



An Independent Licensee of the Blue Cross and Blue Shield Association

**ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
AND
CITY OF KINGSPORT, TN**

This Administrative Services Agreement (the “Agreement”), is by and between City of Kingsport, TN (“Employer”) and BlueCross BlueShield of Tennessee, Inc. (“BlueCross”), and is effective as stated in Section 3.1 of this Agreement. Employer and BlueCross may be individually referred to in this Agreement as a “Party” and are collectively referred to in this Agreement as the “Parties”.

WHEREAS, Employer has established a self-funded Employee Welfare Benefit Plan; however, Employer represents that this Employee Welfare Benefit Plan (“Plan”) is not subject to ERISA;

WHEREAS, BlueCross offers to sponsors of self-funded employee welfare benefit plans certain administrative and related services in connection with such sponsors’ administration of their plans; and

WHEREAS, Employer seeks for BlueCross to provide, and BlueCross agrees to provide, administrative services to and on behalf of Employer and the Plan as set forth in this Agreement.

NOW THEREFORE, in consideration of the promises, covenants, representations, and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

ARTICLE I – RESPONSIBILITIES OF THE PARTIES

- 1.1. BlueCross. BlueCross shall provide administrative claims payment services in accordance with the terms of the Benefit Documents, shall perform other services as set forth in this Agreement, and shall perform other duties specifically assumed by BlueCross pursuant to this Agreement. BlueCross does not assume any financial risk or obligation with respect to Approved Claims or the Plan. BlueCross shall perform its services and duties in accordance with the terms of this Agreement and applicable law and will administer the benefits in accordance with BlueCross’s customary administrative standards and practices and generally accepted standards applicable to claims administration, including other licensees of the Association. To the extent Employer or the Plan engages a third-party Employer Service Vendor to administer certain benefits under the Plan, Employer hereby acknowledges and agrees that (i) BlueCross, BlueCross’ Affiliates, and their subcontractors or assigns shall have no responsibility for any act, error, or omission of such Employer Service Vendor or with respect to the performance of such Employer Service Vendor and (ii) to the extent permitted under the Tennessee Governmental Tort Liability Act (GTLA), Tenn. Code Ann. § 29-20-101 *et seq.*, Employer shall remain fully responsible and liable for the acts or omissions of all Employer Service Vendors.

- 1.2. Employer. Employer shall perform the obligations set forth in this Agreement, including maintaining the Plan in accordance with applicable law, providing information to BlueCross regarding the Plan and Members necessary to administer the Plan, and timely funding and payment of Approved Claims and ASFs.
- 1.3. Benefit Documents. Employer shall provide BlueCross with a current, detailed, accurate copy of the Benefits Documents, which are attached hereto as Exhibit A (“Benefit Documents”). Employer shall notify BlueCross of any changes Employer intends to make to the terms and/or conditions of the Benefit Documents or the Plan. Notification shall be made sufficiently in advance of any such changes so as to permit BlueCross reasonable time to review and/or implement such changes. It is Employer’s obligation to ensure all Benefit Documents, whether or not produced by BlueCross, meet the requirements of applicable laws. Employer agrees that all Association-mandated language shall be included in its Benefit Documents. BlueCross shall not be responsible for administering any Benefit Document that has not been reviewed and accepted by BlueCross. Until Employer has approved changes to the Benefits Documents, BlueCross will administer the quoted benefits according to the descriptions contained in Employer’s Benefits Documents last accepted by BlueCross.
- 1.4. Stop Loss Coverage. Employer has entered into a stop loss arrangement with a stop loss vendor. BlueCross’s duties with regard to this stop loss arrangement are set forth in Exhibit C.
- 1.5. Fiduciary Responsibility. Employer is solely responsible for the fiduciary responsibilities of administering its Plan and maintaining adequate funding to support the Plan, determining eligibility under the Plan, and preparing and providing its covered employees with copies of Benefit Documents. Although Employer’s Plan is not subject to ERISA, Employer acknowledges that BlueCross is acting in a ministerial capacity and is not the “Administrator,” the “Claims Fiduciary,” nor the “Named Fiduciary” of Employer’s Plan, as those terms are defined in ERISA. The “Plan Administrator” of the Plan, as that term is defined in ERISA, is Employer.
- 1.6. Claims Funding. Employer shall timely pay to BlueCross the invoiced amount for Approved Claims. BlueCross shall notify Employer weekly of the estimated amounts necessary to fund payment of the Approved Claims. Employer shall then appropriately fund the Approved Claims in accordance with this Agreement. Nothing in this Agreement shall obligate or shall be deemed to obligate BlueCross to use its funds to satisfy any of Employer’s obligations pursuant to this Agreement or Plan benefits. Employer’s assets and amounts contributed by Members, if applicable, are the only source(s) of funding and payment of Approved Claims or any other benefit provided under the Plan.
- 1.7. Administrative Services Fees (“ASF(s)”). Employer shall timely pay ASFs in accordance with the Agreement. The initial ASF shall be due and payable on the Effective Date of this Agreement.

ARTICLE II – CONFIDENTIALITY

2.1. Confidential Information.

- 2.1.1. Notwithstanding anything in this Agreement to the contrary, the parties acknowledge that Employer is subject to the Tennessee Open Records Act, set

out in Tenn Code Ann. § 10-7-503 *et seq.*, and any documents, materials, or attachments/exhibits, including the Agreement and the information contained in the Agreement, in any format, including but not limited to, paper, electronic, or virtual, are public records pursuant to the Tennessee Open Records Act, are not confidential, and are subject to disclosure in whole or in part to any citizen of Tennessee, without regard to any provision contained in the Agreement declaring information confidential. Records not otherwise made confidential by Tennessee law are public records. To the extent permitted under TORA, The Parties acknowledge that this Agreement and Confidential Information shall be treated as confidential, proprietary and trade secret information. Employer further acknowledges and agrees that BlueCross Confidential Information relating to provider identifiable information, payment rates and discounts, fee schedules, allowed amounts, policies and procedures and/or all other information in which BlueCross has proprietary interest, is proprietary and a valuable trade secret of BlueCross and that any disclosure or unauthorized use thereof will cause irreparable harm and loss to BlueCross. Notwithstanding the foregoing, BlueCross agrees to provide to Employer information reasonably requested by Employer in BlueCross' possession to the extent required for Employer to meet its disclosure obligations with respect to the Plan under applicable law.

2.1.2. The Parties agree that any Protected Health Information that is commingled with Confidential Information disclosed under this Agreement shall be subject to the Business Associate Agreement between the Parties.

2.2. Uses and Disclosures of Confidential Information. Neither Party shall use or disclose the Confidential Information of the other Party, except as permitted herein.

2.2.1. BlueCross's Release or Disclosure. BlueCross may disclose Employer's Confidential Information to providers within BlueCross's networks, to BlueCross's affiliates and other licensees of the Association, and BlueCross's Representatives who: (A) need to know such Employer Confidential Information for performance of responsibilities related to the Plan and/or this Agreement; and (B) are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Agreement. BlueCross may also disclose Employer's Confidential Information pursuant to a valid subpoena, administrative order or court order.

2.2.2. Employer's Release or Disclosure of Confidential Information. Employer shall use BlueCross Confidential Information solely for the purpose of administering Employer's Plan. Employer shall not disclose BlueCross's Confidential Information to a third party, including an Employer Service Vendor, unless the parties enter into an executed information sharing agreement with the third party pursuant to this Section 2.2.2. BlueCross may disclose Confidential Information of Employer to an Employer Service Vendor for Plan administration as directed by Employer, provided, however that (A) BlueCross, Employer and such Employer Service Vendor first must enter into an information sharing agreement approved by BlueCross authorizing BlueCross to disclose Confidential Information to such Employer Service Vendor, (B) any such disclosure shall be subject to the requirements of applicable laws and regulations and their implementing guidance, the policies and procedures of the Association, this Agreement, and such fully-executed information sharing agreement, and (C) the Parties acknowledge and agree that, notwithstanding the foregoing, BlueCross is under no obligation to

release BlueCross Confidential Information at any time. Any information sharing agreement adopted pursuant to this section shall include:

- 2.2.2.1. Written authorization by Employer to release the Confidential Information to the Employer Service Vendor and a statement that Employer has entered into a business associate agreement with such Employer Service Vendor as required by HIPAA;
- 2.2.2.2. A statement that the Employer Service Vendor must have such information in order to perform their job as it relates to the administration of the Plan;
- 2.2.2.3. Protections for the Confidential Information;
- 2.2.2.4. Prohibitions against use of the data to obtain trade secrets, confidential business information, personally identifiable information, or otherwise use in a competitive manner against BlueCross or other licensees of the Association;
- 2.2.2.5. A statement by the Employer and Employer Service Vendor that the disclosure of the Confidential Information is limited to the minimum necessary to fulfill the purpose for which it will be disclosed;
- 2.2.2.6. A detailed description of the intended use (and any impermissible uses) of the Confidential Information;
- 2.2.2.7. A statement that the Confidential Information will not be resold or otherwise commercialized by Employer Service Vendor or any other person;
- 2.2.2.8. The right for BlueCross to confirm, through an audit, that the Confidential Information is not being used or disclosed in an impermissible manner;
- 2.2.2.9. A statement that the Confidential Information will be returned or securely destroyed by the Employer Service Vendor when it is no longer needed for the purpose for which it was disclosed;
- 2.2.2.10. A statement that the Employer Service Vendor will notify BlueCross when the Employer Service Vendor's ownership changes;
- 2.2.2.11. A statement that the Employer Service Vendor will defend or settle and/or hold harmless and indemnify BlueCross, as well as its officers and employees, from all claims, losses, or suits resulting from the Employer Service Vendor's breach of the information sharing agreement or its unauthorized use or disclosure of Confidential Information;
- 2.2.2.12. A statement that the Employer Service Vendor will comply with all laws, rules and regulations applicable to the sharing of information that includes Confidential Information contemplated under the information

sharing agreement and that failure to comply with such laws shall be considered a material breach of such agreement; and

- 2.2.2.13. Any other requirement BlueCross deems necessary based on the intended use of the Confidential Information.
- 2.2.3. Right of Refusal. BlueCross reserves the right to refuse to release: (A) Confidential Information if BlueCross determines, in its sole discretion, that such release has the potential to damage BlueCross, including its reputation or competitive position in the market, or (B) any information BlueCross reasonably believes it cannot divulge due to applicable state or federal laws, Association provisions, applicable privileges or judicial or administrative orders. In no instance shall Employer itself, nor shall Employer allow a third party to, use or disclose BlueCross's Confidential Information: (A) to be aggregated with information of other third parties; (B) for the commercial purposes of any person; or (C) to compete directly or indirectly against BlueCross.
- 2.3. Rights in Data. The Parties agree that BlueCross owns claim or payment data (including any Confidential Information) recorded for or otherwise integrated into BlueCross's data, BlueCross claims processing or other systems, or BlueCross Confidential Information.
- 2.4. Legally Compelled. Employer may disclose Confidential Information if legally compelled by a valid judicial or administrative order; provided however, that Employer shall make every attempt to keep BlueCross's Confidential Information confidential, shall only disclose the minimum information necessary to comply with the order, shall provide written notice to BlueCross immediately upon making the determination that BlueCross's Confidential Information must be disclosed and shall only disclose the information after BlueCross has been notified and has the opportunity to consent to or challenge such disclosure.
- 2.5. Protected Health Information. The Parties have entered into a Business Associate Agreement, the terms of which control the use and disclosure of Protected Health Information, as defined by HIPAA.
- 2.6. Survival. This Article 2 shall survive termination of the Agreement.

ARTICLE III – TERM AND TERMINATION

- 3.1. Term. This Agreement becomes effective at 12:01 A.M. Eastern Time on January 1, 2026 (the "Effective Date") and shall remain in effect until the earliest of the following:
- 3.1.1. Until December 31, 2026, unless Employer and BlueCross agree in a writing executed by both Parties to extend the term prior to December 31, 2026;
- 3.1.2. After the Initial Term of the Agreement, either Party may terminate the Agreement by giving the other Party no less than sixty (60) days advance written notice of the terminating Party's intent to terminate the Agreement as of the date specified in such notice.
- 3.1.3. Any other date mutually agreed upon by the Parties; or

- 3.1.4. The occurrence of any of the events specified in Section 3.2.
- 3.2. Termination by BlueCross. Notwithstanding the provisions of Section 3.1 above, this Agreement shall terminate upon the occurrence of any of the following events, as determined by BlueCross. Such termination shall be effective as of the date identified by BlueCross in its notice of termination to the Employer, and the Parties acknowledge that the termination may be retroactively effective.
- 3.2.1. Employer's failure to timely provide adequate funds, as set forth in Exhibit B, as necessary for the payment of Approved Claims;
- 3.2.2. Employer's failure to pay any ASFs, late payment penalty or other amounts as set forth in Exhibit B or otherwise due to BlueCross under this Agreement;
- 3.2.3. Employer ceases to maintain the Plan;
- 3.2.4. At any time BlueCross reasonably believes that Employer does not have the financial ability to adequately and timely fund claims, and Employer has failed to provide adequate assurances of such ability to BlueCross; or
- 3.2.5. At any time Employer fails to comply with applicable law or otherwise materially breaches this Agreement.
- 3.3. Termination for Invalid Use of BlueCross Confidential Information. If Employer uses or discloses BlueCross's Confidential Information in any manner not authorized by this Agreement, such disclosure shall constitute a material breach that is not subject to cure or correction, and BlueCross may terminate the Agreement immediately pursuant to Section 3.6.3.
- 3.4. BlueCross's Right to Reinstate. BlueCross has the sole discretion to decide whether to reinstate this Agreement if it was terminated pursuant to Subsections 3.2 or 3.3. If BlueCross elects to reinstate this Agreement, Employer shall pay any amounts due and owing under the Agreement prior to its termination plus a reinstatement fee, which shall be twenty-five thousand dollars (\$25,000.00).
- 3.5. Termination by Employer. Employer may terminate this Agreement upon giving BlueCross not less than thirty (30) days advance written notice if the following occurs:
- 3.5.1. BlueCross has been declared insolvent by the State of Tennessee, and its assets and obligations have been turned over to a receiver appointed by the State.
- 3.6. Material Breach.
- 3.6.1. A material breach is the failure by one Party (the "Breaching Party") to perform or carry out a material function or duty required by the terms of this Agreement, where the failure to perform that function or duty seriously impairs the ability to perform of the other Party (the "Non-breaching Party").
- 3.6.2. If the Non-breaching Party determines that a material breach has occurred, it must provide the Breaching Party with written notice and no less than thirty (30) days to cure the breach. If the breach is not cured during such cure period, the Non-

breaching Party may terminate the Agreement effective as of the date set forth in the notice.

- 3.6.3. If the Non-breaching Party determines that the breach is not capable of being cured, the Non-breaching Party may immediately terminate the Agreement upon notice to the Breaching Party, effective as of the date set forth in such notice.
- 3.6.4. If either Party disputes a claimed material breach or that a material breach has been cured or corrected, such Party may immediately request dispute resolution, pursuant to the terms of Article IV of this Agreement.
- 3.7. Effect of Termination. The terms and conditions set forth herein shall be of no further force or effect upon termination of the Agreement, except as follows:
- 3.7.1. The Parties' rights and obligations intended to survive termination of this Agreement shall continue in effect notwithstanding its termination.
- 3.7.2. Termination of this Agreement, except as provided to the contrary herein, shall not affect the rights, obligations and liabilities of the Parties arising prior to termination.
- 3.7.3. The termination of this Agreement does not excuse Employer from paying to BlueCross any and all fees, amounts, reimbursements or claim payments accrued through the date of termination. If termination occurs retroactively, any and all fees, amounts, reimbursements or funding of Approved Claims accrued through the date of termination of the Agreement, including any Run-Out Period, shall be payable to BlueCross by Employer no later than ten (10) days after notice of termination is provided by BlueCross.
- 3.8. Administration After Termination. Provided that Employer has timely paid all outstanding amounts needed to fund Approved Claim and ASFs as of the date the Agreement is terminated and the Agreement has not been terminated by BlueCross pursuant to Sections 3.2, 3.2 or 3.6 of the Agreement, BlueCross, in its sole discretion which shall not be unreasonably withheld, may agree to process Run-Out Claims on behalf of Employer's Plan. The administration of the processing of Run-Out Claims by BlueCross following termination of this Agreement will be subject to the terms of this Agreement, as well as Employer's current and continued timely and sufficient funding of claims payments. Employer acknowledges that there is a separate and distinct administrative fee for BlueCross providing administrative services to pay Run Out Claims, which is set forth in Exhibit B. Any services performed by BlueCross on Employer's behalf after termination of the Agreement will cease no later than 18 months after termination of this Agreement ("Process Conclusion Date").
- 3.9. Final Settlement. BlueCross will complete a final calculation that reconciles any and all claims payments, fund transfers, recoveries received, and other monies potentially due under the Agreement up to the Process Conclusion Date to determine the amount necessary to finalize both Parties' obligations under this Agreement (the "Final Settlement Amount"). BlueCross will send Employer an agreement memorializing the final obligations of the Parties under the Agreement (hereinafter, the "Final Settlement Agreement") approximately two (2) years after termination of this Agreement. Employer will have thirty (30) days from the date of the letter attached to the Final Settlement Agreement to dispute any of the calculations in the Final Settlement Agreement. If Employer has not disputed

the Final Settlement Agreement, or returned a signed Final Settlement Agreement to BlueCross within the provided time period, Employer shall be deemed to have approved and executed the Final Settlement Agreement and BlueCross reserves the right to reduce the Final Settlement Amount to take into account the final amount due BlueCross under the Agreement. Any amounts recovered beyond the Final Settlement shall be retained by BlueCross as reasonable compensation for Services under this Agreement.

ARTICLE IV – DISPUTE RESOLUTION

- 4.1. Arbitration. Notwithstanding any other provision in the Agreement to the contrary, arbitration is not permitted and if a dispute arises between the parties concerning any aspect of the Agreement the parties shall endeavor to resolve claims, disputes and other matters in question between them by mediation which shall be administered in accordance with Rule 31 of the Tennessee Rules of the Supreme Court, unless the parties mutually agree otherwise. If the dispute is not resolved any party may resort to resolution of the dispute by litigation in the state or federal courts for Kingsport, Sullivan County, Tennessee. The parties waive their right to a jury trial.

ARTICLE V – LIABILITY AND INDEMNIFICATION

- 5.1. BlueCross Indemnification to Employer.
- 5.1.1. BlueCross neither insures nor underwrites any of Employer's obligations or liabilities under the Plan and shall have no obligations to Employer related thereto. BlueCross is responsible solely for its acts and for the acts of its subcontractors and employees acting within the scope of their duties under this Agreement. BlueCross is not responsible for any acts or omissions of Employer or its agents or any third parties, including Employer Service Vendors, associated with or contracted by Employer.
- 5.1.2. BlueCross shall indemnify, defend and hold harmless Employer, its directors, officers and employees against any and all third party Losses arising out of or in connection with BlueCross's gross negligence or willful misconduct in the performance of its obligations under the Agreement, provided, however, that BlueCross shall have no obligation to indemnify and hold harmless under this section if the cause of such Losses was the result of (i) the fault, criminal conduct or fraudulent acts of Employer or any of its directors, officers, employees or agents; (ii) direction given by Employer or its directors, officers, employees or agents in the design or administration of the Plan; (iii) Employer's breach of its fiduciary duties; or (iv) Employer's violation of laws.
- 5.1.3. BlueCross's liability to Employer for Losses pursuant to this Agreement shall be limited to the value of the ASFs received by BlueCross under the Agreement prior to the occurrence of the act, action, or failure to act that forms the basis of BlueCross's liability.
- 5.1.4. Notwithstanding the foregoing, BlueCross's duty to indemnify for Losses and hold Employer harmless pursuant to Subsection 5.1.2 shall not extend to Losses arising out of or in connection with acts or omissions of (i) any Network Providers that provide services to Members, or (ii) any act, error, or omission of any Employer

Service Vendor, or any services such Employer Service Vendor provide(s) to the Employer and/or Plan.

5.2. Employer Indemnification of BlueCross.

5.2.1. Employer. Employer is responsible for making eligibility and benefit determinations in connection with the Plan, timely funding and paying all fees and claims for Covered Services and paying any other expenses related to or arising in connection with the Plan. The Parties acknowledge that a governmental entity, as the same is defined in the Tennessee Code Annotated Section 29-20-102, may be protected by the limitation of liability imposed by the Tennessee Governmental Tort Liability Act, as defined in Tennessee Code Annotated Section 29-20-101 et seq.

5.2.2. To the extent Employer directs BlueCross to administer prescription drug benefits with a traditional pricing model, Employer shall indemnify and hold BlueCross harmless to the greatest extent permitted under law for any and all Losses resulting from or arising out of or in connection Employer's direction to adopt traditional PBM pricing and BlueCross's administration of traditional PBM pricing. The foregoing indemnification and hold harmless obligation shall be in addition to, and not in lieu of, any other indemnification provided by Employer to BlueCross under the Agreement and without regard to any limitation of liability under this Agreement. Further, Employer understands, agrees and acknowledges that (i) BlueCross may decline to provide services in connection with the traditional PBM pricing at any time upon notice to Employer; and (ii) BlueCross assumes no liability for any action taken pursuant to the Employer's direction, the Traditional PBM Pricing, or the Agreement.

5.3. Limitation on Liability. In no event will the measure of Losses payable by either Party to the other include, nor will either Party be liable to the other for, any consequential, indirect, incidental, exemplary, special or punitive damages (including, but not limited to, damages due to business interruption, trading losses, competitive advantage or goodwill) arising from or related to this Agreement, whether or not foreseeable, and regardless of the cause of such damages even if the Party has been advised of the possibility of such damages in advance.

5.4. Legal Actions.

5.4.1. Legal Actions Brought Against BlueCross. If a third party claim is asserted against BlueCross (but not Employer) that is based upon actions taken under this Agreement or the Plan, and litigation, arbitration and/or other legal proceeding ("Action") is commenced against BlueCross:

5.4.1.1. BlueCross will provide written notice to Employer as soon as practicable, but in no event more than one hundred twenty (120) days after BlueCross determines that the Action involves a Member or the Plan. Additionally, BlueCross will provide Employer with information with respect to the status of such Action upon Employer's reasonable request. BlueCross shall select and retain counsel as it deems appropriate in connection with such Action with respect to the interests of BlueCross.

- 5.4.1.2. Employer will provide BlueCross with reasonable cooperation in the defense of such Action, provided however, that BlueCross reserves the right to select its own counsel and otherwise be involved in the Action.
 - 5.4.1.3. Employer shall remain liable for the full amount of any benefits paid under the Plan as a result of such Action, in addition to all costs of legal fees, penalties, interest and other expenses recovered by a Member or provider in connection with the Action. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider under the Plan as a result of any Action, or any legal fees or costs recovered by a Member or provider in connection therewith.
- 5.4.2. Legal Actions Brought Against Employer. If an Action is brought against Employer (and not BlueCross):
- 5.4.2.1. Employer will select and retain counsel and will assume liability for the payment of legal fees, costs and disbursements in connection with such Action.
 - 5.4.2.2. BlueCross will provide Employer with reasonable cooperation in the defense of such Action, provided however that BlueCross reserves its right to select its own counsel and otherwise be involved in the Action as necessary to protect BlueCross's interests.
 - 5.4.2.3. Employer shall be liable for the full amount of any benefits Losses paid under the Plan as a result of such Action, as well as any legal fees, penalties, interest and costs recovered by a Member or provider in connection therewith. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider under the Plan as a result of such Action, or any legal fees or costs recovered by a Member or provider in connection therewith.

ARTICLE VI – MISCELLANEOUS PROVISIONS

- 6.1. Acceptance by Payment of Fees. BlueCross expects that Employer will demonstrate its acceptance of the terms of this Agreement by executing this Agreement in a reasonable period of time after receiving it from BlueCross. In the event that Employer has not executed the Agreement by the Effective Date, this Agreement will be considered accepted by and binding upon both Parties if and when Employer makes a payment to BlueCross in order to receive the services described in this Agreement.
- 6.2. Amendment. This Agreement may be modified, amended, renewed or extended only upon mutual written agreement.
- 6.3. Assignment. This Agreement may be assigned to a subsidiary or affiliate of Employer upon ninety (90) days prior written notice to, and with the express written consent of, BlueCross. BlueCross shall not unreasonably withhold its consent to any such assignment by Employer.

- 6.4. Binding Effect of Agreement. The Agreement shall be binding upon and inure to the benefit of the Parties, their officers, directors, employees, successors, and assigns unless otherwise set forth herein or agreed to by the Parties hereto.
- 6.5. Impossibility of Performance. If an act or omission by a third party, including governmental entities, Network Providers or vendors, renders the performance of this Agreement illegal, impossible or impractical, the affected Party shall notify the other of the nature of that act or omission (the “Adverse Event.”) The Parties shall meet and, in good faith, attempt to negotiate a modification to this Agreement that minimizes the Adverse Event. Notwithstanding any other provision of this Agreement, if the Parties fail to reach a negotiated modification concerning the Adverse Event, then the affected Party may immediately terminate this Agreement upon giving written notice to the other Party.
- 6.6. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and such counterparts shall constitute one and the same instrument.
- 6.7. Entire Agreement. This Agreement, including the exhibits and any attachments hereto, all of which are incorporated herein by reference, contains the entire agreement between BlueCross and Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect. The exhibits and attachments to this Agreement include the following:
- 6.7.1. Exhibit A – Benefit Documents
 - 6.7.2. Exhibit B – Administrative Services Fees
 - 6.7.3. Exhibit C – Duties of and Services Provided by BlueCross
 - 6.7.4. Exhibit D – Medical Management Services Provided by BlueCross
 - 6.7.5. Exhibit E – Duties of Employer
 - 6.7.6. Exhibit F – Automated Clearinghouse (ACH) Authorization Agreement
 - 6.7.7. Exhibit G – Inter-Plan Arrangements
 - 6.7.8. Exhibit H –COBRA Administration Provided by Employer or a Third Party
 - 6.7.9. Exhibit I – Health and Wellness Services
 - 6.7.10. Exhibit J – Reserved
 - 6.7.11. Exhibit K – Reserved
 - 6.7.12. Exhibit L – Reserved
 - 6.7.13. Exhibit M – Online Enrollment Specifications through BlueCross Secured Website
 - 6.7.14. Exhibit N – Grievance Services

- 6.7.15. Exhibit O – Reserved
- 6.7.16. Exhibit P – Pharmacy Services
- 6.7.17. Exhibit Q – Business Associate Agreement
- 6.7.18. Exhibit R – Reserved
- 6.7.19. Exhibit S – Audits and Records
- 6.7.20. Exhibit T – Reserved
- 6.7.21. Exhibit U – Reserved
- 6.7.22. Exhibit V – Reserved
- 6.7.23. Exhibit W – Shared Savings
- 6.7.24. Exhibit X – Reserved
- 6.8. Governing Law. This Agreement is subject to and shall be governed by the laws of the United States and State of Tennessee, without regard to conflict of laws provisions.
- 6.9. Interpretation.
 - 6.9.1. If the provisions of this Agreement are in any way inconsistent with the provisions of the Benefit Documents, then the provisions of this Agreement shall prevail and the other provisions shall be deemed modified to the extent necessary to give effect to such provisions.
 - 6.9.2. If the provisions of this Agreement are in any way inconsistent with the provisions of the Exhibits and Attachments hereto, then the provisions of Exhibits and Attachments shall prevail and the inconsistent provisions of this Agreement shall be deemed modified to the extent necessary to give effect to such provisions.
 - 6.9.3. For purposes of this Agreement, the words “include,” “includes” and “including” shall be deemed to be followed by the words “without limitation”, and the word “or” shall not be exclusive.
- 6.10. Independent Entities.
 - 6.10.1. This Agreement is not intended to create nor deemed or construed to create any relationship between Employer and BlueCross other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither the Parties nor their respective directors, officers, employees or representatives shall be construed to be the partner, joint venturer, agent, employer, or representatives of the other Party.
 - 6.10.2. On behalf of itself and its Members, Employer hereby acknowledges its understanding that this Agreement constitutes a contract solely between Employer and BlueCross which is an independent corporation operating under a license from the Association permitting BlueCross to use the BlueCross and BlueShield Service

Marks in the State of Tennessee, and that BlueCross is not contracting as the agent of the Association.

- 6.10.3. Employer acknowledges that BlueCross is independent from any provider rendering services to Members, and that BlueCross is not responsible for any acts or omissions by a provider in rendering care or services to a Member.
- 6.10.4. Employer acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BlueCross and that no person, entity, or organization other than BlueCross shall be held accountable or liable to Employer for any of BlueCross's obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BlueCross other than those obligations created under other provisions of this Agreement.
- 6.11. Legal Action. All actions are subject to Article IV, Dispute Resolution.
- 6.12. Notices. Any notice, request, demand or other communication required to be given pursuant to this Agreement shall be in writing, sent by certified or registered mail, return receipt requested, or by Federal Express or other overnight mail delivery for which evidence of delivery is obtained by the sender, to BlueCross or Employer at the addresses set forth below. The notice shall be effective on the date the notice was posted.

If to BCBST:

BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Attn: Vice President Sales & Account Management

With a copy not constituting notice to:

BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Attn: Senior Vice President and General Counsel

If to Employer:

City of Kingsport
Office of the City Attorney
415 Broad Street
Kingsport, TN 37660

- 6.13. No Third Party Rights. Except as specifically provided herein, none of the provisions of this Agreement is intended to create third party rights, status or beneficiaries in any person or entity.
- 6.14. Reserved.
- 6.15. Severability. If any provision of this Agreement is declared illegal, void or unenforceable, the remaining provisions shall remain in force and effect, unless the severance of that provision substantially deprives a Party of the benefit of its bargain or increases the cost of performing its duties pursuant to this Agreement.

- 6.16. Subsidiaries and Affiliates. Any of the functions to be performed by BlueCross under this Agreement may be performed by BlueCross or any of its subsidiaries, affiliates or designees.
- 6.17. Survival. The rights and obligations of the Parties as set forth herein shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the Parties as expressed herein.
- 6.18. Waiver of Breach. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.
- 6.19. Other Acceptable Forms of this Document. The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, and/or an electronic version.

ARTICLE VII - DEFINITIONS

- 7.1. “Action” means litigation, arbitration and/or other legal proceeding.
- 7.2. “Agreement” means this administrative services agreement entered into by Employer and BlueCross, including all Exhibits and Attachments hereto.
- 7.3. “Approved Claims” means claims processed and approved for payment by BlueCross in accordance with this Agreement.
- 7.4. “ASF(s)” means Administrative Services Fee(s).
- 7.5. “Association” means the BlueCross and BlueShield Association.
- 7.6. “Benefits Documents” means the benefit documents which summarize the benefits of the Employer’s Plan and are attached hereto as Exhibit A.
- 7.7. “BlueCross” means BlueCross and BlueShield of Tennessee, Inc.
- 7.8. “BlueCross Confidential Information” means Confidential Information that BlueCross discloses or authorizes be disclosed to Employer, including BlueCross pricing and payment data and information, such as payment rates, allowed amounts, fee schedules, discounts and payment methodologies; claims data (whether at claim level or aggregated), data and information regarding providers, BlueCross research and technical information; BlueCross’s processes, procedures or policies, and information obtained from and/or about the Association and its programs.
- 7.9. “Confidential Information” means this Agreement and all information or material (whether tangible or intangible) that is shared with or disclosed to the other Party pursuant to this Agreement and the Parties’ relationship, including information identified as proprietary and/or confidential information, information that is confidential as a matter of law (e.g., personnel records), and BlueCross Confidential Information disclosed to Employer. The following shall not constitute Confidential Information for purposes of this Agreement: (a) Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a Party or its Representatives; (b) Confidential Information that was available to a Party on a non-confidential basis prior to its disclosure by the other Party or its Representatives; (c) Confidential Information that becomes available to a Party

on a non-confidential basis from a third party (other than BlueCross's affiliates, subsidiaries or vendors or the Association or other licensee of the Association), provided that third party is not known to be subject to any prohibition against transmitting that information; (d) information that was independently developed by a Party without an use of or reference to the Confidential Information of the other Party, as shown by documents and other competent evidence, or (e) Protected Health Information.

- 7.10. "Effective Date" means January 1, 2026.
- 7.11. "Employee Welfare Benefit Plan" shall have the same meaning as defined in ERISA.
- 7.12. "Employer" means City of Kingsport, TN.
- 7.13. "Employer Service Vendor" means any person providing services to or on behalf of the Plan or the Employer in connection with the Plan or under the Agreement and any subcontractor(s) of such Employer Service Vendor.
- 7.14. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.
- 7.15. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations, as amended.
- 7.16. "Initial Term" means January 1, 2026 through December 31, 2026.
- 7.17. "Losses" means any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, fines, taxes and expenses, including legal costs, fees and expenses.
- 7.18. "Member" means an eligible Employee or eligible Dependent and as that term is further defined in the Benefit Documents.
- 7.19. "Plan" means the self-funded Employee Welfare Benefit Plan established by Employer for the benefit of its eligible Employees and their eligible Dependents.
- 7.20. "Plan Administrator" means the Employer.
- 7.21. "Representatives" means a Party's directors, officers, employees, agents, advisors, Business Associates (as such term is defined in HIPAA), contractors and other representatives.
- 7.22. "Run- Out Claims" means those claims incurred for Covered Services performed prior to the termination of this Agreement, but not yet paid and/or not submitted for payment to BlueCross prior to the termination of this Agreement, where the date a claim is "incurred" is the date the particular service was rendered or the supply was furnished
- 7.23. "Subscriber" means an Eligible Employee enrolled in Employer's Plan.
- 7.24. "Term" means January 1, 2026 through December 31, 2026.
- 7.25. All non-defined, but capitalized terms included in this Agreement are defined in the Benefit Documents.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives. The undersigned persons hereby warrant that they are duly authorized to bind each of their represented Parties to the terms of this Agreement.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.

CITY OF KINGSFORT, TN

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Address: 1 Cameron Hill Circle
Chattanooga, TN 37402

Address: 415 Broad Street
Kingsport, TN 37660

Employer ID No. 62-6000323

EXHIBIT A TO THE ADMINISTRATIVE SERVICES AGREEMENT

BENEFIT DOCUMENTS

Exhibit A consists of the following Benefit Documents

Health Benefit Plan – PPO Options 1 - 3

EXHIBIT B TO THE ADMINISTRATIVE SERVICES AGREEMENT**ADMINISTRATIVE SERVICES FEES (ASF)S AND CLAIMS FUNDING METHODOLOGY**

1. ASFs. Employer shall pay to BlueCross the following ASFs:

1.1. Medical ASF

Rates effective as of:	January 1, 2026	January 1, 2027	January 1, 2028
Admin Fee	\$38.94 per Subscriber per month	\$40.07 per Subscriber per month	\$41.23 per Subscriber per month
Medical Main ASF	\$38.94 per Subscriber per month	\$40.07 per Subscriber per month	\$41.23 per Subscriber per month
Medical Guaranteed ASF	\$38.94 per Subscriber per month	\$40.07 per Subscriber per month	\$41.23 per Subscriber per month
Teladoc Health Base Package	\$0.47 per Subscriber per month	\$0.47 per Subscriber per month	\$0.47 per Subscriber per month
Medical Total ASF	\$39.41 per Subscriber per month	\$40.54 per Subscriber per month	\$41.70 per Subscriber per month

1.1.1. The financial offer above is contingent upon both medical and pharmacy being administered by BlueCross for the duration of the multi-year agreement.

1.1.2. BlueCross may adjust the above fees at any time, under the following circumstances:

1.1.2.1. Changes in the Plan, BlueCross's duties, legislation, regulation or required assessment or tax that changes BlueCross' cost in administering the plan;

1.1.2.2. Termination or addition of a subsidiary, operation or class of employees covered under the Agreement;

1.1.2.3. Fluctuation of the number of Subscribers by more than 10% percent by location, state and/or in aggregate. Calculation of the Medical Total ASF was based on 715 Subscribers;

1.1.2.4. Fluctuation of the Member to Subscriber ratio by +/- 0.05. The Medical Total ASF was based on a Member to Subscriber ratio of 2.13; or

1.1.2.5. Federal, state or local government action, change in law or regulation (or interpretation of a law or regulation) which impacts the benefit levels or affects BlueCross' ability to meet its obligations under this Agreement to Employer, to Employer's Covered Members or to BlueCross' Network Providers, including but not limited to, legislation, regulation(s) or government

action(s) which impose requirements that affect: (i) BlueCross’ ability to determine or administer Covered Services; (ii) provider’s delivery of care or the fees providers charge; or (iii) BlueCross’ contracts with Network Providers. Upon the occurrence of an event described in this Section 1.1.2.5., the Parties will make a good faith effort to reach a new agreement that equitably reflects the circumstances as altered by such law, regulation or government action.

1.1.3. If Employer terminates this Agreement prior to December 31, 2028, Employer agrees that BlueCross will not receive certain additional income it had anticipated and, in such case, Employer will pay BlueCross an amount equal to one month’s Medical Total ASF, based on the average of the number of Subscribers covered under this Agreement for the 3-month period prior to the termination date of this Agreement.

1.2. Stop Loss Interface Fee

Rates effective as of:	January 1, 2026
Stop Loss Interface Fee	\$1.90 per contract per month

2. Inter-Plan Arrangements (BlueCard) Fees¹. When Members access health care services outside of Tennessee, claims for those services are received by the licensee of the Association where the provider is located (the “Host Plan”) and forwarded electronically to BlueCross for adjudication. For claims from providers that participate in the Host Plan’s provider network, the Member and Plan get the benefit of access to the terms and conditions of the Host Plan’s contracted arrangement with the provider, including pricing arrangements. The currently applicable fees for such access to Host Plan’s networks and arrangements (including administrative processing) are as follows:

Access Fees	The Access Fee is charged by the Host Plan to BlueCross for making the Host Plan’s network available to Employer’s Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential BlueCross receives from the applicable Host Plan subject to a maximum of \$2,000 per claim. When charged, BlueCross passes the Access Fee directly on to Employer.	3.21% of network savings, capped at \$2,000.00 per claim
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Administrative Expense Allowance (AEA) Fee	The AEA Fee is a fixed per-claim dollar amount charged by the Host Plan to BlueCross for administrative services the Host Plan 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 your group enrollment. When charged, BlueCross passes the AEA Fee directly on to Employer.	\$5.00 per claim professional and \$11.00 per claim institutional
Nonparticipating Provider Fee		\$3.00 per claim
BlueCross BlueShield Global® Core Fee		\$4.35 per claim Member-submitted, \$5.50 per claim professional, and \$18.55 per claim institutional

¹ See Exhibit G for more detail about Inter-Plan Arrangements. Any fees under such arrangements are set by specific program policies that may change from time to time through a process that the Association administers, and are subject to change by the Association without notice.

3. Reports. BlueCross shall provide Employer with access to BlueCross's standard reporting and interactive reports at no additional charge. Any additional reports requested by Employer shall be subject to an additional charge determined by BlueCross, such charge which will be billed separately. Upon termination of this Agreement, Employer shall pay BlueCross for any and all requested reports, such payment being made in advance of receiving the requested report.
4. Timing, Calculation and Funding of Monthly ASFs. Employer shall pay the applicable ASFs for all Subscribers covered or added during the month. If Employer adds a Subscriber retroactively, Employer shall pay the applicable ASFs for that Subscriber, calculated from the Subscriber's correct enrollment date to the current date. When Employer provides enrollment data and that data does not match BlueCross's data, BlueCross's data will be used to determine the ASF.
 - 4.1. Monthly Enrollment. The monthly ASF is determined each month based on enrollment. On the 15th day of each month, BlueCross shall determine the number of Subscribers covered under Employer's Plan, and this shall be the basis for the ASFs charged by BlueCross for the following month.
 - 4.1.1. Enrollment Changes. Any changes to the initial enrollment will be charged to Employer in accordance with the following:
 - 4.1.1.1. Subscriber added on or before the 15th day of the month: Employer will be charged the monthly ASFs for that Subscriber.
 - 4.1.1.2. Subscriber added after the 15th day of the month: Employer will not be charged the monthly ASFs for that Subscriber.

- 4.1.1.3. Subscriber terminated on or after the 15th day of the month: Employer will be charged the monthly ASFs for that Subscriber.
 - 4.1.1.4. Subscriber terminated before the 15th day of the month: Employer will not be charged the monthly ASFs for that Subscriber.
 - 4.2. Funding of ASFs and Adjustments. On the 20th day of each month, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to pay BlueCross's ASFs for the following calendar month, and funds necessary to complete any adjustments to Approved Claims, fixed, previously agreed-upon charges, previous ASFs and any due late fees. Such payments shall be made in accordance with the Direct Debit Authorization Agreement, which is an Automated Clearinghouse (ACH) Authorization Agreement, attached to this Agreement as Exhibit F. Employer will transfer the amount specified by BlueCross into Employer's account so such funds shall be available for ACH debit by the first day of the following month (the "Due Date").
 - 4.2.1. If the full amount specified by BlueCross to pay ASFs and other fees pursuant to the Agreement is not received by BlueCross by the Due Date, BlueCross may immediately suspend or deny payment of all Approved Claims on behalf of Employer, regardless of the date claims were incurred, until all amounts due and owing are received by BlueCross. If BlueCross elects to not suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding. Notwithstanding the foregoing, BlueCross does not otherwise waive any termination rights it has under the Agreement by electing to suspend payment of Approved Claims.
 - 4.2.2. If Employer notifies BlueCross of a Member's termination within ninety (90) days of the Member's termination, BlueCross will credit Employer with any ASFs that were paid for that Member for that time period.
 - 4.2.3. If Employer does not notify BlueCross of a Member's termination within ninety (90) days of the Member's termination, BlueCross will only credit Employer for the most recent ninety (90) day period of ASFs that were paid by Employer for that Member's coverage.
5. Additional Administration Charges. The cost of services outlined below may be billed as a direct cost to Employer.
 - 5.1. Creation, production, and printing non-standard Member material.
 - 5.2. Investigation and litigation of disputed claims, including the amount of the settlement and any damages (including punitive damages, unless subject to indemnification pursuant to Article V of the Agreement).
 - 5.3. Development and production of customized or unique reports requested by Employer, such as management reports, claim reports, reports for stop loss carriers, and other special reports.
 - 5.4. Customized or unique systems development required by Employer.

- 5.5. Reprinting materials/ID cards off cycle due to changes or misinformation provided by or on behalf of Employer to BlueCross.
 - 5.6. Non-standardized Member mailings.
 - 5.7. Training for on-line eligibility in excess of standard training package.
 - 5.8. Independent Dispute Resolution (“IDR”) Fees for Certain Out-of-Network Provider Claims: Federal administration fees, Certified IDR Entity fees, reasonable legal costs, if applicable, in connection with the IDR process established by the No Surprises Act (within the Consolidated Appropriations Act, 2021) for certain out-of-network provider claims. These amounts are in addition to the final amount paid to the provider for the medical claim itself.
 - 5.9. Shared Savings Fees pursuant to Exhibit W.
 - 5.10. AdHoc requests for clinical information, including plan of care, for a specific member or set of members:
 - 5.10.1. Requests for a discussion/consult/review with a BlueCross Medical Director or Pharmacy Director will incur a charge of \$375 per hour assessed in 15-minute increments.
 - 5.10.2. Requests for a Care Management Nurse to provide detailed information, including Case Management Notes, in excess of 2 members per quarter will incur a charge of \$125 per hour assessed in 15-minute increments.
 - 5.11. Audit Support for third-party reviews and audits that fall outside the scope of Exhibit S.
6. Security Interest. To secure the payment of any amounts due to BlueCross under this Agreement, Employer hereby grants to BlueCross a first priority security interest in and assigns to BlueCross Employer’s right, title and interest in Employer’s debiting account and the proceeds thereof to the fullest extent permitted under the law. In the event of a default by Employer of any of its obligations to BlueCross, including the prompt payment when due of any invoice sent to it by BlueCross, BlueCross shall have the immediate right, upon written notice to Employer, to offset the proceeds of the debiting account against the amount of any unpaid invoice or other obligation owed to BlueCross. Notwithstanding anything in this Agreement to the contrary, Employer does not have the authority to grant a security interest in its property or authorize a lien on its property, so those provisions granting a security interest or lien are enforceable only to the extent permitted by Tennessee law.
7. Claims Funding Methodology. Pursuant to Section 1.6 of the Agreement, the Parties agree that on a mutually acceptable day of each week, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to fund Approved Claims, and BlueCross shall initiate the debit for Approved Claims to be paid. The debit will clear Employer’s account the following business day. BlueCross adjudicates claims in accordance with its internal administrative procedures.
- 7.1. If the full amount specified by BlueCross to fund Approved Claims is not made available to BlueCross within the specified time period, BlueCross may

immediately suspend or deny payment of all Approved Claims, regardless of the date claims were incurred, until all amounts due are received by BlueCross.

- 7.2. If BlueCross elects not to suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% percent per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.
- 7.3. If a partial amount is available, BlueCross may elect (but is not required) to utilize those funds to pay Approved Claims until full payment is made by Employer. BlueCross has full discretion to determine which Approved Claims will be paid with these partial funds, and may or may not exercise that discretion.

BlueCross shall provide Employer with a list of Approved Claims paid on behalf of Employer, within 30 calendar days following the end of each month during which this Agreement remains in effect.

8. Deposit Access. BlueCross has the right to request a cash deposit from Employer at any time during the Agreement year if, in BlueCross' sole discretion, BlueCross has reason to believe that Employer is unable to timely meet its payment obligations under the Agreement. In connection with the request for a cash deposit, BlueCross shall issue a notice to Employer, specifying the amount of the deposit which shall be based on a multiple of an estimate of monthly ASFs and Approved Claims, pursuant to the requirements established in Exhibit E. Should Employer fail to timely pay ASFs or fund Approved Claims within the time specified in the Agreement, BlueCross shall have the right to access funds on deposit without further notice to Employer in order to pay ASFs and/or fund Approved Claims. Any amount remaining in the deposit account upon termination of the Agreement will be included in the Final Settlement pursuant to Section 3.9.
9. Run Out Claims. Provided that Employer has timely paid all outstanding amounts needed to fund Approved Claims and ASFs as of the date the Agreement is terminated, BlueCross will administer run out claims for Employer at the termination of this Agreement for a period of 365 days from the date this Agreement terminates. The monthly ASFs for performing this service shall be the same as the ASFs charged Employer at termination of the Agreement. The monthly ASFs for performing this service shall be based on an average of the number of Subscribers covered under this Agreement for the 3 months immediately prior to the termination date of this Agreement. This fee shall be billed for the first 4 months of the run-out period.
10. Premium Billed Ancillary Products. If Employer has requested that BlueCross provide additional services through other products (i.e., dental), or has requested that BlueCross collect premiums or premium equivalents from subscribers or Members to fund other benefits offered by Employer (i.e., life insurance offered through another carrier, etc.), any additional funds due from Employer to BlueCross for remittance to other carriers or providers of services shall be remitted to BlueCross on the same basis as the ASFs.
11. Employer Fails to Pay. Notwithstanding any other term of the Agreement to the contrary, if Employer fails to pay when due any amount to fund Approved Claims, ASFs or other fees required to be paid to BlueCross under this Agreement, and such default is not cured

within five (5) days of the Due Date, BlueCross reserves the right to consider the Employer delinquent and may, at its option

11.1. Suspend or deny claim payments at any time, in whole or in part; or

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

EXHIBIT C TO THE ADMINISTRATIVE SERVICES AGREEMENT**DUTIES OF AND SERVICES PROVIDED BY BLUECROSS**

1. Generally. It is understood and agreed that BlueCross is empowered and required to act with respect to the Plan only as expressly stated in this Agreement. Employer and BlueCross agree that BlueCross's role under this Agreement is to provide administrative claims payment and similar administrative services in accordance with the terms of the Benefit Documents and the Agreement; that BlueCross does not assume any financial risk or obligation with respect to Approved Claims; and that the services rendered by BlueCross under this Agreement are merely ministerial, and shall not include the power to exercise control over the Plan's assets, if any, or discretionary authority over the Plan.
2. Enrollment: Forms and I.D. Cards. BlueCross shall enroll those individuals who have completed an enrollment form and are determined by Employer to be eligible for benefits under the Plan. Employer shall provide BlueCross with enrollment information in a mutually agreeable format, (i.e., electronically, faxed, paper, etc.) BlueCross is not responsible for verifying data submitted by Employer. BlueCross shall be entitled to rely on the information furnished to it by Employer. Employer shall hold BlueCross harmless for inaccurate information provided by Employer or BlueCross's inability to perform under this Agreement as a result of Employer's failure to provide such information in a timely manner.
 - 2.1. BlueCross shall furnish to Employer, for distribution to Members, forms to be used for enrollment and submission of any other forms determined to be necessary by BlueCross for the administration of the Benefit Documents under this Agreement.
 - 2.2. BlueCross will not furnish enrollment forms to Employer, since Employer will enroll Members and maintain eligibility online as described in Exhibit M, Online Enrollment Specifications through BlueCross Secured Website.
 - 2.3. Once Employer has notified BlueCross in writing that a new Member is eligible for benefits, BlueCross shall update its systems to reflect that Member's coverage.
 - 2.4. Once Employer has notified BlueCross in writing that a Member should be terminated as no longer eligible for coverage, BlueCross shall update its systems to reflect that change in the Member's coverage in accordance with Exhibit B.
 - 2.5. BlueCross will conduct certification and verification of incapacitated dependent information.
3. Claims Processing. BlueCross shall provide claims processing services on behalf of Employer for all properly submitted claims. BlueCross will follow current industry practices and its internal claims processing procedures regarding payment of claims, including timeliness and accuracy of claims payments. For purposes of this paragraph 3, the term "claim(s)" is defined as a request from a provider of Covered Services and/or a Member for payment of monies due for the rendering of Covered Services under the Benefit

Documents, and in conformity with any agreements BlueCross enters into with such providers of Covered Services.

- 3.1. When necessary, BlueCross shall furnish to Employer, for distribution to Members, forms to be used for claims submission, and any other forms determined to be necessary by BlueCross for the administration of the Benefit Documents.
- 3.2. BlueCross will coordinate with other payors, including Medicare, in adjusting claims according to the terms and conditions of coverage, including Medicare Secondary Payor rules. This may delay finalization of the adjudication of a claim, depending on when data is received regarding the claim. If Medicare is primary, BlueCross will adjudicate benefits based on the Medicare allowed amount.
- 3.3. BlueCross shall furnish each Member claiming benefits with an explanation of each claim that is paid, denied or rejected.
- 3.4. BlueCross shall give Members a reasonable opportunity to appeal a denied claim or any portion of a claim within the time frames specified by ERISA, according to the appeals procedure defined in the Benefit Documents.
- 3.5. If Employer notifies BlueCross of a Member's termination from coverage after the Member's termination date, and Approved Claims for that Member were paid in the interim, BlueCross shall request reimbursement from the provider on Employer's behalf to the extent possible. However, if Employer does not notify BlueCross of a Member's termination from coverage ninety (90) days or more after the date of Member's termination of coverage, BlueCross shall not be obligated to attempt to collect any claim payments which were paid before notice of termination was received by BlueCross.
- 3.6. If Employer notifies BlueCross of a Member's termination from coverage after the Member's termination date, and BlueCross made payment of benefits directly to such Member, BlueCross will attempt recovery unless Employer directs BlueCross in writing not to attempt recovery from such Member.
 - 3.6.1. If Employer's Benefit Documents include coverage for pharmacy benefits that are paid by BlueCross's pharmacy vendor or Provider-Administered Specialty Products that are paid by BlueCross, claims paid after a Member's termination cannot be recovered from the provider, pharmacy or any other person or entity, as applicable. However, BlueCross will attempt recovery from the Member on these claims. If Employer does not wish BlueCross to attempt recovery from a specific Member, Employer must direct BlueCross accordingly in writing.
 - 3.6.2. If a claim payment is less than fifty dollars (\$50), BlueCross has no obligation to attempt to collect said claim payment.
 - 3.6.3. If a claim payment was made for services rendered through the BlueCard program, BlueCross has no obligation to attempt to collect claim payments that were for less than fifty dollars (\$50), or in accordance with stated limits in effect at the Host Plan location.

- 3.6.4. If Employer directs BlueCross to use the services of an outside collection agency to collect a claim payment, the fees charged by such entity shall be the sole responsibility of Employer.
 - 3.6.5. If benefits are not recoverable from a provider or Member, Employer remains liable to fund all claims.
 - 3.7. BlueCross will provide Employer with a monthly statement with respect to claims paid in the prior month.
 - 3.8. At the termination of this Agreement and provided that Employer pays BlueCross the applicable fees set forth in Exhibit B, BlueCross shall administer the payment of Run Out claims for Employer. These claims shall be administered as any other claim handled during the term of the Agreement, and shall be subject to the same restrictions.
 - 3.9. RESERVED.
 - 3.10. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, pandemic or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with BlueCross's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, BlueCross 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 Document but is undertaken in order to minimize the effect such catastrophic event has on Members, including: (i) waiving referral, prior authorization or pre-certification requirements for medical and/or pharmacy services; (ii) waiving administrative holds and terminations due to nonpayment of premiums; (iii) allowing early refills on prescription medications; (iv) offering medical and behavioral health visits through telehealth; and (v) reducing or waiving cost-sharing obligations for services. As soon as practicable after a catastrophic event, BlueCross shall report its actions to Employer. Employer shall reimburse BlueCross for all amounts paid in good faith, or as required by law, under the circumstances and such amounts shall constitute Approved Claims for which Employer is responsible for payment, even if the charges incurred were not for services otherwise covered under the Benefits Documents.
- 4. Network Administration. BlueCross shall administer its established cost containment programs and access and availability benefits management programs, as selected by Employer. BlueCross's provider contracts and medical policies control network administration.
 - 4.1. BlueCross shall make available the Blue Network selected by Employer, including network hospitals and other providers or practitioners with which BlueCross has contracted, ("Blue Network") to provide Covered Services to Members. All agreements between providers of services and BlueCross are the sole property of BlueCross, and BlueCross retains the right to the use and control of these provider agreements.

- 4.2. Employer acknowledges that BlueCross does not act either as the agent of or in any fiduciary capacity with respect to Employer, any of its Plans, or any of its Members, when BlueCross negotiates its provider and/or vendor arrangements.
 - 4.3. Employer acknowledges that the Blue Network Provider contracts cannot be modified to meet any specific requirements of Employer, and that BlueCross has the discretion to change the composition, name, etc. without Employer's consent or approval. BlueCross does not guarantee that a specific provider will remain in the network, and BlueCross has the right to determine network adequacy, and to establish and modify billing guidelines and reimbursement arrangements for Network Providers.
 - 4.4. BlueCross negotiates various payment arrangements with providers, including per diem, percent of charges, diagnosis related groups (DRGs,) global case rate and fee schedule arrangements, which vary by provider. Certain facilities may have multiple or a combination of these arrangements. All of these arrangements provide payment to the provider, and claims processed using one of these arrangements are considered Approved Claims.
 - 4.4.1. Savings/discounts are not stated herein in actual amounts or percentages, nor are they guaranteed, since credits can vary by facility, type of service provided and the specific provider agreement at a given facility.
 - 4.4.2. The provider's charge to BlueCross will usually be less than the rate charged for a similar service to the general public. In some cases, however, the rate negotiated by BlueCross for a particular service may be higher than the provider's rate for that service charged to the general public, and BlueCross will pay the negotiated rate.
 - 4.4.3. BlueCross has certain special arrangements with some providers that may exempt those providers from certain administrative and medical management requirements, including, but not limited to, prior authorization, appropriateness review, notification and written referral requirements.
 - 4.4.4. BlueCross may negotiate a settlement of a reimbursement dispute with a provider as part of its internal administrative procedures.
5. Reimbursement to Network and Out-of-Network Providers.
- 5.1. "Network Providers" are providers that have agreed to participate in the Blue Network, and to accept BlueCross's applicable pre-negotiated payment allowance for certain Covered Services as payment in full, and therefore should not bill the Members for any amount in excess of the payment allowance for such service(s). The pre-negotiated payment will be based upon charges for Covered Services or upon an alternative method of payment, including per diem amounts, percent of charges, global case rate and fee schedule arrangements, and may be further reduced by other contractual reductions, adjustments, discounts or offsets based on BlueCross's agreements with Network Providers. Network Providers will file Members' claims with BlueCross, and BlueCross will make payment directly to Network Providers.

- 5.1.1. In the unlikely event of a systems failure at BlueCross (“Outage”) rendering it temporarily impossible to determine which Network Provider rendered services during a specific time period while the Agreement is in force, BlueCross will make estimated payments to Network Providers. This estimate will be based on past service to BlueCross Members, and will be proportionately divided among Employer and other Groups which BlueCross insures or to which BlueCross provides administrative and claims processing service. When the capability to determine which Network Providers did provide services during the Outage is restored, BlueCross will adjudicate the claims submitted on behalf of Members, and notify Employer of any adjustments necessary to Employer’s claims processing funding.
- 5.2. When a Member receives services from a Network Provider, he or she will be responsible for payment of the applicable Deductible, Coinsurance, Cost-Sharing and/or Copayment, as well as charges for any non-covered services. A Member’s Coinsurance for Covered Services received from a Network Provider will be based on the provisions of the Network Provider’s contract, and the lesser of (i) the Network Provider’s pre-negotiated payment allowance, or (ii) charges for Covered Services at the time such Services are provided. BlueCross will not recalculate Coinsurance in the event it recovers a discount or savings with respect to Covered Services after a claim for such Services is paid. Rather, Employer will receive a payment or credit for such savings or discounts.
- 5.3. The Member’s liability for non-covered services, including services that are not covered because of a benefit maximum or other limitation contained in the Benefit Documents, will be based on the Network Provider’s actual charges for such services.
- 5.4. “Out-of-Network Providers” are providers that do not participate in the Blue Network. BlueCross’s payment for Covered Services to any Out-of-Network Provider will be based on Maximum Allowable Charge for the service performed. Except as required by applicable law (including the No Surprises Act enacted as part of the Consolidated Appropriations Act, 2021), upon receipt of a completed claim form, and provided adequate funding from Employer is available, BlueCross shall make payment for Covered Services to the Out-of-Network Provider and not the Member, unless BlueCross receives proof of payment from the Member before payment is made to the provider. Except as required by applicable law, when the Member receives services from an Out-of-Network Provider, he or she will be responsible for the payment of any difference between BlueCross’s payment and such provider’s charge(s), and responsible for any applicable Deductible, Copayment, and Coinsurance, as well as payment of charges for any non-covered services. The Member’s responsibility for Coinsurance will be based on the Maximum Allowable Charge for that service. Maximum Allowable Charge shall be calculated as determined by BlueCross in accordance with the EOC, BlueCross policies and applicable law.
- 5.5. When Members obtain Covered Services outside of Tennessee, BlueCross’s Blue Network reimbursement rules do not apply. Please refer to Exhibit G, Inter-Plan Arrangements, for a description of how out-of-state providers are reimbursed.

- 5.6. BlueCross is responsible for reporting and remitting only those abandoned property funds that were provider payments made with BlueCross funds.
 - 5.7. Employer is required to reimburse the Veteran's Administration ("VA") according to federal law. BlueCross has an agreement with the VA in which there is an established fee schedule. Federal law requires payment to the VA, regardless of the network status, and regardless of the amount of benefits provided for services by an Out-of-Network Provider. BlueCross will reimburse the VA at the rate set forth in the agreement between BlueCross and the VA. The Plan will pay the VA as if it were a Network Provider.
 - 5.8. BlueCross's contracts with Network Providers may include a variety of payment methodologies. These payment methodologies may obligate BlueCross to pay an amount that is in addition to the underlying cost of the service rendered. These additional costs may include program fees, incentive payments, bonus payments, or quality payouts. These provider reimbursements will be passed to Employer as part of the billing process detailed in this Agreement.
 - 5.9. No Member shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under the Plan to a third party, and such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims. Benefit payments under the Plan may not be assigned, transferred, or in any way made over to another party by a Member. Nothing contained in this Agreement or the Plan shall be construed to make the Employer, Plan or BlueCross liable to any third party to whom a Member may be liable for medical care, treatment, or services. If a written authorization is provided to BlueCross by a Covered Person, BlueCross may pay a benefit directly to a provider of medical care, treatment, or services instead of the Member as a convenience to the Member; when this is done, all of the Plan's obligation to the Member with respect to such benefit shall be discharged by such payment. However, BlueCross reserves the right not to honor any direct payment request to any third party, including but not limited to, any provider. The foregoing does not preclude any assignment of payment to Medicaid to the extent required by law. Neither BlueCross, nor the Plan will honor claims for benefits brought by a third-party; such third-party shall not have standing to bring any such claim either independently, as a Member or beneficiary, or derivatively, as an assignee of a Member or beneficiary.
6. Medical Management Services. BlueCross will provide certain services through its Medical Management program. These are described in Exhibit D to this Agreement.
 7. Claims Payments Adjustments.
 - 7.1. Whenever BlueCross becomes aware that a claims payment to a provider or Member is less than the amount to which the provider or Member is entitled, BlueCross shall promptly adjust the underpayment to reflect the proper amount that should be remitted.
 - 7.2. Whenever BlueCross becomes aware that a claims payment to a provider or Member is more than the amount to which the provider or Member is entitled,

BlueCross shall make a diligent attempt to recover such overpayment, in accordance with its customary administrative procedures, and as permitted by applicable law. In the event any part of an overpayment is recovered, Employer will receive a credit from BlueCross. BlueCross shall not be required to institute any legal proceeding to recover such overpayment. BlueCross will follow its policies and procedures to settle overpayments.

- 7.2.1. If a claim payment was made for services rendered through the BlueCard program, BlueCross has no obligation to attempt to collect claim payments that were for less than fifty dollars (\$50), or in accordance with stated limits in effect at the Host Plan location.
- 7.2.2. Subject to the terms in Section 7.2.4, BlueCross will assume liability for an unrecovered overpayment only if and when it is determined that:
 - 7.2.2.1. the overpayment was caused by an act or omission of BlueCross subject to indemnification under Article V, Section 5.1;
 - 7.2.2.2. all reasonable means of recovery under the circumstances have been exhausted; and
 - 7.2.2.3. BlueCross's acts or omissions were not undertaken at the express direction of Employer.
- 7.2.3. BlueCross is not liable for interest on recovered overpayments.
- 7.2.4. Employer acknowledges and agrees that, except in cases of fraud committed by the provider and, subject to applicable law, BlueCross will not recover overpayments from providers more than 18 months after the date that BlueCross paid the claim submitted by the provider.
- 7.2.5. In no event does BlueCross have an obligation to recover on liability for overpayments of claims that were adjudicated for payment more than three (3) years before the overpayment is discovered.
- 7.3. The Parties acknowledge that Employer may not contact Network Providers directly or indirectly regarding rates or charges for services provided to Members. All such contact with Network Providers must be by and through BlueCross.
- 7.4. Overpayment Recoveries: BlueCross, on behalf of Employer, has the right to obtain a refund of an overpayment on any claim(s) paid by BlueCross to a provider or a Covered Person. Unless otherwise agreed upon between BlueCross and the provider, when a provider fails to return an overpayment to BlueCross, BlueCross has the right to utilize the following mechanisms to recover the overpayment. For purposes of Sections 7.4.1 through 7.4.6 below, "Other Plan(s)" or "Another Plan" means any health benefit plan other than the Plan, including, but not limited to, individual and group plans or insurance policies that are administered or insured by BlueCross.
 - 7.4.1. BlueCross has the right to recover overpayments from future payments due by BlueCross to a provider in conjunction with BlueCross's payment of

medical claims for the Plan or from Other Plans, up to an amount equal to the overpayment (hereinafter “Claim Recovery”). When BlueCross identifies an overpayment, BlueCross notifies the provider in writing, identifying the overpayment (including the medical claim(s) at issue), the provider’s ability to grieve BlueCross’s determination of the overpayment, and the timeline for submitting payment for the overpayment. If the provider does not return the requested overpayment as directed, BlueCross may initiate its Claim Recovery process against future payments consistent with this section.

- 7.4.2. BlueCross has the right to reduce payment to a provider by the amount necessary to recover the overpayment to such provider and to reimburse BlueCross for the amount BlueCross reimbursed to Employer (net of fees, if any) in connection with such overpayment.
- 7.4.3. If BlueCross has made overpayments to a Provider for medical claims relating to members enrolled in more than one (1) Other Plan, BlueCross may initiate its Claim Recovery process for multiple overpayments collectively, against future payments owed to such provider on behalf of Another Plan, as part of a single transaction, resulting in an overpayment recovery amount which shall be applied in accordance with BlueCross policies, which prioritize application based on the age of the overpayments, beginning with the oldest outstanding overpayment or has the right to apply the Claim Recovery process as otherwise set forth in this Section 7.4. BlueCross shall not apply recovered amounts in a manner that prioritizes Overpayments based upon the funding type of any plan (e.g., whether the plan is fully-insured or self-funded).
- 7.4.4. Employer acknowledges that BlueCross, may from time to time, conduct Claim Recovery activities with respect to contracted and non-contracted providers as permitted under the terms of any applicable contract and applicable law. If BlueCross conducts Claim Recovery, BlueCross shall record overpayments and returned funds separately and maintain claim details at the Member account, and group levels.
- 7.4.5. Subject to the exception(s) set forth in this Section 7.4, Employer agrees that BlueCross will recover overpayments in accordance with its recovery process and that Employer has no separate or independent right to recover any overpayment from BlueCross, provider, or Another Plan.
- 7.4.6. Employer may, at its option, request on a semi-annual basis, a report on the status of all outstanding overpayments.
- 7.5. In the event that BlueCross becomes aware that a claims payment to a provider or Member was or might have been the result of a fraud, BlueCross shall:
 - 7.5.1. Notify the Plan as soon as possible about the alleged fraudulent claims;
 - 7.5.2. Provide reasonable assistance to the Plan in recovering the alleged fraudulent claims; and

7.5.3. Report the suspected fraud to the appropriate law enforcement agency.

8. Annual Renewal Claims Analysis.

- 8.1. BlueCross will provide an annual renewal analysis of Employer’s claims experience. BlueCross will also provide assistance in benefit design.
- 8.2. Upon request, but not more often than annually, BlueCross will provide an analysis of Employer’s claims incurred but not yet reported.
- 8.3. Upon request, but not more often than annually, BlueCross will provide an analysis of the suggested funding levels for Employer’s Plan, as administered by BlueCross.
- 8.4. Employer acknowledges that these analyses are estimates only, and that the actual experience may differ from these estimates. These are for Employer’s use only, and are not prepared for distribution to or reliance by third parties.

9. Mental Health Parity. The parties acknowledge and agree that Employer is solely responsible for complying with all applicable provisions of ERISA and other laws applicable to Employer’s Plan, including the Mental Health Parity and Addiction Equity Act and its implementing regulations, as amended from time to time (“MHPAEA”). BlueCross agrees to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer to comply with these obligations.

10. Duties with regard to non-BlueRe of Tennessee Stop Loss Carrier. For a separate Interface fee, BlueCross will perform the following services and provide the following information to Employer, or to a third party stop loss carrier and/or Employer Service Vendor, provided that Employer, BlueCross and such third party enter into an executed information sharing agreement pursuant to Section 2.2.2:

- 10.1. Provide monthly Claimants at 50% of Specific Attachment Point Reports.
- 10.2. Provide monthly Aggregate Reports.
- 10.3. BlueCross does not coordinate the payment of the stop loss premium between the stop loss carrier and Employer.
- 10.4. Provide stop loss carrier the following information at renewal to prepare a renewal of Employer’s stop loss coverage. Information to be provided is as follows:

Census	
Age/ Gender	Subscriber Count by age/gender
Zip Codes	Subscriber Count by LOB, State, Zip
Plan Design Summary/ Plan Document	Evidence of Coverage
Trigger Reports:	
50% of Specific Report	50% Report (Includes Diagnosis Only)
Medical & Rx	

Aggregate Claim Reports	Monthly Aggregate Report (excluding claims over specific)
By Month	(included in report)
Enrollment Included	(included in report)
Large Claims Amounts Included	(included in report)

- 10.5. Regardless of whether a claim has met the stop loss dollar limit set out in the agreement between stop loss carrier and Employer, Employer is still responsible for funding all claims processed by BlueCross.
- 10.6. At the termination of this Agreement, BlueCross has no further obligation to provide any reports referenced in this section to Employer, stop loss carrier, or any other third party, other than standard reports for the time period the Agreement was in force, provided that Employer, BlueCross and such third party vendor enter into an executed information sharing agreement pursuant to Section 2.2.2.
- 11. RESERVED.
- 12. Section 111 Mandatory Secondary Payor Reporting. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), titled Medicare Secondary Payor, (hereinafter “Section 111”) mandates that, effective January 1, 2009, all group health plans or their representatives submit certain information to CMS. BlueCross is registered as a medical “Required Reporting Entity” as required under Section 111. BlueCross shall report the Plan’s medical information required by Section 111. Under no circumstances will BlueCross be required to report workers’ compensation or liability insurance information required under Section 111. Employer shall provide all Social Security numbers, tax identification numbers, and the “total number of employees” (as that is defined in the MMSEA) information to BlueCross. BlueCross will not be responsible for any deficiency resulting from Employer’s failure to provide such information to BlueCross.
- 13. Distribution of Materials.
 - 13.1. Employer shall handle and distribute enrollment materials in a timely manner and promptly provide to BlueCross the information necessary to administer this Agreement. Employer’s failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.
 - 13.2. Employer shall distribute notices that Employer and/or BlueCross are legally required to provide (e.g., special enrollment rights) in a timely manner and in accordance with all applicable laws. Any off-renewal changes require 60-days advance notice to Members. Employer shall provide BlueCross with enough advance notice of any off-renewal changes, not to be less than 90 days, for BlueCross to meet its obligations under any applicable law and this Agreement. Employer shall indemnify BlueCross and hold BlueCross harmless from any damages, loss, action, claim or suit (including court costs and attorney’s fees) arising from or related to its failure to provide such notices.
 - 13.3. If BlueCross provides its enrollment and/or change forms (“Forms”) and/or any benefit summaries, and/or comparison sheets (“Documents”) in an electronic medium, and Employer delivers Documents electronically to Members or includes

Documents on Employer's internal intranet or by similar means or for similar purposes, Employer agrees that:

- 13.3.1. electronic access shall be limited to Employer's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;
 - 13.3.2. they will replace any hard-copy Forms that have been modified by BlueCross;
 - 13.3.3. the hard-copy documents on file with BlueCross shall control in the event of any discrepancy; and
 - 13.3.4. Employer remains solely responsible for the content of the Documents and all other legal requirements pertaining to them (e.g., distribution).
- 13.4. BlueCross will create a draft Summary of Benefits and Coverage ("SBC"), based on services provided by BlueCross, and provide to Employer. Employer shall review SBC, and revise or supplement as required, prior to distribution. Employer remains solely responsible for SBC content and all other legal requirements pertaining to SBC (e.g., distribution). BlueCross shall not charge Employer for draft SBC. BlueCross may charge Employer for translation of SBC to any language other than English.
14. Member Outreach. BlueCross, or its subcontractor, shall have the right to contact Members to perform services under this Agreement, or as otherwise required by law, a regulatory body, or an accrediting agency. Employer warrants that the contact information included in its enrollment data was obtained directly from the applicable Member and that Members are aware they may be contacted via that information for non-telemarketing calls, emails, and/or text messages.
15. Provider Administered Specialty Pharmacy Products. Provider Administered Specialty Pharmacy Products are those Specialty Pharmacy Products administered to a Member by a health care provider, whether or not a Network Provider, rather than self-administered by the Member. Provider Administered Specialty Products can only be dispensed from a specialty pharmacy in the BlueCross Preferred Specialty Pharmacy Network.
- 15.1. Provider Administered Specialty Pharmacy Products are those products that meet all three of the following criteria:
- (a) Require in-depth patient teaching, coordination of care, and frequent monitoring to ensure successful use;
 - (b) Described by at least one of the following:
 - i. produced through genetic technology or biopharmaceutical processes;
 - ii. target a chronic, rare, genetic, or complex disease; or
 - iii. require unique handling, distribution, and/or administration; and
 - (c) Are set forth on the Provider Administered Specialty Pharmacy Product List which is maintained by BlueCross (available at www.bcbst.com), as may be amended from time to time for any reason.

- 15.2. “Preferred Specialty Pharmacy Network” means BlueCross’s network of pharmacies that are permitted to dispense Provider-Administered Specialty Pharmacy Products to providers.

All the medications set forth on the Provider Administered Specialty Pharmacy Product List have been determined by BlueCross to meet criteria (a) and (b) of Section 15.1 above. However, some products meeting criteria in (a) and (b) of Section 15.1 above may be excluded from the list. A Provider Administered Specialty Product may be added or removed from this list at any time for any reason. Provider Administered Specialty Pharmacy Products can only be dispensed from a pharmacy in BlueCross’s Preferred Specialty Pharmacy Network. BlueCross will adjudicate claims for Provider Administered Specialty Pharmacy Products for the Employer.

16. Group Health Plan Federal Requirements.

- 16.1. Health Plan Transparency Requirements. The Parties acknowledge that Employer’s Plan is subject to certain requirements under the Affordable Care Act Transparency in Coverage Final Rule and group health plan requirements in Division BB of the Consolidated Appropriations Act, 2021 and its implementing regulations, as set forth below (collectively, “Health Plan Transparency Requirements”). BlueCross (i) agrees to cooperate with Employer in meeting its obligations under the Health Plan Transparency Requirements, and (ii) reserves the right to charge a fee for services related to the implementation and administration of the Group Health Plan Transparency Requirements.

16.1.1. Machine Readable Files. The Parties acknowledge and agree that Employer’s Plan is required to publicly disclose in-network negotiated rates, billed out-of-network charges, and prescription drug pricing information to the public through machine readable files (“MRFs”). BlueCross agrees (a) to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer to comply with these obligations, or (b) at the direction of Employer, to post MRFs on its website on behalf of the Plan, provided however, that Employer retains liability for any Losses resulting from Employer’s failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.

16.1.2. Contract Terms. The Parties acknowledge and agree that, nothing in this Agreement shall directly or indirectly restrict BlueCross and/or the Plan from (i) providing provider-specific cost or quality of care information or data to referring providers, Employer, Members or individuals eligible to become Plan Members; (ii) electronically accessing de-identified claims and encounter information or data under the Plan for each Plan Member, upon request and consistent with applicable law, including but not limited to HIPAA, GINA, and the ADA, or (iii) sharing such Plan information or data, or directing such Plan data be shared, with a HIPAA business associate of the Plan consistent with applicable law and the terms of this Agreement.

16.1.3. Price Comparison Tool. The Parties acknowledge and agree that Employer’s Plan is subject to requirements under applicable law to provide Members with price comparison tools. BlueCross agrees (a) to cooperate with Employer in providing information reasonably requested by Employer

or its designee in order for Employer to comply with the price comparison tool obligations, or (b) at the direction of Employer, to make available to Plan Members a price comparison tool, provided however, that Employer retains liability for any Losses resulting from Employer's failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.

- 16.2. ID Cards. BlueCross will supply identification cards. BlueCross will supply identification cards issued at the group's initial enrollment to Subscribers and identification cards issued at any other time to Subscribers. Identification cards will be issued in the name of Subscribers.
- 16.3. Provider Directory Tool. BlueCross will provide Provider Directories through online access and in accordance with applicable law.
- 16.4. Continuity of Care. The Parties acknowledge and agree that Employer's Plan is subject to continuity of care protections in instances when terminations of certain contractual relationships result in changes in provider or facility network status. BlueCross agrees to coordinate impacted Member's transitions to more appropriate care settings in accordance with applicable law.
- 16.5. Health Care and Prescription Drug Reporting. The Parties acknowledge and agree that the Employer's Plan is subject to requirements under applicable law to report certain health care cost information annually to the federal government, such as costs relating to prescription drugs and air ambulance services. BlueCross agrees (a) to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer's Plan to comply with these reporting obligations, or (b), at the direction of the Employer, to report on the Plan's behalf, provided however, that Employer retains liability for any Losses resulting from Employer's failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.
- 16.6. No Surprises Act. The Parties acknowledge and agree that the Employer's Plan is subject to requirements under the No Surprises Act that is part of the Consolidated Appropriations Act, 2021 (hereinafter, the "NSA"). BlueCross will process those out-of-network claims subject to the NSA in accordance with the terms of the NSA and its implementing regulations. BlueCross will also engage in the Independent Dispute Resolution ("IDR") process with providers, as required under the NSA. Fees for IDR services are set forth in Exhibit B.

EXHIBIT D TO THE ADMINISTRATIVE SERVICES AGREEMENT**MEDICAL MANAGEMENT SERVICES PROVIDED BY BlueCross**

Employer has selected several of BlueCross's Medical Management programs for use by Employer in administering its Plan. All services utilize current medical guidelines and standards. While these services are described below, the services may be updated from time to time without prior notice to Employer.

MEDICAL MANAGEMENT – Precision Care Support

1. Inpatient Review.
 - 1.1. Inpatient Precertification. BlueCross will review inpatient admissions (hospital, subacute facility, skilled nursing facility, inpatient rehabilitation, and 23-hour observation stays) to evaluate the appropriateness of certain procedures and Medical Necessity of the requested services. An initial length of stay is assigned upon admission. Emergency inpatient admissions are reviewed within 24 hours of admission or the next business day. Employer's Plan follows BlueCross's standard precertification requirements.
 - 1.2. Concurrent Review of per diem admissions. BlueCross will review Members' inpatient care (hospital, subacute facility, skilled nursing facility, and inpatient rehabilitation) to ensure Medically Necessary and Medically Appropriate care is delivered. Concurrent review is performed as services are being rendered.
 - 1.3. Outlier Review of DRG admissions. BlueCross will review any outlier days billed by a DRG facility on targeted claims after a service is rendered and before payment is made to ensure cost-effectiveness.
2. Retrospective Review. BlueCross will review targeted claims after a service is rendered and before payment is made. The purpose of retrospective review is to provide determinations regarding Medical Necessity, eligibility and benefits.
3. Prospective Review. BlueCross will review targeted, non-emergency related care procedures, non-routine diagnostics and non-routine pharmacy treatments, as determined by BlueCross, for medical appropriateness and the necessity of the requested procedure and setting prior to the procedure being performed.
4. Pre-determination Review. When requested by a provider or Member, BlueCross will conduct a prospective review to determine whether a procedure will be covered.
5. Specialty Pharmacy Review. If BlueCross administers claims related to Provider Administered Specialty Pharmacy Products, as described in Exhibit C, then BlueCross will review specific drugs administered by licensed health care professionals.
6. Home Health, Home Infusion Therapy Review. BlueCross will review prescriptions for home health care services and home infusion therapy to evaluate the physician's plan of

treatment, appropriateness of setting and Medical Necessity of the prescribed services, both prospectively and concurrently.

7. Lifestyle/Health Educational Program. BlueCross will send condition-specific educational materials to low-risk Members identified through the prior authorization process.
8. Care Coordination. BlueCross's Care Coordination process systematically identifies opportunities to coordinate and manage Members' total care.
 - 8.1. Emergency Services Management Program. Nurses will contact Members who frequently seek emergency room services, identify reasons for the frequent utilization, and provide assistance in controlling future inappropriate use of emergency room services.
 - 8.2. Transition of Care. Throughout the different stages of a Member's treatment, nurses coordinate the Member's transitions to more appropriate care settings.
 - 8.3. Condition-specific Care Coordination Program. Through this program, BlueCross provides assessment and management of low-risk and moderate-risk Members with specific conditions, such as heart disease, respiratory disease, diabetes, asthma or hypertension.
9. Catastrophic Medical and Transplant Case Management. BlueCross's Catastrophic Medical and Transplant Case Management program utilizes a comprehensive approach that includes benefit analysis, preauthorization, concurrent review, discharge planning and cost-effective continuity of care for Members. Members with high-risk conditions such as terminal illness, severe injury, major trauma, cognitive or physical disability, or transplant are identified through prior authorization, medical data and claims data. Registered nurses work with the Member, health care providers and primary caregivers to coordinate the most appropriate, cost-effective care settings.

Benefits paid through the Catastrophic Medical and Transplant Case Management program may vary from the benefits described in the Plan. This is done when BlueCross has determined that the alternative benefits are more Medically Appropriate, cost effective, and ensure the best outcomes. Employer will fund these benefits, and BlueCross's administration of benefits pursuant to the Catastrophic Medical and Transplant Case Management program shall be within the scope of its duties.
10. RESERVED
11. RESERVED
12. Behavioral Health Management. BlueCross will provide the following services as part of its Behavioral Health Inpatient Utilization Management program:
 - 12.1. Inpatient Pre-certification. BlueCross will review all facility based level-of-care admissions (acute care, residential care, partial hospital care, intensive outpatient care and any other care in lieu of acute care) to evaluate the appropriateness of treatment applying Medical Necessity criteria. Emergency inpatient admissions are reviewed within 24 hours of admission or the next business day.

- 12.2. Concurrent Review. BlueCross will review the care of Members in facility-based treatment (acute, residential, partial hospital, intensive outpatient or any other care in lieu of behavioral health acute care) to ensure Medically Necessary and Medically Appropriate care is delivered. Lengths of stay are authorized when care requested meets Medical Necessity criteria.
 - 12.3. Discharge Planning. BlueCross will assess the Member's behavioral health condition and monitor the behavioral health program's discharge planning to ensure appropriate continuation of care, as necessary, when the Member leaves that particular level of care.
 - 12.4. Case Management. BlueCross's Behavioral Health Case management process identifies high risk Members in facility based levels of care and assesses opportunities to coordinate and manage the Member's total behavioral health care to ensure the best outcomes while the Member remains in facility based levels of care.
13. BlueCross shall have the authority, in its discretion, to institute from time to time, utilization management, case management, disease management or other care-related programs. These are processes that demonstrate potential improvement in access, quality, efficiency and Member satisfaction. When BlueCross institutes a care-related program, approved services provided through such programs are deemed Covered Services even if they are normally excluded under the Benefits Documents.

EXHIBIT E TO THE ADMINISTRATIVE SERVICES AGREEMENT**DUTIES OF EMPLOYER**

1. Services. Employer shall:
 - 1.1. Provide BlueCross with a current, detailed description of the Benefit Documents and any subsequent changes, for acceptance by BlueCross;
 - 1.2. Timely pay and fund all fees and claims as described in this Agreement;
 - 1.3. Provide BlueCross with the necessary Subscriber and Member eligibility information and timely provide updates to such information;
 - 1.4. Perform other duties and services as described in this Agreement.
2. Notification Regarding Members. Employer shall notify BlueCross of the addition or deletion of Members as described below:
 - 2.1. When a new Member should be added, Employer shall notify BlueCross within forty-five (45) days of the effective date of coverage for that Member. If BlueCross is not notified that a new Member should be added within this time frame, BlueCross shall have no obligation to adjudicate any claims that were incurred prior to this time frame.
 - 2.2. When a Member should be terminated from coverage, Employer shall notify BlueCross within forty-five (45) days of the effective date of that Member's termination.
3. Final Authority.
 - 3.1. Except as otherwise specifically stated in this Agreement, Employer retains all final authority and responsibility for the Plan including the benefit design of the Plan, funding of claims, claims payment decisions, cost containment program decisions, eligibility and benefit determinations, compliance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), compliance with HIPAA, compliance with reporting and remitting abandoned property funds (except as referenced in Exhibit C, Section 5.6) if required by law, and compliance with any other state and federal laws or regulations applicable to Employer or the administration of the Plan. The phrase "eligibility and benefit determinations" means that Employer determines who is eligible to participate, (i.e., who are employees or dependents) and generally what medical services and supplies are included or excluded as Covered Services identified in the Benefit Documents, but does not include the ultimate responsibility for making medical necessity or other medical management determinations.
 - 3.2. If Employer uses an Employer Service Vendor to provide enrollment data and that third party's data does not match BlueCross's data, BlueCross's data and records will be used to determine the ASF unless and until BlueCross and Employer are able to resolve the discrepancy.

- 3.3. Employer shall submit all information to BlueCross in writing. The accuracy of any changes performed and administered by BlueCross at the instruction of Employer in benefit design, enrollee status, etc., is the responsibility of Employer. BlueCross is entitled to rely on Employer's instructions in performing its duties under this Agreement.
 - 3.4. A Member has the right to appeal any decision regarding or arising out of this Agreement, and that appeals process is defined in the Benefits Documents and the Plan.
 4. Eligibility and Enrollment. As of the first day of the Term of this Agreement, Employer will have delivered enrollment information regarding Members to BlueCross. Employer shall deliver all employee and dependent eligibility status changes to BlueCross on a monthly basis, or more frequently as mutually agreed by the Parties.
 - 4.1. Employer shall be responsible for verifying identity of Members to confirm eligibility and for promptly rescinding coverage of ineligible individuals.
 - 4.2. Employer shall be responsible for providing each Subscriber with a copy of any required documents.
 - 4.3. If an employee waives his/her (or his/her dependents') coverage under the Plan at enrollment or open enrollment, Employer will maintain the original of the waiver, and if the employee has a qualifying event during the plan year, Employer will certify to BlueCross that the employee executed a waiver at enrollment or open enrollment.
5. Financial Obligations.
 - 5.1. Claims Funding. Employer is financially responsible for the timely funding of all Approved Claims and is the Payor of benefits for all Members. Employer will provide BlueCross with such authorizations as are necessary to ensure that required instruments are valid with respect to funding Approved Claims for Covered Services.
6. Assessments.
 - 6.1. Employer retains responsibility and liability for all benefits and expenses incident to the Plan, including any federal, state or local taxes, assessments, or similar government-imposed fees, other than BlueCross's income taxes, that are related to the Plan, the Plan's Members, enrollees, or Participants, or BlueCross's services under this Agreement ("Assessments"). For example, Assessments may be based on: (i) the number of covered lives in the Plan, (ii) the number of covered lives in a given geographic region, (iii) fees paid or payable to BlueCross for services provided under this Agreement, including premiums or premium equivalents, (iv) Approved Claims paid pursuant to this Agreement, or (v) other assessment methodologies that measure the relative value of benefits or services provided or delivered under the Plan. If at any time, during or after the term of this Agreement, BlueCross is required to pay any Assessment on Employer's behalf, Employer shall reimburse BlueCross an amount equal to such Assessment(s), which will be disclosed to Employer via invoice. Additionally, BlueCross pays if any taxes,

penalties or interest are imposed, assessed or accrued on any Assessment, Employer will reimburse BlueCross such additional amounts equal to the tax, penalty or interest.

- 6.2. Employer will pay these additional amounts to BlueCross within thirty (30) days following mailing of invoice. Payments not received within the thirty (30) day period are subject to the late payment charge described in Exhibit B.
 - 6.3. Employer will pay these additional amounts even if the validity of Assessments has not been finally determined. If it is finally determined that such Assessments were not valid, to the extent such Assessments are refunded or otherwise returned to BlueCross by the appropriate Federal, state or local governmental entity, BlueCross will refund to Employer an amount equal to those additional amounts previously paid by Employer plus interest, if any, determined in accordance with BlueCross's regular procedures then in effect, less a pro rata share of any expenses incurred by BlueCross in contesting the validity of such Assessments.
7. Use of Names and Service Marks. Employer agrees to allow BlueCross to use Employer's name and service mark on I.D. cards and other forms necessary to implement this Agreement, for BlueCross's internal purposes, and to promote Employer's relationship with BlueCross to potential or existing providers. BlueCross shall not use Employer's name or service mark for any other purpose without the prior written consent of Employer.

Employer agrees that the names, logos, symbols, trademarks, trade names, and service marks of BlueCross, whether presently existing or hereafter established, are the sole property of BlueCross and BlueCross retains the right to the use and control thereof. Employer shall not use BlueCross's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of BlueCross and shall cease any such usage immediately upon written notice by BlueCross or upon termination of this Agreement, whichever is sooner.

Employer agrees that the names, logos, symbols, trademarks, trade names, and service marks of the Association, whether presently existing or hereafter established, are the sole property of the Association and the Association retains the right to the use and control thereof. Employer shall not use the Association's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of the Association and shall cease any such usage immediately upon written notice by the Association or upon termination of this Agreement, whichever is sooner.

8. Claims Incurred and Submitted but not yet Adjudicated. Employer can request reports regarding claims incurred and submitted but not yet adjudicated through the Account Manager.

EXHIBIT F TO THE ADMINISTRATIVE SERVICES AGREEMENT

DIRECT DEBIT AUTHORIZATION AGREEMENT

Employer has signed a separate Direct Debit Authorization Agreement, which is hereby incorporated by reference as part of this Agreement.

EXHIBIT G TO THE ADMINISTRATIVE SERVICES AGREEMENT

INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services.

Overview

BlueCross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Arrangements.” These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever Members access healthcare services outside the geographic area BlueCross serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BlueCross serves, Members obtain care from healthcare providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement (“nonparticipating providers”) with the Host Blue. BlueCross remains responsible for fulfilling our obligations to Employer. Our 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 Benefits except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Us to provide the specific service or services are not processed through Inter-Plan Arrangements.

1.1. BlueCard® Program.

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

1.1.1. Liability Calculation Method Per Claim – In General.

1.1.1.1. Member Liability Calculation

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

1.1.1.2. Employer Liability Calculation

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

1.1.2. Claims Pricing.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's provider contracts. The following are examples of the negotiated price made available to BlueCross by the Host Blue, but not an exhaustive list of negotiated prices:

- 1.1.2.1. An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- 1.1.2.2. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or
- 1.1.2.3. An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price consistent with its provider contracts. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific claim

and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

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

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated 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. Employer has no ownership interest in any variance account. Variance accounts are notional bookkeeping accounts maintained by the Host Blue and no amounts are segregated or held for the benefit of the Employer.

1.1.3. BlueCard Program Fees and Compensation.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which BlueCross is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in Exhibit B. BlueCard Program Fees and compensation may be revised from time to time as described in section 1.7 below.

1.2. Special Cases: Value-Based Programs.

1.2.1. Value-Based Programs Overview.

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

1.2.2. Value-Based Programs under the BlueCard Program.

1.2.2.1. Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in the following ways: Per member per month, provider incentives, gain share, risk share, retrospective settlements, prospective settlements, share of target savings, Care Coordination Fees and/or other allowed amounts.

The Host Blue may pass these provider payments to BlueCross, which BlueCross 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:

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

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- 1.2.2.1.1. **Per Member Per Month (PMPM) Billings:** Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BlueCross will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or

reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

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

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

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

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.

1.2.3. Care Coordinator Fees.

Host Blues may also bill BlueCross for Care Coordinator Fees for provider services which we will pass on to Employer as follows:

- 1.2.3.1. PMPM billings; or
- 1.2.3.2. 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).

As part of this Agreement/contract, BlueCross and Employer will not impose Member cost sharing for Care Coordinator Fees.

1.2.4. Value-Based Programs under Negotiated Arrangements.

If BlueCross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, BlueCross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in the BlueCard Program section.

As part of this Agreement, BlueCross and Employer may agree to waive Member cost sharing for care coordinator fees.

1.2.5. Value-Based Programs Definitions.

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

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.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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 groups of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

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

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.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

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.

1.3. Prepayment Review & Return of Overpayments.

If a Host Blue conducts prepayment review activities, including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill BlueCross up to a maximum of sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill BlueCross the lesser of the full amount of the third-party fees or up to sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer.

Recoveries of overpayments/from a Host Blue, or its participating and nonparticipating providers, or from post-payment review activities, can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BlueCross, they will be credited to Employer. When a Host Blue identifies and collects these recovery amounts, the Host Blue may bill BlueCross up to a maximum of sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. When this occurs, the Host Blue may bill the lesser of the full amount of the third party fees or up to sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, BlueCross will request the Host Blue to provide full refunds from participating healthcare providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. 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 healthcare providers, notwithstanding to the contrary any other provision of this Agreement.

1.4. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BlueCross will

disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability. See also Exhibit E, paragraph 6.

1.5. Nonparticipating Providers Outside BlueCross's Service Area.

1.5.1. Member Liability Calculation.

1.5.1.1. In General

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

1.5.1.2. Exceptions

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

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

1.5.2. Fees and Compensation.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer are set forth in Exhibit

B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section 1.7 below.

1.6. Blue Cross Blue Shield Global® Core.

1.6.1. General Information.

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

1.6.1.1. Inpatient Services

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

1.6.1.2. 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.

1.6.1.3. Submitting a Blue Cross Blue Shield Global Core Claim

When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider’s itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from BlueCross, the service center, or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

1.6.2. Blue Cross Blue Shield Global Core-Related Fees.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core are set forth in Exhibit B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section 1.7 below.

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

Modifications or changes to Inter-Plan arrangement fees 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, BlueCross 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.

EXHIBIT H TO THE ADMINISTRATIVE SERVICES AGREEMENT**COBRA ADMINISTRATION PROVIDED BY EMPLOYER OR A THIRD PARTY**

In the event that any Member is entitled to continuation of their benefits under the Benefit Documents, BlueCross will continue to perform its duties under this Agreement with regard to that Member as outlined below. BlueCross's and Employer's obligations under this Exhibit shall terminate upon termination of this Agreement.

1. Once notified by Employer that a Subscriber and/or Dependents are eligible for and enrolled in COBRA continuation ("Eligible COBRA Participant"), BlueCross shall:
 - 1.1. Administer health benefits for Eligible COBRA Participants for all benefits selected to be continued by the Eligible COBRA Participants;
 - 1.2. Provide claims processing services;
 - 1.3. Provide access to the provider network(s) selected by Employer, and the BlueCard/BlueCard PPO program;
 - 1.4. Terminate the COBRA continuation coverage for each Eligible COBRA Participant once notified by Employer as required under the terms of the Agreement;
 - 1.5. BlueCross's preference is not to accept COBRA-related information from any Employer Service Vendor; rather, Employer shall provide all information directly to BlueCross. However, BlueCross will accept COBRA-related information from an Employer Service Vendor at the request of Employer.
2. Employer, as the Plan Administrator, shall:
 - 2.1. Provide the eligibility information for all Qualified Beneficiaries to BlueCross with the monthly eligibility information;
 - 2.2. Pay all required premium equivalents or administrative fees for all COBRA Qualified Beneficiaries to BlueCross as required;
 - 2.3. Perform all COBRA administrative duties, including providing notice to Members of a qualifying event, eligibility information, premium collection, and reconciliation of premium and eligibility information;
 - 2.4. To the extent permitted by Tennessee law, hold harmless and indemnify BlueCross for any claims or causes of action that arise from, or are related to, Employer's obligations required by COBRA, including lawsuits, IRS fines, or claims, that result from incorrect premium collection or eligibility information supplied to BlueCross;
 - 2.5. Notify BlueCross of any changes that it becomes aware of that might affect the Eligible COBRA Participant's coverage under COBRA;

- 2.6. Fund all health claims of Qualified Beneficiaries, including those that may have been processed using incorrect eligibility information supplied to BlueCross by Employer.
3. As consideration for the above-referenced services, Employer shall pay BlueCross the current ASF being charged Employer for active Members.

EXHIBIT I TO THE ADMINISTRATIVE SERVICES AGREEMENT

HEALTH AND WELLNESS SERVICES

Employer has selected the Health and Wellness Services described below.

1. Services.

- 1.1. Teladoc Health[®]. Teladoc Health provides access to practitioners via telephone, internet or other telecommunication device, whereby the Practitioner may diagnose a Member's ailment, recommend therapy and, where appropriate, write a non-DEA controlled prescription.

EXHIBIT J TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT K TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT L TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT M TO THE ADMINISTRATIVE SERVICES AGREEMENT**ONLINE ENROLLMENT SPECIFICATIONS THROUGH BlueCross SECURED WEBSITE**

1. BlueCross's Duties and Responsibilities.
 - 1.1. BlueCross will provide a PIN for website access.
 - 1.2. BlueCross will provide instruction upon Employer's request. Such instruction may be done by telephone or personal contact.
 - 1.3. BlueCross will accept data and process enrollment, status change and termination requests in accordance with the eligibility guidelines.
 - 1.4. BlueCross has the right to audit Employer's data transmissions for accuracy and completeness.

2. Employer's Duties and Responsibilities.
 - 2.1. Employer will submit data only on eligible individuals.
 - 2.2. Employer is responsible for the accuracy and completeness of all data submitted.
 - 2.3. Employer will submit data on a timely basis in accordance with this Agreement.
 - 2.4. Employer assumes responsibility for notifying BlueCross when Employer's group administrator or enrollment contact changes, so that BlueCross can revoke that individual's website access. BlueCross will revoke access within 5 working days of being notified. If Employer does not inform BlueCross of any such change, and a former group administrator or enrollment contact enters fraudulent or incorrect information through the website, Employer is responsible for these actions.

EXHIBIT N TO THE ADMINISTRATIVE SERVICES AGREEMENT**GRIEVANCE SERVICES**

This Exhibit describes duties regarding grievance services:

1. First Level Grievance.

- 1.1. BlueCross shall conduct the first level grievance on Employer's behalf. For purposes of handling the first level Grievance, BlueCross is a limited fiduciary under ERISA.
- 1.2. BlueCross shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.
- 1.3. A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.
- 1.4. Member shall have the opportunity to submit written testimony and any additional written information to BlueCross. Oral testimony will not be permitted at the first level grievance.
- 1.5. First level grievance is the only mandatory level of grievance.

2. Second Level Grievance.

- 2.1. BlueCross shall conduct the second level grievance for Employer. For purposes of handling the second level Grievance, BlueCross is a limited fiduciary under ERISA.
- 2.2. BlueCross shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.
- 2.3. A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.
- 2.4. Member shall have the opportunity to present oral testimony and to provide additional information to BlueCross.

3. External Review.

- 3.1. BlueCross shall coordinate the external review procedure on Employer's behalf. For purposes of handling the external review process, BlueCross is a limited fiduciary under ERISA.
- 3.2. BlueCross's external review procedure shall be based on and follow the external review procedure set forth in the Tennessee Code Annotated.
- 3.3. A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.

4. Employer's grievance processes shall be subject to and comply with the review standards applicable to ERISA plans, whether or not it is otherwise governed by ERISA.
5. BlueCross shall, upon Employer's request, provide to Employer any grievance information related to a grievance handled by BlueCross.
6. Nothing shall establish a grievance process that contradicts any statement in this Exhibit.
7. BlueCross shall not be required to perform any grievance services not expressly stated in this Exhibit.

EXHIBIT O TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT P TO THE ADMINISTRATIVE SERVICES AGREEMENT

PHARMACY SERVICES

Effective July 1, 2025 through June 30, 2026

Employer has selected BlueCross to provide pharmacy benefit management services with respect to Employer's Plan.

1. Definitions.

The following definitions apply for purposes of this Exhibit only.

"340B Claim" means a Prescription Drug Claim that adjudicates at 340B Drug Program pricing and is dispensed from a 340B Covered Entity, as identified in the claim file by the submission of "20" in any of the submission clarification code fields and/or a Prescription Drug Claim submitted by pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "38" or "39" in the NCPDP DataQ database.

"340B Covered Entity" means those health care clinics, facilities, or other safety-net health care providers classified by the 340B Drug Program as a "covered entity" which are eligible to purchase 340B Drugs at favorable discounts for dispensing to eligible patients.

"340B Drug" means an FDA-approved prescription drug, an OTC drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin, which is the subject of a discount or rebate agreement between the manufacturer of such drug and a 340B Covered Entity, to provide drug pricing no less favorable than required by the manufacturer's agreements with HHS. For avoidance of doubt, 340B Drugs shall be determined based on the 340B Drug Program Laws, including the definition of "covered outpatient drug" set forth in Section 1927(k) of the Social Security Act, 42 U.S.C §1396r-8(k)(2) & (3).

"340B Drug Program" means the drug pricing program codified as Section 340B of the Public Health Service Act (42 U.S.C. § 256b), and which classifies certain safety-net health care providers as "covered entities" eligible to purchase outpatient prescription drugs for their eligible patients at favorable discounts from manufacturers, as required by HHS.

"Authorized Generics" means a medication that was originally marketed, licensed, and/or sold by the innovator drug manufacturer, but is relabeled, marketed, and/or sold under a generic name by either the innovator or another manufacturer or distributor with the innovator drug manufacturers' permission. For classification purposes, Authorized Generics mean any drug with an NDC attribute type code of "18" as indicated by First Databank.

"Average Wholesale Price" or "AWP" means the average wholesale price of a Prescription Drug. The pricing source of AWP metric unit price must be the National Drug Code ("NDC") of the actual manufacturer of the prescription dispensed. The pricing source of AWP shall not be based on re-labeled or repackaged NDCs. For Prescription Drug Claims, AWP is based on the dispensed 11-digit NDC, as supplied by a single nationally recognized pricing source selected and disclosed by BlueCross, on the date the drug is dispensed. For compound drugs, AWP metric unit price is the proportional AWP metric unit price times the quantity dispensed for the specific ingredients in the compound on the date the drug is dispensed, as set forth in the pricing source.

“Biosimilar Product(s)” means a biological product that is highly similar to a U.S. Food and Drug Administration (FDA) approved biological product, known as a reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. For classification purposes, Biosimilar Product means any drug with an NDC attribute type code of “22” as indicated by First Databank.

“Brand Drug” means an FDA-approved drug manufactured and distributed by an innovator drug company or its licensee that is defined as a brand drug by Medi-Span. For classification purposes, Brand Drug means any drug with Multi-Source indicators of “M”, “N”, or “O” as indicated by Medi-Span. In limited circumstances, BlueCross may preserve the generic status of a product and override the M, N, O indicators and deem the drug to be a Generic Drug through review of additional information, in which case the product will be considered a Generic Drug for purposes of all guarantees set forth in this Agreement. Unless the language expressly states otherwise, a Brand Drug does not include Self-Administered Specialty Pharmacy Product.

“Compound Drugs” means a product where one (1) or more FDA-approved ingredients are prepared by a pharmacist according to a prescriber’s order. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if only water, alcohol, flavoring, coloring, or sodium chloride solutions are added to the active ingredient.

“Covered Drug(s)” means those prescription drugs, supplies, and other items that are covered under the Plan.

“Dispensing Fee” means an amount paid to the Pharmacy for the professional service of filing a Prescription Drug Claim.

“Drug Formulary” means the list of FDA-approved prescription drugs and supplies developed by BlueCross’s Pharmacy and Therapeutics Committee, or its delegate. The drugs and supplies included on the Drug Formulary will be modified by BlueCross, or its delegate, from time to time as a result of factors, including, but not limited to, medical appropriateness, pharmaceutical manufacturer Pharmacy Rebate arrangements, and patent expirations.

“Generic Drug” means a prescription or OTC drug that is therapeutically equivalent and interchangeable with Brand Drugs having an identical amount of the same active ingredient(s) and approved by the FDA through an Abbreviated New Drug Application (ANDA). For classification purposes, Generic Drug means any drug with Multi-Source indicator of “Y” as indicated by Medi-Span. Generic Drugs will also include all Authorized Generics, Single-Source Generics and DAW 5 claims. Unless the language expressly states otherwise, a Generic Drug does not include a Self-Administered Specialty Pharmacy Product.

“Home Delivery Network” means BlueCross’s network of Participating Pharmacies where prescriptions are filled and delivered to Members via mail delivery service. The Home Delivery Network does not include pharmacies in the Specialty Pharmacy Network.

“Ingredient Cost” means the Brand, Generic, or Self-Administered Specialty Pharmacy Products cost minus the Dispensing Fee and applicable taxes.

“Limited Distribution Drugs” or “LDD” means those Specialty Pharmacy Drugs that are distributed to and dispensed by either one or a very limited number of pharmacies.

“Manufacturer Administrative Fees” means those administrative fees paid by manufacturers to the pharmacy benefit manager pursuant to a contract between the pharmacy benefit manager and the manufacturer in connection with the pharmacy benefit manager’s administering, invoicing, allocating, and collecting Pharmacy Rebates.

“Mark III Self-Funded Group Pool” means self-funded groups that have elected to participate in the broker, Mark III’s pooled pricing arrangement with BlueCross and who have not elected to be reconciled individually.

“Member Submitted Claim” means a Prescription Drug Claim submitted by a Member for Covered Drugs dispensed by a Pharmacy for which the Member paid cash.

“Over the Counter Drug” or “OTC” means a drug available without a written prescription.

“Participating Pharmacy” means any pharmacy within BlueCross’s Pharmacy network licensed to provide Covered Drugs to Members.

“Pharmacy Rebate” is revenue received by BlueCross from rebate aggregators or pharmaceutical manufacturers, which is related to Members’ utilization of Covered Drugs. The following are specifically excluded from the definition of Pharmacy Rebate and shall be retained by BlueCross: (a) contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met; and (b) rebates attributable to any payment BlueCross receives for a Provider Administered Specialty Pharmacy Product claim as defined in Exhibit C; and (c) Manufacturer Administrative Fees.

“Prescription Drug Claim” means a Member Submitted Claim or claim for payment submitted by a Participating Pharmacy as a result of dispensing a Covered Drug to a Member.

“Prescription Maximum Allowable Cost” or “Prescription MAC” means a maximum unit ingredient Cost of off-patent prescription drugs or supplies subject to maximum reimbursement payment schedules on the date the drug is dispensed.

“Retail 30 Network” means BlueCross’s network of retail Participating Pharmacies that are permitted to dispense Covered Drugs to Members typically in a 30-day supply.

“Retail 90 Network” means BlueCross’ network of retail Participating Pharmacies that are permitted to dispense maintenance medications typically a 90-day supply.

“Single-Source Generics” means a Prescription Drug that is approved by the FDA under a Generic Drug ANDA and is licensed and then currently marketed by one Generic Drug manufacturer under separate ANDAs. For classification purposes, Single-Source Generics means any drug with Multi-Source indicators of “M” or “N” as indicated by Medi-Span with a brand name code of “G”.

“Specialty Drug List” means the list of Self-Administered Specialty Pharmacy Products applicable to pharmacy guarantees as maintained and updated by BlueCross. This list is updated quarterly and is available upon request.

“Specialty Pharmacy Network” means for purposes of this Exhibit, BlueCross’s network of Participating Pharmacies that are permitted to dispense Self-Administered Specialty Pharmacy Products to Members.

“Self- Administered Specialty Pharmacy Product” means those Specialty Pharmacy Products that a Member administers rather than a provider and that are listed on the Specialty Drug List. Self-Administered Specialty Pharmacy Products can only be dispensed from a specialty pharmacy in the Specialty Pharmacy Network and must meet all three of the following criteria:

- (a) Require in-depth patient teaching, coordination of care, and frequent monitoring to ensure successful use;
- (b) Described by at least one of the following:
 - i. produced through genetic technology or biopharmaceutical processes;
 - ii. target a chronic, rare, genetic, or complex disease; or
 - iii. require unique handling, distribution, and/or administration; and
- (c) Are set forth in the Drug Formulary which is maintained by BlueCross, or its delegate, (available at www.bcbst.com), as may be amended from time to time for any reason.

All the medications set forth in the Drug Formulary have been determined by BlueCross, or its delegate, to meet criteria (a) and (b) above. However, some products meeting criteria in (a) and (b) above may be excluded from the Drug Formulary. A Self-Administered Specialty Pharmacy Product may be added or removed from the Drug Formulary at any time for any reason.

“Usual and Customary Price” or “U&C” means the retail price charged by a Participating Pharmacy for a Covered Drug in a cash transaction on the date the drug is dispensed.

“Vaccine” means a dispensed product used as a preventative inoculation to confer immunity against a specific disease, usually employing an innocuous form, fragment, toxin, or DNA of the disease agent to stimulate antibody production.

“Vaccine Claim” means a Prescription Drug Claim for which the purchase price includes the Ingredient Cost, the Dispensing Fee, the Vaccine fee and the cost to administer the Vaccine. These Prescription Drug Claims are identified with a Medi-Span Generic Product ID (GPI-4) of 1710, 1720, 1799, 1800 or 1899, or has an AHFS Extended Therapeutic Class Code of 8012000 or 80080000.

“Wholesale Acquisition Cost” or “WAC” means the wholesale acquisition cost for a product as published by First Databank, Medi-Span and/or another nationally recognized database, as selected by BlueCross.

“Year 1” means July 1, 2025 through June 30, 2026

2. Pharmacy Services.

BlueCross will provide the following pharmacy benefit management services:

Employer and Member Services	
Toll-free consumer advisor number for Members	Designated account team

Coordinated eligibility submission	Benefit plan setup
Member Submitted Claim processing	Electronic claims processing
Network Pharmacy Services	
Pharmacy help desk	Pharmacy reimbursement
Pharmacy network management	ePrescribing
Home Delivery Services	
Customer service for Members	Benefit education
Installment Payment Program	Prescription delivery – standard
Manage Automatic Refills and Renewals	Bridge supply
Specialty Pharmacy Network Services	
Benefit education	Prescription delivery – standard
Reporting Services	
Web-based client reporting	Billing reports
Website Services	
BlueAccess - access to benefit, drug, health and wellness information; prescription ordering capability; and customer service	Email a Pharmacist – 24/7 access to specialized pharmacists to answer non-urgent questions via email about medications.

Cost Containment and Trend Management Solutions¹		
<u>Solution</u>	<u>Description</u>	<u>Fee</u>
Formulary Management	Drug Formulary program based on evidence-based medicine, integrated utilization management leveraging best practice guidelines and physician expertise to comparatively review and assess new and existing drugs for safety, efficacy and cost control.	No Additional Fee
POS Safety Messaging	A concurrent drug utilization program designed to assist with preventing drug-related adverse events. Online, real-time drug utilization analysis is performed at the point of prescription dispensing, whether the dispensing occurs at the retail Pharmacy or at the home delivery Pharmacy.	No Additional Fee

Cost Containment and Trend Management Solutions¹		
<u>Solution</u>	<u>Description</u>	<u>Fee</u>
Utilization Management	<p>Represents a wide variety of rules-driven programs such as prior authorization, quantity limits, and step therapy to manage trends in patient drug utilization and client drug spend.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prior Authorization - Monitors the dispensing of high-cost medications and those with the potential for misuse by requiring special approval (authorization) for certain drugs. <input type="checkbox"/> Step Therapy - Manages drug costs by ensuring that patients try first-line (first step), clinically effective, lower-cost medications before they “step up” to a higher-cost medication. <input type="checkbox"/> Quantity Management - Sets dispensing limits for certain drugs based on FDA approved dosing guidelines. 	No Additional Fee
Drug Coverage Determinations	<p>Includes initial determinations and reconsideration processes and criteria for benefit design related requests, plan exclusion reviews (clinical or administrative reviews of non-Covered Drugs), copay reviews, plan limit reviews (e.g., age, gender, days’ supply limits), administrative reviews, clinical benefit reviews and direct claim reject reviews. The initial determinations and reconsideration processes are in addition to and occur before the Grievance Procedure. Members may submit Grievances in accordance with the Grievance Procedure outlined in their EOC.</p>	No Additional Fee
Integrated Benefit Management	<p>Integrated solution that provides real-time shared deductible and out-of-pocket accumulations between the medical and pharmacy benefit.</p>	No Additional Fee
Specialty Pharmacy Management	<p>Program encourages the adherence to safe and effective use of specialty drugs according to prescribed regimens. The program achieves savings by establishing benefits for specialty prescriptions, limiting distribution to preferred vendors, establishing prior authorization criteria to assure appropriate utilization, and renegotiating of drug prices annually.</p>	No Additional Fee
Comprehensive Fraud, Waste and Abuse	<p>Comprehensive Fraud Waste and Abuse (FWA) reviews claims on the provider, pharmacy, and member level to identify any abnormal filling practices. Once an entity has been identified as filling potentially fraudulent prescriptions, our criminal investigations team will review and implement mitigation strategies.</p>	No Additional Fee
High Cost Claimant Review	<p>An integrated management program targeting cost stratification and focused interventions for high dollar pharmacy claimants as part of a comprehensive Member population health solution.</p>	No Additional Fee

Cost Containment and Trend Management Solutions¹		
<u>Solution</u>	<u>Description</u>	<u>Fee</u>
Retail Vaccine Program	This preventive services program broadens the reach of flu and other vaccines while reducing costs by providing a convenient and less expensive alternative through the Retail 30 Network.	No Additional Fee
Drug Savings Review	Program to communicate with providers to suggest missing or alternate drug therapies for members taking certain medications. This program consists of algorithmic and clinician reviews that examine members' diagnoses and drug dosages, and when appropriate, recommends changes in therapy. When the algorithm identifies a potentially harmful prescription, specialty trained pharmacists notify the prescribing physician and vending pharmacist before the drug is dispensed.	No Additional Fee
Core Medication Management	Program for members with chronic conditions to ensure they are taking medications properly by addressing potential adherence issues and closing gaps in care. This program analyzes pharmacy claims data and notifies members and providers with refill and late to fill notifications per member's preferred method of communication.	No Additional Fee
Cost Saver	Cost Saver utilizes a third-party contracted Participating Pharmacy network to enable Plan Members to take advantage of lower discount card prices, when available, while retaining the benefit of the drug utilization and clinical programs provided under the Plan. The program, which is eligible for non-specialty medications, is fully automated so it ensures members receive the lowest possible price without any additional discount cards.	No Additional Fee

1. State legislation may impact program availability.

2.1. **Participating Pharmacies**. The amount paid to the Participating Pharmacy for Prescription Drug Claims may or may not be equal to the amount charged to Employer, and BlueCross will absorb any negative margin or retain any positive margin. Subject to applicable law, BlueCross may communicate with Members regarding benefit design, cost savings, availability and use of the selected networks, as well as provide supporting services.

A list of Participating Pharmacies is available to Members on-line. BlueCross does not direct or exercise any control over the professional judgment exercised by any pharmacist providing pharmaceutical related services.

2.2. Any reports requested upon termination will incur an *ad hoc* fee. BlueCross shall not be obligated to release such report until the fee has been paid.

3. Pharmacy Networks and Drug Formulary.

Employer has selected the following Pharmacy networks and Drug Formulary, and such networks and formulary are applicable to the guarantees outlined in this section:

- 3.1. RX04 Network – BlueCross’s national traditional Retail 30 Network.
- 3.2. Plus90 Network - BlueCross’s Retail 90 Network.
- 3.3. Home Delivery Network
- 3.4. Retail Specialty Pharmacy Network – BlueCross’ Retail 30 Network and the Preferred Specialty Network of Participating Pharmacies.
- 3.5. Preferred Formulary

4. Pharmacy Administrative Fees.

Employer shall pay to BlueCross the following Pharmacy Administrative Fees:

Year 1: \$2.00 Per Claim.

The above fee includes a \$2.00 Per Claim fee to be paid to Employer’s broker/consultant. BlueCross will remit the fee to the broker/consultant on Employer’s behalf.

5. Pharmacy Discount Guarantee.

BlueCross guarantees that Employer will obtain a discount off AWP charged for Covered Drugs. Ingredient Cost and Dispensing Fee guarantees are collectively referred to as the “Pharmacy Discount Guarantee.” The Pharmacy Discount Guarantee is identified below for each of the applicable networks.

Pharmacy Discount Guarantees	Brand Drugs	Generic Drugs	Dispensing Fees
Retail 30 Network (1-83 days’ supply)	Year 1: AWP-19.60%	Year 1: AWP-84.85%	Year 1: \$0.25/Rx
Retail 90 Network (84+ days’ supply)	Year 1: AWP-21.50%	Year 1: AWP-86.35%	Year 1: \$0.00/Rx
Home Delivery Network (1+ days’ supply)	Year 1: AWP-24.00%	Year 1: AWP-88.85%	Year 1: \$0.00/Rx
Self-Administered Specialty Pharmacy Network	Year 1: AWP-21.75%		Year 1: \$0.25/Rx

- 5.1. Pricing Per Prescription Drug Claim. Subject to annual reconciliation of the above Pharmacy Discount Guarantee, Employer will pay to BlueCross on a per Prescription Drug Claim basis amounts determined pursuant to the following:
- 5.1.1. Brand Drug will be calculated at the Ingredient Cost plus the applicable Dispensing Fee. Brand Drug Ingredient Cost will be calculated at the lesser of the applicable U&C, Prescription MAC (if applicable), or AWP discount price, including claims where full cost is paid by Member.
 - 5.1.2. Generic Drug will be calculated at the Ingredient Cost plus the applicable Dispensing Fee. Generic Drug Ingredient Cost will be calculated at the lesser of the applicable U&C, Prescription MAC (if applicable), or AWP discount price, including claims where full cost is paid by Member.
 - 5.1.3. The Member's copayment charged for a Covered Drug will be the lesser of the applicable copayment or Ingredient Cost.
 - 5.1.4. Prescription MAC pricing (if applicable) will be applied to all Pharmacy Networks, including Retail 30 Network, Retail 90 Network, Home Delivery Network and Specialty Pharmacy Network. Prescription MAC pricing applied on the Retail 90 Network and Home Delivery Network will be equal to or greater than the Prescription MAC pricing applied at the Retail 30 Network.
 - 5.1.5. Prescription Drug Claims for re-labeled or repackaged NDCs, regardless of dispensing Pharmacy, will be denied.
 - 5.1.6. Pricing methodology may differ from above due to state legislation, where applicable.
- 5.2. Annual Reconciliation. Application of the Pharmacy Discount Guarantee set forth in the table above shall be subject to the following criteria and reconciliation provisions:
- 5.2.1. Separately for each pricing component in the table above, the following calculations will be performed for all Prescription Drug Claims processed in order to reconcile against the Pharmacy Discount Guarantee.
 - 5.2.1.1. Ingredient Cost. The formula indicates the percentage reduction off of AWP Employer will receive and will be calculated as: $\{1 - (\text{total discounted AWP Ingredient Cost (excluding Dispensing Fees and prior to application of copayments, selection penalties, and other Member paid amounts) of applicable Prescription Drug Claims for the annual period} / \text{total undiscounted AWP Ingredient Cost (both amounts will be calculated as of the date of adjudication) for the annual period})\}$.
 - 5.2.1.2. Dispensing Fee. The formula will be calculated as: $\{\text{total Dispensing Fees (prior to application of copayments, selection penalties, and other member paid amounts) of applicable Prescription Drug Claims for the annual period} / \text{total number of Prescription Drug Claims (both amounts will be calculated as of the date of adjudication) for the annual period}\}$.

- 5.2.2. The Pharmacy Discount Guarantee excludes Compound drugs, Biosimilar Products, drugs dispensed at a long term care facility, OTCs, Vaccine Claims, Limited Distribution Drugs, COVID testing-related claims, claims for FDA-approved oral antiviral therapy for the treatment of COVID, 340B claims, onsite pharmacy claims that do not accept standard Retail 30 Network, Retail 90 Network, and Specialty Pharmacy Network pricing terms and conditions, self-administered specialty pharmacy products not filled through BlueCross' Specialty Pharmacy Network, Provider Administered Specialty Pharmacy Products (as defined in Exhibit C of this Agreement), Medicaid subrogation claims, member-submitted claims, coordination-of-benefit claims, claims from pharmacies operated by the Department of Veterans Affairs, the Department of Defense's Military Treatment Facilities Veteran's Administration, and Indian Health Service, Tribes and Urban Indian claims.
- 5.2.3. The Pharmacy Discount Guarantee is measured in the aggregate and reconciled annually across the entire Mark III Self-Funded Group Pool. It is measured in 12-month increments beginning with the first month of Year 1, which may or may not coordinate with Employer's medical contract year. The reconciliation will occur approximately 120 days after the end of each 12-month period. An excess achieved on one or more of the Pharmacy Discount Guarantees shall be used to offset a shortfall in any of the other Pharmacy Discount Guarantees. Should the actual savings achieved across the Mark III Self-Funded Group Pool be less than the guarantee, BlueCross shall pay Employer its proportional share of the shortfall between the actual savings and the guaranteed result. If the reconciliation results in greater savings than the above guarantees, Employer shall retain the surplus. Subject to Final Settlement, Employer shall receive Pharmacy Discount Guarantee shortfall payment, if any, for claims incurred prior to the termination date. If the Agreement or this Exhibit is terminated prior to the completion of the applicable 12-month period, the Pharmacy Discount Guarantee shall become null and void.
- 5.2.4. Claims that have non-standard pricing as a result of government action, for example as part of a public health emergency, will be excluded from the Pharmacy Discount Guarantee.
- 5.2.5. State-regulated dispensing fees will be excluded from the Pharmacy Discount Guarantee.
- 5.2.6. Claims paid under the reimbursement appeals process governed by state law will be excluded from the Pharmacy Discount Guarantee.
- 5.2.7. Self-Administered Specialty Pharmacy Network discount guarantees apply to Covered Drugs on the Standard Specialty Drug List.
- 5.3. Guarantee Conditions. The Pharmacy Discount Guarantee is nullified if any of the following occur:
- 5.3.1. BlueCross is not Employer's exclusive provider of Pharmacy benefit management services.

- 5.3.2. Implementation or addition of 100% Member cost-share Pharmacy benefit plan, under which Employer contributes nothing toward the Prescription Drug Claim costs (i.e., the only benefit the Member receives is a claim discount).
- 5.3.3. BlueCross's Specialty Pharmacy Network is not included, or a days' supply is greater than 30 days.
- 5.3.4. Employer changes its Pharmacy networks, days' supplies, benefit design, Drug Formulary, clinical or trend programs.
- 5.3.5. The pricing source discontinues the reporting of AWP or materially changes the manner in which AWP is calculated. (BlueCross reserves the right to make an equitable adjustment as necessary to maintain the Parties' relative economics and the pricing intent of this Agreement. BlueCross will notify Employer in writing of such adjustment. Employer will have fifteen (15) days to respond to receipt of notification. If written response is not received within fifteen (15) days, adjustment will be deemed acceptable by Employer.)
- 5.3.6. Employer elects to use on-site clinics or Pharmacies to dispense Prescription Drugs to Members which materially reduces the number of Covered Drug claims submitted.
- 5.3.7. Employer does not implement a plan design that permits Members to fill 90 days' supply at a Retail 90 Network Participating Pharmacy.
- 5.3.8. Government action, change in law or regulation, or change in the interpretation of any law or regulation that has an adverse effect on pharmacy network pricing. Should this happen, BlueCross will make a good faith effort to work to reach a new agreement that equitably reflects the circumstances as altered by government action. BlueCross will notify Employer in writing of such adjustment. Employer will have fifteen (15) days to respond to receipt of notification. If written response is not received within fifteen (15) days, adjustment will be deemed acceptable by Employer.
- 5.3.9. The Mark III Self-Funded Group Pool falls below 2,500 members.
- 5.3.10. The drug mix utilization as a result of additional self-funded groups to the Mark III Self-Funded Group Pool drives results that are materially different than estimated.

6. Pharmacy Rebate Guarantee.

BlueCross guarantees that Employer will receive a minimum Pharmacy Rebate as identified below for each of the applicable networks.

Drug Formulary	BlueCross's Preferred Formulary			
Pharmacy Network	Retail 30 1-83 days' supply	Retail 90 84+ days' supply	Home Delivery Network	Self- Administered Specialty Pharmacy Products
Per Brand Drug Prescription claim	Year 1: \$412.00	Year 1: \$927.00	Year 1: \$927.00	Year 1: \$4,500.00

6.1. Annual Reconciliation. Application of the Pharmacy Rebate Guarantees set forth in the table above shall be subject to the following criteria and reconciliation provisions:

6.1.1. The following are excluded from the Pharmacy Rebate Guarantee: Compound Drugs, Provider Administered Specialty Pharmacy Products, Biosimilar Products, drugs dispensed at a long term care facility, home infusion drugs, OTCs, Vaccine Claims, Limited Distribution Drugs, claims for drugs not included on the Drug Formulary, COVID testing-related claims, claims for FDA-approved oral antiviral therapy for the treatment of COVID, 340B Claims, Medicaid subrogation claims, member-submitted claims, coordination-of-benefit claims, claims from pharmacies operated by the Department of Veterans Affairs, the Department of Defense's Military Treatment Facilities Veteran's Administration, and Indian Health Service, Tribes and Urban Indian claims.

6.1.2. The Pharmacy Rebate Guarantee is measured in the aggregate and reconciled annually across the entire Mark III Self-Funded Group Pool. The Pharmacy Rebate payment is distributed within approximately 120 days after the end of each quarter. Should the actual savings achieved across the Mark III Self-Funded Group Pool be less than the Pharmacy Rebate Guarantee, BlueCross shall pay Employer its proportional share of the shortfall between the actual savings and the guaranteed result. If the actual Pharmacy Rebate received is greater than the Pharmacy Rebate Guarantee, Employer shall retain the surplus. Subject to Final Settlement, Employer shall receive Pharmacy Rebate guarantee payment, if any, for claims incurred prior to the termination date. The Pharmacy Rebate Guarantee is measured in 12 month increments beginning with the first month of Year 1, which may or may not coordinate with Employer's medical contract year. The reconciliation will be on an incurred basis and will occur approximately 240 days after the end of each 12-month period. If the Agreement or this Exhibit is terminated prior to the completion of the applicable 12-month period, the Pharmacy Rebate Guarantee shall become null and void.

6.1.3. Claims that have non-standard pricing as a result of government action, for example as part of a public health emergency, will be excluded from the Pharmacy Rebate Guarantee.

- 6.1.4. HIV claims, identified with Medi-Span Generic Product ID (GPI-4) of 1210, and Self-Administered Specialty Pharmacy Products not filled through BlueCross's Specialty Pharmacy Network will be reconciled as Retail under the Rebate Guarantee reconciliation.
- 6.1.5. BlueCross may leverage realized savings relating to the additional value of low cost strategies on minimum guarantees by adding "Rebate Reconciliation Credits" value to the total Pharmacy Rebates actually remitted to Employer when reconciling minimum rebate guarantees. "Rebate Reconciliation Credits" shall consist of (i) the value of price reductions for rebateable products that have experienced a Wholesale Acquisition Cost (WAC) decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the claim is adjudicated, subject to the below cap, and/or (ii) the differential between the WAC of a lower net cost Brand Drug, including but not limited to a Biosimilar Product ("Low Cost Brand"), claim processed, and the WAC of the reference Brand Drug, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time the claim is adjudicated. In no way will the Rebate Reconciliation Credit exceed the Baseline Rebate less the earned Pharmacy Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. "Baseline Rebate" is calculated as follows: In the year the price reduction occurred, Baseline Rebate will be the Pharmacy Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Pharmacy Rebate available for coverage for the reference Brand Drug on the date the claim is adjudicated. For a product experiencing a WAC reduction, in subsequent years the Baseline Rebate will increase over the prior year Baseline Rebate at the WAC inflation rate of the GPI subclass (GPI-6) of the applicable product. BlueCross will notify Employer of any applicable product that qualifies for Rebate Reconciliation Credits. BlueCross agrees to provide reporting upon Employer request demonstrating the net-cost impact in the therapeutic category.
- 6.1.6. Self-Administered Specialty Pharmacy Product rebate guarantees apply to Covered Drugs on the Standard Specialty Drug List.
- 6.2. Guarantee Conditions. The Pharmacy Rebate Guarantee is nullified if any of the following occur:
 - 6.2.1. BlueCross is not Employer's exclusive provider of Pharmacy benefit management services.
 - 6.2.2. Implementation or addition of 100% Member cost-share Pharmacy benefit plan, under which Employer contributes nothing toward the Prescription Drug Claims costs (i.e., the only benefit the Member receives is a claims discount).
 - 6.2.3. BlueCross's Specialty Pharmacy Network is not included. Employer changes its Pharmacy networks, days' supplies, benefit design, Drug Formulary, or implements OTC plans, clinical or trend programs.

- 6.2.4. The pricing source discontinues the reporting of AWP or materially changes the manner in which AWP is calculated. (BlueCross reserves the right to make an equitable adjustment as necessary to maintain the Parties' relative economics and the pricing intent of this Agreement. BlueCross will notify Employer in writing of such adjustment. Employer will have fifteen (15) days to respond to receipt of notification. If written response is not received within fifteen (15) days, adjustment will be deemed acceptable by Employer.)
- 6.2.5. Employer elects to use on-site clinics or Pharmacies to dispense Prescription Drugs to Members which materially reduces the number of Covered Drug claims submitted.
- 6.2.6. Employer does not implement a plan design that permits Members to fill 90 days' supply at a Retail 90 Network Participating Pharmacy.
- 6.2.7. Employer does not implement a Pharmacy benefit design approved by BlueCross consisting of an arrangement whose differential in copayment or its reasonably equivalent value for coinsurance between preferred and non-preferred brand drugs is at least \$15.00.
- 6.2.8. Employer (or its affiliates or agents) contracts directly or indirectly with another party for discounts, utilization limits, Pharmacy Rebates or other financial incentives on pharmaceutical products or formulary programs for claims processed pursuant to this Exhibit.
- 6.2.9. There is an adverse effect on the availability of Pharmacy Rebates due to a government action, change in law or regulation (or interpretation of a law or regulation), or an action by a pharmaceutical manufacturer. (BlueCross reserves the right to make an equitable adjustment as necessary to maintain the Parties' relative economics and the pricing intent of this Agreement. BlueCross will notify Employer in writing of such adjustment. Employer will have fifteen (15) days to respond to receipt of notification. If written response is not received within fifteen (15) days, adjustment will be deemed acceptable by Employer.) Under its Pharmacy Rebate program, BlueCross, or its delegate, may implement Drug Formulary management programs and controls, which may include, among other things, cost containment initiatives, and communications with Members, Participating Pharmacies, and/or physicians. BlueCross reserves the right to modify or replace such programs from time to time. Pharmacy Rebate Guarantees are conditioned on adherence to various Drug Formulary management controls, benefit design requirements and claims volume.
- 6.2.10. The Mark III Self-Funded Group Pool falls below 2,500 members.
- 6.2.11. The drug mix utilization as a result of additional self-funded groups to the Mark III Self-Funded Group Pool drives results that are materially different than estimated.
- 6.3. For purposes of the Federal Anti-Kickback Statute, these Pharmacy Rebates shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. 1320a 7b(b)(3)(A).

- 6.4. BlueCross represents and warrants that it will not enter into any agreement with a pharmaceutical manufacturer for other pharmaceutical revenue in exchange for a reduction of Pharmacy Rebates.

EXHIBIT Q TO THE ADMINISTRATIVE SERVICES AGREEMENT

BUSINESS ASSOCIATE AGREEMENT Between BLUE CROSS BLUE SHIELD OF TENNESSEE, INC. and CITY OF KINGSPORT, TN

This Business Associate Agreement (“BAA”) is effective upon execution and amends and is made part of the Administrative Services Agreement (“ASA”) by and between BlueCross BlueShield of Tennessee, Inc. (“BlueCross”), City of Kingsport, TN (“Employer”) assigned Employer Group Number 130434, and the Group Health Plan (“GHP”).

The ASA is modified to incorporate the terms of this HIPAA Agreement to comply with the requirements of the implementing regulations at 45 Code of Federal Regulations (“C.F.R.”) Parts 160-64 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as modified by the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (“HITECH Act”), and the implementing regulations (“HIPAA Rules”) that are applicable to BlueCross, along with any guidance and/or regulations issued by United States Department of Health and Human Services (“DHHS”). BlueCross and GHP agree to incorporate into this HIPAA Agreement any regulations issued with respect to the HITECH Act that relate to the obligations of BlueCross. BlueCross recognizes and agrees that it is obligated by law to meet the applicable provisions of the HITECH Act.

1. Privacy of Protected Health Information.

- a. Permitted Uses and Disclosures. BlueCross is permitted to use and disclose Protected Health Information that it creates or receives on GHP’s behalf or receives from GHP (or another business associate of GHP) and to request Protected Health Information on GHP’s behalf (collectively, “GHP’s Protected Health Information”) only as follows:
 - i. Functions and Activities on GHP’s Behalf. BlueCross will be permitted to use and disclose GHP’s PHI to perform functions, activities, services, and operations on behalf of GHP, consistent with the Privacy Rule and the HITECH Act as specified in the ASA, including but not limited to: (a) management, operation, and administration of the GHP offered to Members; and (b) services set forth in the ASA, which include payment activities, Health Care Operations, and Data Aggregation.
 - ii. BlueCross’ Operations. For BlueCross’ proper management and administration or to carry out BlueCross’ legal responsibilities, provided that, with respect to disclosure of GHP’s Protected Health Information, either:
 - A) The disclosure is Required by Law; or
 - B) BlueCross obtains reasonable assurance from any person or entity to which BlueCross will disclose GHP’s Protected Health Information that the person or entity will:

- 1) Hold GHP's Protected Health Information in confidence and use or further disclose GHP's Protected Health Information only for the purpose for which BlueCross disclosed GHP's Protected Health Information to the person or entity or as Required by Law; and
 - 2) Promptly notify BlueCross (who will in turn notify GHP in accordance with Section 4(a) of this HIPAA Agreement) of any instance of which the person or entity becomes aware in which the confidentiality of GHP's Protected Health Information was breached.
- C) BlueCross also may use GHP's Protected Health Information to provide Data Aggregation Services. BlueCross may de-identify GHP's PHI it obtains or creates in the course of providing services to Employer.
- b. Minimum Necessary and Limited Data Set. BlueCross' use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, BlueCross will, in its performance of the functions, activities, services, and operations specified in Section 1(a) above, make reasonable efforts to use, to disclose, and to request of a Covered Entity only the minimum amount of GHP's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except that BlueCross will not be obligated to comply with this minimum necessary limitation with respect to:
- i. Disclosure to or request by a health care provider for Treatment;
 - ii. Use for or disclosure to an individual who is the subject of GHP's Protected Health Information, or that individual's personal representative;
 - iii. Use or disclosure made pursuant to an authorization compliant with 45 C.F.R. § 164.508 that is signed by an individual who is the subject of GHP's Protected Health Information to be used or disclosed, or by that individual's personal representative;
 - iv. Disclosure to the DHHS in accordance with Section 5(a) of this HIPAA Agreement;
 - v. Use or disclosure that is Required by Law; or
 - vi. Any other use or disclosure that is excepted from the minimum necessary limitation as specified in 45 C.F.R. § 164.502(b)(2).
- c. Prohibition on Unauthorized Use or Disclosure. BlueCross will neither use nor disclose GHP's Protected Health Information, except as permitted or required by the ASA and this HIPAA Agreement or in writing by GHP or as Required by Law. This HIPAA Agreement does not authorize BlueCross to use or disclose GHP's Protected Health Information in a manner that will violate the 45 C.F.R. Part 164, Subpart E "Privacy of

Individually Identifiable Health Information” (“Privacy Rule”) if done by GHP, except as set forth in Section 1(a)(ii) of this HIPAA Agreement.

d. Information Safeguards.

i. Privacy of GHP’s Protected Health Information. BlueCross will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of GHP’s Protected Health Information. The safeguards must reasonably protect GHP’s Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule, 45 C.F.R. Part 164, Subpart E and this HIPAA Agreement, and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this HIPAA Agreement.

ii. Security of GHP’s Electronic Protected Health Information. BlueCross will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that BlueCross creates, receives, maintains, or transmits on GHP’s behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and as required by the HITECH Act. BlueCross also shall develop and implement policies and procedures and meet the Security Rule documentation requirements as required by the HITECH Act.

e. Subcontractors and Agents. BlueCross will require any of its subcontractors and agents, to which BlueCross is permitted by the ASA and this HIPAA Agreement or in writing by GHP to disclose GHP’s Protected Health Information, to provide reasonable assurance that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to GHP’s Protected Health Information that are applicable to BlueCross under this HIPAA Agreement.

2. Compliance with Transaction Standards. If BlueCross conducts in whole or part electronic Transactions on behalf of GHP for which DHHS has established Standards, BlueCross will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Transaction Rule, 45 C.F.R. Part 162. BlueCross will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions on behalf of GHP that:

- a. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
- b. Adds any data element or segment to the maximum defined data set;
- c. Uses any code or data element that is marked “not used” in the Standard Transaction’s implementation specification or is not in the Standard Transaction’s implementation specification; or

- d. Changes the meaning or intent of the Standard Transaction's implementation specification.

3. Individual Rights.

- a. Access. BlueCross will, within Thirty (30) days following GHP's request, make available to GHP or, at GHP's direction, to an individual (or the individual's personal representative) for inspection and obtaining copies of GHP's Protected Health Information about the individual that is in BlueCross' custody or control, consistent with the requirements of 45 C.F.R. § 164.524 so that GHP may meet its access obligations under 45 C.F.R. § 164.524 and, where applicable, the HITECH Act. BlueCross shall make such information available in an electronic format where directed by GHP.
- b. Amendment. BlueCross will, upon receipt of written notice from GHP, promptly amend or permit GHP access to amend any portion of GHP's Protected Health Information, so that GHP may meet its amendment obligations under 45 C.F.R. § 164.526.
- c. Disclosure Accounting. So that GHP may meet its disclosure accounting obligations under 45 C.F.R. § 164.528:
 - i. Disclosures Subject to Accounting. BlueCross will record the information specified in Section 3(c)(iii) below ("Disclosure Information") for each disclosure of GHP's Protected Health Information, not excepted from disclosure accounting as specified in Section 3(c)(ii) below, that BlueCross makes to GHP or to a third party.
 - ii. Disclosures Not Subject to Accounting. BlueCross will not be obligated to record Disclosure Information or otherwise account for the following disclosures of GHP's Protected Health Information:
 - A) That occurred before April 14, 2003;
 - B) For Treatment, Payment or Health Care Operations activities;
 - C) To an individual who is the subject of GHP's Protected Health Information disclosed, or to that individual's personal representative;
 - D) Pursuant to an authorization compliant with 45 C.F.R. § 164.508 that is signed by an individual who is the subject of GHP's Protected Health Information disclosed, or by that individual's personal representative;
 - E) For notification of and to persons involved in the care or payment related to the health care of an individual who is the subject of GHP's Protected Health Information disclosed and for disaster relief;
 - F) To law enforcement officials or correctional institutions in accordance with 45 C.F.R. § 164.512(k)(5);

- G) For national security or intelligence purposes in accordance with 45 C.F.R. § 164.512(k)(2);
 - H) In a Limited Data Set;
 - I) Incident to a use or disclosure that BlueCross is otherwise permitted to make by the ASA and this HIPAA Agreement; and
 - J) Otherwise excepted from disclosure accounting as specified in 45 C.F.R. § 164.528.
- iii. Disclosure Information. With respect to any disclosure by BlueCross of GHP's Protected Health Information that is not excepted from disclosure accounting by Section 3(c)(ii) above, BlueCross will record the following Disclosure Information as applicable to the type of accountable disclosure made:
- A) Disclosure Information Generally. Except for repetitive disclosures of GHP's Protected Health Information as specified in Section 3(c)(iii)(B) below and for disclosures for large Research studies as specified in Section 3(c)(iii)(C) below, the Disclosure Information that BlueCross must record for each accountable disclosure are the requirements set forth in the HIPAA Privacy Rule, including, but not limited to: (i) the disclosure date, (ii) the name and (if known) address of the entity to which BlueCross made the disclosure, (iii) a brief description of GHP's Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure. BlueCross further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations.
 - B) Disclosure Information for Repetitive Disclosures. For repetitive disclosures of GHP's Protected Health Information that BlueCross makes for a single purpose to the same person or entity (including GHP), the Disclosure Information that BlueCross must record is either the Disclosure Information specified in Section 3(c)(iii)(A) above for each accountable disclosure, or (i) the Disclosure Information specified in Section 3(c)(iii)(A) above for the first of the repetitive accountable disclosures, (ii) the frequency, periodicity, or number of the repetitive accountable disclosures, and (iii) the date of the last of the repetitive accountable disclosures.
 - C) Disclosure Information for Large Research Activities. For disclosures of GHP's Protected Health Information that BlueCross makes for particular Research involving Fifty (50) or more individuals and for which an Institutional Review Board or Privacy Board has waived authorization during the period covered by an individual's disclosure accounting request, the Disclosure Information that BlueCross must record is (i) the

name of the Research protocol or activity, (ii) a plain language description of the Research protocol or activity, including its purpose and criteria for selecting particular records, (iii) a brief description of the type of GHP's Protected Health Information disclosed for the Research, (iv) the dates or periods during which BlueCross made or may have made these disclosures, including the date of the last disclosure that BlueCross made during the period covered by an individual's disclosure accounting request, (v) the name, address, and telephone number of the Research sponsor and of the researcher to whom BlueCross made these disclosures, and (vi) a statement that GHP's Protected Health Information relating to an individual requesting the disclosure accounting may or may not have been disclosed for a particular Research protocol or activity. BlueCross will, upon request of GHP or an individual requesting the disclosure accounting, assist GHP or the individual to contact the Research sponsor and the researcher if it is reasonably likely that GHP's Protected Health Information relating to the individual was disclosed for the particular Research protocol or activity.

- iv. Availability of Disclosure Information. Unless otherwise provided by applicable laws, BlueCross will maintain the Disclosure Information for at least Six (6) years following the date of the accountable disclosure to which the Disclosure Information relates.

Business Associate will make the Disclosure Information available to GHP within Sixty (60) days following GHP's request for such Disclosure Information to comply with an individual's request for disclosure accounting.

- d. Restriction Agreements and Confidential Communications. BlueCross will comply with any agreement that GHP makes that either (i) restricts use or disclosure of GHP's Protected Health Information pursuant to 45 C.F.R. § 164.522(a), or (ii) requires confidential communication about GHP's Protected Health Information pursuant to 45 C.F.R. § 164.522(b), provided that GHP notifies BlueCross in writing of the restriction or confidential communication obligations that BlueCross must follow. GHP will promptly notify BlueCross in writing of the termination of any such restriction agreement or confidential communication requirement and, with respect to termination of any such restriction agreement, instruct BlueCross whether any of GHP's Protected Health Information will remain subject to the terms of the restriction agreement.

4. Privacy Obligation Breach and Security Incidents.

- a. Reporting.

- i. Privacy Breach. BlueCross will report to GHP any use or disclosure of GHP's Protected Health Information not permitted by the ASA and this HIPAA Agreement or in writing by GHP. In addition, BlueCross will report, following discovery and without unreasonable delay, but in no event later than ten (10) business days following discovery, any "Breach" of "Unsecured Protected Health

Information" as these terms are defined by the Breach Notification Regulation. BlueCross shall cooperate with GHP in investigating the Breach and in meeting the GHP's obligations under the Breach Notification Regulation and any other security breach notification laws.

- ii. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by BlueCross to have been, accessed, acquired, or disclosed during such Breach. BlueCross will make the report to GHP's Privacy Division not more than Twenty (20) business days after BlueCross' notice pursuant to subsection (i). BlueCross will report the following as information is available:
 - A) Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;
 - B) Identify GHP's Protected Health Information accessed, used or disclosed as part of the Breach (e.g., full name, social security number, date of birth, etc.); and
 - C) Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure.
- iii. Security Incidents. BlueCross will report to GHP any attempted or successful (A) unauthorized access, use, disclosure, modification, or destruction of GHP's Electronic Protected Health Information or (B) interference with BlueCross' system operations in BlueCross' information systems, of which BlueCross becomes aware. BlueCross will make this report upon GHP's request, except if any such security incident resulted in a disclosure of GHP's Protected Health Information not permitted by this HIPAA Agreement, BlueCross will make the report in accordance with Section 4(a)(i) above.

b. Termination of Agreement.

- i. Right to Terminate for Breach. GHP may terminate ASA if it determines, in its sole discretion, that BlueCross has breached any provision of this HIPAA Agreement and upon written notice to BlueCross of the breach, BlueCross fails to cure the breach within Thirty (30) days after receipt of the notice. GHP may exercise this right to terminate Agreement by providing BlueCross written notice of termination, stating the failure to cure the breach of the HIPAA Agreement that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in GHP's notice of termination. If for any reason GHP determines that BlueCross has breached the terms of this HIPAA Agreement and such breach has not been cured, but GHP determines that termination of the Agreement is not feasible, GHP may report such breach to the DHHS.

- ii. BlueCross may terminate Agreement if it determines, after reasonable consultation with GHP, that GHP has breached any material provision of this HIPAA Agreement and upon written notice to GHP of the breach, GHP fails to cure the breach within Thirty (30) days after receipt of the notice. BlueCross may exercise this right to terminate Agreement by providing GHP written notice of termination, stating the failure to cure the breach of the HIPAA Agreement that provides the basis for the termination. Any such termination will be effective upon such reasonable date as the parties mutually agree. If BlueCross reasonably determines that GHP has breached the terms of this HIPAA Agreement and such breach has not been cured, but BlueCross and GHP mutually determine that termination of the Agreement is not feasible, BlueCross may report such breach to the DHHS.
- c. Obligations on Termination.
- i. Return or Destruction of GHP's Protected Health Information as Feasible. Upon termination or other conclusion of Agreement, BlueCross will, if feasible, return to GHP or destroy all of GHP's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of GHP's Protected Health Information. BlueCross will require any subcontractor or agent, to which BlueCross has disclosed GHP's Protected Health Information as permitted by Section 1(e) of this HIPAA Agreement, to if feasible return to BlueCross (so that BlueCross may return it to GHP) or destroy all of GHP's Protected Health Information in whatever form or medium received from BlueCross, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of GHP's Protected Health Information, and certify on oath to BlueCross that all such information has been returned or destroyed. BlueCross will complete these obligations as promptly as possible, but not later than Sixty (60) days following the effective date of the termination or other conclusion of Agreement.
 - ii. Procedure When Return or Destruction Is Not Feasible. BlueCross will identify any of GHP's Protected Health Information, including any that BlueCross has disclosed to subcontractors or agents as permitted by Section 1(e) of this HIPAA Agreement, that cannot feasibly be returned to GHP or destroyed and explain why return or destruction is infeasible. Where GHP agrees that such return or destruction is infeasible, BlueCross will limit its further use or disclosure of such information to those purposes that make return or destruction of such information infeasible. If GHP does not agree, subparagraph A above shall apply. BlueCross will require such subcontractor or agent to limit its further use or disclosure of GHP's Protected Health Information that such subcontractor or agent cannot feasibly return or destroy to those purposes that make the return or destruction of such information infeasible. BlueCross will complete these obligations as

promptly as possible, but not later than Sixty (60) days following the effective date of the termination or other conclusion of Agreement.

- iii. Continuing Privacy and Security Obligation. BlueCross' obligation to protect the privacy and safeguard the security of GHP's Protected Health Information as specified in this HIPAA Agreement will be continuous and survive termination or other conclusion of Agreement and this HIPAA Agreement.
 - iv. Other Obligations and Rights. BlueCross' other obligations and rights and GHP's obligations and rights upon termination or other conclusion of Agreement will be those set out in the ASA.
- d. Indemnity. BlueCross will indemnify and hold harmless GHP and any GHP affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted use or disclosure of GHP's Protected Health Information or other breach of this HIPAA Agreement by BlueCross or any subcontractor or agent under BlueCross' control.
- i. Right to Tender or Undertake Defense. If GHP is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted use or disclosure of GHP's Protected Health Information or other breach of this HIPAA Agreement by BlueCross or any subcontractor or agent under BlueCross' control, GHP will have the option at any time either (A) to tender its defense to BlueCross, in which case BlueCross will provide qualified attorneys, consultants, and other appropriate professionals to represent GHP's interests at BlueCross' expense, or (B) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case BlueCross will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.
 - ii. Right to Control Resolution. GHP will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it, notwithstanding that GHP may have tendered its defense to BlueCross. Any such resolution will not relieve BlueCross of its obligation to indemnify GHP under this Section 4(c).

5. General Provisions.

- a. Inspection of Internal Practices, Books, and Records. BlueCross will make its internal practices, books, and records relating to its use and disclosure of GHP's Protected Health Information available to GHP and to DHHS to determine GHP's compliance with the Privacy Rule, 45 C.F.R. Part 164, Subpart E.
- b. Definitions. The terms "Covered Entity," "Electronic Protected Health Information," "Protected Health Information," "Standard," "Trading Partner Agreement," and "Transaction" have the meanings set out in 45 C.F.R. § 160.103. The term "Standard

Transaction” has the meaning set out in 45 C.F.R. § 162.103. The term “Required by Law” has the meaning set out in 45 C.F.R. § 164.103. The terms “Health Care Operations,” “Payment,” “Research,” and “Treatment” have the meanings set out in 45 C.F.R. § 164.501. The term “Limited Data Set” has the meaning set out in 45 C.F.R. § 164.514(e). The term “use” means, with respect to Protected Health Information, utilization, employment, examination, analysis or application within Business Associate. The terms “disclose” and “disclosure” mean, with respect to Protected Health Information, release, transfer, providing access to or divulging to a person or entity not within Business Associate. For purposes of this HIPAA Agreement, GHP’s Protected Health Information encompasses GHP’s Electronic Protected Health Information. Any other capitalized terms not identified here shall have the meaning as set forth in the HIPAA Rules.

- c. Amendment to Agreement. Upon the compliance date of any final regulation or amendment to final regulation promulgated by DHHS that affects BlueCross’ use or disclosure of GHP’s Protected Health Information or Standard Transactions, the Agreement and this HIPAA Agreement will automatically amend such that the obligations imposed on BlueCross remain in compliance with the final regulation or amendment to final regulation.
- d. Other Acceptable Forms of this HIPAA Agreement. The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, or an electronic version.
- e. Communications. Member requests or other communications or notices required or contemplated by this HIPAA Agreement shall be in writing and shall be delivered by hand, by overnight courier service, or by first class mail, postage prepaid, addressed to the appropriate party at the address below, or to such other party or address as may be hereafter specified by written notice:

BlueCross BlueShield of Tennessee, Inc.
Privacy Office 1.4
1 Cameron Hill Circle
Chattanooga, TN 37402
Telephone: 888-455-3824


Member requests or other communications or notices shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; or as of Three (3) business days after the date of mailing.


6. Conflicts. The terms and conditions of this HIPAA Agreement will override and control any conflicting term or condition of the ASA. All non-conflicting terms and conditions of the ASA remain in full force and effect.

IN WITNESS WHEREOF, GHP and BlueCross execute this HIPAA Agreement in multiple originals to be effective on the last date written below.

**BLUE CROSS BLUE SHIELD
OF TENNESSEE, INC.**

CITY OF KINGSPORT, TN

By: 
Printed Name: John Maki
Title: Vice President, Sales and
Account Management
Date: October 18, 2016
Address: 1 Cameron Hill Circle
Chattanooga, TN 37402

By: 
Printed Name: Mike McIntire
Title: Vice Mayor
Date: 12/29/2016
Address: _____

ATTEST:

DEPUTY CITY RECORDER

APPROVED AS TO FORM:

CITY ATTORNEY

EXHIBIT R TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT S TO THE ADMINISTRATIVE SERVICES AGREEMENT

AUDITS and RECORDS

1. Audit of BlueCross.

1.1. Audits Generally. During the term of this Agreement, Employer may audit BlueCross, at Employer's own expense, in accordance with the following requirements:

- 1.1.1. Employer shall provide a written audit request to BlueCross at least 45 days in advance of the requested audit date. Such request shall include the requested audit date, the requested auditor, the manner of compensation for the auditor, and information about the nature, purpose, scope and objectives of the audit.
- 1.1.2. Employer and BlueCross will agree on an independent, third party auditor to conduct the audit ("Auditor").
- 1.1.3. The audit shall be conducted in accordance with the terms of BlueCross's standard audit agreement and this Agreement. The audit agreement shall be finalized and executed by BlueCross, the Auditor, and Employer prior to the commencement of the audit.
- 1.1.4. The audit shall be limited in scope to claims paid within the 12 months prior to the date the Audit Agreement is executed by the final signatory ("Audit Time Period").
- 1.1.5. Employer agrees that its audit rights are limited to BlueCross and do not extend to BlueCross's vendors or subcontractors. Any BlueCross audit shall be performed based on the information in BlueCross's records.
- 1.1.6. With respect to any audit, claims adjustments will be based on actual claims reviewed and not upon sampling, statistical projections or extrapolations.
- 1.1.7. The Parties agree that claims adjudicated following BlueCross's claims processing guidelines shall be deemed to have been properly adjudicated, including, but not limited to, the claims processed through the BlueCard program.
- 1.1.8. BlueCross shall be required to supply only such information which is in its possession and which is reasonably necessary for Employer to administer the Plan or for the auditor to perform its duties provided in the mutually agreed upon agreement, provided that such disclosure is not prohibited by any third party contracts to which BlueCross is a signatory or any requirements of the law. Employer hereby represents that, to the extent any disclosed information contains personally identifiable or health information about a Member, the Member has authorized disclosure to Employer or Employer otherwise has the legal authority to have access to such information.

1.1.9. Employer shall not hire a third party to conduct a contingent fee audit, where the third party's compensation, in whole or in part, is based on a percentage of errors (or savings, or uncovered recoveries, etc.), which may be found by the third party in its audit. BlueCross may request, and Employer will provide, the proposal for compensation of any requested auditor.

1.2. Medical Claims Audits.

1.2.1. While this Agreement is in effect, Employer may perform one medical claims audit during each calendar year.

1.2.2. After the termination of this Agreement by either Party and any applicable run-out period, Employer may perform one medical claims audit during the 15 months after the effective date of termination. With respect to medical claims audits, medical claims include claims for Provider Administered Specialty Pharmacy Products when BlueCross has agreed to administer those claims.

1.2.3. The only claims subject to audit are those claims paid during the Audit Time Period. Any claims paid prior to the Audit Time Period shall not be subject to audit.

1.2.4. For each Audit Time Period, no more than 250 claims shall be selected for review.

1.2.5. Claims audits will be conducted using the Benefit Plan approved by and in the possession of BlueCross and that was in effect at the time the claims being audited were adjudicated. Submitting the Benefit Plan to BlueCross later than six (6) months after the start of the applicable Benefit Period will cause Employer to lose its right to audit that Benefit Period.

1.3. Pharmacy Claims Audits.

1.3.1. While this Agreement is in effect, Employer may perform one pharmacy claims audit during each calendar year.

1.3.2. After the termination of this Agreement by either Party and any applicable run-out period, Employer may perform one pharmacy claims audit during the 15 months after the effective date of termination.

1.3.3. The only claims subject to audit are those claims paid during the Audit Time Period. Any claims paid prior to the Audit Time Period shall not be subject to audit.

1.3.4. For each Audit Time Period, no more than 250 claims shall be selected for review.

1.3.5. Claims audits will be conducted using the Benefit Plan approved by and in the possession of BlueCross and that was in effect at the time the claims being audited were adjudicated. Submitting the Benefit Plan to BlueCross

later than six (6) months after the start of the applicable Benefit Period will cause Employer to lose its right to audit that Benefit Period.

1.4. Clinical Process Audits.

1.4.1. In lieu of an audit identified above, Employer may perform one clinical process audit during each calendar year that this Agreement is in effect.

1.4.2. Employer shall have no right to conduct a clinical process audit upon termination of this Agreement.

1.4.3. The only processes subject to audit are those processes that were performed by BlueCross during the Audit Time Period. Any process performed by BlueCross prior to the Audit Time Period shall not be subject to audit.

1.4.4. With respect to a clinical process audit, the audit, scope and methodology will be consistent with generally acceptable auditing standards.

1.4.5. For each Audit Time Period, no more than 25, randomly selected case files shall be reviewed as part of a clinical process audit.

2. Reports. BlueCross will provide to Employer reports as specified in Exhibit B.

3. Books and Records. BlueCross shall maintain books and records directly related to its payment of claims on behalf of Employer pursuant to this Agreement, in accordance with its customary business practices. Upon execution of an applicable agreement relating to use and confidentiality, BlueCross shall make such books and records available for inspection by authorized representatives of Employer at BlueCross's home office, during normal business hours, upon reasonable advance written request, at Employer's expense, during the term of this Agreement and for 6 years from the date of the Final Settlement. The required agreement shall be determined by BlueCross based on the intended use of the information.

EXHIBIT T TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT U TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT V TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT W TO THE ADMINISTRATIVE SERVICES AGREEMENT

SHARED SAVINGS

BlueCross will perform recovery services in the identified areas and, as compensation for these services, BlueCross will retain a percentage of any recovery ("Shared Savings") as identified below. Shared Savings will be taken in accordance with BlueCross's administrative processes. Shared Savings will be reconciled via reporting updated on a weekly basis.

1. Legal Recoveries. BlueCross may represent the interest of Employer in any litigation against a third party where the claims are related to subrogation or overpayments for pharmaceutical products, medical devices, durable medical equipment/supplies, and/or other such claims resulting in causes of action described below. This representation grants BlueCross the ability to identify, pursue, negotiate settlements of, and/or recover direct legal or equitable claims related to the services performed pursuant to this Agreement. Employer grants to BlueCross the specific authority and discretion to opt Employer in or out of any class or direct settlement in which both BlueCross and/or Employer may be considered class members or settling parties, and the authority to pursue any recoveries for claims paid as a result of fraud, abuse or other inappropriate action by a third party. These claims include, but are not limited to, all legal claims Employer can assert whether based on common law or statute, such as RICO, antitrust, deceptive trade practices, consumer fraud, insurance fraud, unjust enrichment, breach of fiduciary duty, breach of contract, breach of covenant of good faith and fair dealing, torts (including fraud, negligence and product liability), breach of warranty, medical monitoring, false claims and kickbacks. If BlueCross obtains a recovery from any of these efforts, BlueCross will reimburse Employer's pro rata share of the recovery. This share is calculated from the Employer's claims history of Covered Members at the time of such recovery, less the Employer's pro rata share of the costs, if any, fees paid to outside counsel and any other costs incurred in obtaining a recovery. BlueCross will not charge the Employer for any costs if BlueCross does not obtain a recovery that exceeds those costs. The authority granted herein survives the termination of this Agreement.
 - 1.1. Subrogation Recoveries.
 - 1.1.1. BlueCross will enforce Employer's subrogation rights. For all subrogation recoveries received on or after January 1, 2023, BlueCross will retain a fee of 39% of the gross subrogation recovery. Employer is responsible for payment of: (a) any outside attorneys' fees incurred in enforcing Employer's subrogation rights; and (b) any other expenses arising in connection with litigation to enforce its subrogation interest, including, but not limited to, court costs and discovery expenses.
 - 1.1.2. For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, and any expenses associated with the litigation. The remaining amount is the net recovery, and the amount that Employer will receive as a credit.

- 1.2. Mass Tort Recoveries.
 - 1.2.1. BlueCross will perform mass tort recoveries on behalf of Employer. BlueCross will retain a fee of 39% of all mass tort recoveries received on or after January 1, 2023.
 - 1.2.2. For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, the attorneys' fee (if any) and any other litigation expenses from each recovery amount received. This net recovery is the amount that Employer will receive as a credit.
- 1.3. Class Action Recoveries.
 - 1.3.1. BlueCross will perform class action recoveries on behalf of Employer. BlueCross will retain a fee of 39% of all class action recoveries received on or after January 1, 2023.
 - 1.3.2. For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, the attorneys' fee (if any) and any other litigation expenses from each recovery amount received. This net recovery is the amount that Employer will receive as a credit.
2. Audit Services. BlueCross will conduct audits in varying manners and forms, including but not limited to, pre-payment claims audits, post-payment claims audits, eligibility overpayment audits, and provider audits. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross's right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 39% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial audit finding. For audit services performed before the Process Conclusion Date, BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.
3. Enhanced Payment Integrity Services. BlueCross, or its delegate, may conduct pre-payment and post payment enhanced payment integrity reviews. BlueCross, or its delegate, will determine whether and in what manner to conduct such activities, and notwithstanding any provision of this Agreement to the contrary, Employer authorizes BlueCross to conduct such activities. When the enhanced pre-payment or post payment integrity review identifies an overpayment or prevents an overpayment from occurring, BlueCross will retain 39% of any such recoveries or prevention savings. Savings are determined at the time of the initial audit finding.
4. Coordination of Benefit Services. BlueCross will conduct coordination of benefits activities. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross's right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 39% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial finding. For coordination of benefit services performed before the

Process Conclusion Date, BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.

5. Provider Administered Specialty Pharmacy Product Rebates. BlueCross may receive rebates and other consideration related to claims for Provider Administered Specialty Pharmacy Products ("Provider Administered Specialty Pharmacy Product Rebates"). BlueCross retains 100% of Provider Administered Specialty Product Rebates. Contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met are specifically excluded from the definition of Provider Administered Specialty Pharmacy Product Rebates and shall be retained by BlueCross.
6. Pharmacy Rebates.
 - 6.1. For Pharmacy Rebates based on service dates occurring on or after January 1, 2017, Employer will receive 100% of Pharmacy Rebates (as defined in Pharmacy Services Exhibit).
7. Out-of-Network Cost Management Program. When permitted by Association rules and guidelines, BlueCross will calculate a reduction in billed charges for Members' claims for Covered Services received from Out-of-Network Providers (as defined in Exhibit C, Section 5.4). Claims eligible for this service must meet BlueCross's established criteria. As consideration for this service, BlueCross shall receive a fee of fifteen percent (15%) of the reduction of billed charges. This program excludes claims subject to the No Surprises Act.

EXHIBIT X TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED