CITY OF SANTA FE

MEMORANDUM

DATE: March 27, 2025

TO: Quality of Life Committee, Finance Committee, and Governing Body

FROM: Alvin Valdez, Benefits and Wellness Manager Alvin Valdez

Via: Bernadette Salazar, Human Resources Director Bernadette Salazar
Travis Dutton Leyda, Chief Procurement Officer
Emily Oster, Finance Director
Chris Ryan, Senior Assistant City Attorney

SUBJECT: Health Benefits Administrative Services Contract

Vendor Name: Blue Cross Blue Shield New Mexico

Vendor Number: 10765

RFP Number: 25068

ACTION:
Request for Approval of an Administrative Services to administer a self-funded health insurance plan Contract with Blue Cross Blue Shield of New Mexico. Compensation not to exceed $23,054,885.00, excluding gross receipts tax, for the first year. The contract includes provisions for potential extension up to ten years from the date of the final signature, subject to negotiation of additional terms and conditions, unless earlier terminated under the terms of paragraph 5 (Termination) or paragraph 6 (Appropriations) of Contract

CONTRACT NUMBER:
The FY26 Munis Contract number is 3250504

BACKGROUND ANND SUMMARY:
The City of Santa Fe administers a self-funded health insurance plan. Under a self-funded model, both the City and its employees contribute premiums to cover healthcare claims and administrative costs. This model allows for greater customization of the plan and significant cost savings. To manage this plan, the City contracts with a third-party administrator (TPA) responsible for processing claims and performing administrative functions.

The City of Santa Fe's current contract with Cigna Healthcare is set to expire on June 30, 2025. As a result, a Request for Proposals (RFP) was issued for the selection of a Health Benefits Administrator for Fiscal Year 2026 and beyond. For the first time in the City's procurement history, the Best Value Approach (BVA) was utilized. This new procurement method is designed to identify highly qualified vendors by evaluating comprehensive service offerings and competitive pricing through a metrics- and data-driven process. The BVA model emphasizes transparency and objectivity, requiring a blind, unbiased review of all Offerors'

submissions by a panel of stakeholders.

Pursuant to Resolution No. 2005-02, the City is required to appoint members of the Benefits Advisory Committee for City Employees to serve on the evaluation committee.

- Louis Demella, representing AFSCME
- Eric Sanchez, representing Police
- Isaiah Gonzales, representing Fire
- Bernadette Salazar, representing Non-Union Employees and Human Resources

In addition to the evaluation panel, the City's contracted Health Benefits Consultant team, AON, conducted an independent and thorough analysis of each submission. Following completion of the evaluation process, Blue Cross Blue Shield of New Mexico (BCBSNM) received the highest overall score and was selected as the recommended vendor for contract award. For additional details on the evaluation process, scoring methodology, and results, please refer to the attached Health Evaluation Committee Report.

The City is proposing to enter into a new contract with **Blue Cross Blue Shield of New Mexico (BCBSNM)** as the third-party administrator for the City's self-funded health insurance program. BCBSNM has demonstrated expertise in administering comprehensive health insurance benefits and is capable of maintaining the City's current plan options with minimal disruption. Additionally, BCBSNM offers improved guarantees, financial credits, and service-level commitments that are anticipated to enhance member experience and generate cost efficiencies for the City.

The proposed contract is currently structured as a four-year agreement, with the option to extend the term up to ten years, where the initial annual cost is **$23,054,885.00,** with an estimated four (4) year total value of **$92,219,540.00 (including New Mexico Gross Receipts Tax)**. The agreement allows for the issuance of purchase orders as a guarantee of payment for services provided, and covers administrative fees, claims processing, and related health insurance services. The City and BCBSNM may negotiate extending the term of this contract for up to **ten (10) years** from the date of final signature, unless otherwise terminated according to the contract provisions.

Recommendation:
Staff recommends approval of the contract with Blue Cross Blue Shield of New Mexico for the provision of health insurance administrative services for the City's self-funded health plan.

Fiscal Impact:
Funding for this contract is included in the approved budget for employee health benefits and will be subject to annual appropriation.

Budget Officer / Designee: _____ **Date:** 03/27/2025

Budget Officer Comment/Exceptions: _____

PROCUREMENT METHOD:

The procurement method used was NMSA 1978, Section 13-1-111, RFP

Chief Procurement Officer (CPO) / Designee: _____ **Date:** 03/27/2025

CPO Comment/Exceptions: RFP # 25068

ASSOCIATED APPROVALS:

IT Components included? ☐ Yes | ☒ No

Approval: _____ **Title:** _____ **Date:** _____

Comment/Exceptions: _____

Vehicles included? ☐ Yes | ☒ No

Approval: _____ **Title:** _____ **Date:** _____

Comment/Exceptions: _____

Construction to City Facilities, Furniture, and/or Fixtures included? ☐ Yes | ☒ No

Approval: _____ **Title:** _____ **Date:** _____

Comment/Exceptions: _____

Is this an externally funded purchase? ☐ Yes | ☒ No

If yes, what is the issuing agency: _____

Approval: _____ **Title:** _____ **Date:** _____

Comment/Exceptions: _____

Is this a Capital Asset or Project? ☐ Yes | ☒ No

Project Ledger Number: _____

Approval: _____ **Title:** _____ **Date:** _____

Comment/Exceptions: _____

ATTACHEMENTS:

Contract
COI
Evaluation Committee Report -> Emailed
Aon FY26 Medical/RX Presentation
Resolution No. 2005-52 GIBAC
SOW Determination
Horizons Services

Item #: 25-0134
Munis Contract #: 3250504
RFP#: 25068

CITY OF SANTA FE

ADMINISTRATIVE SERVICES CONTRACT

THIS CONTRACT is made and executed by and between the **City of Santa Fe**, New Mexico, hereinafter referred to as the '**City**,' and **Blue Cross and Blue Shield of New Mexico**, hereinafter referred to as the '**Contractor**.' This Contract becomes effective upon approval by the City's Governing Body and execution by the Mayor, as set forth below.

RECITALS

WHEREAS, the Chief Procurement Officer of the City has determined that this Contract complies with the provisions of NMSA 1978, Sections 13-1-28 through 13-1-199, and that the procurement process adhered to the requirements of NMSA 1978, Section 13-1-111 for the Request for Proposals (RFP); and

The City and the Contractor hereby agree as follows:

1. **Scope of Work**

The Contractor shall provide the following services-for the City:

- Medical/pharmacy administration services, individual stop loss ($250,000 current and $300,000 option), aggregate stop loss, and wellness
  - Employee Assistance Program (EAP) – will consider stand alone and carved-in (with medical or life) solutions
- Dental administration services
- Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA)
- Wellness Program Assistance

2. **Standard of Performance; Licenses**

A. The Contractor does hereby accept its designation as an administrative service, rendering services related to Health Benefits Administrative Services for the City, as set forth in this Contract. The Contractor represents that Contractor possesses the personnel, experience, and knowledge necessary to perform the services described under this Contract.

B. The Contractor agrees to obtain and maintain throughout the term of this Contract, all applicable professional and business licenses required by law, for itself, its employees, agents, representatives, and subcontractors.

3. **Compensation**

A. The City shall pay to the Contractor in full payment for services satisfactorily performed at the rate listed on the Exhibits, attached herein, the dollar amounts per

employee per month fees such compensation not to exceed twenty-three million, fifty-four thousand, eight hundred eight-five dollars ($23,054,885.00), excluding gross receipts tax for year one (1). The New Mexico gross receipts tax levied on the amounts payable under this Contract totaling ($23,054,885.00) shall be paid by the City to the Contractor. **The total amount payable to the Contractor under this Contract, including gross receipts tax and expenses, shall not exceed (TOTAL AMOUNT INCLUDING GRT) for year one (1). Compensation total contract term shall be based on the available budget and services provided totaling approximately ninety-two million, two hundred nineteen thousand, five hundred forty dollars ($92,219,540.00).**

B. Payment. The total compensation under this Contract shall not exceed **$23,054,885.00** including New Mexico gross receipts tax for the first year. All subsequent years shall be based on the available budget and work performed. This amount includes New Mexico gross receipts tax. **This amount is not a guarantee that the work assigned to be performed by Contractor under this Contract shall equal the amount stated herein. The Parties do not intend for the Contractor to continue to provide Services without compensation when the total compensation amount is reached. Contractor is responsible for notifying the City when the Services provided under this Contract reach the total compensation amount. In no event will the Contractor be paid for Services provided that exceed the total compensation amount without this Contract being amended in writing prior to services, in excess of the total compensation amount being provided.**

C. **Intent**. In consideration of Contractor 's obligations as set forth in the Agreement and at the end of each Employer Payment Period (as defined in Exhibit A's Exhibit 2, Section 2), the City shall pay to Contractor or shall provide access for Contractor to obtain, Employer Payment amount due for that Employer Payment Period.

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

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

E. ***Late Payments.*** Late payments are subject to the penalties outlined in Exhibit C, Section 7.

4. Term

THIS CONTRACT SHALL NOT BECOME EFFECTIVE UNTIL APPROVED BY THE MAYOR. As permitted by NMSA 1978, Sections 13-1-150 through 13-1-152, the parties may negotiate additional terms for the extension of this Contract for up to **ten (10) years from date of final signature** unless terminated pursuant to paragraph 5 (Termination) and paragraph 6 (Appropriations).

5. Termination

This Contract may be terminated as follows:

a. By either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with thirty (30) days' prior written notice to the other party; or

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

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

d. By Contractor, if the City fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon the City's failure to cure the non-payment within thirty (30) days of written notice of the nonpayment to the City as provided in Exhibit C, Section 7.1.

6. Appropriations

The terms of this Contract are contingent upon sufficient appropriations and authorization being made by the Governing Body for the performance of this Contract. If sufficient appropriations and authorization are not made by the Governing Body, this Contract shall terminate immediately upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the City proposes an amendment to the Contract to unilaterally reduce funding, the Contractor shall have the option to terminate the Contract or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

7. Status of Contractor

The Contractor and its agents and employees are independent contractors performing professional services for the City and are not employees of the City. The Contractor and its agents and employees shall not accrue leave, retirement, insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Contract. The Contractor acknowledges that all sums received hereunder are reportable by the Contractor for

tax purposes, including without limitation, self-employment and business income tax. The Contractor agrees not to purport to bind the City unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

8. Assignment

The Contractor shall not assign or transfer any interest in this Contract or assign any claims for money due or to become due under this Contract without the prior written approval of the City.

9. Subcontracting

In performing the Services, primary Contractor, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Contractor shall remain fully responsible and liable for performance of any such Services to be performed by Contractor but contracted or delegated to other entities. Further, any of the Services may be performed by Contractor, any subsidiary or affiliate of Contractor, and any successor entity or entities to Contractor, whether by merger, consolidation, or reorganization, without prior written approval by the City. No subcontracts shall obligate direct payment from the City.

10. Release

Subject to the terms of Exhibit C, Section 8, final payment of the amounts due under this Contract shall operate as a release of the City, its officers and employees from all liabilities, claims and obligations whatsoever arising from or under this Contract.

11. Confidentiality

Any confidential information provided to or developed by the Contractor in the performance of this Contract shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the City.

12. Product of Service -- Copyright

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

13. Conflict of Interest; Governmental Conduct Act

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Contract, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Contract.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Contract, will continue to comply with, and that this Contract complies with all applicable provisions of the Governmental Conduct Act, NMSA 1978, Section 10-16.

C. The Contractor's representations and warranties in Paragraphs A and B of this Article are material representations of fact upon which the City relied when this Contract was executed by the parties. The Contractor shall provide immediate written notice to the City if, at any time during the term of this Contract, the Contractor learns that the Contractor's representations and warranties in Paragraphs A and B of this Article were erroneous on the effective date of this Contract or have become erroneous due to new or changed circumstances. If it is later determined that the Contractor's representations and warranties in Paragraphs A and B of this Article were erroneous on the effective date of this Contract or have become erroneous due to new or changed circumstances, in addition to other remedies available to the City and notwithstanding anything in the Contract to the contrary, the City may immediately terminate the Contract.

D. All terms defined in the Governmental Conduct Act have the same meaning in this section.

14. Amendment

A. This Contract shall not be altered, changed, or amended except by instrument in writing executed by the parties hereto and all other required signatories.

B. If the City proposes an amendment to the Contract to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Contract, pursuant to the termination provisions as set forth in Article 4 herein, or to agree to the reduced funding.

C. This Contract may be amended by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation, or order ("Law") or by Contractor or the Blue Cross Blue Shield Association hereinafter referred to know as "Association," may be implemented by Contractor upon at least sixty (60) calendar days' prior notice to the City or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If the City does not object within sixty (60) days after receiving such notice, the proposed amendment will be deemed to be agreed upon and will become a part of this Agreement. If the City objects to such amendment within thirty (30) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. In the event of such objection, if the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to terminate the Agreement, as set forth in Section 5, or, at its option, Contractor may cease performing the obligations impacted by such Law.

15. Entire Agreement

This Contract, together with any other documents incorporated herein by reference and all related Exhibits and Schedules constitutes the sole and entire agreement of the Parties with respect to the subject matter of this Contract, and supersedes all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to the subject matter. In the event of any inconsistency between the statements in the body of this Contract, and the related Exhibits and Schedules, the statements in the body

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

The Exhibits and Addenda of this Agreement are:

a. Exhibit A - Administrative Services Agreement

b. Exhibit B – Claim Administrator Services

c. Exhibit C – Fee Schedule and Financial Terms

d. Exhibit D – Notices/Required Disclosures

e. Exhibit E – ASO BPA

f. Exhibit F – Blue Cross and Blue Shield Association Disclosures and Provisions

g. Exhibit G – Recovery Litigation Authorization

h. Exhibit H – Pharmacy Benefit Management Services

16. Penalties for violation of law

NMSA 1978, Sections 13-1-28 through 13-1-199, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities, and kickbacks.

17. Equal Opportunity Compliance

The Contractor agrees to abide by all federal and state laws and rules and regulations, and Santa Fe City Code, pertaining to equal employment opportunity. In accordance with all such laws of the State of New Mexico, the Contractor assures that no person in the United States shall, on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Contract. If Contractor is found not to be in compliance with these requirements during the life of this Contract, Contractor agrees to take appropriate steps to correct these deficiencies.

18. Applicable Law

The laws of the State of New Mexico shall govern this Contract, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with NMSA 1978, Section 38-3-2. By execution of this Contract, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Contract.

19. Workers Compensation

The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Contract may be terminated by the City.

20. Other Insurance

If the services contemplated under this Contract will be performed on or in City facilities or property, Contractor shall maintain in force during the entire term of this Contract, the following insurance coverage(s), naming the City as additional insured.

A. **Commercial General Liability** insurance shall be written on an occurrence basis and be as broad as ISO Form CG 00 01 with a limit of $2,000,000 per occurrence and $2,000,000 in the aggregate for claims against bodily injury, personal and advertising injury, and property damage. Said policy shall include broad form Contractual Liability coverage and list the City of Santa Fe their officials, officers, employees, and agents as additional insureds.

B. **Broader Coverage and Limits**. The insurance requirements under this Contract shall be the greater of (1) the minimum coverage and limits specified in this Contract, or (2) the broader coverage and maximum limits of coverage of any insurance policy or proceeds available to the Named Insured. It is agreed that these insurance requirements shall not in any way act to reduce coverage that is broader or that includes higher limits than the minimums required herein. No representation is made that the minimum insurance requirements of this Contract are sufficient to cover the obligations of Contractor hereunder.

C. Contractor shall maintain the above insurance for the term of this Contract and name the City as an additional insured and provide for 30 days cancellation notice on any Certificate of Insurance form furnished by Contractor. Such certificate shall also specifically state the coverage provided under the policy is primary over any other valid and collectible insurance and provide a waiver of subrogation

21. Records

a. **Records Retention.** Contractor shall retain all Claim records for the longer of (i) the time period required by applicable law or (ii) the time period required by Contractor's records retention policy, which policy is subject to change by Contractor. The failure to agree upon a retention period shall not constitute breach of this Agreement.

b. **Record Requests.** For a period of one (1) year following termination of this Agreement, Contractor shall, upon the request of the City for general purposes ("Data Reclamation Request"), provide to the City, a copy of all Claim determination records, excluding any and all of the Business Confidential

Information of Contractor, other Blue Cross and/or Blue Shield companies, or Contractor's subsidiaries, affiliates, and vendors, in the possession of Contractor. Within a mutually agreeable time frame of receipt of the Data Reclamation Request, Contractor shall transmit the dataset in a form mutually agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by the City. The time period for general record requests does not impact nor restrict any legal, regulatory, or mandated data requests.

22. Indemnification

The Contractor shall defend, indemnify and hold harmless the City from all actions, proceeding, claims, demands, costs, damages, attorneys' fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this Contract, caused by the negligent act or failure to act by the Contractor, its officers, employees, servants, subcontractors or agents, resulting in injury or damage to persons or property during the time when the Contractor or any officer, agent, employee, servant or subcontractor thereof has or is performing services pursuant to this Contract. The Contractor shall not be liable for or be required to defend or indemnify against any claims, suits or proceedings resulting from any negligent act or omission on the part of the City, its officers or its employees. Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement.

23. New Mexico Tort Claims Act

Any liability incurred by the City of Santa Fe in connection with this Contract is subject to the immunities and limitations of the New Mexico Tort Claims Act, NMSA 1978, Sections 41-4-1, et. seq. The City and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Contract modifies or waives any provision of the New Mexico Tort Claims Act.

24. Invalid Term or Condition

If any term or condition of this Contract shall be held invalid or unenforceable, the remainder of this Contract shall not be affected and shall be valid and enforceable.

25. Enforcement of Contract

A party's failure to require strict performance of any provision of this Contract shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Contract shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

26. Notices

Any notice required to be given to either party by this Contract shall be in writing and shall be delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

To the City: Bernadette Salazar, Human Resources, 200 Lincoln Avenue, Santa

Fe, NM, 87504 To the Contractor:

Blue Cross Blue Shield of New Mexico, Amanda Romero, 5701 Balloon Fiesta Parkway NE, Albuquerque, NM 87113, Amanda_Romero@bcbsnm.com

27. Authority

If Contractor is other than a natural person, the individual(s) signing this Contract on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter a binding contract.

28. Non-Collusion

By signing this Contract, the Contractor certifies that they have not, either directly or indirectly, engaged in any action that restrains free competitive bidding in connection with the proposal submitted to the City.

29. Default and Force Majeure

Except as it pertains to Claims and Fees under this Contract , the City reserves the right to cancel all, or any part of any orders placed under this Contract without cost to the City, if the Contractor fails to meet the provisions of this Contract and, except as otherwise provided herein, to hold the Contractor liable for any excess cost occasioned by the City due to the Contractor's default. The Contractor shall not be liable for any excess costs if failure to perform the order arises out of causes beyond the control and without the fault or negligence of the Contractor; such causes include, but are not restricted to, acts of God or the public enemy, acts of the State or Federal Government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of subcontractors due to any of the above, unless the City shall determine that the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery scheduled. The rights and remedies of the City provided in this Clause shall not be exclusive and are in addition to any other rights now being provided by law or under this Contract.

IN WITNESS WHEREOF, the Parties have executed this Contract as of the date of the signature by the required approval authorities below.

CITY OF SANTA FE: CONTRACTOR:

Alan Webber (Apr 10, 2025 16:22 MDT)

ALAN WEBBER, MAYOR

Marlene Baca,
BCBSNM, VP

DATE: March 24, 2025

NMBTIN #:02-393150-007

ATTEST:

ANDREA SALAZAR (Apr 10, 2025 17:09 MDT)

XIV

CITY CLERK GB MTG 04-09-25

CITY ATTORNEY'S OFFICE:

Christopher W. Ryan
Christopher W. Ryan (Mar 26, 2025 16:29 MDT)

SENIOR ASSISTANT

CITY ATTORNEY

APPROVED FOR

FINANCES:

Emily K. Oster 03/27/2025

FINANCE DIRECTOR

EXHIBIT A

BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is July 1, 2025.

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

Account Number: NM423417

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

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

By:

Title: BCBSNM, Sales VP

Date: March 24, 2025

CITY OF SANTA FE ("EMPLOYER")

By: _____

Title: _____

Date: _____

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

RECITALS

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

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

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

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

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

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

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

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

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

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by IROs as described in Exhibit B and/or the most current ASO BPA, but in no event shall Claim Administrator have any liability or responsibility for any claim determination, act, or omission by an IRO in connection with any Independent External Review.

1.5 **Claim Administrator Review of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty

(30) days' prior written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of Claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed. If Employer requests for itself or directs Claim Administrator to work directly with Employer's third-party consultants and/or subcontractors ("Employer's Vendor(s)") in connection with the Services Claim Administrator is providing to Employer, Employer acknowledges and agrees that the services offered by the Employer's Vendor(s) to Covered Persons are offered as a component of the Plan and are consistent with the Employer's Plan design and supported by the Employer's Plan documents. Employer shall remain fully responsible and liable for the performance of any of Employer's Vendors to the extent Employer contracts for services related to the Plan or delegates to other entities any of its obligations under the Plan and for communicating with Covered Persons about any potential consequences or implications related to the services provided by the Employer's Vendor(s). Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to work with Employer's Vendor(s).

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

2.2 **Employer's Vendor's Responsibility**. Employer will identify to Claim Administrator any of Employer's Vendors and describe to Claim Administrator the services they provide to the Plan. Employer represents and warrants that it has entered into separate contracts with any of Employer's Vendors. Employer agrees that in connection with any services the Employer's Vendor(s) perform related to the Plan, Employer's Vendor(s) shall not engage with or contact any Providers except as authorized in writing by Claim Administrator. Employer agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of Employer's Vendor(s). Employer also agrees Claim Administrator or any of Claim Administrator's affiliates, delegates, subcontractors, or assigns performance under this Agreement shall be excused to the extent they are unable to perform or their performance is affected due to the actions or omissions of Employer's Vendor(s).

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

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

2.5 **Notices to Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this

Agreement is terminated pursuant to Section 6.1, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit D to Covered Persons.

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

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

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

c. Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement.

d. By providing Covered Persons information that may include a telephone and text number, the Employer agrees that Claim Administrator may use that information to secure the Covered Person's consent to contact them via their preferred method of communication (e.g., phone, text, email) with the Claim Administrator.

e. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.7 **Grandfathered Health Plans (If Applicable).** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least sixty (60) days' advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide notice thereof as required) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference into and become part of this Agreement, and Employer represents and warrants that the information it submits on such Form is true, complete, and accurate.

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

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

2.10 **Employer Audits Claim Administrator.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days' prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Any review of Claim information by Employer or an authorized agent of Employer to evaluate Claim Administrator's performance of the administrative services provided

according to the terms of this Agreement shall be subject to the terms of this Section. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator's policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Prior to Employer's authorized gaining access to the information and files maintained by Claim Administrator, Employers agent shall agree to the terms of the data exchange agreement referenced in section 3.4 and agree to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

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

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

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

3.4 **Providing Data to Employer's Vendor(s).** If Employer requests for itself or Claim Administrator to provide data directly to Employer's Vendor(s), Employer acknowledges and agrees that it will execute and shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement. Employer hereby acknowledges and agrees, and Employer's Vendor(s) shall acknowledge and agree:

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

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

under its contract with Employer, to the same extent that it protects its own confidential information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed.

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

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

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

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

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

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

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

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

3.7 **De-Identified Data.** Employer authorizes Claim Administrator to deidentify PHI or PII. Claim Administrator may use or disclose a limited or de-identified data set for any purpose permitted by HIPAA and/or the HIPAA Privacy Rule in effect as of the effective date of this Agreement, unless subsequently prohibited by superseding law or expressly restricted under the BAA entered into between the Parties.

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

4.1 **Litigation.** Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. It is further agreed that each party (provided no conflicts of interest exist) shall

fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement."

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

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

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

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

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

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

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

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator shall administer Overpayment recoveries in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan. Employer agrees that it will not perform or engage any other party to perform Overpayment recovery activities with respect to Providers or Covered Persons without prior written consent of Claim Administrator.

4.3 **Third Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim

Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third parties' fees, as defined in the ASO BPA, associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

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

4.5 **Directions Regarding First Dollar Coverage.** If, either on the applicable ASO BPA or other document, Employer directs Claim Administrator to process and adjudicate Claims at one hundred percent (100%) of the applicable Allowable Amount and/or Allowable Charge, regardless of whether the high-deductible health plan's deductible has been met ("First Dollar Coverage"), Employer acknowledges and agrees that such direction is a benefit design decision and the responsibility of the Employer. Notwithstanding any other provision of this Agreement, Employer shall reimburse Claim Administrator for losses incurred as a result of claims brought by any employees of Employer, participants in any benefit plan provided by Employer, or any governmental agency, in connection with or arising out of, directly or indirectly of the First Dollar Coverage. Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to provide First Dollar Coverage.

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

4.7 **Notice and Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such, including but not limited to initiation of Dispute Resolution under Section 4.11 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon Timely prior written notification to the other Party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

4.8 **Limitations; Limitation of Liability.** No action or dispute shall be brought to recover under this Agreement after the expiration of six (6) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents, or independent

contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of gross negligence, fraud, or criminal actions by Claim Administrator.

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

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

b. **Confidential Mediation.** In the event the Parties fail to agree with respect to any matter covered herein and only after making good faith efforts to resolve any dispute under this Agreement under this section, prior to filing an action in any Court, Employer or Claim Administrator shall submit the dispute to confidential, mediation, pursuant to the New Mexico Mediation Procedures Act, NMSA 1978, secs. 44-7b-1 through 44-7b-6, subject to the following:

1. The mediation shall be conducted by a mediator agreed to by the Parties. If the Parties are unable to agree on a mediator, the Mayor shall, in good faith, select a mediator (a licensed member of the New Mexico State Bar) with the intention of selecting an individual who will objectively work with the parties to achieve resolution.
2. Mediation shall be held in Santa Fe, New Mexico.
3. The mediator's fees and any costs imposed by the mediator will be shared equally by the Parties.
4. . This provision precludes Employer from filing an action at law or in equity and from having any dispute covered by this Agreement heard by a judge or jury.
5. Except as may be required by law and subject to NMRA 11-408, neither a Party nor the mediator may disclose the existence, content, or results of any mediation pursuant to this section without the prior written consent of both Parties.

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

4.10 **Transparency and Surprise Billing Procedures.** Claim Administrator agrees to provide Employer the services and processes described in this section consistent with the Consolidated Appropriations Act of 2021 ("CAA"), Transparency in Coverage Final Rule, and the No Surprises Act ("NSA").

a. **Transparency Procedures.**

1. ***Network Provider Data Verification.*** Claim Administrator will maintain a central database of Network Providers' demographic information, which shall include name, address, phone number, specialty, and, if available, web address ("Data Elements"). Claim Administrator will initiate an outreach to Network Providers to verify the accuracy of the Data Elements up to ninety (90) days following the last recorded update or verification. Claim Administrator has implemented commercially reasonable procedures to track the receipt of updated data from a Network Provider and update the central database within appropriate timeframes.
2. ***Directory of Verified Network Providers.*** Claim Administrator will provide an online Provider directory representing the Network Providers who render Covered

Services which may be billed to plans and policies administered by Claim Administrator. This directory shall include Providers contracted with Claim Administrator, Providers contracted with any Blue Cross and/or Blue Shield Plan, and any other entity performing Covered Services. The directory will not reflect services administered by external claims administrators or other Providers not contracted through Claim Administrator.

Providers who fail to confirm the accuracy of the Data Elements may be subject to removal from the Provider directory until they confirm the accuracy of their information.

To the extent information for the Provider directory is provided by a third party, Claim Administrator shall not be responsible for delays in updates to Provider data directories, or misinformation due to such delays in receiving information from such third party.

3. ***Provider Network Status Verification.*** Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide written, electronic, or print confirmation of the Provider's Network status within an appropriate timeframe. This verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

   Employer acknowledges that Claim Administrator will not issue a written confirmation of Provider Network status when request is sought through a third-party service center.

4. ***ID Cards.*** Claim Administrator will include up to four (4) lines of text for deductible limits and up to four (4) lines of text for out-of-pocket maximum limits for major medical coverage on the member ID card. The limits will reflect both family and individual limits when applicable to policy, together with in- and out-of-network limits.

   For policies that include prescription drug coverage through Prime with an independent out-of-pocket maximum limit or Deductible, one (1) line of text for deductible limits and one (1) line of text for out-of-pocket maximum limits will be included on the ID card.

   Claim Administrator will include a phone number and a website URL for customer assistance information on ID cards issued by Claim Administrator.

   Claim Administrator will issue physical ID cards in accordance with its standard processes and will not re-issue physical ID cards unless requested by Employer, in which case additional charges may apply. All newly issued physical ID cards will contain the information reflected in this section.

5. ***Machine-Readable Files.*** Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by the Centers for Medicare and Medicaid Services ("CMS") standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The files will not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer hereby acknowledges and agrees that neither Claim

Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the performance, acts, or omissions of any of Employer's Vendors.

6. ***Cost Sharing Estimator Tool.*** Claim Administrator will make available a Cost Sharing Estimator Tool ("CSET") to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through either self-service tools or telephone upon member request, a secure member portal, and via a mobile application, for active policies, and include services in accordance with the following schedule:

   Effective with the plan year beginning on or after January 1, 2023, enrollees will be able to search for the cost of five hundred (500) services, as defined by CMS, covered by the Plan administered by Claim Administrator, to identify the estimated cost for the procedure, illustrate how the member's benefits will apply to the procedure, and disclose if there may be any prerequisites to care, such as requiring a prior authorization for a service or procedure.

   For each plan year beginning on or after January 1, 2024, the services that can be estimated through the CSET will support all services and procedures covered by the Plans that are administered by Claim Administrator.

   To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the acts or omissions of any of Employer's Vendors.

7. ***Drug Cost Reporting.*** Claim Administrator will provide on behalf of Employer, based on the type of pharmacy coverage and data Claim Administrator administers and maintains for Employer, health and drug cost reporting to the extent within the possession of Claim Administrator as contemplated by Section 204 of the CAA according to Claim Administrator's standard processes and procedures, unless otherwise mutually agreed in writing.

8. ***Continuity of Care.*** In the event of a Provider termination for reasons other than failure to meet quality standards or fraud, Claim Administrator shall notify individuals enrolled under the Plan who are continuing care patients with respect to the Provider at the time of the termination. Claim Administrator will provide each individual who is a continuing care patient of a terminated Provider, the opportunity to request to continue to have the same benefits provided, under the same terms and conditions as would have applied under the Plan had the termination not occurred, with respect to the treatment provided by the Provider for a specified duration (for purposes of this section, "Continuity of Care"). Claim Administrator will identify continuing care patients and provide Continuity of Care in accordance with Claim Administrator policies.

9. ***Required Disclosure/Notices.*** Claim Administrator will post the disclosure on patient protections against balance billing on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the Plan's behalf.

10. ***Mental Health Parity.*** Claim Administrator will, consistent with industry standards, support reasonable requests of Employer for data or other documentation that Employer may need to analyze and document the Plan's compliance with applicable Mental Health Parity requirements, including amendments to Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008. So long as Employer

has elected to implement Claim Administrator's standard non-quantitative treatment limitations ("NQTLs") and so long as Claim Administrator administers both mental health/substance abuse benefits and medical/surgical benefits on behalf of Employer, Claim Administrator will provide, when requested by Employer, the most current documentation with respect to Claim Administrator's administered NQTLs under the Plan which may be necessary for Employer to meet the NQTL documentation requirements set forth in the CAA and released guidance. In addition, in the event that the U.S. Department of Labor or other regulatory agency ("Agency") with competent jurisdiction over the Plan initiates an audit or other assessment related to the Plan's compliance with mental health parity requirements, including the obligation to perform and/or make available the comparative analyses described above, Claim Administrator agrees to provide expedited support to enable Employer and the Plan to timely provide or otherwise make available or accessible the documentation requested by the reviewing entity. Both Parties agree and understand that no data or other documentation provided by Claim Administrator under this Section shall be reasonably interpreted as the Claim Administrator's certification of the compliance of the Plan or any Claim Administrator's administered NQTLs or other processes with State or Federal Mental Health Parity requirements nor does it obviate the Employer's obligation under MHPAEA to independently comparatively analyze each NQTL applied in its Plan. Employer agrees that assessing and making conclusions as to the compliance of the Plan with such NQTL requirements is solely the responsibility of Employer.

b. **Surprise Billing Requirements of the No Surprises Act.**

1. ***Qualifying Payment Amount.*** As it pertains to Employer's self-funded plans, Employer acknowledges that NSA requires, among other things, that member cost-share for certain items and services the Plan covers are calculated based on the lesser of the Provider's billed charge or the NSA's "Qualifying Payment Amount" ("QPA"). Up and until October 31, 2024, with respect to the calculation of QPA, Employer elects to use and adopts the QPA calculated by Claim Administrator based on Claim Administrator's self-funded business. Employer acknowledges litigation is pending over various regulatory provisions that govern QPA. The referenced litigation (or agency rulemaking or guidance related to the litigation) could require changes to how QPA is calculated for Employers' self-funded plans. Pursuant to Claim Administrator's understanding of previous agency guidance, Claim Administrator calculates QPA for self-funded plans based on all of Claim Administrator's self-funded business, i.e., QPAs are not calculated specific to each Employer's self-funded plan(s). It may be infeasible or impracticable for Claim Administrator to make certain changes to how such calculations are made, maintained, and/or used in processing Claims for Employer's Plans on or after November 1, 2024. To illustrate, such limitations could include, but are not limited to, the following: Claim Administrator does not have access to contracts or contracted rates of other claim administrators; and Claim Administrator's current capabilities and the fees and expenses charged to Employer herein do not support calculating, maintaining, and/or processing Claims with Employer- or Plan-specific QPA calculations. If the litigation (or agency rulemaking or guidance related to the litigation) requires changes to how QPAs are calculated for self-funded plans, and Claim Administrator agrees such changes to QPA calculations are practicable and feasible for Claim Administrator to make, maintain, and use in processing Claims, and Claim Administrator opts not charge additional fees or expenses for any such changes, Claim Administrator may institute such changes to calculation of QPA without further notice; otherwise, the Parties shall mutually agree in writing whether and how Claim Administrator shall calculate QPA for Claims beginning on or after November 1, 2024.

2. ***Negotiation and Independent Resolution Process.*** Employer acknowledges that Claim Administrator will make on the Plan's behalf an initial payment amount on Claims consistent with Employer's direction as established by Employer's Plan and this Agreement. For covered NSA-eligible items and services reported on Claims from nonparticipating Providers (i.e., generally noncontracted), a Provider may seek additional payment through a dispute process established by the NSA and related regulations. This process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

Employer authorizes Claim Administrator, or for Claims for service rendered outside of Claim Administrator's service area another Blue Cross and/or Blue Shield licensee, to represent the Plan with respect to any Claim with items or services for which a Provider seeks to negotiate as provided by the NSA, or for which a Provider institutes IDR.

With respect to any negotiations where Claim Administrator represents the Plan to resolve any disputed Claim, Employer expressly authorizes Claim Administrator in such negotiations to attempt to resolve any disputed Claim, (i) for an amount not to exceed the greater of the QPA or the amount allowed on the initial notice of payment or denial of the claim, or (ii) as otherwise directed by Employer in the ASO BPA and agreed to by Claim Administrator.

Claim Administrator will maintain a summary description of its currently applicable approach to negotiation of services or Claims subject to the dispute resolution process of the NSA. The approach will be generally the same or similar for Claims under Employer's Plan as for similarly-situated Claims under Claim Administrator's fully insured health insurance policies.

Employer acknowledges and agrees that Claim Administrator shall follow its then-current negotiation approach, that such negotiations may not be successful, and may result in institution of IDR despite the approach outlined above or as otherwise directed by the Employer (with or without exhaustion of the full settlement authority Employer may grant to Claim Administrator), which in turn may result in additional administrative fees, as well as IDR entity fees in the event of settlement after institution of an IDR or an IDR loss. Notwithstanding the additional administrative fee and other possible expenses, Employer acknowledges that the approach set forth herein, or as it may direct (subject to Claim Administrator's agreement) in the ASO BPA for attempting to resolve these Claims, notwithstanding the potential for IDR losses, is in the Plan's interest.

Negotiation services Claim Administrator provides shall include communicating with Provider, supplying requested documentation as appropriate, and proposing and documenting resolution of disputed Claims. Services in connection with an IDR shall also include handling interactions with the IDR entity and Provider, supplying requested information in connection with the IDR, and analyzing circumstances of disputed Claims to determine position on disputed Claims. On a quarterly basis, Claim Administrator shall provide Employer with information regarding the status of negotiations and IDR decisions.

Employer acknowledges that Claim Administrator undertakes negotiations at the direction of the Employer, undertakes such negotiations because they are necessary to the operation of the Plan, that the compensation to be paid to Claim Administrator for such negotiations is reasonable, and that, notwithstanding any other section of this Agreement, Claim Administrator does not act as a fiduciary, including under ERISA in connection with the negotiation or IDR of any disputed Claim. Employer is solely responsible for payment of any amounts determined to be payable as a result of such negotiations or awards entered through IDR on NSA-eligible items and services. Employer shall reimburse Claim Administrator for satisfaction of any award entered in IDR and any subsequent payment made

thereon and/or any judgment entered thereon. Employer acknowledges that other terms, conditions, or fees may apply with respect to any negotiations or IDR processes performed by another Blue Cross and/or Blue Shield licensee.

c. **Effect of Future Changes in Law and Regulations.** The laws and regulations that are the subject of this Section 4.12 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective sixty (60) days after such notice.

Employer acknowledges that Employer, and not Claim Administrator, shall be responsible for making the necessary adjustments to its ERISA Plan Document(s) (if applicable) and Summary Plan Description(s) to be consistent with Employer's election, including any amendments to governing Plan documents.

SECTION 5: ERISA

5.1 **In Relation to the Plan.** Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a plan document, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of Employer, Employer agrees that no allocation or delegation of any responsibilities under the Plan or any other employee welfare benefit plan of Employer is effective with respect to or accepted by Claim Administrator except as set forth in this Agreement.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's separate employee welfare benefit plan as defined under ERISA. Employer represents and warrants that (i) Employer has a named Plan Administrator and a Named Fiduciary within the meaning of §414(g) of the Internal Revenue Code of 1986, as amended; and (ii) said Plan Administrator serves within the meaning of §3(16)(A) of ERISA.

5.3 **Claim Administrator's Limited Fiduciary Responsibility.** Employer hereby delegates to Claim Administrator the discretionary authority to administer claims in accordance with the terms of Employer's ERISA welfare benefit plan and to make initial claim determinations concerning the availability of Plan benefits and final internal review and benefit determinations for appealed Claims. Claim Administrator hereby acknowledges and agrees that it shall act as an ERISA fiduciary to the Plan solely with respect to its adjudication of such claims and appeals. Employer acknowledges and agrees that Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, Employer acknowledges and agrees that Claim Administrator shall have no discretionary authority under its agreement with Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by Employer, Employer's other vendors and Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contractors, and subcontractors of any type. Employer further agrees and acknowledges that Claim Administrator shall have no other authority or obligation to act on behalf of the Plan or Plan participants or beneficiaries as a fiduciary. In addition, Employer agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan Participants or beneficiaries with respect to any litigation, whether as a fiduciary or otherwise, including litigation by participants or beneficiaries or benefits under the Plan, except as may be required under Claim Administrator's indemnification obligations under this Agreement.

SECTION 6: OTHER PROVISIONS

6.1 **Relationship of the Parties and Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented, or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers, or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. Nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents. Claim Administrator or its subsidiaries or affiliates may also have ownership interests in certain Providers who provide Covered Services to Covered Persons, and/or in vendors or other third parties who provide services related to this Agreement or provide services to certain Providers. Upon Employer request (not more than once per calendar year), Claim Administrator will provide a list of such entities to Employer.

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

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

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

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

6.5 **Notice of Annual Meeting.** Employer is hereby notified that it is a member of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois, each year on the last Tuesday in October at 12:30 P.M. For purposes of this section, the term "member" means the group, trust, association, or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee, or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 7: DEFINITIONS

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

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

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

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

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

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

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

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

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

7.3 **"Allowable Charge"** means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. For Medical Covered Services.

i. ***For Network Providers*** - The Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

ii. ***For Providers other than Medical Network Providers ("Non-Contracting Providers")***- The Allowable Charge will be the lesser of:

1. the Provider's billed charges, or;

2. Claim Administrator's non-contracting Allowable Charge. Except as otherwise provided in this Section, the non-contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the Claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than one hundred percent (100%) of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, or is unable to be determined based on the information submitted on a Claim, the Allowable Charge for Non-Contracting Providers will be reimbursed at Claim Administrator's default percent of billed charges. Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event Claim Administrator does not have any Claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used

by Medicare in processing the Claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments. Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor. In the event the non-contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person may be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's non-contracting Allowable Charge for a particular service, the Covered Person may call the Customer Service number shown on the back of the Covered Person's Identification Card. Notwithstanding anything to the contrary in the Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be consistent with the In-Network benefit level for Covered Services provided, the amount the Provider has agreed to accept as payment for Covered Services in accordance with a single case agreement, or one-hundred percent (100%) of billed charges, whichever is less.

Each of these amounts is calculated excluding any Network or contracting Provider Copayment or Coinsurance imposed with respect to the Covered Person.

b. When Covered Services are received outside the state of New Mexico from a Provider who does not have a written agreement with Blue Cross and/or Blue Shield of New Mexico or with the local Blue Cross and/or Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and/or Blue Shield Plan ("Host Plan") servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

c. ***For Prescription Drug Benefits,*** the Allowable Charge is determined as follows:

i. **Participating Pharmacy –** For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Charge, for purposes of calculating Employer Payment and the Covered Persons' required deductible and Coinsurance, shall be the cost mutually agreed upon by Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference, if applicable.

ii. **Out-of-Network Pharmacy –** For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered, the Allowable Charge for purposes of calculating both Employer Payment and the Covered Persons' required deductible and Coinsurance shall be the lesser of the charge which the particular Out-of-Network Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus twenty-five percent (25%) unless otherwise agreed upon by Claim Administrator and Employer.

7.4 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology,

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

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

7.6 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction.

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

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

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

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

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

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

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

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

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

7.16 **"Fee Schedule"** means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee

Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit C.

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

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

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

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

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

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

7.23 **"Overpayment"** means a payment to a Provider or a Covered Person that was in excess of the actual correct amount based on the Plan's benefit design and Claim Administrator's or other Blue Cross and/or Blue Shield companies' Provider contracts and policies, or a payment that was made in error, including but not limited to, Provider's unsupported billing practices.

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

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

7.26 **"Primary Care Practitioner"** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to Covered Persons, who initiates the patient's referral for specialist care, who maintains continuity of patient care, who is a Network Provider at the time Covered Services are rendered, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care. Primary Care Practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also serve as Primary Care Practitioners, as defined by the State in which the professional is in practice (otherwise known as a "Primary Care Provider").

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

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

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

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

7.31 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are generated every Sunday are due within forty-eight (48) hours of notification to Employer by Claim Administrator. Weekly claim invoices have a seven (7) calendar day grace period. If payment has not been received by the seventh day of the grace period, late fees will apply. An autogenerated notification email will be sent ten (10) calendar days after payment was due if no payment has been received by Claim Administrator. The Employer will be considered delinquent twenty (20) calendar days after the invoice was generated if payment has not been received by Claim Administrator. Monthly fees (e.g., Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

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

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

EXHIBIT B
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

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

- **CLAIMS ADJUDICATION**

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

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

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

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

- **ENROLLMENT SERVICE**

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

- **DISABLED DEPENDENT CERTIFICATION**

  Certify the disabled status of any dependent children of Covered Persons, based on Claim Administrator's review of information provided by Employer, the Covered Person, or the dependent's medical Provider(s), following either the Standard or Custom Rules as indicated on the most current ASO BPA, for purposes of administering the Employer's age limit for eligibility.

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

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

- **INTERNAL APPEALS**

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

- **MEMBERSHIP**

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

- **STANDARD REPORTS**

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

- **STOP LOSS COORDINATION**

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

- **REPORTING SERVICES**

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

- **ACTUARIAL AND UNDERWRITING**

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

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and if the Employer is a target of a pattern of fraudulent or abusive activities inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit G.

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

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

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

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

- **PROVIDER NETWORK(S)**

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

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

  Pursuant to Exhibit D, Section 6 titled "Medicare Secondary Payer Information Reporting", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), Claim Administrator will issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, Claim Administrator will

remit such funds to Employer, less any amount(s) owed to Claim Administrator from such funds, in accordance with Claim Administrator's established procedures, for disposition by Employer as may be required under applicable law. If requested by Employer via prior written notice as required by Claim Administrator, Claim Administrator will escheat such funds on behalf of Employer, less any amount(s) owed by payees to Claim Administrator, from such funds, to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

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

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Services under Exhibit B do not include providing Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations such as support functions. The term Services does not include services provided by Employer's Vendor(s).

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **ADVANCED PAYMENT REVIEW ("APR")**

  Provide a program that may include post-service, prospective, and retrospective Claim coding or billing reviews to identify discrepancies, errors, or billing inconsistencies of Claim Payments as identified by Claim Administrator.

- **ADDITIONAL PROGRAMS OR SERVICES**

  Claim Administrator may offer additional programs or services for an additional fee if elected by Employer and identified as a Service in the most recent BPA or other Exhibit to this Agreement.

- **EXTERNAL REVIEW COORDINATION**

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

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, cancer services and support, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator. Audits relating to Wellbeing Management shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. Such Services may be subject to a service charge and/or additional Claim Charge.

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

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

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

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

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

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

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

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

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, cancer services and support, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator. Audits relating to Health Advocacy Solutions shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. Such Services may be subject to a service charge and/or additional Claim Charge.

- **FLEXACCESS™**

  Claim Administrator or its designee(s) will proactively enroll Covered Persons into a program designed to lower prescription drug costs through manufacturer copay assistance programs. Under this program, copays for a select list of applicable drugs are maximized within the benefit plan design, and the manufacturer-provided copay assistance programs are applied to offset medication costs. The manufacturer copay assistance will not apply to Covered Persons' deductibles and out-of-pocket maximum accumulators. Through active outreach to Covered Persons, Claim Administrator or its designee(s) will help Covered Persons attempt to enroll in a copay assistance program prior to paying for any Covered Person's claim.

- **FLEXACCESS™ QUALIFIED HDHP**

  Claim Administrator or its designee(s), through active outreach to Covered Persons, will help Covered Persons attempt to enroll in a manufacturer assistance program. Under this program, the manufacturer provided assistance may be used by the Covered Person at the point of sale to offset their out-of-pocket medication costs. Claim Administrator or its designee(s) will ensure manufacturer assistance funds used by Covered Persons do not apply to the Covered Persons accumulators.

- **GENE THERAPY SOLUTION: CELL AND GENE NAVIGATION & GENE OUTCOMES**

  Provide (1) the mutually agreed upon member navigation services for Covered Persons who are eligible to receive gene and cellular therapy services to assist such Covered Persons with obtaining services at a participating Provider, and (2) access to payments resulting from outcome-based agreements held, directly or indirectly, with Manufacturers of gene and cellular therapy drugs. Claim Administrator may receive payments in the event that select gene or cellular therapy treatments fail to meet the outcome-based metrics set forth in the outcome-based agreement with the Manufacturer. Claim Administrator will pay Employer the agreed upon percentage of the outcome based payment set forth in the BPA of the outcome based payment received by Claim Administrator. Notwithstanding the foregoing, the Employer will not be eligible to receive any payments received from outcome-based agreements after final settlement, following the termination of this Agreement and the completion of any applicable Run-Off period.

EXHIBIT C
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

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

Inter-Plan Arrangement Fees:

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

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

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

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

SECTION 2: EXHIBIT DEFINITIONS

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

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

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

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

2.4 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Exhibit D Section 6 titled "Medicare Secondary Payer Information Reporting.")

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

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

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

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

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

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

a. At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that sixty (60) days' prior written notice is given by Claim Administrator;

b. On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;

c. On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;

d. On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;

e. The information upon which Claim Administrator's projections were based (e.g., benefit levels, census/demographics, producer/broker fees) becomes outdated or inaccurate; or

f. On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

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

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

a. Any applicable Supplemental Charge(s); and/or

b. Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or

c. Any other fees that may be assessed by third parties for services rendered to Employer, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or

d. Any other fees for services mutually agreed upon by the Parties in writing.

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

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

3.8 ***Shared Savings Programs.*** Claim Administrator may offer programs that include compensation to the Claim Administrator based on shared savings as may be described in the most recent BPA or in another mutually agreed writing between the Parties. In general, these "Shared Savings Programs" measure savings as reductions in expected or actual Claims costs by reason of the Employer's adoption of the program. Employer acknowledges and agrees that Claim Administrator does not act as a fiduciary under ERISA when engaging in activities related to Shared Savings Programs under this Section because such activities do not constitute an exercise of discretion or control over Plan assets or Plan administration.

SECTION 4: CLAIM PAYMENTS

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

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

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

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

SECTION 6: CLAIM SETTLEMENTS

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

a. Claim Payments paid by Claim Administrator in the particular Claim Settlement Period.

b. Claim Payments paid by Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim settlement.

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

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

6.2 ***Employer Underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within ninety (90) days from the last day of the Claim Settlement Period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

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

SECTION 7: LATE PAYMENTS AND REMEDIES

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

a. Suspend Claim Payments; or

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

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

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

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

b. The maximum rate permitted by state law.

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

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

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

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

8.3 ***Final Settlement.*** A final settlement shall be made within ninety (90) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments or recoveries for Overpayments, including, but not limited to, subrogation or litigation activities, regardless of when such adjustments or recoveries occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

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

EXHIBIT D
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

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

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

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

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service nor that any Provider is a subcontractor of Claim Administrator with respect to any aspect of this Agreement. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

2.3 **Physician Ratings and Rankings.** Employer acknowledges that Claim Administrator may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized

standards and guidelines to rate and rank certain Physicians, classify certain Physicians into tiers, and may publish and make available to Employer and Covered Persons certain Physician-specific information that includes, and is not limited to, ratings, rankings, tiers, and other comparisons of a Physician's performance against certain standards, measures and other physicians, and that Claim Administrator may publish and/or share such information with Employer, Covered Persons and other third parties. Notwithstanding this or any other provisions of this Agreement to the contrary, in no event shall any reference or statement by Claim Administrator about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee as to future services provided by any Physician or Provider or the anticipated outcome of such services.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non-Network Provider for a Covered Service in non-emergency situations, benefit payments to such non-Network Provider are not based upon the amount billed. Non-Network Providers may bill the Plan's Covered Person for any amount up to the difference between the billed charge and the amount the Claim Administrator has paid for the Plan's portion of the bill. For more detailed information regarding benefit payments for Network and Non-Network Providers, please see the definition of Allowable Charge in Section 7 Definitions of this Agreement. A Covered Person may obtain further information about the Network status of Providers and information on out-of-pocket expenses by calling the toll-free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

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

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

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

4.3 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons

hereunder are entitled to receive any portion of any such payments, discounts and/or allowances except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate Covered Persons' deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the Parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts, payments and/or other allowances that Prime has negotiated with pharmacies (or other suppliers) are passed through to Claim Administrator. For the administrative services that Prime provides as part of the mail order and specialty pharmacy program, Prime may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the mail-order and/or specialty pharmacy. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

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

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

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

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM and Claim Administrator's own rebate contracts with pharmaceutical manufacturers. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, Employer's benefit design, and rebate arrangements entered into by the PBM,

none of which Claim Administrator directly controls, and rebate arrangements between Claim Administrator and pharmaceutical manufacturers. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Claim Administrator may provide Employer with a rebate credit, the amount of which is set forth in the ASO BPA (the "Rebate Credit"). The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets notwithstanding the actual amount of rebates, payments, discounts and/or other allowances provided to Claim Administrator by the PBM or pharmaceutical manufacturers. Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its Plan have no right to, or legal interest in, any portion of the rebates, payments, discounts and/or other allowances provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates, payments, discounts and/or other allowances. Rebate Credits shall not continue after termination of the prescription drug program.

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

SECTION 6: MEDICARE SECONDARY PAYER INFORMATION REPORTING

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

6.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer's failure to provide accurate and timely information in response to Claim Administrator's request may impact Claim payments.

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

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

6.5 Employer acknowledges that Employer shall be responsible for any Civil Money Penalties ("CMP") imposed against Claim Administrator as a result of Employer's failure to promptly notify Claim Administrator of any change in the number of individuals employed by Employer or status of its Employees that might affect the order of payment under the MSP statute.

SECTION 7: REIMBURSEMENT PROVISION

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

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

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

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

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

SECTION 8: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for, and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 8.

EXHIBIT E
ASO BPA

EXHIBIT F
BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2: ADMINISTRATIVE SERVICES ONLY

Claim Administrator provides administrative Claims payment services only as set forth in this Agreement and does not assume any financial risk or obligation with respect to Claims.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

Employer, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Claim Administrator to use the Blue Cross and/or Blue Shield Service Mark in the State of New Mexico, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization

other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 *Out-of-Area Services*

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

4.2 *BlueCard Program*

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

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

(1) Covered Person Liability Calculation.

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

(2) Employer's Liability Calculation.

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

b. ***Claims Pricing***

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

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

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

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

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

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

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

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer. A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its health care provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a health care provider may bill for non-covered health care

services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

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

4.3 ***Negotiated Arrangements***

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

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

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

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

payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

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

4.4 ***Special Cases: Value-Based Programs***

a. ***Value-Based Programs Overview***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a) PMPM billings; or

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

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

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

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

4.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/Hospital bill audits, credit balance audits, utilization review

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

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

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

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

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

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Health Care Providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's Non-Participating Healthcare Provider local payment or the pricing requirements required by applicable law. The Covered Person may be responsible for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

a. In certain situations, Claim Administrator may use other payment bases to determine the amount Claim Administrator will pay for services rendered by Non-Participating Health Care Providers, such as:

i. Billed charges for Covered Services;

ii. The payment Claim Administrator would make if the health care services had been obtained within Claim Administrator's service area;

iii. A special negotiated payment, as permitted under Inter-Plan Arrangements; or

iv. The lesser of

1. the amount described in (1), above; or

2. for professional Providers, a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or for hospital or facility Providers, a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, a Covered Person may be liable for the difference between the

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

b. ***Fees and Compensation***

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

4.8 ***Blue Cross Blue Shield Global Core***

a. ***General Information***

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

(1) Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the service center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

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

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

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

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

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable

Inter-Plan Arrangements may be revised from time to time as provided for in Section 4.9 below.

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

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

EXHIBIT G
RECOVERY LITIGATION AUTHORIZATION

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

1. Claim Administrator shall have the right to select and retain legal counsel.
2. Any lawsuit filed or arbitration initiated by Claim Administrator will be done in the name of Claim Administrator for its own benefit, as well as on behalf of Employer and possibly other parties. Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of Employer and/or the Plan without Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of Employer and/or the Plan with attorneys identified as counsel for Employer or in the name of two or more parties, including Employer and Claim Administrator, with attorneys identified as counsel for Employer, Claim Administrator and possibly other parties.
3. The Parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit.
4. Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.
5. Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated, or litigated.
6. Claim Administrator shall have the right to assign claims belonging to Employer and/or the Plan to a third party for the purpose of allowing the third party to pursue the claims on Employer's behalf via mediation, arbitration, or litigation. If such an assignment is made, the rights and obligations of Claim Administrator in this Exhibit G shall become the rights and obligations of the third party for purposes of the assigned claims only.
7. Any and all recoveries, net of all investigative and other expenses relating to the recovery made through any means pursuant to the provisions of this Exhibit, including any costs of settlement, mediation, arbitration, litigation or trial including attorney's fees, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by Claim Administrator on any reasonable basis it deems appropriate.
8. Any and all information, documents, communications, or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions, and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions, and reports to the full extent allowed by state or federal law. Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of Claim Administrator.
9. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.
10. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.
11. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration, or settlement negotiation; therefore, Employer acknowledges that the efforts of Claim Administrator may not result in recovery or in full recovery in any particular case.

12. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require Claim Administrator to assert any claims on Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after Claim Administrator has asserted a claim on behalf of Employer and/or the Plan but before any recovery, Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

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

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

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

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

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

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

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

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

EXHIBIT H
PHARMACY BENEFIT MANAGEMENT SERVICES
(GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT)

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

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

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

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

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

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

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

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

6. **Pharmacy Network:**

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

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

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

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

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

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

g. **Audits**: In addition to the audit rights available pursuant to Section 2.11 of the Agreement or as otherwise required by law, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the Agreement. Subject to the audit terms pursuant to Section 2.11 of the Agreement or as otherwise required by law, Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from Claim Administrator or Prime without prior written approval by Prime or Claim Administrator as applicable. Employer will bear its own cost and expenses for all such audits.

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

7. **Claims Processing**

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

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

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

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

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

f. **Benefit Plan Design**:

In the event Employer wishes to implement Benefit Plan design changes; for example, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the BPA Addendum may no longer be applicable. If such Benefit Plan design changes impact the existing pricing, a new BPA Addendum pricing must be negotiated. Revised pricing proposed by Claim Administrator shall be effective pursuant to Section 6.4 Amending and

Ex. C Section 3.3 of this Agreement, provided that if Parties cannot agree on the terms of the new BPA Addendum pricing, Employer shall be allowed to (a) proceed to dispute resolution, as set forth in the Agreement or (b) terminate this Exhibit with 90 days' prior written notice to the other Party. Failure to reach agreement on the new Addendum pricing shall not be a breach of contract.

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

9. **Termination**

This Exhibit may be terminated as follows:

a. By either Party at the end of the Guarantee Period, upon ninety (90) days' prior written notice to the other Party; or

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

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

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

e. By Claim Administrator pursuant to Ex. C Section 7.1, upon Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and BPA Addendum.

If Employer terminates this Exhibit under sections 9(a), 9(b), or 9(c) above, or by Claim Administrator under sections 9(d) or 9(e), prior to the end of the Guarantee Period, then applicable network discount and/or minimum Rebate guarantees set forth in the BPA Addendum will not be effective for such Guarantee Period.

10. **Program Pricing Terms**

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

a. Pharmacy Program Claims

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

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

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

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

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

b. Rebates for Drugs Covered under the Prescription Drug Program

In connection with Rebates earned for drugs covered under the prescription drug program, Rebate Credits are paid to Employer pursuant to the terms of the BPA Addendum and shall not continue after termination of the Prescription Drug Program or the PBM Exhibit.

Additional information about rebates and Rebate Credits are included in the Agreement and the ASO BPA.

c. **Specialty Drug Claims**

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

d. **Copayments/Deductibles/Coinsurance**

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

11. DEFINITIONS

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

"Average Wholesale Price" or **"AWP"** means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.

"Benefit Plan" means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.

"Brand Drug" means, except as otherwise designated in the Additional Provisions of the BPA Addendum, a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.

"Claim" or **"Claims"** means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.

"Claim Administrator" has the meaning set forth in the Agreement.

"Claims Adjudication" means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract, and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

"Compound Drug" means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added.

"Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Allowable Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member's Benefit Plan.

"Copayment/Deductible" means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member's Benefit Plan.

"Covered Prescription Drug Products and Services" means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member's Benefit Plan, subject to any Copayment/Deductible or Coinsurance.

"Dispensing Fee" means the negotiated fee for Network Participants' professional service of filling a prescription and is added to the Ingredient Cost for the prescription.

"Drug Utilization Review" or **"DUR"** means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored, and acted upon consistent with the Member's Benefit Plan. DUR can be prospective, concurrent, or retrospective.

"Drug List" means a list of pharmaceutical products which is available to Network Participants, Members, physicians, or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

"Extended Supply Network" or **"ESN"** means claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Eighty-Four (84) days' quantity supply of medication, provided that the Member's Benefit Plan provides for an ESN benefit.

"Foreign Claim" means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.

"Generic Drug" means, unless otherwise designated in the Additional Provisions of the BPA Addendum, a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.

"Guarantee Period" means the period of time set forth in the BPA Addendum for which the AWP network discount and Dispensing Fees and/or Rebates are guaranteed.

"Ingredient Cost" means the negotiated rate (e.g., discount of AWP or MAC) for a prescription drug dispensed by a Network Participant and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable for the given prescription drug and the professional service of dispensing such drug.

"Legend Drugs" means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

"Limited Distribution Drug" or **"LDD"** means a Specialty Drug whose dispensing is restricted by the pharmaceutical manufacturer to specified pharmacies as reflected on the limited distribution list provided by Prime or Claim Administrator.

"MAC List" means the list of unit prices established by Prime for multi-source Covered Drugs, with each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by Prime and updated from time to time in accordance with this Exhibit and the BPA Addendum.

"Mail Service" means the service through which Members may receive Covered Prescription Drug Products and Services through the mail from a pharmacy designated by Claim Administrator or PBM to dispense prescription drugs from one or more central locations.

"Manufacturer" means a company that manufactures, and/or distributes pharmaceutical drug products.

"Manufacturer Administration Fee" means all negotiated fees received by Prime from any given Manufacturer, directly or through a group purchasing organization, relating to administration of Rebates under a Manufacturer Agreement.

"Maximum Allowable Cost" or **"MAC"** means the unit price established by Prime for a specific multi-source drug present on the MAC List at the time of service.

"Member" or **"Members"** means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.

"Network Contract" has the meaning set forth in the definition of "Network Participant."

"Network Participant" means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with Prime or Claim Administrator ("Network Contract") to provide Covered Prescription Drug Products and Services to Members, as may be amended. References to "Network Participant" may exclude Specialty Pharmacies and/or Mail Service pharmacies (separately defined in this Exhibit) as context dictates.

"Paper Claims" means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.

"Pricing Source" means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which establishes and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services.

"Provider Tax" means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

"Rebate(s)" means any discount or other remuneration of any kind received or recovered by Prime, directly or through a group purchasing organization, from any Manufacturer which is directly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees or fees retained by a group purchasing organization for its role in securing Rebates and/or Manufacturer Administrative Fees.

"Rebate Credit" has the meaning set forth elsewhere in this Agreement.

"Rebate Management Services" means the services which Prime is obligated to provide pursuant to Section 4.

"Specialty Drugs" means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are for serious or chronic conditions, oral medications and/or that have special handling or storage requirements, or are infused medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is determined by Prime or Claim Administrator, may be further defined in the BPA Addendum, and subject to change.

"Specialty Pharmacy(ies)" means a pharmacy designated by Claim Administrator or PBM to dispense Specialty Drugs to a Member through the mail or other similar delivery method from one or more central locations.

"Usual and Customary" or **"U&C"** means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

"Utilization Management" means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members.

Such services include, but are not limited to, the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.

"Zero Balance Due Claim" means any Claim where the Member cost share covers one hundred percent (100%) of the Allowable Charge for such Claim.

City of Santa Fe PSA with ASA Exhibit (For Execution 3.24.25) (002)

Final Audit Report 2025-03-26

Created:	2025-03-26
By:	JULIE KENNY (jckenny@santafenm.gov)
Status:	Signed
Transaction ID:	CBJCHBCAABAAtqcpopmURZPnAQdYgz44uzuWFdOczC9r

"City of Santa Fe PSA with ASA Exhibit (For Execution 3.24.25) (002)" History

Document created by JULIE KENNY (jckenny@santafenm.gov)
2025-03-26 - 10:19:21 PM GMT- IP address: 63.232.20.2

Document emailed to cwryan@santafenm.gov for signature
2025-03-26 - 10:19:45 PM GMT

Email viewed by cwryan@santafenm.gov
2025-03-26 - 10:20:13 PM GMT- IP address: 104.47.64.254

Signer cwryan@santafenm.gov entered name at signing as Christopher W. Ryan
2025-03-26 - 10:20:39 PM GMT- IP address: 63.232.20.2

Document e-signed by Christopher W. Ryan (cwryan@santafenm.gov)
Signature Date: 2025-03-26 - 10:20:41 PM GMT - Time Source: server- IP address: 63.232.20.2

Agreement completed.
2025-03-26 - 10:20:41 PM GMT

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
03/27/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 155 N. WACKER, SUITE 1200 CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 CN101825276-ALL-GAXW-24-25	**CONTACT NAME:** Healthcare Team **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** Healthcare.AccountsCSS@marsh.com
INSURED HEALTH CARE SERVICE CORPORATION A MUTUAL LEGAL RESERVE COMPANY AND ITS SUBSIDIARIES 300 EAST RANDOLPH CHICAGO, IL 60601	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Old Republic Insurance Company — 24147 **INSURER B :** N/A — N/A **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-010916063-01 **REVISION NUMBER:** 5

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			MWZY 317249 24	11/01/2024	11/01/2025	EACH OCCURRENCE	$ 2,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBEREXCLUDED? [ ] N/A						E.L. EACH ACCIDENT	$
	(Mandatory in NH)						E.L. DISEASE - EA EMPLOYEE	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

City of Santa Fe
200 Lincoln Ave.
Santa Fe, NM 87501

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA LLC

Ali Lenti

GABALDON, RACHEL D.

From:	DUTTON-LEYDA, TRAVIS K.
Sent:	Thursday, March 27, 2025 4:56 PM
To:	VALDEZ, ALVIN A.; DIAZ, JAMIE-RAE; LOVATO, JOANN D.; MIERA, KRISTY A.
Cc:	MARTINEZ, MARCOS D.; GABALDON, RACHEL D.
Subject:	RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Greetings,

Here is an updated determination as discussed with Marcos and Chris.

The scope of work as written would be General Services. This determination relates only to that question and is no comment on whether the scope of work or procurement method meet all legal standards. I reserve the right to change this determination if the scope of work differs from the scope of work submitted for the original determination. This procurement must be conducted using the processes and procedures set forth by the City of Santa Fe, Central Purchasing, the Procurement Manual, and state statutes.

Please note:

- Save this email as a PDF and upload it into the corresponding Munis records.
- Check with WorkQuest dba Horizons of New Mexico (vendor # 8673) (mloehman@horizonsofnewmexico.org) if this service appears on their approved list.
- If your request includes anything that needs to be reviewed and preapproved by another City Department/Division, please send the same SOW to the corresponding email address and include their response in your packet/Munis.

  -IT components (anything IT) - ereview@santafenm.gov

  -Vehicles – dmjaramillo@santafenm.gov

  -Grants - grants@santafenm.gov

  - Construction, Facilities, Furniture, Fixtures, Equipment, etc. - jsburnett@santafenm.gov

  -Emergency Related Purchases - bgwilliams@santafenm.gov

  -Asset over $5k - jxbolden@santafenm.gov

- Ensure that the appropriate templates and forms are used https://intranet.santafenm.gov/finance_1 and documented procedures/laws/rules are followed.
- > $20k per year, when processing this procurement, please ensure the procurement number issued by Munis and the procurement name are used in the appropriate documents and the subject of emails.
- If you are processing a procurement where the forecasted amount is =/> $60k, per NMSA 1978, Section 13-1-102, the procurement method must be ITB (if you choose not to use a cooperative or an existing contract). If you feel you need to process an RFP, you must get an Authorization and Plan approved before you process.

- < $20k per year, one quote is acceptable.
- From $20k to $60k per year, if you aren't using a cooperative or existing contract, you'll need to provide 3 quotes in your req. Must use the Munis Bid Module after 12/21/2023.
- Please keep this as part of the procurement file for future reference.
- Figure out your funding source and **inform Purchasing**. To ensure that the proper documents and language are used, it is important to identify the funding source for the subsequent contract. For instance, if federal funds are involved, the procurement request and subsequent contract must include the necessary federal language. Therefore, it is crucial to determine the funding source beforehand.
- Please review the pages linked below to determine whether any of the existing contracts/price agreements or cooperative agreements are applicable to this request. You might be able to use an existing price agreement to save time and money.
    - https://www.generalservices.state.nm.us/state-purchasing/statewide-price-agreements/ (if you choose to use a Statewide, you do not need to ask Horizons if they can do the work. State Purchasing must offer the SOW to Horizons prior to placing the award on their website.)
    - https://naspovaluepoint.org/categories/
    - https://www.omniapartners.com/publicsector/contracts
    - https://www.buyboard.com/home.aspx
    - https://www.h-gac.com/Home
    - https://www.gsaelibrary.gsa.gov/
    - https://www.sourcewell-mn.gov/contract-search

- Submit or send your request to the appropriate MS Teams channel or email address:
    - RFPs requests to https://teams.microsoft.com/l/channel/19%3ad63b9c8b586d424fa5eed34177146ac5%40thread.tacv2/RFP%2520Requests?groupId=a367d8c2-992f-4c74-8e7d-0ccb6950c9a1&tenantId=77b69f5a-55ed-4363-8616-4867b0bc707f
    - ITBs requests to https://teams.microsoft.com/l/channel/19%3a48e1e4588c0440a09cfbd9b907ed42d4%40thread.tacv2/ITB%2520Requests?groupId=a367d8c2-992f-4c74-8e7d-0ccb6950c9a1&tenantId=77b69f5a-55ed-4363-8616-4867b0bc707f
    - Determination requests to purchasing_det@santafenm.gov
    - And all other requests to purchasing@santafenm.gov

Thank you for submitting this scope of work for my review.

Book time to meet with me

Regards,

Travis Dutton-Leyda
Chief Procurement Officer
City of Santa Fe
200 Lincoln Avenue
Santa Fe, NM 87501
505-629-8351
tkduttonleyda@santafenm.gov

https://santafenm.gov/finance-2/purchasing-1

Vendor Registration and Current Procurement Opportunities:
https://cityofsantafenmvendors.munisselfservice.com/Vendors/VBids/SearchResults.aspx

Internal Link: https://intranet.santafenm.gov/finance_1

CITY OF SANTA FE
FINANCE

"The future belongs to those who believe in the beauty of their dreams." — Eleanor Roosevelt

From: VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>
Sent: Thursday, March 27, 2025 2:34 PM
To: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Jaime,

Attached is the Certificate of Insurability, the final document needed from BCBSNM for the Memorandum Packet. Once Travis signs the ECR, I believe he can share it with you and if not, please let me know ASAP and I will send to you. This should complete the packet.

Alvin

From: VALDEZ, ALVIN A.
Sent: Thursday, March 27, 2025 1:57 PM
To: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Jamie,

Attached is the signed administrative contract.

Alvin

From: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>
Sent: Thursday, March 27, 2025 1:45 PM
To: LOVATO, JOANN D. <jdlovato@santafenm.gov>; VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

I believe Alvin is working on the evaluation committee report. I will be routing the procurement memo and contract for signatures.

Once I receive the contract from Alvin I will get the packet routed.

Alvin,
Please send me the contract once you receive it back from legal.

Thank you!

Jamie-Rae Diaz
City of Santa Fe | Human Resources
Administrative Manager
Office (505) 955-6604
Cell (505) 470-3791
Jldiaz@santafenm.gov

From: LOVATO, JOANN D. <jdlovato@santafenm.gov>
Sent: Thursday, March 27, 2025 1:24 PM
To: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Hi Jaime Rae,

The memo looks good and I confirmed that we can keep the names of the evaluators in the memo.

Regarding the Evaluation Committee report... I thought that I had seen an email that it was currently being routed for signatures. Is this the case? Do you need our assistance in routing this document?

Thank you.

JoAnn D. Lovato Montaño
Procurement Manager
505-469-6045
City of Santa Fe

From: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>
Sent: Thursday, March 27, 2025 12:32 PM
To: VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Purchasing Team,
Attached is the revised memo which include Bern's edits, please see attached and confirm all is ok prior to sending for signatures.

Alvin,
I will include you on all signatory once we get the ok from purchasing.

Jamie-Rae Diaz
City of Santa Fe | Human Resources
Administrative Manager

Office (505) 955-6604
Cell (505) 470-3791
Jldiaz@santafenm.gov

From: VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>
Sent: Thursday, March 27, 2025 12:28 PM
To: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

She did, including myself. I would let her know that there were a couple more edits that needed to be made, that they were made, and this needs to be sent out for her signature again. Also, respectfully request, that she call or text Emily and Chirs, letting them know their signatures will be required and that it is of the highest priority. Please ensure I am the first signature

If you need me to jump in if we don't get signatures let me know.

Alvin

From: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>
Sent: Thursday, March 27, 2025 12:24 PM
To: VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>; DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Alvin,
Did Bern want the signatures of the staff below included on this portion of the memo? I ask only because this can delay the signature process.

Via: Bernadette Salazar, Human Resources Director
Travis Dutton Leyda, Chief Procurement Officer
Emily Oster, Finance Director
Chris Ryan, Senior Assistant City Attorney

Jamie-Rae Diaz
City of Santa Fe | Human Resources
Administrative Manager
Office (505) 955-6604
Cell (505) 470-3791
Jldiaz@santafenm.gov

From: VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>
Sent: Thursday, March 27, 2025 12:04 PM
To: DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>; DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>
Subject: RE: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you

Hello All,

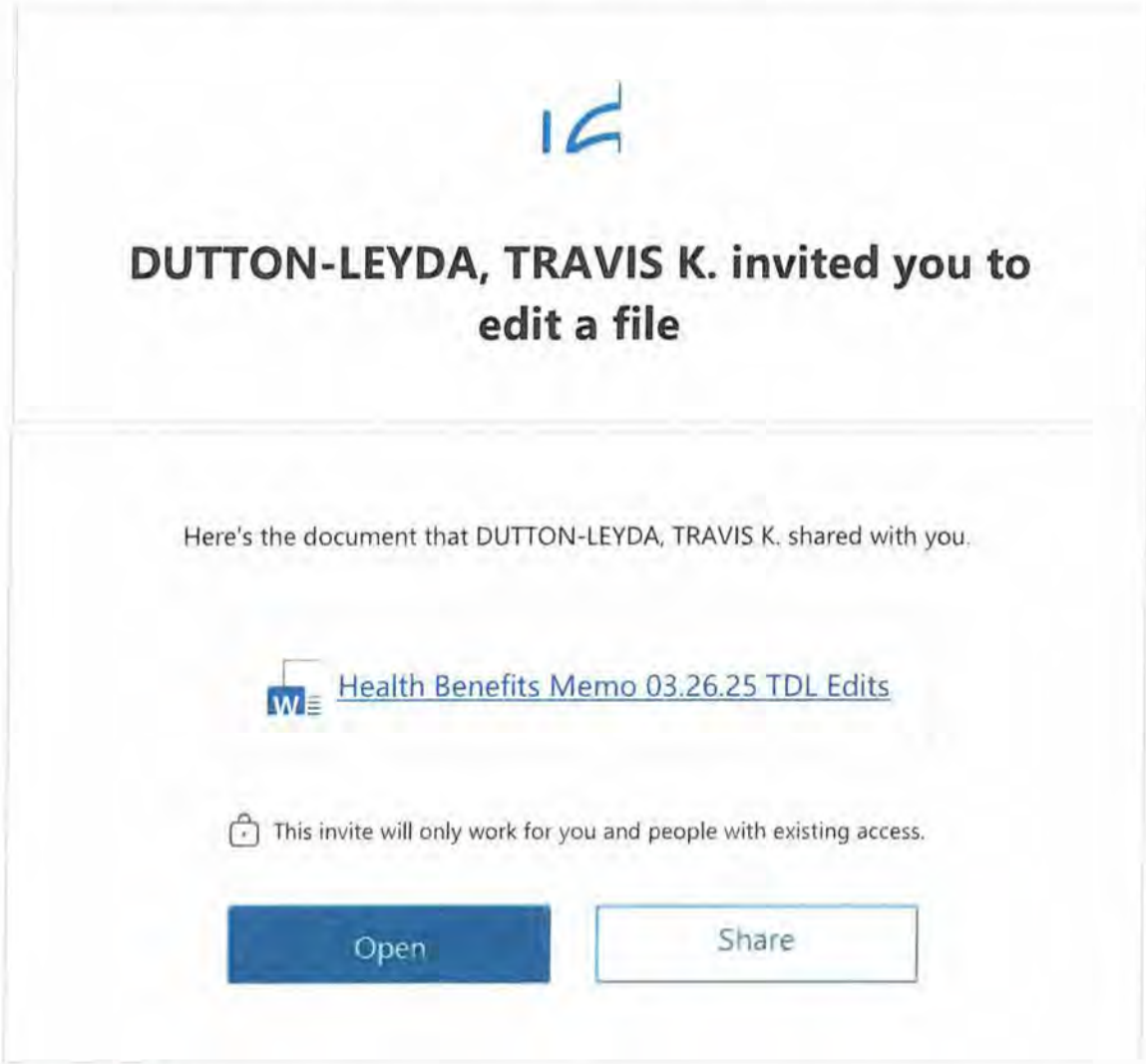
Attached is an update version of the Health Benefits Memo, as Bern requested additional information and had some edits.

Also attached are Documents that need to be included with the packet. We do have two (2) outstanding attachments, BCBSNM COI and the Evaluation Committee Report. We still need one or two signatures on the ECR

Please let me know if you have any questions.

Alvin

From: DUTTON-LEYDA, TRAVIS K. <tkduttonleyda@santafenm.gov>
Sent: Thursday, March 27, 2025 11:14 AM
To: DIAZ, JAMIE-RAE <jldiaz@santafenm.gov>; LOVATO, JOANN D. <jdlovato@santafenm.gov>; MIERA, KRISTY A. <kamiera@santafenm.gov>; VALDEZ, ALVIN A. <aavaldez1@santafenm.gov>
Subject: DUTTON-LEYDA, TRAVIS K. shared "Health Benefits Memo 03.26.25 TDL Edits" with you



Services Offered to the City of Santa Fe (9.2023)

Approved:
These services have been approved by the New Mexico Council for Purchasing from Persons with Disabilities and are available through Horizons of New Mexico.

- ADA Accessibility Consulting Services
- Auctioneering Services
- Bulk Mailing and Sorting
- Call Center Services
- Computer Refurbishing
- Courier Services
- Decontamination, Sanitation and Sterilization Services
- Debris Removal
- Document Imaging
- Document Shredding
- Envelope Stuffing
- General Labor
- Hard Drive Destruction
- Janitorial and Housekeeping Services – Including Carpet Cleaning & Floor Care
- Landscape Irrigation
- Landscaping
- Mailing Services
- Management of an Assistive Technology Reuse and Recycling Program
- Meeting Minute Preparation Services
- Pest Control and Extermination Services
- Printing Services
- Rest Area Maintenance
- Screen Printing
- Snow Removal
- Yard, Grounds, and Lawn Maintenance

Permissive:
The services have been approved by the New Mexico Council for Purchasing from Persons with Disabilities as permissible for sale under the State Use Act through Horizons of New Mexico. While the Council recognizes that certain Horizons of New Mexico members are capable of performing the services listed below, said services are considered permissive and excluded from the mandatory aspect of the State Use Program. Any procurement of the below services through Horizons of New Mexico is at the discretion of the purchasing agent and will be considered by the Council on a case-by-case basis.

- Graphic Design
- Graphic Design - Logo Design
- IT – Enterprise Application
- IT – IV & V
- IT Network and Database Management
- IT Support
- IT Security Services
- IT – Web Design
- IT – Web Programmer
- Marketing
- Social Media Marketing
- Training Services

For the complete State Use service list, please go to: http://horizonsofnewmexico.org/services.html

6121 Indian School Rd. NE Suite 102, Albuquerque, NM 87110 | 505-345-1540 |
mloehman@horizonsofnewmexico.org

City of Santa Fe, New Mexico

200 Lincoln Avenue, P.O. Box 909, Santa Fe, N.M. 87504-0909
www.santafenm.gov

Alan Webber, Mayor

Councilors:
Signe I. Lindell, Mayor Pro Tem, District 1
Alma G. Castro, District 1
Michael J. Garcia, District 2
Carol Romero-Wirth, District 2
Lee Garcia, District 3
Pilar F.H. Faulkner, District 3
Jamie Cassutt, District 4
Amanda Chavez, District 4

Dear City Staff,

In accordance with State Statute and City Ordinances, this document serves as a blanket ***services'*** determination and is valid until June 30, 2025, for the types of general, professional, and construction services that are clearly one of the types pre-established and approved by the State Purchasing Agent and City CPO.

Please continue to obtain determinations for services that do not clearly and fully fit within the types listed below. For mixed or hybrid services, unclear scopes of work, and design-build projects, a specific determination will be required. In these cases, please email purchasing_det@santafenm.gov to obtain the necessary CPO determinations for your procurement needs.

Should you have any questions or require clarification on a particular service, feel free to contact CPD.

The following are General Services:

- Air/bus, vehicle charter/rental service
- Auctioneers
- Audio-visual equipment setup and routine maintenance for events and presentations (including projectors, microphones, and speakers)
- Banking Services (routine, transaction-based)
- Boiler testing/water treatment service
- Bookkeeping service (routine, transaction-based)
- Building alarm systems, service and repair
- Check collection service
- Clothing, textile fabrication repair service
- Commercial laundry service, dry cleaning, etc.
- Communications systems installation, servicing, and repair
- Conference and trade show coordination

The following are Professional Services:

- Accountants (certified public accountants and registered public accountants)
- Actuaries
- Analysts of processes, programs, fiscal impact, and compliance
- Appraisers
- Archeologists
- Architects
- Artwork, original (services creating the artwork)
- Audio/video media productions (design, development, and/or oversight of)
- Auditors
- Broadband
- Business process re-engineering
- Counselors
- Consultants (including IT Consultants)
- Curriculum/Examination development
- Data Backup Services
- Data Storage and Management Services
- Design
- Economists
- Engineers
- Environmental monitoring: noise level, safety, hazardous gas detection, radiation monitoring service, etc.
- Financial Advisors
- Grant writing
- Graphic designers (creative or original in nature)
- Independent Verification and Validation
- Information Technology Hosting when it includes Maintenance and Support
- Information Technology Maintenance
- Information Technology Management

General Services (continued):

- Medical equipment rental or repair service (wheelchairs, walkers, etc.), including measurements, adjustments, and modifications to meet patient needs
- Metal/pipe/wiring detection service
- Office furnishings installation, refurbishment, and repair service
- Package inspection and crating
- Painting service
- Paper shredding
- Parking lot sweeping/snow removal service
- Pest/weed control service
- Photographic/micrographic processing and delivery, includes aerial and ground photography (if analysis is included, then personal service)
- Printing/duplicating service
- Process serving
- Property management (rent collection, property maintenance, etc.)
- Recycling/disposal/litter pickup service
- Retreat and workshop planning, conduct, coordination, etc.
- Security/armored car services
- Shop welding/metal fabrication service
- Software as a Service
- Steam cleaning, high pressure washing, parts cleaning service
- Studio photography service (does not include portrait painting)
- Telephone interview service (conduct of survey using prescribed survey instrument)
- Towing service
- Training – when offered as a regular course by an institution (such as a college or university)
- Travel service — air, surface, water
- Vehicle inspection, lubricating, and repair services
- Videotaping and recording service
- Warehouse dry/cold storage rental service
- Weather information service

General Services (continued):

- Debt collection service
- Delivery/courier service
- Document storage, duplication, retrieval, review, and destruction service
- Drug testing and screening (standard tests)
- Engraving service
- Equipment installation, preventive maintenance, inspection, calibration, and repair
- Equipment rental services
- Exams administration and scoring service
- Executive recruitment
- Firefighting/suppression service
- Food preparation, vending, and catering services
- Health screening, basic diagnostic (wellness, blood pressure monitoring, blood draw, etc.)
- Herbicide application service
- Household goods packing, storage, transportation service
- HVAC system maintenance service
- Information Technology Hosting (only)
- Information Technology Help Desk Services
- Information Technology Services requiring software or equipment
- Information Technology Software and Hardware Support Services
- Interpretive services: written/oral/sign language
- Inventory service
- Janitorial service, carpet cleaning, window washing
- Laboratory testing and analysis (standard tests only)
- Land clearing/debris removal service
- Landscaping—tree planting, grooming service, lawn mowing, etc. (but not landscape architects)
- Language translation service
- Linen rental service
- Marine equipment inspection, certification, and repair

Professional Services (Continued):

- Information Technology Programming
- Information Technology Risk Assessment
- Insurance Adjusters
- Investigators (personnel-related, etc.)
- Investment advisors and management
- Labor negotiators
- Landscape Architects
- Lawyers
- Lobbyists
- Managed Network Services
- Management and system analysts
- Management consultants
- Marketing consultants (including identifying market opportunities, conduct of marketing programs, planning, promotion, market research surveys, etc.)
- Medical arts practitioners
- Network Cybersecurity Services
- Network Installation
- Planners
- Policy Advisors
- Product Development Services
- Program/Project Managers
- Psychologists
- Public relations advisors/Publicists
- Publication development (creation of audio/video productions, brochures, pamphlets, maps, signs, posters, annual reports, etc.)
- Researchers
- Scientists (Bio/Chem/Env/Geo/Hydro/Mech, etc.)
- Speech writers
- Statisticians

Professional Services (Continued):

- Surveyors
- Trade developers
- Training – when it is specifically designed for an agency as opposed to established courses (such as out of the box training offered to all at a training company, university, or college)
- Web design and development

The following are Construction Services:

- Bid-Build (Standard)
- Construction Managers
- New Construction (including buildings, roads, bridges, utilities)
- Remodeling and Renovations (interior and exterior work)
- Demolition (including site clearance)
- Excavation and Earthwork
- Electrical Work (installation, repair, upgrades)
- Permanent installation or upgrades of audio-visual systems (including wiring and structural modifications)
- Plumbing (installation, repair, maintenance)
- Masonry and Concrete Work
- Roofing (installation, repair, maintenance)
- Structural Repair and Reinforcement
- Painting and Finishing (for construction purposes)
- Mechanical Work (HVAC systems, etc.)
- Site Preparation and Land Grading
- Utility Installation and Repair (water, sewer, gas lines)

Travis Dutton-Leyda, Chief Procurement Officer

_____ Date: 11/21/2024

Emily Oster, Finance Director

Emily K. Oster

_____ Date: 11/26/2024

Health Benefits Packet

Final Audit Report 2025-03-27

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BCBS Packet 1

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Renewal Meeting

FY 2026 Medical / Rx

Quality of Life Committee Meeting

City of Santa Fe

Presented: April 2, 2025

City of SF Health Benefits Administration Summary

- ***Self-Funded Health Plan Management:*** The City employs a third-party administrator to manage claims and perform key administrative duties for its self-funded health insurance plan.

- ***Contract Renewal Impending:*** The current administrator's contract concludes on June 30, 2025, prompting the issuance of an RFP for Fiscal Year 2026 onward.

- ***Benefits Advisory Committee Involvement:*** In alignment with Resolution No. 2005-02, the City appoints Benefits Advisory Committee members from AFSCME, Police, Fire, and Non-Union sectors for the proposal evaluation.

- ***Innovative Procurement with BVA:*** For the first time, the City adopted the Best Value Approach (BVA), a method focusing on metrics and data to select vendors offering exceptional service and value.

- ***Top Vendor Selection:*** Post-evaluation, Blue Cross Blue Shield of New Mexico (BCBSNM) emerged as the top vendor, recommended for the upcoming contract based on superior service and cost-effectiveness.

- ***BCBSNM's Expertise***: BCBSNM has demonstrated expertise in administering comprehensive health insurance benefits that are anticipated to enhance member experience and generate cost efficiencies.

City of SF Health Benefits Administration Summary

- ✓ ***Smart & Stable Plan Design That Saves You Money:***
  - o The plan design remains unchanged with a notable 3% cost reduction.
  - o 3% savings will be implemented via a Benefits Deduction “Holiday’ during a December pay period (no employee benefit deductions for medical, dental, or vision).
  - o Allows for greater savings than the 3% Premium deduction over 26 pay periods

- ✓ ***Broad City Employee Savings***: The City of SF currently employees 1,390 employees, of those employees, 1,146 employees carry Medical coverage, meaning that 83% of our employee base will see a Holiday savings.

- ✓ ***Minimal Provider Disruption:*** The provider network match rates are high—97.05% overall, with 97.79% for medical providers, 96.24% for ancillary services, and 95.22% for medical facilities.

- ✓ ***Most Valuable Guarantee***: 98.3% in-network utilization guarantee for medical claims.

- ✓ ***Enhanced Open Enrollment Support:*** Strategic initiatives, educational trainings through OE, including one-on-one sessions, live in-person assistance at multiple locations, and in-network care providers on site, in order to ease the transition for employees.

Medical Plan Rate History (FY2020 - Current)

Fiscal Year	Recommendations for Plan Sustainability	Actual Change to Rate or Plan
FY2025 (July 1, 2024-June 30, 2025)	6.8% increase to medical insurance rates	All rates except HRA EE Only rate increased 6.8% HRA EE Only rate was reduced from $82 to $75 to comply with ACA Affordability requirements
FY2024 (July 1, 2023-June 30, 2024)	0.5% increase to medical insurance rates	Fire Union Employees - 0.5% increase to medical insurance rates All employees except Fire Union-7% increase to medical insurance rates (0.5% for FY2024 and the remaining 6.5% from FY2023)
FY2023 (July 1, 2022-June 30, 2023)	18.5% increase to medical insurance rates	Fire Union Employees-18.5% increase to medical insurance rates All employees except Fire Union-12% increase to medical insurance rates (with a minimum of 6.5% increase for FY2024)
FY2022 (July 1, 2021-June 30, 2022)	11.1% increase to medical insurance rates	No increases to insurance rates for any employees and no plan design changes due to COVID.
FY2021 (July 1, 2020-June 30, 2021)	9.2% increase to medical insurance rates	No increases to insurance rates for any employees due to COVID. To offset the cost, there were minor plan design changes to include: copay increases for office/specialist visit, IP/OP hospital visit ambulance; decrease to copay for telehealth; copay and visit limit changes to Acu, Chiro, Napra, MT, PT, ST and OT
FY2020 (July 1, 2019-June 30, 2020)	11% increase to medical insurance rates	9.9% increase to medical insurance rates for all employees and 11.4% increase to dental insurance rates. No plan design changes.

AON

Current and Prior Year Experience – Medical and Rx Plans

City of Santa Fe

Claims by Month by Plan Year-All Plans Combined

A	B	C	D	E	F	G	H	I
Current Period 2024-2025	**Subscribers**	**Members**	**Funding**		**Expense**		**Gain / Loss**	**Loss Ratio**
			Plan Funding	**Funding PMPM**	**Total Expense (Claims+Admin)**	**Expense PMPM**		
July 2024	1,123	2,539	$1,803,358	$710.26	$1,638,095	$645.17	$165,263	90.8%
August	1,118	2,527	$1,802,756	$713.40	$2,078,097	$822.36	-$275,341	115.3%
September	1,117	2,525	$1,798,443	$712.25	$1,884,034	$746.15	-$85,591	104.8%
October	1,117	2,525	$1,789,445	$708.69	$2,030,406	$804.12	-$240,960	113.5%
November	1,118	2,527	$2,723,440	$1,077.74	$2,119,211	$838.63	$604,229	77.8%
December	1,122	2,537	$1,831,080	$721.75	$2,009,263	$791.98	-$178,183	109.7%
January 2025	1,110	2,509	$1,836,099	$731.81	$1,713,426	$682.91	$122,673	93.3%
Year-to-Date Totals	**7,825**	**17,689**	**$13,584,622**	**$767.97**	**$13,472,532**	**$761.63**	**$112,090**	**99.2%**
% Change vs 23-24	**-0.9%**	**0.1%**		**5.2%**		**5.4%**		**0.1%**

A	B	C	D	E	F	G	H	I
Prior Period 2023-2024	**Subscribers**	**Members**	**Funding**		**Expense**		**Gain / Loss**	**Loss Ratio**
			Plan Funding	**Funding PMPM**	**Total Expense (Claims+Admin)**	**Expense PMPM**		
July	1,138	2,549	$1,707,634	$669.92	$1,944,794	$762.96	-$237,159	113.9%
August	1,133	2,548	$1,699,529	$667.00	$1,652,113	$648.40	$47,415	97.2%
September	1,132	2,556	$1,700,247	$665.20	$1,575,314	$616.32	$124,933	92.7%
October	1,132	2,546	$1,730,267	$679.60	$2,145,497	$842.69	-$415,230	124.0%
November	1,133	2,546	$1,730,651	$679.75	$1,888,105	$741.60	-$157,454	109.1%
December	1,137	2,542	$2,557,671	$1,006.16	$2,077,085	$817.11	$480,586	81.2%
January 2024	1,125	2,520	$1,727,356	$685.46	$1,626,666	$645.50	$100,690	94.2%
February	1,127	2,523	$1,708,470	$677.16	$1,711,253	$678.26	-$2,784	100.2%
March	1,126	2,516	$1,688,854	$671.25	$1,858,045	$738.49	-$169,192	110.0%
April	1,117	2,482	$1,679,460	$676.66	$2,304,109	$928.33	-$624,650	137.2%
May	1,117	2,479	$2,498,993	$1,008.07	$1,736,550	$700.50	$762,443	69.5%
June	1,123	2,477	$1,671,684	$674.88	$1,367,923	$552.25	$303,761	81.8%
Year-to-Date Totals	**13,540**	**30,284**	**$22,100,815**	**$729.79**	**$21,887,454**	**$722.74**	**$213,361**	**99.0%**
% Change vs 22-23	**1.1%**	**-1.0%**	**1.6%**	**2.6%**	**13.9%**	**15.1%**		**12.2%**

FY2026 Total Cost Scenarios – Medical and Rx Plans

- Total Budget for current plan year (matching RFP enrollment of 1,134) is $23.3M. The City's portion of the budget is $17.84M; the remaining $5.46M comes from employee contributions.

- Based on prevailing healthcare cost increases, a Status Quo renewal for the Fiscal Year spanning July 1, 2025 – June 30, 2026 would be an approximate 5% increase. This increase of $1.16M would bring the total to $24.5M

- The City of Santa Fe received multiple responses to your Request For Proposal regarding Medical and Rx coverage for FY2026
- The most competitive of these reflected fixed costs (admin fees and Stop Loss insurance) of $2.65M and ESTIMATED net claims of $19.5M, for a total projected cost of $22.15M, or a 3.7% decrease.
  - This proposal and all scenarios reflect no plan design changes
  - All three existing plans would remain available, with no changes to deductibles, coinsurance percentages, or copay amounts for services

FY2026 Total Cost Scenarios – Medical and Rx Plans

- Aon performed underwriting projections for the FY2026 plans and our results lead us to accept that the bidder's claims cost projections are generally reasonable, but slightly on the aggressive side. As a result, we are presenting two potential scenarios below

- Aggressive Scenario – 3% decrease to budgets and rates
  - City costs: $17.30M, EE costs: $5.30M, Total Budget: $22.6M
  - Decrease of ($543K) City, ($166K) Employees, ($710K) Total

- Moderate Scenario
  - No change to City budgets or Employee Contribution bi-weekly rates
  - Consideration of Premium Holiday – eliminate one bi-weekly contribution during FY2026
  - City costs: $17.84M, EE costs: $5.25M (with Premium Holiday), Total Budget: $23.1M

FY2026 Renewal – Aggressive Scenario Contribution Impact – 3% Decrease

		Rate (City)	Rate (EE)	TOTAL
FY2025	**PREMIUM PLAN - AFSCME/POA/Non-Union**			
Tier	EMPLOYEE	$362.58	$111.38	$473.96
	EE & SPOUSE	$753.25	$231.38	$984.63
	EE & CHILD(REN)	$710.51	$218.23	$928.74
	EE & FAMILY	$866.62	$266.22	$1,132.84
FY2026	**PREMIUM PLAN - AFSCME/POA/Non-Union**			
Tier	EMPLOYEE	$351.53	$107.99	$459.52
	EE & SPOUSE	$730.29	$224.33	$954.62
	EE & CHILD(REN)	$688.86	$211.58	$900.43
	EE & FAMILY	$840.21	$258.11	$1,098.31
	Bi-Weekly Difference if City Implements Rate Reduction			
Difference	**PREMIUM PLAN - AFSCME/POA/Non-Union**			
Tier	EMPLOYEE	($11.05)	($3.39)	($14.44)
	EE & SPOUSE	($22.96)	($7.05)	($30.01)
	EE & CHILD(REN)	($21.65)	($6.65)	($28.31)
	EE & FAMILY	($26.41)	($8.11)	($34.53)

		Rate (City)	Rate (EE)	TOTAL
FY2025	**PREMIUM PLAN - FIRE UNION**			
Tier	EMPLOYEE	$400.37	$122.98	$523.35
	EE & SPOUSE	$831.72	$255.48	$1,087.20
	EE & CHILD(REN)	$784.50	$240.98	$1,025.48
	EE & FAMILY	$956.93	$293.93	$1,250.86
FY2026	**PREMIUM PLAN - FIRE UNION**			
Tier	EMPLOYEE	$388.17	$119.23	$507.40
	EE & SPOUSE	$806.37	$247.69	$1,054.07
	EE & CHILD(REN)	$760.59	$233.64	$994.23
	EE & FAMILY	$927.77	$284.97	$1,212.74
	PREMIUM PLAN - FIRE UNION			
	EMPLOYEE	($12.20)	($3.75)	($15.95)
	EE & SPOUSE	($25.35)	($7.79)	($33.13)
	EE & CHILD(REN)	($23.91)	($7.34)	($31.25)
	EE & FAMILY	($29.16)	($8.96)	($38.12)

As of December 2024, 91% of employees are enrolled in the Premium plan.
Similar impacts to Core and HRA plans

- City Contributions would decrease $543K to $17.3M
- Employee Contributions would decrease $166K to $5.3M
- Total Budget would decrease $710K to $22.6M

FY2026 Renewal – Contribution Impact Comparisons

Annual Difference Under Proposed Scenarios

PREMIUM PLAN - AFSCME/POA/Non-Union

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($86.58)	($111.38)	($24.80)
	EE & SPOUSE	($179.92)	($231.38)	($51.46)
	EE & CHILD(REN)	($169.52)	($218.23)	($48.71)
	EE & FAMILY	($206.96)	($266.22)	($59.26)

PREMIUM PLAN - FIRE UNION

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($95.68)	($122.98)	($27.30)
	EE & SPOUSE	($198.64)	($255.48)	($56.84)
	EE & CHILD(REN)	($187.20)	($240.98)	($53.78)
	EE & FAMILY	($228.54)	($293.93)	($65.39)

CORE PLAN - AFSCME/POA/Non-Union

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($82.68)	($106.39)	($23.71)
	EE & SPOUSE	($171.86)	($221.02)	($49.16)
	EE & CHILD(REN)	($157.82)	($203.09)	($45.27)
	EE & FAMILY	($197.60)	($254.30)	($56.70)

CORE PLAN - FIRE UNION

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($91.26)	($117.46)	($26.20)
	EE & SPOUSE	($189.54)	($244.04)	($54.50)
	EE & CHILD(REN)	($174.20)	($224.24)	($50.04)
	EE & FAMILY	($218.14)	($280.78)	($62.64)

HRA PLAN - AFSCME/POA/Non-Union

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($58.24)	($75.00)	($16.76)
	EE & SPOUSE	($147.16)	($189.29)	($42.13)
	EE & CHILD(REN)	($135.46)	($174.21)	($38.75)
	EE & FAMILY	($169.52)	($217.96)	($48.44)

HRA PLAN - FIRE UNION

Tier		3% Redux	Prem Holiday	Difference
	EMPLOYEE	($58.24)	($75.00)	($16.76)
	EE & SPOUSE	($162.50)	($209.01)	($46.51)
	EE & CHILD(REN)	($149.50)	($192.33)	($42.83)
	EE & FAMILY	($187.20)	($240.70)	($53.50)

- 3% Reduction: Employee Contributions would decrease $166K to $5.3M
- Premium Holiday: Employee Contributions would decrease $210K to $5.25M
- Under Premium Holiday, employees would contribute $16 to $65 less than under the 3% reduction
- Total Employee Savings is almost $50K greater via Premium Holiday

CITY OF SANTA FE, NEW MEXICO

RESOLUTION NO. 2005-52

INTRODUCED BY:

A RESOLUTION

CREATING A GROUP INSURANCE BENEFITS ADVISORY COMMITTEE FOR CITY EMPLOYEES.

WHEREAS, the crisis in health care costs has forced the city of Santa Fe to move its retirees to the state retiree health insurance plan ; and

WHEREAS, this decision was made based on input received from an employee committee;

WHEREAS, future costs of health care for city employees continues to escalate: and

WHEREAS, group insurance benefits should be procured, monitored and evaluated by those impacted in order to inform the governing body and insure that all city group insurance plans are in the best interests of the city and its employees.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE CITY OF SANTA FE that:

Section 1. NAME: A special committee, called the group insurance benefits advisory committee, is established.

Section 2. PURPOSE AND RESPONSIBILITIES.

A. The group insurance benefits advisory committee is formed for the purposes of advising the city manager and the governing body regarding group insurance benefits for city employees. The committee shall:

(1) Present to the governing body recommendations on group insurance issues within three months of the passage of this resolution;

(2) Review and advise the city manager on all group benefits coverages, whether insured or self-insured, included or to be included in the city group plans;

(3) Review and advise the city manager on all professional, technical or consulting contracts to be entered into in connection with city group plans; and

(4) Report annually by March 1 to the city manager and governing body on the effectiveness of the cost-containment measures required by this section.

B. The committee shall complete their responsibilities according to the following:

(1) The group insurance coverages considered may include, but are not limited to, life insurance, accidental death and dismemberment, hospital care and benefits, surgical care and treatment, medical care and treatment, dental care, eye care, obstetrical benefits, prescribed drugs, medicines and prosthetic devices, Medicare supplement, Medicare carveout, Medicare coordination and other benefits, supplies and services through the vehicles of indemnity coverages, health maintenance organizations, preferred provider organizations, and other coverages considered by the committee to be advisable;

(2) To the extent practicable, each basic plan of benefits recommended by the committee shall cover preexisting conditions; and

(3) Any group medical insurance plan recommended by the committee shall include effective cost-containment measures to control the growth of health care costs.

Section 3. DURATION: The committee is an on-going committee until such time as the governing body repeals or amends this resolution.

Section 4. MEMBERSHIP: The committee shall include one representative of each bargaining unit, one non-union employee and others designated by the city manager's office, including representatives from the human resources department and the finance department. Members of the committee shall serve terms of four years. If a member ceases to be a city employee, fails to attend three consecutive meetings of the committee or changes job classification inconsistent with the membership, that position shall be deemed vacant and filled accordingly.

Section 5. MEETINGS: The committee shall meet at least quarterly and provide opportunities for city employees to voice concerns and express opinions.

PASSED, APPROVED, and ADOPTED this 8th day of June, 2005.

LARRY A. DELGADO, MAYOR

ATTEST:

YOLANDA Y. VIGIL, CITY CLERK

APPROVED AS TO FORM:

BRUCE THOMPSON, CITY ATTORNEY

Jp/cmassign/misc com/group insurance benefits com res

25-0134 Blue Cross and Blue Shield of New Mexico

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