case of professional Provider Claims, Plan Liability Amount will be based upon the negotiated rate obtained by Anthem or its Vendor, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

Unidentified Recoveries. Anthem shall retain any funds received through recovery processes that are paid to Anthem and, following good faith and reasonable efforts, cannot be tied to a specific Employer or Member.

Plan Program Credit. Anthem will provide a Plan Program Credit in the amount of $161,000.00. The Plan Program Credit only applies to expenses that are incurred and credited from January 01, 2023 through December 31, 2023 and, subject to Anthem approval, may be applied towards any combination of the following:

- Plan Communications
- Anthem health and wellness programs

The Plan Program Credit does not apply towards third party health and wellness programs, personnel costs, general consultant expenses, commissions, travel, office equipment and supplies, cash incentives, and programming expenses that are not directly related to the administration of health care benefits. Anthem may pay a third party directly for approved Plan Program Credit amounts upon written direction from Employer.

Integrated Engagement Services Preferred. Included in the Base Administrative Services Fee

Includes 5 integrations. Additional fees will be incurred for new integrations with non-Anthem vendors. To the extent any Carve-Out Administrators (as defined in the Integrated Engagement Services Preferred Schedule) charge Anthem a fee to access, send or process data, such fee will be passed through to Employer.

Integrated Engagement Services Preferred Early Termination Fee. Employer shall pay Anthem the early termination fee described below if Employer terminates the Integrated Engagement Services Preferred Schedule, before the identified time period has expired, for any reason other than Anthem's failure to comply with a material duty or obligation related to the administration of the Integrated Engagement Services Preferred Schedule. If Employer terminates the Integrated Engagement Services Preferred Schedule 12 months or less after that Schedule's Effective Date, Employer shall pay $60,000.00 to Anthem. If Employer terminates the Integrated Engagement Services Preferred Schedule more than 12 months but less than 24 months after that Schedule's Effective Date, Employer shall pay $30,000.00 to Anthem. No fee is assessed if Employer terminates the Integrated Engagement Services Preferred Schedule 24 months or more after that Schedule's Effective Date.

Fee for Non-Standard Payment Terms for Paid Claims. Under Anthem's standard payment terms, the Invoice Due Date as specified in the invoice is 3 business days or less from the date the invoice is sent. Employer has negotiated a non-standard payment arrangement whereby the Invoice Due Date set forth in the invoice will be 7 business days following the date that the invoice is sent. The fee for this arrangement is waived for this Agreement Period.

Fee for Non-Standard Payment Terms for Administrative Services Fees. Under Anthem's standard payment terms, the Invoice Due Date as specified in the invoice is 3 business days or less from the date the invoice is sent. Employer has negotiated a non-standard payment arrangement whereby the Invoice Due Date set forth in the invoice will be 7 business days following the date that the invoice is sent. The fee for this arrangement is waived for this Agreement Period.

Section 4. Paid Claims, Billing Cycle and Payment Method

A. Paid Claims

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

B. Billing Cycle

Weekly

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities, unless otherwise indicated in Section 3(C) of this Schedule A.

C. Payment Method

ACH or Wire Transfer Reimbursement for Paid Claims. Employer shall deposit the amount due in a designated Anthem bank account by the Invoice Due Date. The deposit shall be made in accordance with any policies and regulations of the bank necessary to assure that the deposit is credited to Anthem's account no later than the next business day.

Section 5. Administrative Services Fees Billing Cycle and Payment Method

A. Billing Cycle

Monthly List Bill (pay as billed)

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

B. Payment Method

ACH or Wire Transfer Reimbursement. Employer shall deposit the amount due in a designated Anthem bank account by the Invoice Due Date. The deposit shall be made in accordance with any policies and regulations of the bank necessary to assure that the deposit is credited to Anthem's account no later than the next business day.

Section 6. Claims Runout Services

A. Claims Runout Period

Medical:

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

B. Claims Runout Administrative Services Fee

Medical:

The fee for Claims Runout Services will be equal to 9% of Claims processed and paid by Anthem or through Inter-Plan Arrangements. Fees in Sections 3(B) and 3(C) of this Schedule A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, discount share fees, network access fees; or (ii) apply to the Agreement Period but were not billed during the Agreement Period, will be billed and payable during the Claims Runout Period. Payment is due to Anthem by the Invoice Due Date.

Section 7. Inter-Plan Arrangements

Certain fees and compensation are charged each time a Claim is processed through the BlueCard Program and include, but are not limited to, Access Fees, Administrative Expense Allowance Fees, Central Financial Agency Fees and ITS Transaction Fees. Other Inter-Plan Arrangement related fees that Anthem may charge include, but are not limited to, fees for BlueCross Blue Shield Global Core® Program services. These fees may be separately billed or included in Paid Claims. The extent to which these fees and compensation are (i) included in the Base Administrative Services Fee; or (ii) included in Paid Claims or separately billed to Employer is as follows:

BlueCard Fees

Access Fees and AEA will be included in the Base Administrative Services Fees for Claims incurred in the Anthem Service Areas for the following states: California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin.

Access Fees (Network Provider Claims only):

• 2.02% for 1,000 - 9,999 Blue PPO enrolled Subscribers of network savings, capped at $2,000.00 per Claim.

Administrative Expense Allowance Fees ("AEA") (Network Provider and Non-Network Provider Claims):

• Network Provider - $4.00 per professional Claim and $9.75 per institutional Claim for 1,000–49, 999 Blue PPO enrolled Subscribers.

• Non-Network Provider - $3.00 per Claim.

Central Financial Agency Fee ("CFA") (Network Provider, Non-Network Provider and Blue Cross Blue Shield Global Core Claims):

• $0.35 per payment notice.

ITS Transaction Fee ("ITS") (Network Provider, Non-Network Provider and Blue Cross Blue Shield Global Core Program Claims):

• $0.05 per transaction.

Blue Cross Blue Shield Global Core Fees

Administrative Expense Allowance Fee:

• $4.35 per Member-submitted Claim;

• $5.50 per professional Claim; and

• $18.55 per institutional Claim.

All other fees associated with the Blue Cross Blue Shield Global Core program, except the CFA and ITS Fees described above, are included in the Base Administrative Services Fee.

Section 8. Other Amendments. The Administrative Services Agreement is otherwise amended as follows:

Notice of Loss of Grandfathering Status

In the event Employer maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), Employer shall not make any changes to such plan(s), including, but not limited to, changes with respect to Employer contribution levels, without providing Anthem with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem may result in the plan(s) losing grandfathered status and significant penalties and/or fines to Employer and Anthem. In the event Employer implements changes to its plan(s) and does not provide advance notice to Anthem, Employer agrees to indemnify Anthem according to the indemnification provisions set forth elsewhere in this Agreement for any penalties, fines or other costs assessed against Anthem.

Additionally, at each renewal after September 23, 2010, Employer shall affirm in writing, upon reasonable request of Anthem, that it has not made changes to its plan(s) that would cause the plan(s) to lose its/their grandfathered status.

If Employer loses grandfathered Plan status under PPACA and notifies Anthem of such loss no fewer than 90 days before the effective date of the change, Anthem will implement the additional group market (insurance) reforms that apply to non-grandfathered health Plans subject to the provisions of Article 18 of this Agreement.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: _____

Title: Vice President, Sales and Client Management

Date: October 9, 2023

SCHEDULE B
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Schedule B shall govern the Agreement Period from January 1, 2023 through December 31, 2023. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans.

Anthem may also offer additional, optional services to Employer, and such services, whether or not purchased by Employer, are not included in the services set forth below in this Schedule B. By way of example and not limitation, Anthem may offer certain optional programs that include utilization management activities. In such event, the services associated with those programs are not included in the services described below. Services under Article 13 will only be pursued or performed for Claims associated with these programs or that would have been impacted by these programs if the programs are purchased by Employer. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

Anthem's benefits and administration as described in this paragraph:

- Anthem definitions, and exclusions
- Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
- Claims incurred and paid as provided in Schedule A, excluding activities related to Claim recovery
- Accumulation toward plan maximums beginning at zero on effective date
- Anthem Claim forms
- ID card
- Explanation of Benefits (Non-customized)

• Acceptance of electronic submission of eligibility information in HIPAA-compliant format
• Preparation of Benefits Booklet (accessible via internet)
• Account reporting - standard data reports
• Standard billing and banking services
• Plan Design consultation
• Employer eServices
  - Add and delete Members
  - Download administrative forms
  - View Member Benefits and request ID cards
  - View eligibility
  - View Claim status and detail
• Responsible Reporting Entity for the Plan
• Information for preparation of SBC

Claims and Customer Services

- Claims processing services
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair

Care Management

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy
- SpecialOffers
- Member Digital Tools

Networks

- Network Access and Management
- Online Provider directory

Other Services Required by Federal Law not Otherwise Specified in the Agreement (as of the applicable effective date)

- Advance explanation of benefits
- Member cost transparency tool access
- Continuity of care administration for Provider termination from the network
- Air ambulance Provider reporting
- Upon request, Anthem will provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Employer in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.
- Posting of machine readable files on a monthly basis for the services Anthem administers for the Plan on www.anthem.com
- Aggregated Consolidated Appropriations Act Section 204 reporting (currently referred to as RxDC reporting) as applicable for the services that Anthem provides under the Agreement. This reporting does not include the D1 Premium and Life Years report.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: Robert Fenn

Title: Vice President, Sales and Client Management

Date: October 9, 2023

SCHEDULE C
TO THE
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Schedule C provides certain guarantees pertaining to Anthem's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for the period from January 1, 2023 through December 31, 2023 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Schedule C and made a part of this Schedule C. This Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule C, the terms of this Schedule C shall control. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Attachments to this Schedule C, the terms of the Attachments to this Schedule C shall control unless otherwise specified.

Section 1. **General Conditions**

A. The Performance Guarantees described in the Attachments to this Schedule C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Performance Category. The term Performance Category describes the general type of Performance Guarantee.

2. Reporting Period. The term Reporting Period refers to how often Anthem will report on its performance under a Performance Guarantee.

3. Measurement Period. The term Measurement Period is the period of time under which Anthem's performance is measured, which may be the same as or differ from the period of time equal to the Performance Period.

4. Penalty Calculation. The term Penalty Calculation generally refers to how Anthem's payment will be calculated, in the event Anthem does not meet the target(s) specified under the Performance Guarantee.

5. Amount at Risk. The term Amount at Risk means the amount Anthem may pay if it fails to meet the target(s) specified under the Performance Guarantee.

B. Anthem shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Schedule C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem shall be based on Anthem's then current measurement and calculation methodology, which shall be available to Employer upon request.

C. Any audits performed by Anthem to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Parties do not have an executed Agreement, Anthem shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Schedule C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by Anthem or its Vendors.

F. If Employer terminates the Agreement between the Parties prior to the end of the Performance Period, or if the Agreement is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. Anthem reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Schedule C upon the occurrence, in Anthem's determination, of:

1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee;

2. an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Agreement;

3. a change in law or regulation that materially impacts underwriting assumptions made at the time of offering such Performance Guarantees.

Should there be a change in occurrence as indicated above and these changes negatively impact Anthem's ability to meet the Performance Guarantees, Anthem shall have the right to modify the Performance Guarantees contained in the Attachments.

H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Schedule C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

I. Some Performance Guarantees measure and compare year to year performance. The term Baseline Period refers to the equivalent time period preceding the Measurement Period. Anthem will require specified historical Claims and utilization data to establish the Baseline Period for the first year of a Performance Guarantee utilizing a Baseline Period.

J. As determined by Anthem, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

L. All Performance Guarantees in which Anthem will make outbound calls or will reach out through email or other means to members will exclude members who Anthem cannot reach due to incorrect or invalid telephone numbers, including numbers where permission is required by law but not provided, or those members who have requested that Anthem not contact them.

M. All Performance Guarantees may be revisited and may potentially be impacted due to a cause beyond the reasonable control of a Party such as a pandemic (an outbreak of disease that affects an exceptionally high proportion of members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement or Baseline Period that impacts a meaningful portion of the Employer population.

Section 2. Payment

A. If Anthem fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem shall pay Employer the amount set forth in the Attachment described under the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees, which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, Anthem has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Schedule C against any amounts owed by Employer to Anthem under: (1) any Performance Guarantees contained in the Attachments to this Schedule C; (2) the Agreement; or, (3) any applicable Stop Loss Policy

C. Notwithstanding the foregoing, Anthem's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement, in this Schedule C, and the Attachments, including providing Anthem with the information or data required by Anthem in the Attachments. Anthem shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts Anthem's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, which expressly includes but is not limited to Employer or its vendor's failure to timely provide Anthem with accurate and complete data or information in the form and format expressly required by Anthem.

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

Section 3. Performance Guarantee Amounts at Risk

A. Amount at Risk

The total amount at risk for the below performance guarantees between Anthem and Augusta Richmond County shall not exceed the following:

- Operations Guarantees: 20% of Base Medical Administration fees
- Network Guarantees: 20% of Base Medical Administration fees

B. Maximum Amount Payable

The maximum amount payable under all guarantees between Anthem and Augusta Richmond County shall not exceed 40% of the Base Medical Administration fees. The Maximum Amount Payable provisions above do not apply to Pharmacy-related Performance Guarantees.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: _____

Title: Vice President, Sales and Client Management

Date: October 9, 2023

ATTACHMENT 1 TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

Operations Performance Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period from January 1, 2023 through December 31, 2023. This Attachment is intended to supplement and amend the Agreement between the Parties.

Performance Category	**Amount At Risk**
Claims Timeliness - (14 Calendar Days)	4% of Base Admin. Services Fees
Claims Financial Accuracy	4% of Base Admin. Services Fees
Claims Accuracy	2% of Base Admin. Services Fees
Average Speed to Answer	2% of Base Admin. Services Fees
First Call Resolution	2% of Base Admin. Services Fees
Member Satisfaction NPS	2% of Base Admin. Services Fees
Management Reports	2% of Base Admin. Services Fees
Account Management Satisfaction	2% of Base Admin. Services Fees
Total Amount At Risk – Operations	**20%**

Additional Terms and Conditions:

- For purposes of imposing penalties, measurement shall not begin until the start of the fourth month of the initial Agreement period for the following measures: Claims Timeliness, Claims Financial Accuracy, Claims Accuracy, Average Speed of Answer, and First Call Resolution.

- Performance will be based on the results of a designated service team/business unit assigned to Augusta Richmond County, unless the guarantee is noted as measured with Employer-specific Data.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement and Reporting Period
Claims Timeliness (14 Calendar Days)	4% of Base Admin. Services Fees	A minimum of 90% of Non-investigated medical Claims will be processed timely. Non-investigated Claims are defined as medical Claims that process through the system without the need to obtain additional information from the Provider, Subscriber or other external sources. Processed Timely is defined as Non-investigated medical Claims that have been adjudicated within 14 calendar days of receipt. This Guarantee will be calculated based on the number of Non-investigated Claims that Processed Timely divided by the total number of Non-investigated Claims. The calculation of this Guarantee does not include Claim adjustments. The calculation of this Guarantee also excludes in any quarter, Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented. This will be measured with Employer-specific Data.	**Result** 90.0% or Greater 88.0% to 89.9% 86.0% to 87.9% 85.0% to 85.9% Less than 85.0%	**Penalty** None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual
Claims Financial Accuracy	4% of Base Admin. Services Fees	A minimum of 99% of medical Claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical Claims paid correctly divided by the total dollar amount of audited medical Paid Claims. The calculation of this Guarantee includes both underpayments and overpayments. The calculation of this Guarantee does not include Claim adjustments or Claims in any quarter in which an Employer requests changes to Plan benefits, until all such changes have been implemented.	**Result** 99.0% or Greater 98.0% to 98.9% 97.0% to 97.9% 96.0% to 96.9% Less than 96.0%	**Penalty** None 25% 50% 75% 100%	**Measurement Period** Annual **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Claims Accuracy	2% of Base Admin. Services Fees	A minimum of 97% of medical Claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical Claims paid and denied correctly divided by the total number of audited medical Claims paid and denied. The calculation of this Guarantee excludes in any quarter Claims for an Employer that requests changes to Plan benefits, until all such changes have been implemented.	**Result** / **Penalty** 97.0% or Greater / None 96.0% to 96.9% / 25% 95.0% to 95.9% / 50% 94.0% to 94.9% / 75% Less than 94.0% / 100%	**Measurement Period** Annual **Reporting Period** Annual
Average Speed to Answer	2% of Base Admin. Services Fees	The average speed to answer (ASA) will be 45 seconds or less. ASA is defined as the average number of whole seconds members wait and/or are in the telephone system before receiving a response from a customer service representative (CSR) or an interactive voice response (IVR) unit. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system.	**Result** / **Penalty** 45 seconds or less / None 46 to 48 seconds / 25% 49 to 51 seconds / 50% 52 to 54 seconds / 75% 55 or more seconds / 100%	**Measurement Period** Annual **Reporting Period** Annual
First Call Resolution	2% of Base Admin. Services Fees	A minimum of 85% of member calls will be resolved during the initial contact with no further follow up required. First Call Resolution is defined as member callers receiving a response to their inquiry during an initial contact with no further follow-up required. This Guarantee will be calculated based on the total number of members who receive a First Call Resolution divided by the total number of calls received into the customer service telephone system.	**Result** / **Penalty** 85.0% or Greater / None 83.0% to 84.9% / 25% 81.5% to 82.9% / 50% 80.0% to 81.4% / 75% Less than 80.0% / 100%	**Measurement Period** Annual **Reporting Period** Annual

<table>
<tr><th>Performance Category</th><th>Amount at Risk</th><th>Guarantee</th><th>Penalty Calculation</th><th>Measurement and Reporting Period</th></tr>
<tr>
<td>Member Satisfaction – NPS</td>
<td>2% of Base Admin. Services Fees</td>
<td>This Guarantee establishes a Quality Benchmark transactional Net Promoter Score (NPS) of 40. Anthem will either: (i) meet or exceed the Quality Benchmark; or, (ii) there will be an improvement in the Net Promoter Score from the Baseline Period.
The survey is conducted after a member contacts a customer service representative (CSR). Each member who completes a transaction with Anthem will be asked to provide a rating on a scale from 0 (Not at All Likely) to 10 (Extremely Likely) to a question that asks how likely the member would recommend Anthem to a friend or colleague based on the member's most recent transaction. The transactional Net Promoter Score will be calculated by subtracting the percentage of Detractors (members who provide a rating from 0 to 6) from the percentage of Promoters (members who provide a rating of 9 or 10).
To determine the results for (i), Anthem shall compare the Net Promoter Score in the Measurement Period to the Quality Benchmark.
The improvement for (ii) will be determined by comparing the Net Promoter Score in the Measurement Period to the Net Promoter Score in the Baseline Period.
The Baseline Period is the equivalent time period preceding the Measurement Period.
This will be measured with Employer-specific Data.</td>
<td>
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>Net Promoter Score increased</td><td>None</td></tr>
</table>
If Net Promoter Score stayed to same or decreased AND is
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>40 or Greater</td><td>None</td></tr>
<tr><td>39.0 to 39.9</td><td>25%</td></tr>
<tr><td>38.0 to 38.9</td><td>50%</td></tr>
<tr><td>37.0 to 38.9</td><td>75%</td></tr>
<tr><td>Less than 37.0</td><td>100%</td></tr>
</table>
</td>
<td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Annual</td>
</tr>
<tr>
<td>Management Reports</td>
<td>2% of Base Admin. Services Fees</td>
<td>Standard automated reports will be made available to Employer by no later than 25 calendar days following the end of the month.
The reports will include financial, utilization and clinical information.
This will be measured with Employer-specific Data.</td>
<td>
<table>
<tr><th>Result</th><th>Penalty</th></tr>
<tr><td>Reports are late 1 month</td><td>None</td></tr>
<tr><td>Reports are late 2 months</td><td>25%</td></tr>
<tr><td>Reports are late 3 or more months</td><td>100%</td></tr>
</table>
</td>
<td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Annual</td>
</tr>
</table>

<table>
<tr><th>Performance Category</th><th>Amount at Risk</th><th>Guarantee</th><th>Penalty Calculation</th><th>Measurement and Reporting Period</th></tr>
<tr><td>Account Management Satisfaction</td><td>2% of Base Admin. Services Fees</td><td>A minimum average score of 3.0 will be attained on the Account Management Satisfaction Survey (AMSS).
A minimum of 3 responses per Employer to the AMSS is required to base the score on Employer-specific responses only. If 3 responses are received from the Employer, an average score is calculated by adding the scores from each respondent divided by the total number of Employer respondents. If fewer than 3 responses are received, the score will be calculated as follows:
2 Employer responses: 2/3 of the score will be based on Employer-specific AMSS results and 1/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.
1 Employer- response: 1/3 of the score will be based on Employer- specific AMSS results and 2/3 of the score will be based on the aggregate score of all AMSS results received by the Account Management Team.
0 Employer responses: The score will be based on the aggregate score of all AMSS results received by the Account Management Team.</td><td><table><tr><th>Result</th><th>Penalty</th></tr><tr><td>3.0 or higher</td><td>None</td></tr><tr><td>2.5 to 2.9</td><td>25%</td></tr><tr><td>2.0 to 2.4</td><td>50%</td></tr><tr><td>Less than 2.0</td><td>100%</td></tr></table></td><td><u>Measurement Period</u>
Annual

<u>Reporting Period</u>
Annual</td></tr>
</table>

ATTACHMENT 2 TO SCHEDULE C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

Network Guarantees

This Attachment is made part of Schedule C and will be effective for the Performance Period from January 1, 2023 through December 31, 2023. This Attachment is intended to supplement and amend the Agreement between the Parties.

Performance Category	**Amount At Risk**
Network Provider Discount – Expected Discount 63.1%	20% of Base Admin. Services Fees
Total Amount At Risk - Network	**20%**

Additional Terms and Conditions

- This/These Guarantee(s) applies to following time periods:(Measurement Period)
  - Year 1: Claims Incurred from January 1, 2023 through December 31, 2023 and Paid from January 1, 2023 and through March 31, 2024.
- This Guarantee excludes the following Providers: Children's Healthcare Network.
- This Guarantee excludes the total Claims Charges for any Member that exceeds $150,000 in paid claims in the Measurement Period.
- Anthem has the right in its sole discretion to modify or terminate this Guarantee if any of the following conditions occur:
  - Anthem is no longer the sole administrator for Employer's Plan
  - Employer fails to maintain at least an average enrollment of enrollment of 2,022 Subscribers.
  - As previously mentioned, a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by Anthem or the measurement of a Performance Guarantee.
  - Anthem will use Employer's service mix to determine a composite Network Discount. For example:

Service	**Proposed Discount Guarantee %**	**Actual Utilization at Policy Year End**	**Final Discount**
Inpatient	51.0%	30.6%	53.1%
Out Patient	55.0%	37.8%	54.2%
Professional	48.0%	31.6%	49.0%
Composite Discount*	51.6%	100.0%	52.22%
	*Composite Discount using Group Utilization		

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
Network Provider Discount	20% of Base Admin. Services Fees	Anthem guarantees a minimum Network Provider Discount based upon the following Target Amounts: 58.4% Inpatient Hospital/ 70.0% Outpatient Hospital/ 56.8% Professional. This Guarantee excludes the following Providers: Children's Healthcare Network. This Guarantee excludes the total Claims Charges for any Member that exceeds $150,000 in paid claims in the Measurement Period. Eligible Claim Charges are defined as charges for Covered Services provided to Members enrolled in OA POS Plans. Eligible Claim Charges will be based on Anthem primary Claims only and will not include charges related to Prescription Drug Claims, Inter-Plan Program fees, state surcharges, Anthem Provider payment innovation programs or services rendered outside the United States. Allowed Amount is defined as the amount paid by Anthem to OA POS Network Providers on Eligible Claim Charges plus any Member Cost Shares. This Guarantee will be calculated by dividing the OA POS Network Provider Allowed Amount by the OA POS Network Provider Eligible Claim Charges. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount. The resulting percentage shall be subtracted from 100% to determine the Network Provider Discount. This will be done for each service. Anthem will then apply Employer's actual utilization to both the actual discount and Target Amounts and then determine the difference between a composite result achieved versus the composite result based on the Target Amounts. Anthem has the right in its sole discretion to modify or terminate this Guarantee if any of the following conditions occur: • Anthem is no longer the sole administrator for Employer's Plan • Employer fails to maintain at least an average enrollment of 2,022 Subscribers.	If Actual Results are lower than the final Guarantee by: **Result** / **Penalty** 0-2% / None 2.1%-3.0% / 25% 3.1%-4.0% / 50% 4.1%-5.0% / 75% More than 5.0% / 100%	**Measurement Period** *This period applies to Claims incurred from January 1, 2023 through December 31, 2023 and Paid from January 1, 2023 and through March 31, 2024. **Reporting Period** Annual

Performance Category	Amount at Risk	Guarantee	Penalty Calculation	Measurement and Reporting Period
		• The geographic distribution of Subscribers changes by more than 5% in any state or 10% in total from the Employer census provided for purposes of establishing this Guarantee. Only Claims submitted to a Blue Cross and/or Blue Shield licensee for processing and adjudication shall be considered for purposes of this Discount Guarantee. This Guarantee assumes that, per the uniform data standard specifications released on 12/9/2020, Provider billed charge trend will be as follows: 6% inpatient, 7% outpatient and 4.5% professional. This Guarantee is subject to modification if actual billed charge trend falls below these amounts." This will be measured with Employer-specific Data.		

PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Pharmacy Benefits Administrative Services Schedule ("Pharmacy Services Schedule") is by and between Employer and CarelonRx, Inc., an Anthem Affiliate that will be referenced as the pharmacy benefits manager ("PBM") for the purposes of this Pharmacy Services Schedule. The Pharmacy Services Schedule supplements and amends the Agreement between the Parties and is effective from 1/1/2023 through 12/31/2027 (which, for purposes of this Pharmacy Services Schedule and its Exhibits, is defined as the "Agreement Period"). Description of the Pharmacy Services and applicable fees for such services are set forth in the Exhibits (the "Exhibits") to this Pharmacy Services Schedule and made a part of this Pharmacy Services Schedule. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to the Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Exhibits to this Pharmacy Benefits Schedule, the terms of the Exhibits shall control.

A. **Definitions**. The following definitions apply to this Pharmacy Services Schedule. Terms not otherwise defined in this Pharmacy Services Schedule shall have the same meaning as such term is otherwise defined in the Agreement.

- **Annualized Adjusted Prescription Drug Claims**. The annualized sum of the total number of: (i) retail Prescription Drug Claims with less than 84 days supply; (ii) retail Prescription Drug Claims with greater than or equal to 84 days supply multiplied by a factor of 3; (iii) mail order Prescription Drug Claims multiplied by a factor of 3; and (iv) Specialty Prescription Drug Claims.
- **Authorized Generics**. Prescription Drugs produced by brand pharmaceutical companies and marketed under a private label, at Generic Drug prices. Authorized Generics are identical to their Brand Drug counterpart in both active and inactive ingredients.
- **Average Wholesale Price (AWP)**. The benchmark price of a Prescription Drug based on the actual 11-digit National Drug Code ("NDC") for the product and package size on the date dispensed to a member as established and reported by Medi-Span or by another nationally recognized pricing source selected by PBM in its sole discretion.
- **Biosimilar Products**. Drugs that (a) are highly similar to a US-licensed referenced biological product, notwithstanding minor differences in clinically inactive components, where there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and/or (b) are approved pursuant to 42 USC Section 262(k) or any successor legislative provision thereto.
- **Brand MAC**. A multi-source Brand Drug that is included on the Maximum Allowable Cost ("MAC") list and paid at the MAC cost basis.
- **Brand Name Prescription Drugs or Brand Drugs.**Products for which the Medi-Span multi-source code field equals "M", "N,", or "O" as of the fill date for the dispensed NDC-11.
- **Branded Generic Claims**. Multi-source Brand Drugs that were billed to the Employer at the Generic Drug cost.
- **Compound Drug**. A mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.
- **Covered Prescription Services**. A Covered Service that is Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member's Benefits Booklet.
- **Dispense As Written Claims With Code 1**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because substitution was not allowed by the Provider.
- **Dispense As Written Claims With Code 2**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Member requested the Brand Drug.

- **Dispense As Written Claims With Code 3**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.
- **Dispense As Written Claims With Code 4**. Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.
- **Dispense As Written Claims With Code 5**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as "House Generic Claims").
- **Dispense As Written Claims With Code 6**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.
- **Dispense As Written Claims With Code 7**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Brand Drug is mandated by state and federal laws and regulations.
- **Dispense As Written Claims With Code 8**. Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug is not available in the marketplace.
- **Dispense As Written Claims With Code 9**. Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.
- **Dispense As Written Claims**. Claims where a Brand Drug was dispensed when a Generic Drug exists and is available.
- **Dispensing Fee**. The amount paid for professional services rendered by a licensed pharmacist in dispensing Prescription Drugs.
- **Drug Rebates**. Drug Rebates as referenced herein shall include Medical Drug Rebates and/or Prescription Drug Rebates.
- **Formulary**. The list of Prescription Drugs or products (which may include over-the-counter drugs, supplies, devices, equipment, and other items such as disposable insulin syringes, and other diabetic supplies) developed, published, and revised from time to time by PBM.
- **Generic Dispensing Rate**. The total number of Generic Prescription Drug Claims received by PBM divided by the total number of Prescription Drug Claims received by PBM.
- **Generic Prescription Drugs or Generic Drugs.**Products with a Medi-Span multi-source code field equal to "Y" as of the fill date and are not otherwise defined as Brand Drugs or Specialty Drugs.
- **Ingredient Cost**. The component of the prescription price that represents the charge for the ordered Prescription Drug product, supply, or other product (excluding any Dispensing Fee, administrative fee, or taxes).
- **Limited Distribution Drugs**. Drugs supplied by a limited number of pharmacies as determined by the drug manufacturer. Multiple pharmacies wholly owned by an entity or affiliated shall be considered one pharmacy for purposes of this definition.
- **Mail Order Pharmacy**. A Network Pharmacy that provides Covered Prescription Services to Members via mailing or shipping utilizing the United States Postal Service and/or other common shipping carrier, including FedEx and/or United Parcel Service.
- **Manufacturer Administrative Fees**. Amounts received by PBM directly or indirectly from manufacturers for administering, allocating, and collecting Prescription Drug Rebates that are attributable to Prescription Drugs.
- **Medical Drug Rebates**. Rebates Anthem and/or PBM receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by Anthem and covered under the medical benefit portion of the Plan(s).
- **Most Favored Nations Limitations**. Government restrictions that preclude pharmacies from making pricing agreements with PBMs or others that are more favorable than those afforded to state-run programs, such as Medicaid.
- **Multi-Source Brand Drug**. A Brand Drug that is no longer subject to patent exclusivity and is available in both brand and generic form from more than one manufacturer or labeler.

- **Network Pharmacy or Network Pharmacies**. A Mail Order Pharmacy, Retail Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Covered Prescription Services to Members and has entered into a participating pharmacy Agreement with PBM or its Vendor to dispense Covered Prescription Services to Members.
- **New to Market Drug**. A Specialty Drug or product that is newly introduced for sale by pharmaceutical manufacturers and made available for dispense at pharmacies and shall be deemed as such for one hundred eighty (180) days following its NDC effective date.
- **Pharmacy Benefit Plan**. That portion of the Benefits Booklet that describes Covered Prescription Services that is administered by PBM. Pharmacy Benefit Plan coverage includes any deductible or co-insurance provided for under the Covered Prescription Services.
- **Powder Claims**. Claims for drugs where the dosage form, as identified by Medispan database or other nationally recognized pricing source selected by PBM in its sole discretion from time to time, is powder.
- **Prescription Drug**. Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included on PBM's Formulary (e.g., certain over-the-counter drugs).
- **Prescription Drug Claim**. A Claim submitted to PBM for payment of Prescription Drug benefits that PBM invoices Employer for Prescription Drugs dispensed to Members by pharmacies. PBM's invoice shall be included as part of the invoice Anthem bills for other Paid Claims, as further set forth in the Agreement.
- **Prescription Drug Rebates**. Any rebate, Manufacturer Administrative Fees, and/or price protection payment associated with utilization that PBM receives and that is contingent upon and related directly to a Member's use of a Prescription Drug during the Agreement Period. Prescription Drug Rebates do not include any discount, price concession, or other direct or indirect remuneration PBM receives for the purchase of a Prescription Drug or for the provision of any products or services to manufacturer(s).
- **Retail Pharmacy**. A Network Pharmacy that provides Covered Prescription Services to Members at the point of sale or via delivery by an employee of the Network Pharmacy or contracted delivery courier. For purposes of clarification, delivery does not include mailing or shipping Covered Prescription Services to Members utilizing the United States Postal Service and/or other common shipping carrier, including FedEx and/or United Parcel Service.
- **Secondary Claims**. Claims where PBM is the secondary payer due to Coordination of Benefits (COB) with one or more other payers.
- **Single Source Generics**. Those Generic Drugs that are provided by three or fewer pharmaceutical manufacturers as defined at the GPI14 level or such Generic Drugs that are in the market with supply limitations or competitive restrictions.
- **Specialty Drugs**. Drugs dispensed from a Specialty Service Pharmacy and/or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. The Specialty Drug list is a PBM developed and maintained list of Specialty Drugs and is modified by PBM from time to time.
- **Specialty Service Pharmacy**. A Network Pharmacy that provides Specialty Drugs to Members.
- **Specialty Starter Fill**. A prescription dispensed to Members who are initiating treatment on select medications for which: (a) the days' supply is typically limited to 15 days or less; (b) is a split fill; and (c) the NDC utilized for such medication is a specialty NDC.
- **Usual and Customary (U&C) Charge**. The amount a cash paying customer pays a pharmacy for a Prescription Drug. PBM shall require Network Pharmacies to submit the Usual and Customary Charges with all Claim submissions.
- **Zero Balance Claim**. A Claim where the Ingredient Cost plus Dispensing Fee plus tax is less than or equal to the Member cost share and the Member pays 100% of the Claim.

B. **Obligations of PBM.**

In addition to the services provided by Anthem under Article 2 of this Agreement, and if applicable to the Pharmacy Benefit Plan and as indicated in Exhibit B, PBM will provide the following pharmacy benefit management administrative and support services (the "Pharmacy Services"):

1. **Network Pharmacy Services.**

   a. PBM shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM or its Vendors under which such pharmacies agree to provide pharmacy services to Members and accept negotiated fees for such services ("Network Pharmacies"). PBM shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.

   b. PBM shall arrange for the dispensing of covered Prescription Drugs to Members through one or more networks of Network Pharmacies. If a Member obtains a covered Prescription Drug from a pharmacy that is not in the network, the Member shall be responsible for the total cost of the covered Prescription Drug. PBM's network will provide Members adequate access to the covered Prescription Drugs at the Network Pharmacies. Employer acknowledges that the availability of Prescription Drugs is subject to market conditions and that PBM cannot, and does not, assure the availability of any Prescription Drug from a Network Pharmacy.

   c. PBM and/or its Vendors shall perform periodic onsite or field audits of Network Pharmacies to ensure compliance with billing requirements as well as other terms and conditions of the Network Pharmacy agreements. PBM will pay Employer, or apply as a credit to invoices, one hundred percent (100%) of the amounts PBM recovers from these audits, minus a recovery fee as set forth in Exhibit A and, if applicable, Attachment 1 to Exhibit D. These audits are separate and distinct from daily Claims review audits, for which there is no additional fee and which are included in the list of services offered as part of the Pharmacy Administrative Services Fee as set forth in Exhibit B. Employer will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Employer that are not required by applicable law.

   d. Pursuant to the terms of the contract between PBM and Network Pharmacy, no Network Pharmacy shall charge, collect a deposit from, or have any recourse against a Member for the covered Prescription Drugs other than applicable cost shares, including in the event of breach of the Agreement and/or this Pharmacy Services Schedule by Employer or insolvency of Employer. This provision shall survive the termination of the Agreement and/or this Pharmacy Services Schedule for any covered Prescription Drug provided to a Member prior to such termination.

   e. PBM shall offer Employer a Mail Order Pharmacy program through which Members may receive mail order covered Prescription Services. The Mail Order Pharmacy shall dispense Covered Prescription Drugs upon receipt from a Member of (i) a valid new or refill prescription order and (ii) applicable cost share. The covered Prescription Drug shall be mailed or shipped to the Member's address set forth in the eligibility file, or as appearing on the face of the prescription, so long as such address is within the United States. Additional fees for express mail, shipping or handling may be charged to Members. PBM may suspend such services to a Member if Member fails to remit any applicable cost share due.

   f. PBM shall offer Employer a specialty pharmacy program through which Members may receive specialty pharmacy drug services. PBM shall provide all necessary information and forms to Members to obtain these specialty Prescription Drug services.

   g. PBM shall operate a toll-free call center to respond to inquiries from Network Pharmacies regarding Pharmacy Services provided by PBM provided pursuant to this Pharmacy Services Schedule, including but not limited to technical and claims processing issues and Member eligibility verification ("Pharmacy Help Desk"). The Pharmacy Help Desk shall be available 24 hours a day, 7 days a week.

2. **Drug Formularies.**

   a. PBM will furnish and maintain a drug Formulary for use with the Pharmacy Benefit Plan, and PBM shall periodically review and update its Formulary. Employer shall adopt such Formulary as part of the design of the Pharmacy Benefit Plan. The drug Formulary will be made available to Members on PBM's web site and upon request may be provided to Employer in a mutually acceptable format for Employer's distribution to Members.

   b. PBM has placed certain Prescription Drugs on formularies that are developed through a process involving two committees, the Pharmacy and Therapeutics Committee ("P&T") and the Value Assessment Committee ("VAC"). The P&T examines the safety and efficacy of a Prescription Drug in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The VAC examines member impact, provider impact, economics, law and regulations, and market dynamics as it determines tiering and utilization management edit placement of Prescription Drugs on the formularies in a manner consistent with the clinical determinations of the P&T.

   c. This provision is intentionally removed.

   d. If a Formulary exception process is included in the Employer's Plan design, in the event a Member or Provider believes that a Prescription Drug or supply not included on a Formulary is medically necessary to treat the Member's individual condition, the Member or Provider may request a coverage exception. In the coverage exception process, PBM will consider a variety of factors that include, but are not limited to, Prescription Drugs previously tried and failed by the Member to treat a particular diagnosis or condition, whether the Member is clinically stable on the Prescription Drug, and/or whether switching to a covered Prescription Drug would result in a clinically significant adverse reaction or other harm to the Member.

3. **Claims Processing Services.**

   a. PBM shall perform administrative services for Employer, including but not limited to, processing Claims with a Claims Incurred Date indicated in Section 1 of Exhibit A for Covered Prescription Services in accordance with the Pharmacy Benefit Plan. PBM will pay, on Employer's behalf, only Claims that are: (1) timely submitted by Network Pharmacies through PBM's point-of-sale service system; and (2) properly submitted by Members as requests for reimbursement for Covered Prescription Services. Employer may request PBM, on an exception basis, to process and pay Claims that were denied by PBM or take other actions with respect to the Pharmacy Benefit Plan that are not specifically set forth in this Agreement or the Benefits Booklet. PBM may honor such requests subject to system override capability and Employer paying a processing fee that has been mutually agreed to by the Parties.

   b. PBM will implement certain administrative overrides to authorize the dispensing of Prescription Drugs in response to certain requests that include but are not limited to requests for lost/stolen drugs and vacation supplies.

   c. PBM shall disburse to Member or Network Pharmacies payments that it determines to be due according to the provisions of the Pharmacy Benefit Plan.

   d. PBM shall provide notice in writing when a Member submitted Claim has been denied or a prior authorization request has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Pharmacy Benefit Plan and shall otherwise satisfy applicable law governing the notice of a denied Claim.

   e. Notwithstanding anything to the contrary in the Agreement, PBM will provide pharmacy Coordination of Benefits (COB) services as described in this provision if listed on Exhibit A and, if applicable, Attachment 1 to Exhibit D for the fee set forth on Exhibit A and, if applicable, Attachment 1 to Exhibit D. Employer shall be responsible for providing other party insurance liability information for Members on its eligibility file. If the eligibility file is provided by Employer and PBM determines that coverage under this Agreement is deemed secondary, the Member Claim will reject at point of sale and instruct the Member to submit the Claim to the third party payer that is deemed primary. PBM shall coordinate benefits with the third party payers as appropriate.

4. **Utilization and Clinical Management Programs.**

   a. PBM will provide a concurrent drug utilization program that assists pharmacies in identifying potential drug interactions, incorrect drug dosage, and inappropriate drug use and misuse. The program utilizes real-time Member health and safety protocols designed to monitor and screen each claim against the Member's Prescription Drug profile and is designed to help promote appropriate Prescription Drug use and help prevent adverse Member reactions. PBM shall make available to prescribing Providers, subject to such prescribing Providers' system capabilities, electronic access to Member eligibility; Prescription Drug Formulary status; Member medication history; a listing of Formulary alternative Prescription Drugs; and applicable cost share.

   b. PBM shall offer additional programs to help ensure clinically appropriate use of Prescription Drugs, and effectively manage the cost of care that may include but not be limited to drug edits (i.e. prior authorization, step therapy, quantity limits, and dose optimization), enhanced fraud waste and abuse program, and medication review. Employer shall pay fees for the programs selected by Employer as set forth on Exhibit A. Employer shall abide by all applicable policies and procedures of the programs selected that may require Employer to provide requested information prior to PBM initiating the service.

5. **General Provisions.**

   a. PBM shall assist Employer in determining whether its Prescription Drug benefit constitutes "creditable prescription drug coverage" as that term is used under the Medicare Part D laws (specifically, 42 C.F.R. 423.56). Unless otherwise agreed to by the Parties, Employer shall be solely responsible for communicating with Members regarding creditable prescription drug coverage matters.

   b. PBM shall make available a toll-free number staffed by adequately trained personnel to address Member questions.

   c. PBM will provide Employer with PBM's standard management and utilization reporting package in connection with the Pharmacy Services provided pursuant to this Pharmacy Services Schedule. At Employer's expense, PBM may prepare and provide custom and ad hoc reports within an agreed-upon time and format, at the rate set forth in Exhibit A of this Pharmacy Services Schedule, as applicable.

   d. PBM will provide Pharmacy Services in accordance with the Pharmacy Benefit Plan and the Plan document(s) adopted by Employer. The Pharmacy Services shall be procedural only and shall be performed by PBM within the framework of policies, interpretations, rules, practices, and procedures made, established, and provided in writing to PBM by Employer.

   e. PBM will maintain all licenses, permits, certifications, registrations, and other regulatory approvals required by law necessary for the performance of PBM's obligations pursuant to this Pharmacy Services Schedule.

   f. PBM will maintain at least one of the following accreditations during the term of the Agreement and this Pharmacy Services Schedule: (a) National Committee for Quality Assurance ("NCQA") certification; (b) Utilization Review Accreditation Commission ("URAC") Drug Utilization Management accreditation; and/or (c) such other NCQA certifications and URAC accreditations applicable to the Pharmacy Services provided hereunder.

   g. PBM shall not be responsible for any adverse consequences from Employer's request to change from one pharmacy benefit administrator to another pharmacy benefit administrator.

   h. PBM agrees to be bound by its obligations under HIPAA as a Business Associate under the same terms as entered into by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. dba Anthem Blue Cross and Blue Shield under its Business Associate Agreement with Employer.

C. **Obligations of Employer**. To the extent not already provided under Article 3 of this Agreement, Employer shall:

1. Provide PBM with timely, accurate and complete information necessary for PBM to provide the Pharmacy Services. PBM shall be under no obligation to verify the accuracy and completeness of information provided to it by Employer.

2. Provide accurate, timely, complete, and ongoing Member eligibility information to PBM using PBM's prescribed format and methods. Such information shall include, but shall not be limited to, the number and names of Members eligible for and covered under the Pharmacy Benefit Plan and any other information determined by PBM to be necessary to provide Pharmacy Services. PBM will load Member eligibility data no later than three business days after receipt from Employer. PBM will be entitled to rely on the accuracy and completeness of the Member eligibility data from Employer. Employer shall be solely responsible for any errors in Member eligibility data that Employer provides to PBM.

D. **Drug Rebate Management.**

1. During any Agreement Period, Employer shall not contract, directly or indirectly through a third party, with a manufacturer or any other third party for rebates, discounts, or other financial incentives on claims that are eligible for Prescription Drug Rebates under this Agreement. In the event that PBM determines such violation of this paragraph, Employer shall be deemed ineligible to earn Prescription Drug Rebates, the Drug Rebate Program will be suspended, and Employer shall be required to reimburse PBM for any Prescription Drug Rebates that were previously earned. If Employer fails to reimburse PBM for such Prescription Drug Rebates within 10 business days of PBM's request, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM. Additionally, PBM may renegotiate the guarantees and/or any pricing terms of the Agreement.

2. Employer acknowledges and agrees that Prescription Drug Rebate amounts are subject to change for reasons including but not limited to:

   a. Prescription Drug Rebate eligibility is modified under an agreement between PBM and/or its Vendor and a manufacturer;

   b. laws and regulations affecting the distribution or the amount of Prescription Drug Rebates available or payable under such laws and regulations; or

   c. any action(s) or inaction(s) by manufacturer that impacts the availability or amount of Prescription Drug Rebate earned, that includes, but is not limited to, manufacturer's discontinuation of the covered Prescription Drugs.

   If any change set forth in (a) - (c) above occurs, PBM may provide written notice to Employer of such change as soon as reasonably practicable. In such event, PBM shall notify Employer and revise or eliminate such payment as of the effective date of the reduction or elimination of the Prescription Drug Rebate payment. Such reduction or elimination of the Prescription Drug Rebate payment shall result in either a change in the Base Administrative Services Fee as described in Article 18(c) of the Agreement or a change in the percentage of Prescription Drug Rebates retained by PBM.

3. PBM will use reasonable efforts to negotiate and collect Prescription Drug Rebates from manufacturers. PBM shall not be required to institute litigation to negotiate and collect Prescription Drug Rebates from manufacturers. If PBM or its designee does elect to bring suit to recover Prescription Drug Rebates from manufacturers, PBM shall be entitled to deduct all reasonable attorney's fees and other expenses incurred in such litigation prior to payment of the Prescription Drug Rebates to Employer. Neither Party shall be responsible to the other Party, its affiliates, directors, employees, agents, successors, or permitted assigns for any claim arising from: (i) any failure by a manufacturer to pay any Prescription Drug Rebates; (ii) any breach of an agreement relating to the transactions contemplated by or otherwise relating to this Agreement by any manufacturer; or (iii) any negligence or misconduct of any manufacturer.

4. In the event that PBM, its Vendor, and/or manufacturer identifies through audit or other means that Employer has received an overpayment or an erroneous Drug Rebate payment, Employer shall immediately refund such amounts. If Employer fails to do so, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM.

5. Prescription Drug Rebates paid pursuant to the Agreement and Exhibit A of the Pharmacy Services Schedule are intended to be treated as "discounts" pursuant to the Federal Anti-Kickback Statute set forth at 42 C.F.R. § 1320a-7b and implementing regulations.

6. PBM shall continue to provide Employer its share of the Prescription Drug Rebates under this provision until the termination of this Agreement and any applicable Claims Runout Period. PBM shall provide a final report of the Prescription Drug Rebates received attributable to Employer's Plan after the end of the Claims Runout Period. Any Prescription Drug Rebates received by PBM after the end of the Claims Runout Period shall be retained by PBM.

7. Employer acknowledges and agrees that no Prescription Drug Rebates shall be paid pursuant to Exhibit A unless and until this Pharmacy Benefit Services Schedule is fully executed.

E. **Pharmacy Base Administrative Services Fees and Expenses**

1. Employer agrees to pay PBM fees for the Pharmacy Services as set forth on Exhibit A.

2. PBM's fees for the Pharmacy Services may be renegotiated in the event of substantial changes that would increase or decrease the obligations or costs of providing the Pharmacy Services, including but not limited to changes in the Pharmacy Benefit Plan, legislative changes, or postal rate changes. In addition to other rights set forth in Article 18(c) of the Agreement, PBM shall have the right to change the Pharmacy Base Administrative Services Fees or other fees provided in Exhibit A if: (a) PBM is no longer the sole provider of the Covered Prescription Services contemplated in this Pharmacy Services Schedule; (b) Employer implements an on-site pharmacy; or (c) a change in applicable law occurs resulting in an increase in the cost or amount of Covered Prescription Services under this Agreement. PBM shall provide notice to Employer of the change in the Pharmacy Base Administrative Services Fees at least 30 days prior to the implementation date of such change. Any change in the Pharmacy Base Administrative Services Fees will be effective as of the date the change occurs, even if that date is retroactive. If such change is unacceptable to Employer, either Party shall have the right to terminate this Pharmacy Services Schedule by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Pharmacy Base Administrative Services Fees, PBM shall provide a revised Exhibit A, and, if applicable, Schedule A, that will then become part of this Agreement without the necessity of securing Employer's signature on the Exhibit and, if applicable, Schedule.

3. If changes in the Pharmacy Benefit Plan are incompatible with existing systems and procedures and require PBM or its subcontractor to perform additional programming, reports, or services, such additional activities will be performed at the expense of Employer, if agreed to by PBM.

4. Employer shall be responsible for out-of-pocket production costs, travel expenses, and banking expenses incurred by PBM in carrying out implementation activities at the request of Employer.

5. PBM shall not provide or be responsible for the expenses or costs of services furnished by attorneys, actuaries, certified public accountants, investment counselors, or investment analysts, or for similar services performed for Employer. PBM shall not be authorized to engage such services or incur any expense or cost therefore without the written consent of Employer. In the event that such services are engaged by PBM at the written request of Employer, Employer shall be responsible for all costs and expense thereof, that shall be separately billed by the provider of the services or by PBM as incurred.

6. Employer agrees to pay PBM fees for Claims Runout Services described in Section 5 of Exhibit A of the Pharmacy Services Schedule.

F. **Audits.**

1. Unless otherwise provided for in this Section F of the Pharmacy Services Schedule, the parties acknowledge and agree that the Claims audit provisions set forth in Article 12 of the Agreement shall apply. However, in the event of any conflict between the Claims audit provisions in Article 12 of the Agreement and this Pharmacy Services Schedule, the terms and conditions of this Pharmacy Services Schedule shall govern with respect to the provision of Pharmacy Services.

2. Employer, must provide at least 60 days prior written notice to PBM of its intent to conduct an audit of PBM's performance under this Pharmacy Services Schedule to ensure compliance with the Agreement and applicable laws. The scope of an audit including time, place, type and duration of all audits must be reasonable, agreed to by PBM, and in accordance with PBM's audit procedures and guidelines. Onsite audits and access to claims processing systems will not be permitted.

3. Any Employer requests for a third party auditor to audit will constitute Employer's direction and authorization to PBM to disclose Employer-specific information, including Member information and PHI, to Employer's auditor. PBM will provide Employer's auditor with access to all applicable Employer-specific information reasonably necessary to determine the accuracy of Claims payments and verify PBM's performance under this Pharmacy Services Schedule, subject to PBM's third party confidentiality obligations; provided, however, any other documentation requested during the course of an audit not in the audit scope or necessary for the audit, will be provided at PBM's discretion.

4. Employer shall not be permitted to audit any contract between PBM, its Vendors, subcontractors, or manufacturers.

G. **Termination.** In addition to the provisions in Article 19 of this Agreement,

1. Either Party may terminate this Pharmacy Services Schedule by giving 90 days notice prior to the date of the termination.

2. This Pharmacy Services Schedule shall terminate on the date the Agreement is terminated unless otherwise agreed to by the Parties. If the Parties agree to continue the Pharmacy Services Schedule after termination, applicable provisions of the Agreement shall remain in effect until a new agreement is reached by the Parties.

3. This Pharmacy Services Schedule shall terminate on the effective date of any governmental body's action that prohibits all activities contemplated under this Pharmacy Services Schedule.

4. Following termination of only this Pharmacy Services Schedule, the remainder of the Agreement shall continue in full force and effect during the Agreement Period. Termination of this Pharmacy Services Schedule will not terminate the rights or obligations of either Party arising out of the period during which this Agreement was in effect.

5. In the event of termination of this Pharmacy Services Schedule, PBM shall not be responsible for notifying Members of such termination or of the procedure to be followed to retain or obtain Plan coverage.

6. Upon notice of termination of this Pharmacy Services Schedule for any reason other than for non-payment of amounts due under this Schedule, the Parties will mutually develop a transition plan that includes but is not limited to: (1) a schedule of transition activities and timelines for completion; (2) a detailed description of the respective roles of PBM and Employer; and (3) such other information and planning as necessary to ensure that the transition takes place according to an agreed upon schedule and with minimum disruption to Members. The transition plan shall be subject to written approval by both Parties.

7. Unless mutually agreed to in writing by the Parties, upon termination of this Pharmacy Services Schedule, Employer shall cease adoption and use of PBM's Formulary as part of its Plan and agrees that it shall not copy, distribute, or sell PBM's Formulary.

IN WITNESS WHEREOF, the Parties have executed this Schedule to be effective as of the Effective Date.

Augusta-Richmond County

By: _____

Title: _____

Date: _____

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: _____

Title: Vice President, Sales and Client Management

Date: October 9, 2023

CarelonRx, Inc.

By: _____

Title: _____

Date: _____

EXHIBIT A - FEES & EXPENSES
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Exhibit A shall govern the Agreement Period from 1/1/2023 through 12/31/2027 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Section 1. Effective Date and Renewal Notice

This Agreement Period shall be from 12:01 a.m. 1/1/2023 to the end of the day of 12/31/2027.

Paid Claims shall be processed pursuant to the terms of this Pharmacy Services Schedule when incurred and paid as follows:

- Incurred from 1/1/2023 through 12/31/2027 and
- Paid from 1/1/2023 through 12/31/2027.

PBM shall provide any offer to renew this Pharmacy Services Schedule at least 60 days prior to the end of an Agreement Period.

Section 2. Broker and Consultant Base Compensation

Not Applicable

Section 3. Pharmacy Administrative Services Fees

Change to Administrative Services Fees. The Administrative Services Fees in Section 3 of Schedule A of the Agreement and the Pharmacy Administrative Services Fees in Section 3 of Exhibit A may be changed during the Agreement Period based upon an event in Article 18(c) of the Agreement or Section E(2) of the Pharmacy Services Schedule.

A. Pharmacy Base Administrative Services Fee

Pharmacy Base Administrative Services Fee. The Pharmacy Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee shall be:

- $1.25 per Prescription Drug Claim January 1, 2023 through December 31, 2023
- $1.25 per Prescription Drug Claim January 1, 2024 through December 31, 2024
- $1.25 per Prescription Drug Claim January 1, 2025 through December 31, 2025
- $1.25 per Prescription Drug Claim January 1, 2026 through December 31, 2026
- $1.25 per Prescription Drug Claim January 1, 2027 through December 31, 2027

B. Drug Rebate Allocation

1. PBM and/or its Vendor has negotiated programs with pharmaceutical manufacturers for drug rebates on certain Prescription Drugs dispensed to Members and has arranged for payments of such rebates to be made directly to PBM ("Drug Rebate Programs"). PBM has entered into such Drug Rebate Programs on its behalf and not on behalf of Employer, and therefore retains all rights, title, and interest to any and all actual Prescription Drug Rebates it receives from manufacturers and/or its Vendor. Such Drug Rebate Programs are not based solely on the Prescription Drug utilization of one Employer Plan, but rather are based on the Prescription Drug utilization of all individuals enrolled in PBM managed programs. The Prescription Drug Rebates are conditioned on certain Prescription Drugs being included on the Formulary that PBM requires Employer to adopt as part of its Plan. Employer shall be paid or credited a portion or the amount attributable to its actual or estimated value of Prescription Drug Rebates as described in Section 3(B) of Exhibit A.

2. PBM may receive Manufacturer Administrative Fees directly from pharmaceutical manufacturers. In addition, PBM may receive service fees from pharmaceutical manufacturers for providing services (e.g., Provider and Member education programs that promote clinically appropriate and safe dispensing and use of Prescription Drugs). For purposes of this Pharmacy Services Schedule, service fees received by PBM shall not be considered Prescription Drug Rebates. For purposes of this Pharmacy Services Schedule, Manufacturer Administrative Fees received by PBM shall be considered Prescription Drug Rebates.

3. Minimum Pharmacy Rebate Offset and Guarantee: PBM shall transfer to Anthem an amount that will be used by Anthem to reduce the Base Administrative Services Fee set forth in Section 3(A) of Schedule A. The amount of such offset, also referred to as the Pharmacy Rebate Offset is set forth in Section 3(A) of Schedule A. PBM shall reconcile each quarter the Pharmacy Rebate Offset that Employer received against the amount representing 100% of the actual Prescription Drug Rebates PBM has guaranteed in the Prescription Drug Rebate Performance Guarantee as defined in Exhibit C. If the actual Prescription Drug Rebate amount the PBM receives is greater than the Pharmacy Rebate Offset the Employer received from PBM, then PBM shall return the difference between the actual Prescription Drug Rebate amount and the Pharmacy Rebate Offset to the Employer. Provided, however, if the total Prescription Drug Rebates Performance Guarantee as defined in Exhibit C, exceeds the amount described herein, the PBM will pay the Employer the difference at annual true up.

4. Medical Drug Rebates.

   From January 1, 2023 through December 31, 2023:

   PBM shall pay to Employer 100% of the Medical Drug Rebates earned through participation in the applicable pharmacy program and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers subject to any deduction for shared savings under Section 3(C) of this Exhibit A. The actual rebate amount will be determined by reconciling the Medical Drug Rebate amount payable against shared savings on an annual basis.

   From January 1, 2024 through December 31, 2024:

   PBM shall pay to Employer 100% of the Medical Drug Rebates earned through participation in the applicable pharmacy program and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers subject to any deduction for shared savings under Section 3(C) of this Exhibit A. The actual rebate amount will be determined by reconciling the Medical Drug Rebate amount payable against shared savings on an annual basis.

   From January 1, 2025 through December 31, 2025:

   PBM shall pay to Employer 100% of the Medical Drug Rebates earned through participation in the applicable pharmacy program and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers subject to any deduction for shared savings under Section 3(C) of this Exhibit A. The actual rebate amount will be determined by reconciling the Medical Drug Rebate amount payable against shared savings on an annual basis.

   From January 1, 2026 through December 31, 2026:

   PBM shall pay to Employer 100% of the Medical Drug Rebates earned through participation in the applicable pharmacy program and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers subject to any deduction for shared savings under Section 3(C) of this Exhibit A. The actual rebate amount will be determined by reconciling the Medical Drug Rebate amount payable against shared savings on an annual basis.

From January 1, 2027 through December 31, 2027:

PBM shall pay to Employer 100% of the Medical Drug Rebates earned through participation in the applicable pharmacy program and attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers subject to any deduction for shared savings under Section 3(C) of this Exhibit A. The actual rebate amount will be determined by reconciling the Medical Drug Rebate amount payable against shared savings on an annual basis.

Employer shall not be eligible to earn Medical Drug Rebates as of the effective date of Employer elimination or reduction of any of the following pharmacy programs: Right Drug Right Channel - Pharmacy to Medical, Right Drug Right Channel - Medical to Pharmacy, Site of Care, and Medical Pharmacy Specialty Drug Review.

C. Other Fees or Credits

Fee for Pharmacy Prior Authorization. $55.00 per authorization.

Fee for Step Therapy. PBM shall charge a fee of $0.30 per pharmacy Claim.

Fee for Quantity Limits. PBM shall charge a fee of $0.55 per pharmacy Claim for applying frequency and quantity limits to certain Prescription Drugs.

Fee for Pharmacy Physician Review. $800.00 per review

Fee for Vaccine Administration. PBM shall charge a fee for the administration of vaccines at a retail pharmacy location of $2.50 per vaccine.

Fee for Custom Communications. PBM shall charge a fee of $2.00 per custom communication requested by the Employer.

Fee for Member-Submitted Claims. PBM shall charge a fee of $2.50 per Claim for each Member-submitted Claim.

Fee for Clinical Care Gap Outreach Program (Enhanced) (also referred to as Rx Care Nexus Program): PBM shall charge a fee of $0.60 per pharmacy Claim for additional clinical scope and chronic conditions managed, increased actionable interventions, and expansion of clinical programs such as: behavioral health management, adherence outreach, new start education, Formulary alternatives, primary non-adherence, and clinical safety and efficacy.

Fee for Specialty Cost Optimization. The charge to Employer for administration and management of the Specialty Cost Optimization Program is 50% of the shared savings attained through PBM's Specialty Cost Optimization Program capped at $0.50 PMPM. PBM's shared savings fee shall be deducted from the Medical Drug Rebate due Employer. In no event will PBM charge Employer a shared savings fee if the Medical Drug Rebate due to the Employer is less than the shared savings fee due to PBM.

Fee for Pharmacy Network Audit. The charge to Employer is 25.00% of the total amount recovered from periodic onsite or field audits of Network Pharmacies, including, but not limited to, audits to determine compliance with billing requirements and the terms and conditions of the Network Pharmacy agreements. These audits are separate and distinct from Claims processing and financial accuracy audits.

Fee for Employer Reporting – Base Package. PBM's Base Package is included at no cost and includes access to RxGuide (unlimited). All custom reporting requests will be charged at $150 per hour of time needed to generate customized ad hoc reports.

PBM Services Early Termination Fee. In consideration of the special pricing arrangements under this Agreement, Employer shall pay PBM an Early Termination Fee, as described below, if Employer terminates the pharmacy portion of the Plan before the end of the Performance Period (as defined in Exhibit C) for any reason other than PBM's failure to comply with a material duty or obligation related to the administration of pharmacy benefits under this Agreement.

The Early Termination Fee shall be calculated by multiplying $1.50 PSPM by (i) the average monthly Subscriber count for the 6 months immediately prior to termination; multiplied by (ii) the number of months remaining in the Performance Period. If Employer intends to terminate the pharmacy portion of the Plan before the end of the Performance Period, Employer must provide PBM with the required termination notice under Section G of the Pharmacy Services Schedule. In the event Employer terminates the pharmacy portion of the Plan before the end of the Performance Period, the applicable Early Termination Fee will be billed to Employer with the amount due within 30 days of the termination date.

Fee for Member Communications. PBM shall charge a fee of $1.30 per letter for the following programs:

- Non-FDA Approved Drug Block
- Re-Labeler Program
- Safety Communications/Drug Recalls and Withdrawals
- New Implementation Formulary Disruption Letters
- Commercial Formulary Member Notifications (Includes Newly Available Generic Notification When Required By Law)

Invoices for Prescription Drug Claims: When PBM invoices Employer for retail Network Prescription Drug Claims, the amount billed will reflect pricing that is equal to the amount that is paid to pharmacies for those Claims.

Pharmacy Plan Implementation Program Credit. PBM shall provide a credit totaling $50,000.00 to Employer for use from January 1, 2023 through December 31, 2023 as a credit to defray applicable implementation costs incurred. This full credit amount only applies if Employer's enrollment exceeds 2,255 Subscribers from January 1, 2023 through December 31, 2023. If enrollment is below 2,255 Subscribers, the credit amount decreases proportionally. After December 31, 2023, if enrollment is below 2,255 Subscribers, PBM shall not require that Employer refund any previously paid credits. For any applicable services outlined below that are provided by a vendor, Employer's request to PBM for application of credit for vendor's services must be accompanied by copies of vendor's invoices to Employer in order for PBM to apply a credit to Employer's weekly Claims invoice. PBM will not reimburse Employer's vendors directly. Services from a vendor that is a direct competitor of PBM are not eligible for reimbursement.

The credit can be used for the following implementation related purposes:

- Custom communication services provided by either PBM or an outside vendor;
- Implementation expenses;
- Claims audit equal to actual billed charges*;
- Clinical audit equal to actual billed charges*;
- Wellness programs purchased by Employer from PBM; or
- Additional reporting or data feeds equal to the actual billed charges.

Personnel expenses, programming expenses that are not directly related to administration of health care benefits and travel are not reimbursable. Employer acknowledges and agrees that PBM will report the payment or credit where required by law to do so.

It is the intention of the Parties that, for the purposes of the Federal Anti-Kickback Statute, this Plan Implementation Program Credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A). To the extent required by laws or contractual commitment, Employer agrees to fully and accurately disclose and report any such discount, rebate, credit or allowance to Medicare, Medicaid or other government health care program as a discount against the price of the Prescription Drugs provided under this Pharmacy Services Schedule.

Flat Fee - Plan Program Credit. PBM will provide a Plan Program Credit in the amount of $20,000.00. The Plan Program Credit is only available from 1/1/2023 through 12/31/2027 and, subject to PBM approval, may be applied towards any combination of the following:

- Plan Communications
- Wellness Programs
- Implementation Audit
- Claims Audit
- Additional Reporting or Data Feeds
- and Other – such as Innovation or Technology

The Plan Program Credit does not apply towards programming expenses that are not directly related to administration of health care benefits, personnel expenses, travel, and incentives.

Employer shall submit all requests for reimbursement under the Plan Program Credit noted above to PBM with documentation of Employer expenses and costs no later than thirty (30) days after the end of the then current contract year. PBM shall reimburse Employer within 30 days of receipt of Employer's request and supporting documentation. Any funds remaining sixty (60) days after the end of then current year in the Plan Program Credit allowance will be retained by PBM.

It is the intention of the Parties that, for the purposes of the Federal Anti-Kickback Statute, this Plan Program Credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A). To the extent required by laws or contractual commitment, Employer agrees to fully and accurately disclose and report any such discount, rebate, credit or allowance to Medicare, Medicaid or other government health care program as a discount against the price of the Prescription Drugs provided under this Pharmacy Services Schedule.

Unidentified Recoveries. PBM shall retain any funds received through recovery processes that are paid to PBM and, following good faith and reasonable efforts, cannot be tied to a specific Employer or Member.

Section 4. Pharmacy Administrative Services Fees and Paid Claims Billing Cycle and Payment Method

Billing cycles and payment methods are contained in Schedule A.

Section 5. Claims Runout Services

A. Claims Runout Period

Claims Runout Period shall be for the 12 months following the date of termination of this Pharmacy Services Schedule.

B. Claims Runout Administrative Services Fee

Pharmacy:

The fee for Claims Runout Services will be waived. Fees in Section 3(C) of this Exhibit A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to the Pharmacy Services Schedule Period but were not billed during the Pharmacy Services Schedule Period, will be billed and payable during the Claims Runout Period. Payment is due to PBM by the Invoice Due Date.

IN WITNESS WHEREOF, the Parties have executed this Exhibit to be effective as of the pharmacy Agreement Period.

Augusta-Richmond County

By: _____

Title: _____

Date: _____

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. dba Anthem Blue Cross and Blue Shield

By: Robert Fear

Title: Vice President, Sales and Client Management

Date: October 9, 2023

CarelonRx, Inc.

By: _____

Title: _____

Date: _____

EXHIBIT B - PHARMACY SERVICES
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

The following is a list of standard services that PBM will provide under this Pharmacy Services Schedule for the Pharmacy Administrative Services Fees set forth on Section 3 of Exhibit A. These services will be furnished to Employer in a manner consistent with PBM's standard policies and procedures for self-funded plans. PBM may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also set forth on Exhibit A.

Prescription Benefit Services

- Mail Order Pharmacy
- Specialty Pharmacy Services
  - Prescription eServices
  - Pharmacy locator
  - Online Formulary
- Point of sale Claims processing (not including pharmacy COB services)
- Mail Order Claims processing
- Mail Order call center with toll free number
- Mail Order regular shipping and handling
- Standard management reports
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Pharmacy help desk with toll free number
- Daily Claims review audits of Network Pharmacies
- Assistance in determining "creditable prescription drug coverage" under Medicare Part D
- Integration of medical and pharmacy Claims data for proactive prior authorizations (i.e., a Member's diagnosis from medical Claims is incorporated into the pharmacy Claim system to seamlessly approve prior authorizations where diagnoses are required)

EXHIBIT C - PERFORMANCE GUARANTEES
OF THE PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Exhibit C provides certain guarantees pertaining to PBM's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for each year in the period from 1/1/2023 through 12/31/2027 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Exhibit C and made a part of this Exhibit C. This Exhibit shall supplement and amend the Pharmacy Benefits Administrative Services Schedule between the Parties. If there are any inconsistencies between the terms of the Agreement and this Exhibit C, the terms of this Exhibit C shall control. If there are any inconsistencies between the terms contained in this Exhibit, and the terms contained in any of the Attachments to this Exhibit C, the terms of the Attachments to this Exhibit C shall control.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachments to this Exhibit C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Allocation. The term Allocation is the percent of total Amount at Risk to each Performance Guarantee.
2. Amount at Risk. The term Amount at Risk means the amount PBM may pay if it fails to meet the target(s) specified under the Performance Guarantee.
3. Measurement Period. The term Measurement Period is the period of time under that PBM's performance is measured, that may be the same as or differ from the period of time equal to the Performance Period.
4. Performance Category. The term Performance Category describes the general type of Performance Guarantee.
5. Reporting Period. The term Reporting Period refers to how often PBM will report on its performance under a Performance Guarantee.
6. Service Feature. The term Service Feature is a service standard stipulated and defined to be guaranteed.

B. PBM shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Exhibit C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by PBM shall be based on PBM's then current measurement and calculation methodology, that shall be available to Employer upon request.

C. Any audits performed by PBM to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

D. If the Agreement is not executed, PBM shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Exhibit C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by PBM or its Vendors.

F. If Employer terminates the Agreement or the Pharmacy Services Schedule between the Parties prior to the end of the Performance Period, or if the Agreement or the Pharmacy Services Schedule is terminated for non-payment, then Employer shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

G. Guarantees apply only as long as there are at least 61,164 Annualized Adjusted Prescription Drug Claims.

H. PBM reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Exhibit C upon the occurrence, in PBM's determination, of any of the following:

1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by PBM or the measurement of a Performance Guarantee;
2. an increase or decrease of 20.00% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Pharmacy Services Schedule;

3. a failure by Employer to implement its responsibilities under the clinical management programs that are part of the Plan;
4. a failure by Employer to adopt the Formulary;
5. a change in the proportionate mix of Employer's retail and mail order Prescription Drug Claims of more than 20.00% (including but not limited to a change in the overall Members' percentage of usage of retail versus Mail Order Pharmacies);
6. a change in pharmacy utilization patterns of more than 20.00% (including but not limited to a change in the overall Members' percentage of usage of Brand Drugs versus Generic Drugs versus Specialty Drugs);
7. a change that results in PBM no longer being the exclusive source of Prescription Drug Rebates for Employer's Plan;
8. the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, that was not disclosed or known by PBM as of the effective date of this Attachment to Exhibit C;
9. PBM is no longer the sole administrator for Employer's Prescription Drug Plan;
10. a government action or major change in pharmaceutical industry practices that eliminates or materially reduces the manufacturer Drug Rebate program; or
11. a failure by Employer to maintain the selected Formulary and applicable clinical edits or Employer has excepted Members from application of the selected Formulary and clinical edits that prevent full savings from accruing.
12. product offering decisions by drug manufacturers that result in: (a) a reduction of Prescription Drug Rebates, including the introduction of a lower cost alternative product which may replace an existing Brand Drug that is eligible for Prescription Drug Rebates; (b) an unexpected launch of a Brand Drug and/or Generic Drug; (c) unforeseen delays in expected Brand Drug and/or Generic Drug launches; or (d) a Brand Drug converted to over-the-counter ("OTC") status, recalled or withdrawn from the market.
13. A failure by Employer to maintain and implement a Plan design wherein non-preferred drugs have either a $15.00 higher Copayment or a 50% higher coinsurance (ex: preferred = 30%, non-preferred = 45%) than preferred Prescription Drugs.

Should there be a change in occurrence as indicated above and these changes negatively impact PBM's ability to meet the Performance Guarantees, PBM shall have the right to modify the Performance Guarantees contained in the Attachments.

I. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Exhibit C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances that are beyond the control of PBM, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, pandemics, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

J. As determined by PBM, Performance Guarantees may be measured using either aggregated data or Employer-specific Data. The term Employer-specific Data means the data associated with Employer's Plan that has not been aggregated with other Employer data. Performance Guarantees will specify if Employer-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

K. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if Employer participates in the program and its components for the entirety of the Measurement Period associated with the Performance Guarantee.

L. Employer acknowledges and agrees that each Performance Guarantee will be measured based on the Measurement Period as described in the Attachments to this Exhibit C and prorated to account for Employer specific Effective or renewal dates when measured using aggregated data. The Performance Guarantee will begin on the Employer Effective Date. However, if the Employer terminates the Pharmacy Benefits Schedule before the end of a Measurement Period, the Performance Guarantee measured will be based on the entire Measurement Period during which the termination occurred.

Section 2. Payment

A. If PBM fails to meet any of the obligations specifically described in a Performance Guarantee described in the Attachments to this Exhibit C, PBM shall pay Employer the amount set forth in the Section describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees that will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, PBM has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Exhibit C against any amounts owed by Employer to PBM under: (1) any Performance Guarantees contained in the Attachments to this Exhibit C; or (2) the Agreement.

C. Notwithstanding the foregoing, PBM's obligation to make payment under the Performance Guarantees is conditioned upon Employer's timely performance of its obligations provided in the Agreement and the Pharmacy Schedule, in this Exhibit C and the Attachments, including providing PBM with the information or data required by PBM in the Attachments. PBM shall not be obligated to make payment under a Performance Guarantee if Employer or Employer's vendor's action or inaction adversely impacts PBM's ability to meet any of its obligations provided in the Attachments related to such Performance Guarantee, that expressly includes but is not limited to Employer or its vendor's failure to timely provide PBM with accurate and complete data or information in the form and format expressly required by PBM.

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

E. PBM shall reconcile the Pricing Performance Guarantees described in Attachment 1 to Exhibit C on an annual basis, calculated in accordance with Section 4 of this Exhibit C. The reconciliation for each year of the Performance Period will be submitted to Employer within 90 days after the end of the Measurement Period and any resulting value shortfall shall by paid by PBM to Employer within 30 days following submission of the reconciliation report.

F. PBM shall pass through rebate amounts guaranteed by PBM as described in Attachment 1 to Exhibit C on a quarterly basis in accordance with Section 3 of this Exhibit C to Employer within 120 days after the end of the calendar quarter. PBM will pass through additional collections from prior quarters in subsequent quarterly disbursements. PBM shall reconcile the Performance Guarantees for each rebate Performance Guarantee described in Attachment 1 to Exhibit C on an annual basis, calculated in accordance with Section 3 of this Exhibit C. The reconciliation for each Measurement Period will be submitted to Employer within 10 months following the end of the Measurement Period and any resulting value shortfall shall be paid by PBM to Employer within 30 days following the reconciliation. Prescription Drug Rebates collected post annual reconciliation attributable to the reconciled Measurement Period shall be retained by PBM.

Section 3. Prescription Drug Rebate Performance Guarantees

A. Any payment due to Employer under a rebate Performance Guarantee will be offset by favorable results achieved in any other rebate Performance Guarantee.

B. This Performance Guarantee will be determined by comparing the total Prescription Drug Rebates Performance Guarantee to the Prescription Drug Rebates credited to the Employer pursuant to the Pharmacy Services Schedule and Section 3(B) of Exhibit A. If the total Prescription Drug Rebates Performance Guarantee exceeds the Prescription Drug Rebates credited to the Employer, PBM will credit Employer the difference.

C. For purposes of these Performance Guarantees, the following Claims will not be included in the calculation:

- Medicare Part D Claims;
- 340B Claims;
- Vaccines
- Supplies;
- Prescriptions filled through the Employer's on-site pharmacy;
- Single Source Generics;
- Compound Drugs;
- Authorized Generics;

- Brand MAC;
- Over-the-counter ("OTC") drugs;
- Member-submitted Claims;
- Coordination of Benefits (COB)/ Secondary Claims;
- Limited Distribution Drugs;
- New to Market Drugs;
- Biosimilar Drugs;
- Out-of-Network Claims;
- Indian Health Claims;
- Long Term Care Claims;
- IV Infusion Drugs
- Military VA Claims;
- Non-Formulary Claims;
- Multi-Source Brands;
- Specialty Drug Starter Fill;

D. The Parties acknowledge and agree that Prescription Drug Rebate Guarantees may be revised in the event of product offering decisions by drug manufacturers that result in: (a) a reduction of Prescription Drug Rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable Brand Drug; (b) an unexpected launch of a Brand Drug and/or Generic Drug; (c) unforeseen delays in expected Brand Drug and/or Generic Drug launches; or (d) a Brand Drug converted to over-the-counter ("OTC") status, recalled or withdrawn from the market.

- A change in Employer's ERISA status or failure of Employer to provide accurate ERISA status.

E. Prescription Drug Rebate Guarantees do not apply to Paid Claims processed through institutional, hospital or staff model/hospital pharmacies where the pharmacy, most likely, has its own manufacturer contracts (rebate or purchase discounts), or through pharmacies that participate in the Federal government pharmaceutical purchasing program.

F. COVID test kits, COVID anti-viral medication and COVID vaccines are excluded from the Prescription Drug Rebate Guarantees under this Pharmacy Services Schedule.

Section 4. Prescription Drug Pricing Performance Guarantees

A. To determine any payment due to Employer under these Prescription Drug Pricing Performance Guarantees, each Performance Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for:

- Retail pharmacy
- Mail Order
- Retail 90
- Specialty Drugs

(each such subset of Paid Claims for Prescription Drugs is referred to as a "Pricing Guarantee Category").

Each guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Performance Guarantee within that Pricing Guarantee Category. Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a Retail Pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Performance Guarantee provided in this Pharmacy Services Schedule to determine if the Performance Guarantee is met.

B. Any payment due to Employer under any Performance Guarantee within a Pricing Guarantee Performance Category will be offset by favorable results achieved in any other guarantee regardless of the Pricing Guarantee Performance Category.

C. The following conditions apply to this Performance Guarantee:

1. This Performance Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.
2. Drugs identified at the time the prescription is filled as Single Source Generics, will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
3. Drugs identified at the time the prescription is filled as Brand MAC, will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
4. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 3 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
5. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 4 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
6. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 5 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
7. Drugs identified at the time the prescription is filled as Dispense As Written Claims with code 6 will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
8. Member Pay the Difference Claims will be included in the Generic Discount and Generic Dispensing Fee Performance Guarantees.
9. "Discount" and "Dispensing Fee" shall refer to and mean effective rate/aggregate pricing, not per Paid Claim discount rates or dispensing fee.
10. COVID test kits, COVID anti-viral medication and COVID vaccines are excluded from the Prescription Drug Pricing Guarantees under this Pharmacy Services Schedule.
11. Claims for Covered Prescription Services delivered by a Retail Pharmacy to a Member will be included in the Retail Pharmacy Network Pricing Guarantees and not within the Mail Order Pharmacy Pricing Guarantees.

D. PBM reserves the right to make changes to any of the Prescription Drug Pricing Performance Guarantees provided in the Attachments to this Exhibit C upon the occurrence, in the PBM's determination, of the following:

1. The percentage of Claims subject to a consumer driven health plan (CDHP) is materially different from the assumption used to develop the Prescription Drug Pricing Performance Guarantee.

E. The following Claims will be excluded from this Performance Guarantee:

- Medicare Part D Claims;
- 340B Claims;
- Vaccines
- Supplies;
- Prescriptions filled through the Employer's on-site pharmacy;
- Claims paid on the basis of U&C charges;
- Compound Drugs;
- Authorized Generics;
- Over-the-counter ("OTC") drugs
- Member-submitted Claims;
- Coordination of Benefit (COB) Claims/Secondary Claims;
- Out-of-Network Claims;
- Indian Health Claims;

- Long Term Care Claims;
- IV Infusion Drugs;
- Military VA Claims;

F. In the event that there are court or government imposed or industry wide or pricing source initiated changes in the AWP reporting source or source changes in the methodology used for calculating AWP, including, without limitation, changes in the mark-up factor used in calculating AWP (collectively, the "AWP Changes"), the terms of any financial relationship between the Parties that relate to AWP will be modified by PBM such that the value of AWP for the purpose of such relationship(s) will have the same economic equivalence in the aggregate to the value used by the Parties prior to the AWP Change. The intent of this provision is to preserve the relative economics of both Parties for such financial relationships based upon AWP to that which existed immediately prior to the AWP Change.

In the event that the AWP pricing benchmark used by PBM's PBM hereunder is replaced with another benchmark calculation, PBM may switch to such new pricing benchmark. If a change to Pricing Guarantees is deemed necessary PBM will provide written notice of new pricing terms at least 30 days before the effective date of the change.

ATTACHMENT 1 TO EXHIBIT C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

Pharmacy Performance Guarantees

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 1/1/2023 through 12/31/2027. This Attachment is intended to supplement and amend the Agreement between the Parties. The Measurement Period for these Performance Guarantees will be annual, unless otherwise specified herein. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

Pharmacy Performance Guarantee	Measurement and Reporting Period
Prescription Drug Rebate Guarantees **Minimum Drug Rebates:** (a) The Prescription Drug Rebates Employer receives from PBM will not be less than the following amounts ("Total Drug Rebates Guarantee"): **NATIONAL FORMULARY** **NON-SPECIALTY DRUGS** **BRAND NAME PRESCRIPTION DRUGS** (1) An amount equal to the sum of $354.73 (2023), $389.68 (2024), $426.73 (2025), $435.60 (2026), $446.68 (2027) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Retail Pharmacies for a supply of less than 84 days; plus (2) An amount equal to the sum of $607.04 (2023), $650.71 (2024), $687.96 (2025), $709.01 (2026), $726.19 (2027) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Retail Pharmacies for a supply of 84 days or greater. (3) An amount equal to the sum of $894.92 (2023), $919.22 (2024), $1,000.45 (2025), $1,029.62 (2026), $1,053.09 (2027) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at Mail Order Pharmacies. **SPECIALTY DRUGS** **BRAND NAME PRESCRIPTION DRUGS** (1) An amount equal to the sum of $2,976.39 (2023), $3,335.31 (2024), $3,686.61 (2025), $3,787.27 (2026), $3,821.35 (2027) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at retail and mail order Pharmacies	**Measurement Period** Annual **Reporting Period** Annual

Pharmacy Performance Guarantee	Measurement and Reporting Period
Prescription Drug Pricing Guarantees **Prescription Drug Pricing:** (a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories: **BASE RETAIL PHARMACIES** **RETAIL PHARMACIES** The guarantees for Retail Pharmacies will be the following amounts: 1. Brand Discount: AWP minus 19.25% (2023), 19.35% (2024), 19.45% (2025), 19.55% (2026), 19.65% (2027) 2. Brand Dispensing Fee: $0.50 (2023), $0.50 (2024), $0.50 (2025), $0.50 (2026), $0.50 (2027) 3. Generic Discount: AWP minus 85.00% (2023), 85.15% (2024), 85.30% (2025), 85.45% (2026), 85.60% (2027) 4. Generic Dispensing Fee: $0.50 (2023), $0.50 (2024), $0.50 (2025), $0.50 (2026), $0.50 (2027) **RETAIL 90 PHARMACY PHARMACIES** The guarantees for RETAIL 90 Pharmacies dispensing 84-90 day supplies will be the following amounts: 1. Brand Discount: AWP minus 21.50% (2023), 21.60% (2024), 21.70% (2025), 21.80% (2026), 21.90% (2027) 2. Brand Dispensing Fee: $0.40 (2023), $0.40 (2024), $0.40 (2025), $0.40 (2026), $0.40 (2027) **MAIL ORDER OPTIONS** **MAIL ORDER PHARMACY** The guarantees for mail order will be the following amounts: 1. Brand Discount: AWP minus 24.00% (2023), 24.10% (2024), 24.20% (2025), 24.30% (2026), 24.40% (2027) 2. Brand Dispensing Fee: $0.00 (2023), $0.00 (2024), $0.00 (2025), $0.00 (2026), $0.00 (2027) 3. Generic Discount: AWP minus 87.50% (2023), 87.65% (2024), 87.80% (2025), 87.95% (2026), 88.10% (2027) 4. Generic Dispensing Fee: $0.00 (2023), $0.00 (2024), $0.00 (2025), $0.00 (2026), $0.00 (2027)	**Measurement Period** Annual **Reporting Period** Annual

Pharmacy Performance Guarantee	Measurement and Reporting Period
SPECIALTY SERVICE OPTIONS **SPECIALTY DRUGS** **The guarantees for Specialty DRUGS will be the following amounts:** 1. Discount: AWP minus 22.50% (2023), 22.60% (2024), 22.70% (2025), 22.80% (2026), 22.90% (2027) 2. Dispensing Fee: $0.00 (2023), $0.00 (2024), $0.00 (2025), $0.00 (2026), $0.00 (2027)	

ATTACHMENT 2 TO EXHIBIT C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

Pharmacy Operations Guarantees

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 01/01/2023 through 12/31/2027. This Attachment is intended to supplement and amend the Agreement between the Parties. The Measurement Period for these Performance Guarantees will be annual, unless otherwise specified herein. Annual and quarterly reporting periods indicated below are based on calendar years and calendar quarters. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement. Payment by PBM to Employer shall be made within 90 days following the reconciliation. The amount at risk for the Pharmacy Operations Guarantees is $50,000.00.

Performance Category	Guarantee	Reporting Period	Reporting Level	Amount at Risk Allocation
Claims Processing - TAT for Member Submitted Claims - No Intervention Required	Member submitted claims not requiring intervention shall be processed within 5 business days.	Quarterly	BOB	09.09%
Claims Processing - TAT for Member Submitted Claims - Intervention Required	Member submitted claims with issues or requiring intervention shall be processed within 10 business days.	Quarterly	BOB	09.09%
Member Services - Phone Abandonment Rate	PBM guarantees calls to Member Services toll-free phone lines shall have an abandonment rate of 02.00% or less.	Quarterly	BOB	09.09%
Member Services - Phone Speed of Answer	For inbound calls to PBM Member Services toll-free phone lines, PBM shall answer 100% of inbound calls within an average of 25 seconds (including calls routed to an IVR).	Quarterly	BOB	09.09%
Member Services - Call Blockage	PBM will have a call blockage rate of no greater than 0%. Carrier will have a call blockage rate of no greater than 01.00%; provided that in no case shall PBM instruct or permit carrier to block calls.	Quarterly	BOB	09.09%
PBM Mail Order Pharmacy - Dispensing Accuracy	PBM accuracy in dispensing prescriptions from its PBM Mail Order Pharmacies (correct drug, correct strength, correct dosage form, correct labeling, and correct member) shall be at least 99.995%.	Quarterly	BOB	09.09%
PBM Mail Order Pharmacy - TAT - No Intervention Required	PBM's Mail Order Pharmacies will dispense and ship all clean prescriptions (those not requiring intervention or clarification) within an average of 1 business day(s).	Quarterly	BOB	09.09%

Performance Category	Guarantee	Reporting Period	Reporting Level	Amount at Risk Allocation
PBM Mail Order Pharmacy - TAT - Intervention Required	PBM's Mail Order Pharmacies will dispense and ship all nonclean prescriptions (those requiring intervention or clarification) for covered drugs to members within an average of 4 business days.	Quarterly	BOB	09.09%
PBM Specialty Pharmacy - On-time Delivery of Scheduled Orders	PBM Specialty Pharmacy guarantees 99.25% on-time delivery of scheduled orders.	Quarterly	BOB	09.09%
Pharmacy Network - Pharmacy Access	Subject to the availability of any active retail pharmacy within the specified area, the PBM National Network shall include a pharmacy within 1 mile(s) of the residence of at least 98.50% of urban Members, within 3 miles of the residence of at least 98.50% of suburban Members, and within 10 miles of the residence of at least 98.50% of rural Members, when there is an active retail pharmacy within 1 mile(s) of urban Members residences, within 3 miles of suburban Members residences, and within 10 miles of rural Members residences, as measured on a calendar year and Employer specific basis.	Annually	BOB	09.09%
System - Claims Processing System Availability	PBM on-line claims processing system shall be available to accept and process claims a minimum of 99.98% of the time excluding any system maintenance periods.	Quarterly	BOB	09.09%

ATTACHMENT 3 TO EXHIBIT C
Performance Guarantees
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

Clinical Care Gap Outreach Program (Enhanced) (also referred to as Rx Care Nexus Program)

Performance Guarantee

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 01/01/2023 through 12/31/2027 ("Performance Period"). This Attachment is intended to supplement and amend the Agreement between the Parties. The Performance Period for this Performance Guarantee will be on a 12 month contract year basis, unless otherwise specified herein. The annual reporting period is based on a twelve 12 month contract year.

For purposes of this Attachment to Exhibit C, Measurement Period shall be defined as the Performance Period timeframe plus an additional 6 months after the end of the applicable Performance Period. The additional 6 months is required to ensure Claims from the Performance Period are fully settled and to fully evaluate the aggregate gross savings realized from the Claims incurred during the Performance Period.

This Performance Guarantee is guaranteed upon offer and acceptance of: 1) the Rx Care Nexus Program as set forth in Exhibit A of this Pharmacy Schedule; and 2) renewal of the medical portion of the Agreement. Any payment by PBM to Employer shall be made within 30 days following the reconciliation.

This Performance Guarantee is conditioned upon Employer maintaining at least 1,000 enrolled Members on average during the Measurement Period.

A. Administration of Guarantee

1. The Rx Care Nexus Program includes interventions around adherence outreach for both non-compliant and new to therapy patients as well as patient and Provider outreach when lower-cost, clinically appropriate therapeutic equivalents are available for targeted drugs.
2. The pricing for the Rx Care Nexus Program as set forth in Exhibit A of this Pharmacy Services Schedule is based on Employer agreeing to implement all of the current conditions in the Rx Care Nexus Program: asthma/COPD, behavioral health conditions, diabetes, cardiovascular conditions, hyperlipidemia, hypertension, gastroesophageal reflux disease, osteoporosis, seizure disorders.
3. PBM guarantees that the aggregate gross savings realized from the Rx Care Nexus Program services over the Performance Period shall be 2:1 of the aggregate fees paid by Employer for the Rx Care Nexus Program for that Performance Period.
4. This Guarantee is contingent upon Employer providing PBM with (a) the required prior year Member, eligibility and prescription data elements prior to calculation of the Return on Investment ("ROI") if PBM was not Employer's PBM in the calendar year prior to Employer's implementation of the Rx Care Nexus Program; and (b) sufficient and accurate eligibility information, which includes current telephone numbers and email addresses of Members.
5. The ROI savings calculation shall be determined as follows:
    a. Improved Medication Adherence: For Members whose adherence to a drug therapy improves, medical savings is derived from avoided adverse medical events as a result of taking medications appropriately. These savings totals are derived from published literature and undergo actuarial review. For every gap closure, this total is applied once annually per avoided adverse event;
    b. Lower Cost Alternatives: Savings derived by difference in cost between high priced branded/nonformulary medication and lower cost generic or therapeutic alternatives. Savings is tracked at a Member/Claim level for 3 years after first alternative fill; and
    c. Medication Management: Saving derived from removing or reducing inappropriate utilization (i.e., inappropriate dose or frequency of medication therapies) and successful recommendation to guideline directed therapy (i.e., addition or change of medication therapy) to avoid adverse medical events and/or duplication of therapy. The annualized actual Claim cost savings is derived by comparing post intervention costs versus prior intervention.

    PBM will include the associated savings in its ROI Guarantee.

6. Employer acknowledges and agrees that the estimated health care savings described above in Section A.5 above reflect an estimate of the health care costs presumed to be avoided through the actions of PBM to improve medication adherence and close gaps in care associated with certain chronic conditions that typically have high levels of medical costs. This amount will be an estimate of the health care costs avoided by the Plan through the associated condition-specific savings identified in current peer reviewed clinical literature.

7. PBM reserves the right to revise the ROI Guarantee in the event of changes to Plan design or Member population that materially impacts the effectiveness of the Rx Care Nexus Program. Employer acknowledges it shall not be eligible to receive an ROI savings guarantee under any other pharmacy program, which includes adherence or closing gaps in therapy, or in addition to any other integrated savings guarantee program during any period that Employer receives an ROI savings guarantee under the Rx Care Nexus Program.

B. Measurement and Reporting

The Performance Period for this Performance Guarantee will be on a 12 month contract year basis. The annual reporting period is based on a 12 month contract year.

C. Annual Amount at Risk

The annual amount at risk shall be 100% of the Rx Care Nexus Program fee, which is set forth on Exhibit A to the Pharmacy Services Schedule.

D. Final Settlement and Reconciliation

1. At the end of the Measurement Period, there will be a settlement and reconciliation.

2. The final settlement and reconciliation will be submitted to Employer within 1 month immediately following the end of the applicable Measurement Period.

3. In the event PBM fails to meet the ROI Guarantee, PBM shall, within 1 month following submission of the final reconciliation to Employer as set forth in Section D.2 above, credit Employer for its portion of any ROI shortfall following the end of the applicable Measurement Period to the extent necessary under the ROI Guarantee. PBM's maximum obligation under the ROI shall be the amount of Rx Care Nexus Program fees paid by Employer during the applicable Performance Period.

CONFIDENTIALITY AGREEMENT
SAMPLE ONLY

This Confidentiality Agreement ("Agreement"), effective as of the last date signed below, is entered into by Elevance Health on behalf of itself and its affiliates and subsidiaries (each an "Elevance Health Company" and collectively "Elevance Health") and ("Recipient"). Elevance Health and Recipient may be referred to each as a "Party" and collectively as the "Parties".

1. **Scope**. The Parties acknowledge and agree that: (a) Elevance Health is a third party administrator and/or insurer for certain self-funded and fully insured group health plans operated on behalf of employers (each a "Plan" and collectively the "Plans"); (b) pursuant to separate agreements between the Plans and Recipient, Recipient performs services necessary for the administration of the Plans; (c) the Parties reasonably anticipate that certain Plans have requested or will request that Elevance Health provide to Recipient certain information; and (d) the terms and conditions of this Agreement shall govern Recipient's use and disclosure of Elevance Health's P/C Information (as defined herein) contained in the information provided by Elevance Health to Recipient, regardless of the Plan involved.

2. **Specifications and Permitted Purpose**. "Information" shall mean the data that Elevance Health agrees to release to Recipient pursuant to each Plan request. The Information shall conform to the specifications set forth in an Elevance Health Data Release Specifications Form, and shall be for Recipient's use only in accomplishing the particular plan administration purpose ("Permitted Purpose") identified therein. "Data Release Specifications Form" means a form substantially similar to the sample attached hereto as Exhibit A. Each Data Release Specifications Form agreed to by the Parties shall be deemed incorporated into this Agreement by reference.

3. **P/C Information**. Recipient acknowledges that the Information includes Elevance Health's Proprietary Information and Elevance Health's Confidential Information. "Elevance Health's Proprietary Information" means the non-public, trade secret, commercially valuable, or competitively sensitive information of an Elevance Health Company, or other material and information relating to the products, business, or activities of an Elevance Health Company, including but not limited to: (i) Information about the Elevance Health Company's provider networks, provider negotiated fees, provider discounts, and provider contract terms; (ii) information about the systems, procedures, methodologies, and practices used by an Elevance Health Company in performing its services such as underwriting, claims processing, claims payment, and health care management activities; and (iii) combinations of data elements that could enable information of this kind to be derived or calculated. "Elevance Health's Confidential Information" means information that an Elevance Health Company is obligated by law or contract to protect, including but not limited to: (i) Social Security Numbers; (ii) provider tax identification numbers (TINs); (iii) National Provider Identification Numbers (NPIs); (iv) provider names, provider addresses, and other identifying information about providers; and (v) drug enforcement administration (DEA) numbers, pharmacy numbers, and other identifying information about pharmacies. Elevance Health's Proprietary Information and Elevance Health's Confidential Information may be referred to together as the "P/C Information." "Elevance Health Company, " as used in the definitions set forth in this Section 3 and for purposes of this Agreement also includes a licensee of the Blue Cross and Blue Shield Association (each a "Blue Plan"), to the extent Elevance Health provides such Blue Plan's Information to Recipient.

4. **Business Associate Status and Obligations**. The Parties acknowledge and agree that: (a) the Information may include protected health information ("PHI"), as that term is defined and used in the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder at 45 C.F.R. §§ 160-164 (collectively, "HIPAA"); (b) each Party may be the Plans' Business Associate as defined and governed by HIPAA; (c) to the extent required by HIPAA, each Plan has required or will require such Party separately to enter into a Business Associate Agreement with the Plan, setting forth its obligations pursuant to 45 C.F.R 164.502(e); and (d) Recipient's use and disclosure of the P/C Information shall be governed by this Agreement; however, Elevance Health's disclosure of PHI to Recipient and Recipient's subsequent use and disclosure of the PHI separate and apart from the P/C Information shall be governed by HIPAA and the Plans' applicable Business Associate Agreements.

5. **Permitted and Non-permitted Uses**. Recipient shall use the P/C Information solely for the Permitted Purpose set forth in the applicable Data Release Specifications Form and to develop related reports and information for the applicable Plan(s). Recipient shall not, without Elevance Health's advance written consent: (a) use the P/C Information, or reports or summaries arising therefrom, for any other purpose; (b) alter the P/C Information in any manner; (c) combine the P/C Information with other data to create or add to an aggregated database for Recipient's own internal use or analysis or for use in producing analyses, reports, extracts, or summaries that will or could be made available to any person or entity other than the applicable Plan; (d) combine the P/C Information provided for a particular Permitted Purpose with P/C Information provided for another purpose; (e) sell or disclose the P/C Information to any other person or entity, including without limitation affiliates of Recipient, except as expressly permitted herein; or (f) except to accomplish the Permitted Purpose, use the P/C Information for its own internal use and analysis. The provisions of this section shall survive the termination of this Agreement.

6. **Permitted and Non-permitted Disclosures**. Recipient shall maintain the P/C Information in strict confidence, and, except as expressly permitted in this Section 6, shall only permit access to and use of the P/C Information by those of its employees and agents whose access and use are necessary to accomplish the Permitted Purpose and who are bound to maintain the P/C Information in strict confidence. Recipient may disclose the P/C Information associated with a particular request to the applicable Plan, but shall not disclose it to any other person or entity, including but not limited to another carrier or vendor, except as expressly permitted herein. At the direction of the applicable Plan, Recipient may disclose the minimum amount of P/C Information necessary to a consultant or vendor of the Plan who has entered into a confidentiality agreement with Elevance Health (or amended its existing confidentiality agreement with Elevance Health via the addition of a Data Release Specifications Form) with respect to the disclosure. Additionally, Recipient may disclose the minimum amount of P/C Information necessary to Recipient's own consultants or vendors who need to know the P/C Information to fulfill the Permitted Purpose, but only if Recipient: (a) enters into a Confidentiality Agreement with the consultant or vendor containing provisions regarding the use and disclosure of such P/C Information at least as stringent as those contained in this Agreement; and (b) provides Elevance Health with advance written notice of the identity of the consultant or vendor to whom the disclosure is to be made. Elevance Health reserves the right to require such consultant or vendor to enter into a Confidentiality Agreement with Elevance Health prior to such disclosure by Recipient.

7. **Data Protections and Security**. Recipient shall afford the P/C Information the same protections it would employ if the P/C Information were its own proprietary and confidential information, but no less than a reasonable degree of protection. Recipient shall implement reasonable and appropriate safeguards and technical controls designed to use, store, transmit, and dispose of the P/C Information in a manner intended to ensure that the P/C Information will only be used for the Permitted Purpose and that the P/C Information will be protected against reasonably anticipated threats to its security. If Recipient receives the Information from Elevance Health via electronic means such as FTP transmission, Recipient shall use reasonable physical and software-based security measures commonly used in the electronic data interchange field to protect the P/C Information. Recipient shall implement and comply with, and shall not attempt to circumvent or bypass, Elevance Health 's security procedures for the use of the electronic method of Information transmission.

8. **Systems Access**. If Elevance Health grants Recipient the right to access Elevance Health's benefits administration or other electronic systems ("Systems") in order to view, use, or facilitate the transfer of the Information, the following conditions shall apply: (a) the Systems, and any passwords, user identification codes, and documentation with respect to the Systems shall be treated as Elevance Health's Proprietary Information for purposes of this Agreement; (b) Recipient's right to access the Systems is nonexclusive and nontransferable, and Recipient shall not share, lease or otherwise transfer its right to access and use the Systems to any other person or entity; (c) all rights, title and interest in the Systems remain Elevance Health's; (d) Recipient shall only access the Information described on the applicable Data Release Specifications Form which is necessary to accomplish the Permitted Purpose; (e) all Systems access shall be achieved through the interfaces and protocols provided or authorized by Elevance Health, and Recipient shall comply with any and all reasonable restrictions and limitations pertaining to such access as shall be communicated to Recipient by Elevance Health in writing; and (f) Recipient shall immediately notify Elevance Health of any unauthorized use of Recipient's access credentials or other unauthorized access to the Systems.

9. **Providers**. Except in reports provided to the applicable Plan as permitted by this Agreement, Recipient shall not in any report, or in any other medium, refer to any provider of health care or pharmacy by name or by any other identifying reference. Recipient shall not contact any provider of health care or pharmacy concerning any information obtained pursuant to this Agreement unless the contact is coordinated by Elevance Health.

10. **Disclaimer and Exculpation**. Elevance Health provides the Information on an "as-is" basis, and makes no representation or warranty as to the accuracy or reliability of any conclusions or interpretations made by Plans and/or Recipient on the basis of the Information. Recipient releases Elevance Health and its agents and employees from any and all liability whatsoever for any erroneous, inaccurate, or incomplete Information.

11. **Disposition of the P/C Information**. Upon termination of this Agreement or the conclusion of Recipient's use of the P/C Information to accomplish the Permitted Purpose, Recipient shall destroy the P/C Information or return it to Elevance Health. Notwithstanding the foregoing, Recipient may retain the P/C Information pursuant to Recipient's reasonable record retention policies and procedures in compliance with applicable law; provided, however, that Recipient shall continue to be bound by the confidentiality terms of this Agreement with respect to the P/C Information for as long as such P/C Information is retained.

12. **Excepted Information**. This Agreement shall not be construed to restrict the disclosure by Recipient of information that (a) other than as a result of breach of this Agreement, has been previously published, is now public knowledge, or becomes public knowledge; (b) other than in violation of this Agreement, is independently developed by Recipient; (c) is made available to Recipient by any person or entity other than Elevance Health, provided the source of such information is not subject to any confidentiality obligations with respect to it; or (d) is required to be disclosed pursuant to law, order, regulation, or judicial or administrative process, but only to the extent of such required disclosures.

13. **Investigation of Suspected Breach**. If Elevance Health reasonably believes that Recipient has breached this Agreement, Elevance Health shall have the right to investigate. Recipient shall permit Elevance Health or its designee to observe and review onsite Recipient's processes and records relating to how the P/C Information has been stored, used, and disclosed, and shall reasonably cooperate with Elevance Health. Elevance Health shall give Recipient at least seventy-two (72) hours' advance notice and shall perform any onsite review at its own cost and expense, during normal business hours, and in a manner reasonably designed to protect the confidentiality of Recipient's confidential information and to avoid interfering with Recipient's business operations. If Elevance Health's review confirms that a breach has occurred, then notwithstanding any other provision of this Agreement and in addition to any other available remedies: (a) Elevance Health shall have the right, at its sole option, to discontinue any ongoing releases of Information to Recipient and terminate this Agreement immediately upon notice to Recipient; and (b) notwithstanding the terms of Section 11, Recipient shall immediately return all P/C Information then in its possession to Elevance Health.

14. **Equitable Relief**. Recipient acknowledges that irreparable injury could result to Elevance Health and its business if Recipient breaches its obligations under this Agreement. Without prejudice to any other rights and remedies available to it, Elevance Health shall be entitled to seek a restraining order, injunction or other equitable relief to prevent any actual, intended, or likely injuries which may result from a breach by Recipient.

15. **Legal Prohibition**. In the event that any local, state or federal law now in existence or hereafter enacted or decided (including rulings of regulatory agencies) prohibits Elevance Health from providing any or all of the Information, Elevance Health shall be relieved of any obligation to do so and shall notify Recipient in writing.

16. **Successors and Assigns**. This Agreement shall inure to the benefit of all successors and assigns of the Parties.

17. **Severability**. The unenforceability or nullity of any of the provisions of this Agreement, either in whole or in part, shall not render any other provision unenforceable or null and void.

18. **Headings**. All headings used in this Agreement are used for reference purposes only, and shall not affect the meaning or interpretation of any provision of this Agreement.

19. **Governing Law**. The validity, interpretation, and enforcement of this Agreement shall be governed by the laws of the State of Indiana.

20. **Notice**. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be sent via certified or registered mail with return receipt requested or via a recognized courier service to the Notice Address set forth below.

21. **Multiple Counterparts**. This Agreement and any subsequent amendment to it may be executed in several counterparts and by each of the Parties on a separate counterpart, each of which, when so executed and delivered shall be an original, but all of which together shall constitute but one and the same instrument. A facsimile signature shall be deemed equivalent to an original ink signature. This Agreement (and any subsequent amendment) shall not become binding on either of the Parties until each Party has transmitted to the other Party a counterpart executed by the transmitting Party.

22. **Entire Agreement**. This Agreement constitutes the entire agreement between the Parties, superseding any and all earlier agreements, either oral or written, between the parties with respect to the subject matter hereof, and no earlier agreement, statement or promise relating to the subject matter of this Agreement will be valid or binding.

23. **Termination**. Unless earlier terminated pursuant to Section 13, this Agreement shall remain in effect until such time as either Party provides at least ninety (90) days' written notice to the other Party of its decision to terminate this Agreement; provided, however, that the obligations related to the use, disclosure, and protection of the P/C Information shall have no expiration.

24. **Amendment**. From time to time local, state or federal legislative bodies, boards, departments or agencies may enact or issue laws, rules, or regulations pertinent this Agreement. In such event, the parties agree that Elevance Health shall have the right to unilaterally amend this Agreement to reflect such change.

In consideration of the mutual obligations contained in this Agreement, the sufficiency of which is hereby acknowledged, the Parties agree to the terms and conditions herein. Each of the undersigned represents, warrants, and covenants that he or she has the authority and the right to enter into this Agreement binding the Party on whose behalf the Agreement is hereby executed:

ELEVANCE HEALTH:	**RECIPIENT**:
Elevance Health, Inc. on behalf of itself and its affiliates and subsidiaries	_____
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date
_____	_____
Notice Address:	**Notice Address**:
220 Virginia Avenue	_____
Indianapolis, IN 46204	_____
Attn: General Counsel	_____

EXHIBIT A
SAMPLE ONLY

DATA RELEASE SPECIFICATIONS FORM

This Data Release Specifications Form amends, supplements, and is incorporated into the Confidentiality Agreement(s), identified herein, and previously entered into between the Parties. For any prior Data Release Specifications Form or data request approved by Elevance Health under a Confidentiality Agreement which included an "Exhibit A - Elevance Health Standard Record Layout – Medical, " such Exhibit A shall be deleted in its entirety. For avoidance of doubt and regardless of any "sample" File Record Layout provided to the Recipient or referenced in the Confidentiality Agreement or attachments thereto, all data request made under this or subsequent Data Release Specifications Form shall be fulfilled in accordance with Elevance Health's Data Release Policy.

Name of Employer for whom data release is requested: _____

Incurred Date Range of requested historical data (if applicable): _____

Paid Date Range of requested historical data (if applicable): _____

Requested frequency of ongoing data releases (if applicable): _____

Purpose(s) for which Elevance Health Data and Non-Elevance Health Data is requested. Describe in full detail how the Elevance Health Data and Non-Elevance Health Data will be used and/or disclosed:

_____

List all other parties, if any, to whom Recipient wishes to disclose the Elevance Health Data and Non-Elevance Health Data (name and address). (Each may be required to enter into an Agreement with Elevance Health.)

(As applicable INSERT - {Third Party Full Legal Name}, {Full Address})

_____

(If applicable INSERT - {Agreement Type} / {Agreement Signatories} / {Execution Date})

_____

File Layout Specifications: Attach requested deliverable's layout(s) or format(s), which are subject to Elevance Health's approval.

{INSERT AGREED TO DELIVERABLE LAYOUT(S) / FORMAT(S)}

RECIPIENT:		**ELEVANCE HEALTH:**	
<INSERT VENDOR NAME (as listed in Agreement)>		ELEVANCE HEALTH INC. ON BEHALF OF ITSELF AND ITS AFFILIATES AND SUBSIDIARIES	
Signature:	_____	Signature:	_____
Printed Name:	_____	Printed Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Confidentiality Agreement (Title/Parties/Date):

<Agreement Type> / <Agreement Signatories> / <Execution Date>

By signing this Data Release Specifications form, the Parties acknowledge and agree that, to the extent applicable, it will satisfy the requirement for a "File Record Layout Form" and/or "Data Release Specifications Form" and will serve the same purpose with respect to any confidentiality agreements requiring the use of a File Record Layout Form or Data Release specifications Form.

INTEGRATED ENGAGEMENT SERVICES PREFERRED SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Augusta-Richmond County

This Integrated Engagement Services Preferred Schedule ("Schedule") supplements and amends the Administrative Services Agreement ("Agreement") and is effective January 1, 2023 ("Effective Date"). If there are any inconsistencies between the provisions of this Schedule, any other Schedule, and/or the Agreement, the terms of this Integrated Engagement Services Preferred Schedule shall control, but only as they relate to Integrated Engagement Services Preferred. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

A. DEFINITIONS. For purposes of this Schedule, the following words and terms, if they appear in this Schedule, shall have the meanings assigned to them below unless the context or use clearly indicates another meaning or intent:

1. **CARVE-OUT ADMINISTRATOR**. If applicable, a third party vendor providing services to Employer and which, in connection with such services, will provide information to Anthem, or otherwise coordinate with Anthem, in connection with the Integrated Engagement Services.
2. **ENGAGEMENT APPLICATION**. The mobile application and web site on which the Integrated Engagement Services will be displayed to Users.
3. **ENGAGEMENT FUNCTIONALITY**. A component of the Integrated Engagement Services which will be made available on the Engagement Application as of its applicable Production Ready Date.
4. **INTEGRATED ENGAGEMENT SERVICES**. The consumer engagement services which are provided by Anthem to Employer.
5. **PRODUCTION READY DATE**. For medical transparency, the day immediately following the day Anthem delivers notice to Employer that the implementation is complete with respect to medical transparency. For each other Engagement Functionality, the day immediately following the day Anthem delivers notice to Employer that such Engagement Functionality will be made available to Users.
6. **USER**. A Subscriber or a Subscriber's covered dependent who is at least 18 years of age and, if applicable, a non-covered individual who is eligible to receive Integrated Engagement Services.

B. INTEGRATED ENGAGEMENT SERVICES

1. The Engagement Application will be accessible via secure sign-on with authentication, and will permit Users to also access the Anthem.com web site and, as applicable, the web sites of Employer's Carve-Out Administrators.

C. GENERAL PROVISIONS

1. **Conforming Data**. To the extent that data is required from Employer or Employer's Carve-Out Administrator(s) in order to provide the Integrated Engagement Services or any Engagement Functionality or feature included in the Integrated Engagement Services:
   a. Employer acknowledges and agrees that enrollment in Integrated Engagement Services constitutes written permission and consent from Employer for Anthem: 1) to contact Carve-Out Administrator(s) to begin implementation and set-up for Integrated Engagement Services; and 2) to collect applicable benefit and claims data from Carve-Out Administrator(s).
   b. Employer must provide, or ensure that each Carve-Out Administrator provides Anthem with the necessary data in accordance with Anthem's specifications regarding timeliness, quality, content, file format, and medium (the "Conforming Data").
   c. Employer acknowledges that Anthem's ability to perform the Integrated Engagement Services and to satisfy any applicable performance measures or guarantees is dependent on the timely receipt by Anthem of the Conforming Data.
   d. Employer agrees that if the Conforming Data is not provided or is not provided in a timely manner, Anthem shall have no obligation to provide the Integrated Engagement Services, or perform related reporting or other obligations until such time as the Conforming Data is received and integrated by Anthem.

e. Anthem will not be penalized in any manner, be deemed to be in breach of the Agreement, or be deemed to have failed to achieve any applicable performance measures or guarantees, to the extent that performance has been prevented or materially negatively affected by the failure of Employer or Employer's Carve-Out Administrator(s) to provide the Conforming Data.

2. **Change in Carve-Out Administrator(s)**. If Employer changes Carve-Out Administrators, a one-time fee shall apply for each such change.

3. **Use of Employer Brands**. To the extent that Employer's name, marks, logo or other such content (collectively, "Employer Brands") will be displayed or included on any printed materials as part of the Integrated Engagement Services, Employer grants Anthem a royalty-free license to use such Employer Brands for purposes of the Integrated Engagement Services.

4. **Taxes**. Employer shall be responsible for any sales and use tax or other similar tax of any nature assessed with respect to the Integrated Engagement Services or any product or service included within the Integrated Engagement Services by a government authority under applicable law. Employer agrees to reimburse Anthem in full for all such remitted taxes upon receipt of Anthem's invoice.

5. **Termination of Integrated Engagement Services**. Subject to any applicable early termination fee as set forth in Schedule A, this Schedule may be terminated during the term of the Administrative Services Agreement only if Employer provides Anthem with 90 days' advance written notice.

6. **Federal and State Compliance**. Employer is solely responsible for compliance with the Family and Medical Leave Act and, to the extent applicable to Employers' wellness program(s), for compliance with the Americans with Disabilities Act, the Internal Revenue Code, federal and state nondiscrimination laws, and other federal and state laws and regulations governing wellness programs.

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
dba Anthem Blue Cross and Blue Shield

By: Robert Tew

Title: Vice President, Sales and Client Management

Date: October 9, 2023

Anthem Spending Accounts

CDHP Group Questionnaire

This questionnaire is for ☑ **New Employer** ☐ **Renewing Employer** ☐ **Product Modification/Mid-year Change**
What is the effective date? 01/01/2024

Instructions

1. Complete section A. The remaining sections should only be completed if offering the applicable benefit account.
2. For existing employers, please provide current Employer ID (Case #) in section A.
3. Submit completed application to the Anthem Implementation Lead.

Section A: Employer Information and Accounts

Employer Name		Tax ID
Employer ID (Case Number)	Effective Date	
Number of Benefit Eligible Employees	Estimated Number of Participants	
Employer Contact Name #1	Phone	Email
Employer Contact Name #2	Phone	Email
Employer Contact Name #3	Phone	Email
Broker/Consultant Contact Name	Phone	Email

Check the box for each type of account being offered, then complete the applicable sections:

☐ Health Savings Account (HSA): Section B, I

☑ Flexible Spending Account (FSA): Sections C, F, G, H, I *(Healthcare FSA, Limited Purpose FSA, and Dependent Care)*

☐ Commuter- Transit and Parking: Sections D, F, G, H, I

☐ Health Reimbursement Arrangement (HRA) or Health Incentive Account Plus (HIP): Sections E, F, G, H, I

- ☐ Member Pay HRA with Debit Card: Section E1
- ☐ Provider Pay HRA with an Upfront Deductible: Section E2
- ☐ Provider Pay Medical Split HRA: Section E3
- ☐ HRA Provider Pay: Section E4
- ☐ HRA Rollover: Section E5
- ☐ Custom HRA (Please attach prior approval for any customization requirements and/or benefit configurations)

Section B: Health Savings Accounts ☐ Not Applicable

If this is a Renewal or Mid-Year Change, please select one of the following: ☐No changes from previous year ☐See requested changes below

HSA Custodian: WealthCare Saver

***WealthCare Saver** will distribute HSA Custodial Agreements, Terms and Conditions, and Privacy Notices to employees within 10 days of HSA account opening.*

Do you have a prior HSA custodian for which you would like to facilitate an employer managed bulk transfer? No

If yes, please specify the below information:

HSA Custodian Name:

HSA Custodian Phone Number:

Who will pay monthly administration fees for HSAs? Actives Employer COBRA Employer

Please select method of providing payroll contributions: ACH Pull - Upload Files Online (up to 400 enrollees)

Payroll frequency and date: Payroll frequency: Date of first contribution:

Payroll frequency: Date of first contribution:

Provide employer HSA contribution, if applicable.

Employee: $ Employee Plus One: $ Family: $ Frequency: Expected date of first contribution:

Contributions will not post automatically based on this form. Deposits that occur on weekends or bank holidays will become available within 2-3 business days.

Will incentives be offered to employees to earn additional HSA dollars by completing health activities? No

Only applies for account deposits, if you have selected gift cards as the redemption option, please select 'No'

Extra-Bucks Account: No

An Extra Bucks account helps your employees transition from an HRA that has rolled over to an HSA plan. Any HRA funds that would have rolled over can be deposited into an account to be used for medical coinsurance only. Note: If you have a prior administrator for your HRA, we will require a file from your prior administrator to credit funds into the "Extra Bucks" account.

Do you want to fund by divisions, group suffix, or funding group? No

Would you like to use the below bank account to fund HSA payroll deposits and non-HSA claims?*

**If different bank accounts is selected, the below bank account information will be used for HSA payroll deposits and Section G will need to be completed for non-HSA claims.*

☐ *For renewing clients, select here to continue using the bank account information on file.*

Employer HEREBY authorizes Anthem, or its agents, to initiate ACH transfers for the following depository in accordance with the NACHA Operating Rules outlined below:

Bank Account Number Routing Number Type of Account:

Financial Institution Name

Name of Authorized Signer Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

If there is a filter preventing unauthorized bank entries, please see the filters to add below. Both submitting bank BMO and your chosen Custodian must be added.

SUBMITTING BANK (ODFI): BMO HARRIS BANK N/A. ACCOUNT NAME:Med-I-Bank ROUTING NUMBER: 075000051

ORIGINATION ID: 07500005 COMPANY ID (Daily POS Settlements): 1383261866 COMPANY ID (RESUBMITS): W383261866 COMPANY ID: 3333313100.

Note there is a $1 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

WealthCare Saver (HSA Deposits):

BMO HARRIS BANK N/A. COMPANY ID: I900808825 ROUTING NUMBER: 071000288

Note there is a $0.01 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

NACHA Operating Rules

Employer HEREBY authorizes Anthem or its agent, , to initiate ACH debit entries (or correcting credit entries) to the bank account listed below. Anthem or its agent shall ACH debit the employer group for the sum total of claim reimbursement activity each day. Anthem or its agent shall notify the employer of claims activity through an email as well as an employer funding report. Employer agrees not to dispute any debits with its bank provided the transaction(s) correspond to the terms indicated in this Agreement.

Both parties agree to be bound by NACHA Operating Rules as they pertain to these transactions. Employer acknowledges that the origination of ACH transactions to its account must comply with the provisions of U.S. law. This Authorization will remain in effect until Employer cancels it in writing or provides a new account authorization, allowing at least ten (10) business days for Anthem and its agent to act. Employer understands that if an ACH debit fails for any reason, including insufficient funds, and Anthem or its agent becomes obligated to settle claims, Employer will indemnify Anthem or its agent for such amounts within one (1) business day of receiving notice from Anthem or its agent. A charge of $100.00 may be assessed for each ACH return. Failure to transfer funds to Anthem or its agent as set forth herein may result in the suspension or termination of services.

If there is a filter preventing unauthorized bank entries, please see the filters to add below. Both submitting bank BMO and your chosen Custodian must be added.
SUBMITTING BANK (ODFI): BMO HARRIS BANK N/A. ACCOUNT NAME:Med-I-Bank ROUTING NUMBER: 075000051
ORIGINATION ID: 07500005 COMPANY ID (Daily POS Settlements): 1383261866 COMPANY ID (RESUBMITS): W383261866 COMPANY ID: 3333313100.

Note there is a $1 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.
WealthCare Saver (HSA Deposits):
BMO HARRIS BANK N/A. COMPANY ID: I900808825 ROUTING NUMBER: 071000288

Section C: Flexible Spending Accounts, Limited Purpose FSA, and Dependent Care Accounts ☐Not Applicable

If this is a Renewal or Mid-Year Change, please select one of the following: ☐ No changes from previous year ☐ See requested changes below

Please select which accounts will be offered:			
Plan Options	☑ **FSA – Section 213(d)**	☐ **Limited Purpose FSA**	☑ **Dependent Care**
Plan Start to End Date	to		
Claim Run-out Date			
Terminated employees can submit claims for: *(Terminated employees are not eligible for grace period or spend down)*	If "Other", please specify:		
Maximum Annual Election *(Amount must include employer contributions from Employer Contribution field below, if any)*	Amount:	Amount:	Amount:
Grace Period* *(Allows claims to be incurred for 75 days after the last day of the plan year. For example, a calendar year plan's grace period ends March 15.)*			
Carryover* *(If your plan allows employees to carryover up to the IRS Maximum, the employee must be enrolled in the new FSA benefit year)*	Note: Enrollment required to participate in next year's carryover funds beyond grace period Will a carryover be offered? Is there a minimum rollover amount? No What is the rollover expiration period? If so, how much?		
Allow participants to update their LPFSA to full purpose once their minimum deductible has been met?	Not Applicable	No (standard)	Not Applicable
DCA Spend Down Provision *(Allows termed members to incur new expenses through the plan year)*	Not Applicable	Not Applicable	
Employer Contribution	$ per EE per year	$ per EE per year	$ per EE per year
Payroll Contribution Method			
Payroll Frequency and Date	Payroll Frequency:	First Payroll Date:	
Debit Card Access			

**The grace period allows a participant to use any remaining funds from the previous plan year for a period of 2 ½ months after. It cannot be offered in combination with the carryover. A carryover allows participants to roll forward any unused funds, up to the IRS Maximum, into the future plan year. The funds can be used for previous and current dates of service during the claim run out, after which it can only be used for current dates of service.*

Section D: Transit and Parking Accounts ☐ Not Applicable

If this is a Renewal or Mid-Year Change, please select one of the following: ☐ No changes from previous year ☐ See requested changes below

Please select which accounts will be offered:

Plan Options	☐ **Transit**	☐ **Parking**
Terminated employees can submit claims for:	If "Other", please specify:	
Maximum Monthly Election (Amount must include employer contributions from Employer Contribution field below, if any)	Amount:	Amount:
Employer Contribution	$ per EE per month	$ per EE per month
Payroll Contribution Method		
Payroll Frequency and Date	Payroll Frequency:	First Payroll Date:
Debit Card Access		

Section E: Health Reimbursement Arrangements ☐ Not Applicable

If this is a Renewal or Mid-Year Change, please select one of the following: ☐No changes from previous year ☐See requested changes below

Please complete one HRA section per PLAN ID. If offering more than one HRA, please complete the Appendix at the end of this application. *(e.g. if offering an HRA and an HIA+ (HIP) plan fill out one in section E and the other details in the Appendix.)*

HRA1: Group Suffix

Plan Start Date | Plan End Date | Claim Run-Out Date

Terminated employees can submit claims for 90 days (Standard) | If "Other", please specify:

HRA Funding per Employee

Will HRA funds be pro-rated based on entry date in the plan?

If not pro-rated, will HRA funds be distributed to employees on a monthly, quarterly or annual basis?

Select one tier only then specify annual allocation level per tier *(2 tier only for <1,000)*:
Dollar amount in each field below must be populated.

Will incentives be offered to employees to earn HRA dollars by completing health activities?
If 'Yes', please select one:

If offering ability to earn incentives on top of the employer HRA allocation, enter the HRA allocation amounts below.

***Health Incentive Account Plus**: Health Incentive Plan (HIP) + Health Reimbursement Arrangement (HRA): Eligible expenses and method of spending will be same as HRA. If 'yes' is selected, complete HRA Section.*

*If offering **incentive HRA only**, select your funding tier and enter 0.00 for each coverage type.*

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

SELECT ONE OFFERING FROM SECTIONS E1 – E4.

Section E1: Member Pay HRA with Debit Card

Indicate the services you would like to cover. A debit card will be offered to all members:
☑ Medical ☐ Dental ☐ Vision ☐ Rx ☐ OTC

Section E2: Provider Pay HRA with an Upfront Deductible – No Debit Card

Indicate the services you would like to cover.
☐ Auto Pay Medical:
- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx

Select one tier that matches the employee HRA Funding Tier, then specify the HRA up front deductible *(2 tier only for <1,000)*:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Do you want an embedded deductible per individual? If so, provide the individual upfront deductible.

☐ Individual Deductible: $

Section E3: Provider Pay Medical Split HRA: Employer HRA Covers a Percent of Each Claim – With Optional Rx Debit Card

Indicate the Member Responsibility by claim:

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx Debit Card

Section E4: HRA Provider Pay – No Debit Card

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance

☐ Rx

Section E5: HRA Rollover

Would you like to offer an HRA rollover? No

If you select 'yes', please fill out this section. If you select 'no', please move to the next section.

Rollover Date *(recommend 3 months from the effective date and the first of the month)*:

Minimum rollover amount *(recommend $0)*: **$**

How much of remaining employee funds should rollover to the next plan year?

If "Percent" or "Percent Up to Cap" are selected, specify percent value: %

Select one tier only then specify maximum rollover amount for each tier:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

For first year accounts, will a HRA be expected to roll over from a previous administrator or system?

If yes, please select:

☐ LITES ☐ Other:

No data file impact

Section F: Debit Cards and Account Priority

Plan Priority

Please indicate which plan will be the priority.

☐ Health Reimbursement Account (HRA) ☐ Flexible Spending Account (FSA)

Substantiation (Non-HSA Accounts Only)

The IRS requires transactions be substantiated and if not appropriately substantiated that debit cards will be suspended.

Suspend debit cards

If "Do not suspend debit cards" is chosen, you acknowledge that you understand that in certain cases this benefit could be considered taxable. Anthem will provide and require a hold harmless agreement prior to enabling this option. This hold harmless can be requested from your account manager.

The following transactions will be approved without participant intervention in compliance with IRS regulations:

- Prescription and OTC items purchased at IIAS pharmacies
- Recurring expenses
- Transactions that match amounts from a claim file
- Copays
- Copay multipliers

Please indicate if you use one of the following carriers:

☐ Anthem Dental ☐ Anthem Vision ☐ Anthem Rx (Pharmacy)

☐ Non-Anthem Rx PBM:

☐ Non-Anthem Dental

☐ Non-Anthem Vision

Section G: Prefunding and Frequency of Replenishment for Accounts Other Than HSA

Please indicate preferred billing method for claims and debit card utilization. We will initiate an ACH debit for prefunding and ACH debit on frequency selected here: Daily, 3% prefund required

- The Employer agrees that all funds are solely Employer's funds, are part of Employer's general assets, and do not include any employee/beneficiary contributions.
- The Employer appoints Anthem or its subcontractor as agent to hold funds for the sole purpose of satisfying Employer payment obligations.
- An initial prefund is required which will be debited approximately three to four weeks prior to the plan start date. If elections are not available to calculate reserve by the 15th of the month prior to effective date, reserve will be calculated using an estimate.
- The prefund is calculated by using the following formula: FSA, FSL, and MP HRA - Total Annual Election x % prefund selected. Extra Bucks, Incentive Only, and DCA/Commuter without FSA – is calculated separately.
- If the amount of employees enrolled increases month to month, we reserve the right to recalculate the prefund amount and request additional funds.
- If claim utilization during the week exceeds the reserve on hand, additional funds will be requested off-cycle to cover the shortage.
- The employer is required to have sufficient funds in the bank account designated to cover the activity on the account or all activity will be frozen. If reserve funds have not been received prior to effective date, cards will not work and claims will not be reimbursed.
- Any amounts remaining at the end of the run out are returned to the employer within 180 days, not to exceed 240 days.
- If there are less than 1,000 employees enrolled, 0% prefund will be required if daily schedule is selected.
- Prefund is required for all plans with the exception of PP HRA.

Do you require to fund by divisions, group suffix, or funding group?

If ACH Debit is selected, please provide bank account that should be used for claims and debit card swipes. Employer HEREBY authorizes Anthem or its agents to initiate ACH transfer entries for the following depository in accordance with NACHA Operating Rules outlined below:

Designate the plans this bank account will fund: Specific plan(s)

If specific plan is selected, select the plan and complete below. If additional plans are selected, complete additional ACH forms in Appendix 3.

☑ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number Routing Number Type of Account: Checking

Financial Institution Name

Name of Authorized Signer Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

Spending Account Utilization (Claim & Debit Card Activity for NON-HSA Plans):
BMO HARRIS BANK N/A. ACCOUNT NAME:Med-I-Bank ROUTING NUMBER: 075000051
ORIGINATION ID: 07500005 COMPANY ID (Daily POS Settlements): 1383261866 COMPANY ID (RESUBMITS): W383261866 COMPANY ID: 3333313100.
Note there is a $1 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

WealthCare Saver (HSA Deposits):
BMO HARRIS BANK N/A. COMPANY ID: I900808825 ROUTING NUMBER: 071000288
Note there is a $0.01 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

NACHA Operating Rules

Employer HEREBY authorizes Anthem or its agent, , to initiate ACH debit entries (or correcting credit entries) to the bank account listed below. Anthem or its agent shall ACH debit the employer group for the sum total of claim reimbursement activity each day. Anthem or its agent shall notify the employer of claims activity through an email as well as an employer funding report. Employer agrees not to dispute any debits with its bank provided the transaction(s) correspond to the terms indicated in this Agreement.

Both parties agree to be bound by NACHA Operating Rules as they pertain to these transactions. Employer acknowledges that the origination of ACH transactions to its account must comply with the provisions of U.S. law. This Authorization will remain in effect until Employer cancels it in writing or provides a new account authorization, allowing at least ten (10) business days for Anthem and its agent to act. Employer understands that if an ACH debit fails for any reason, including insufficient funds, and Anthem or its agent becomes obligated to settle claims, Employer will indemnify Anthem or its agent for such amounts within one (1) business day of receiving notice from Anthem or its agent. A charge of $100.00 may be assessed for each ACH return. Failure to transfer funds to Anthem or its agent as set forth herein may result in the suspension or termination of services.

Section H: Optional Services

Please select any additional services for Anthem to provide:
Additional fees may apply.

☐ Plan Document Creation: $50 per document (maximum $350)

☐ Plan Document Maintenance: $125/hour

☐ Non-Discrimination Testing: $75 per test (maximum $350)

☐ Custom Third-Party Substantiation Vendor File Feed (one-time fee)

- Current carrier $3,500
- New carrier $7,000

Additional fees may apply for non-standard templates

Dental:

Vision:

Pharmacy:

Section I: Signature Section

Date

Signature

Name

Title

Section J: Internal Use Only

Brand: Anthem BlueCross BlueShield

Customer Phone Number:

Appendix 1. Additional Health Reimbursement Arrangements

HRA2: Group Suffix

Plan Start Date	Plan End Date	Claim Run-Out Date
Terminated employees can submit claims for	If "Other", please specify:	

HRA Funding per Employee

Will HRA funds be pro-rated based on entry date in the plan?

If not pro-rated, will HRA funds be distributed to employees on a monthly, quarterly or annual basis?

Select one tier only then specify annual allocation level per tier *(2 tier only for <1,000)*:
Dollar amount in each field below must be populated.

Will incentives be offered to employees to earn HRA dollars by completing health activities?
If 'Yes', please select one:

If offering ability to earn incentives on top of the employer HRA allocation, enter the HRA allocation amounts below.

***Health Incentive Account Plus**: Health Incentive Plan (HIP) + Health Reimbursement Arrangement (HRA): Eligible expenses and method of spending will be same as HRA. If 'yes' is selected, complete HRA Section.*

*If offering **incentive HRA only**, select your funding tier and enter 0.00 for each coverage type.*

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Who will be sending incentive files?

☐ Vendor ☐ Employer

What format(s) will the file be submitted in?

SELECT ONE OFFERING FROM APPENDIX 1-1 – 1-5.

Appendix 1-1: Member Pay HRA with Debit Card

Indicate the services you would like to cover. A debit card will be offered to all members:
☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ OTC

Appendix 1-2: Provider Pay Medical with Optional Rx/Dental/Vision Debit Card

Indicate the services you would like to cover.
☐ Auto Pay Medical:
- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx (Debit Card)
☐ Dental (Debit Card)
☐ Vision (Debit Card)

Appendix 1-3: Provider Pay HRA with an Upfront Deductible – No Debit Card

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx

Select one tier that matches the employee HRA Funding Tier, then specify the HRA up front deductible *(2 tier only for <1,000)*:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Do you want an embedded deductible per individual? If so, provide the individual upfront deductible.

☐ Individual Deductible: $

Appendix 1-4: Provider Pay Medical Split HRA: Employer HRA Covers a Percent of Each Claim – With Optional Rx Debit Card

Indicate the Member Responsibility by claim:

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx (Debit Card)

Appendix 1-5: HRA Provider Pay – No Debit Card

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance

☐ Rx

Appendix 1-6: HRA Rollover

Would you like to offer an HRA rollover?
If you select 'yes', please fill out this section. If you select 'no', please move to the next section.

Rollover Date *(recommend 3 months from the effective date and the first of the month)*:

Minimum rollover amount *(recommend $0)*: **$**

How much of remaining employee funds should rollover to the next plan year?

If "Percent" or "Percent Up to Cap" are selected, specify percent value: %

Select one tier only then specify maximum rollover amount for each tier:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Was there a rollover of unused funds with a different administrator last year?

Does this group require rollover of unused HRA funds from a renewing legacy Lumenos HRA account that was administered on LITES?
No data file impact

Appendix 2. Additional Health Reimbursement Arrangements

HRA2: Group Suffix

Plan Start Date	Plan End Date	Claim Run-Out Date
Terminated employees can submit claims for	If "Other", please specify:	

HRA Funding per Employee

Will HRA funds be pro-rated based on entry date in the plan?

If not pro-rated, will HRA funds be distributed to employees on a monthly, quarterly or annual basis?

Select one tier only then specify annual allocation level per tier *(2 tier only for <1,000)*:
Dollar amount in each field below must be populated.

Will incentives be offered to employees to earn HRA dollars by completing health activities?
If 'Yes', please select one:

If offering ability to earn incentives on top of the employer HRA allocation, enter the HRA allocation amounts below.

***Health Incentive Account Plus**: Health Incentive Plan (HIP) + Health Reimbursement Arrangement (HRA): Eligible expenses and method of spending will be same as HRA. If 'yes' is selected, complete HRA Section.*

*If offering **incentive HRA only**, select your funding tier and enter 0.00 for each coverage type.*

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

SELECT ONE OFFERING FROM APPENDIX 2-1 – 2-5.

Appendix 2-1: Member Pay HRA with Debit Card

Indicate the services you would like to cover. A debit card will be offered to all members:

☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ OTC

Appendix 2-2: Provider Pay Medical with Optional Rx/Dental/Vision Debit Card

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx (Debit Card)

☐ Dental (Debit Card)

☐ Vision (Debit Card)

Appendix 2-3: Provider Pay HRA with an Upfront Deductible – No Debit Card

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx

Select one tier that matches the employee HRA Funding Tier, then specify the HRA up front deductible *(2 tier only for <1,000)*:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Do you want an embedded deductible per individual? If so, provide the individual upfront deductible.

☐ Individual Deductible: $

Appendix 2-4: Provider Pay Medical Split HRA: Employer HRA Covers a Percent of Each Claim – With Optional Rx Debit Card

Indicate the Member Responsibility by claim:

Indicate the services you would like to cover.

☐ Auto Pay Medical:

- ☐ In Network Medical Deductible
- ☐ In Network Coinsurance
- ☐ In Network Copays*
- ☐ Out of Network Medical Deductible
- ☐ Out of Network Coinsurance
- ☐ Out of Network Copays*

**Not recommended for Provider Pay*

☐ Rx (Debit Card)

Appendix 2-5: HRA Provider Pay – No Debit Card

Indicate the services you would like to cover.

- ☐ Auto Pay Medical:
  - ☐ In Network Medical Deductible
  - ☐ Out of Network Medical Deductible
  - ☐ In Network Coinsurance
  - ☐ Out of Network Coinsurance
- ☐ Rx

Appendix 2-6: HRA Rollover

Would you like to offer an HRA rollover?
If you select 'yes', please fill out this section. If you select 'no', please move to the next section.

Rollover Date *(recommend 3 months from the effective date and the first of the month)*:

Minimum rollover amount *(recommend $0)*: **$**

How much of remaining employee funds should rollover to the next plan year?

If "Percent" or "Percent Up to Cap" are selected, specify percent value: %

Select one tier only then specify maximum rollover amount for each tier:

Employee (S)	Employee + Adult (A)	Employee + Child (C)	Employee + Children (N)	Family (F)
$	$	$	$	$

Was there a rollover of unused funds with a different administrator last year?

Does this group require rollover of unused HRA funds from a renewing legacy Lumenos HRA account that was administered on LITES?
No data file impact

Appendix 3. Additional ACH Authorization

This bank account is for: *Select all that apply:* ☐ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number | Routing Number | Type of Account:

Financial Institution Name

Name of Authorized Signer | Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

This bank account is for: *Select all that apply:* ☐ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number | Routing Number | Type of Account:

Financial Institution Name

Name of Authorized Signer | Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

This bank account is for: *Select all that apply:* ☐ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number | Routing Number | Type of Account:

Financial Institution Name

Name of Authorized Signer | Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

BMO HARRIS BANK N/A. ACCOUNT NAME:Med-I-Bank ROUTING NUMBER: 075000051
ORIGINATION ID: 07500005 COMPANY ID (Daily POS Settlements): 1383261866 COMPANY ID (RESUBMITS): W383261866 COMPANY ID: 3333313100.
Note there is a $1 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

WealthCare Saver (HSA Deposits):
BMO HARRIS BANK N/A. COMPANY ID: I900808825 ROUTING NUMBER: 071000288
Note there is a $0.01 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

This bank account is for: *Select all that apply:* ☐ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number | Routing Number | Type of Account:

Financial Institution Name

Name of Authorized Signer | Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

This bank account is for: *Select all that apply:* ☐ HRA ☐ FSA ☐ FSL ☐ DCA ☐ Transit ☐ Parking

Bank Account Number | Routing Number | Type of Account:

Financial Institution Name

Name of Authorized Signer | Title of Authorized Signer

Signature/e-Signature

E-mail Contact (for daily settlement notification)

BMO HARRIS BANK N/A. ACCOUNT NAME:Med-I-Bank ROUTING NUMBER: 075000051
ORIGINATION ID: 07500005 COMPANY ID (Daily POS Settlements): 1383261866 COMPANY ID (RESUBMITS): W383261866 COMPANY ID: 3333313100.
Note there is a $1 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

WealthCare Saver (HSA Deposits):
BMO HARRIS BANK N/A. COMPANY ID: I900808825 ROUTING NUMBER: 071000288
Note there is a $0.01 non-refundable pre-note to ensure the account can be debited. If there is a filter preventing unauthorized bank entries, please make sure these filters are added.

Employer HEREBY authorizes Anthem, or its agents, to initiate ACH transfers for the above depository(ies) in accordance with the NACHA Operating Rules outlined below:

Employer HEREBY authorizes Anthem or its agent, , to initiate ACH debit entries (or correcting credit entries) to the bank account listed above. Anthem or its agent shall ACH debit the employer group for the sum total of claim reimbursement activity each day. Anthem or its agent shall notify the employer of claims activity through an email as well as an employer funding report. Employer agrees not to dispute any debits with its bank provided the transaction(s) correspond to the terms indicated in this Agreement.

Both parties agree to be bound by NACHA Operating Rules as they pertain to these transactions. Employer acknowledges that the origination of ACH transactions to its account must comply with the provisions of U.S. law. This Authorization will remain in effect until Employer cancels it in writing or provides a new account authorization, allowing at least ten (10) business days for Anthem and its agent to act. Employer understands that if an ACH debit fails for any reason, including insufficient funds, and Anthem or its agent becomes obligated to settle claims, Employer will indemnify Anthem or its agent for such amounts within one (1) business day of receiving notice from Anthem or its agent. A charge of $100.00 may be assessed for each ACH return. Failure to transfer funds to Anthem or its agent as set forth herein may result in the suspension or termination of services.

Signature/e-Signature