ADMINISTRATIVE SERVICES AGREEMENT

For Employer Account Number(s): 111003

IN WITNESS WHEREOF, the parties hereto have executed this Agreement 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 (Claim Administrator)

By: _____

Title: VP of Sales

Date: 1-5-15

Witness: _____

THE REGENTS OF THE UNIVERSITY OF NEW MEXICO, FOR ITS PUBLIC OPERATION KNOWN AS UNIVERSITY OF NEW MEXICO HOSPITALS (UNM Hospitals)

By: _____

Florencio Gallegos

Title: Purchasing Director

Date: 12/16/2014

By: _____

Stephen McKerman

Title: CEO, VP Hospital Operations

Date: 12/17/2014

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

RECITALS

WHEREAS, the Employer on behalf of the Group Health Plan has executed an ASO Benefit Program Application ("ASO BPA") and the Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 5, with such ASO BPA and this Agreement collectively referred to hereinafter as the "Agreement", unless specified otherwise; and

WHEREAS, the Employer has established and adopted an employee health benefit plan ("Plan") as described in its plan document, which shall be provided by the Employer to the Claim Administrator; and

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

WHEREAS, it is desirable to set forth more fully the obligations, duties, rights and liabilities of the Claim Administrator and the Employer, as representative of the Group Health Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree as follows:

SECTION 1: APPOINTMENT

The Employer hereby retains and appoints the Claim Administrator to provide services as hereinafter described in connection with the administration of the Plan.

SECTION 2: AGREEMENT DEFINITIONS

2.1 **"Administrative Charge"** means the monthly service charge that is required by the Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is indicated in the most current Fee Schedule specifications of the most current Exhibit 5 - ASO BPA of this Agreement.

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

a. ***For Medical 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.

b. ***For Medical Providers other than Medical Network Providers ("Non-Contracting Providers")*** - The Allowable Charge will be the lesser of: **(i)** the Provider's billed charges, or; **(ii)** the 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 the Claim Administrator. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Claim Administrator and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Claim Administrator does not have

any claim edits or rules, the 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 the 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 will 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 the 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 Group Health Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts – not to exceed billed charges:

(i) the median amount negotiated with Network or Contracting Providers for Emergency Care Services furnished;

(ii) the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the In-Network or contracting cost-sharing provisions for the Out-of Network Provider services, but substituting the In-Network or contracting cost-sharing provisions for the Out-of-Network or Non-Contracting Provider cost-sharing provisions; or

(iii) the amount that would be paid under Medicare for the Emergency Care Services.

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

c. 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 Blue Shield of New Mexico or with the local Blue Cross and Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and 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.

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

(i) **Participating Pharmacy** – the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.

(ii) **Out-of-Network Pharmacy** – the Pharmacy's usual charge, not to exceed the amount the Plan would reimburse a Participating Pharmacy for the same service.

e. ***For Covered Dental Services,*** if dental benefits coverage is elected on the most current Exhibit 5 – ASO BPA, the Allowable Charge is determined in accordance with the type of dental benefits coverage elected:

(i) **Participating Dentist** – the amount the Dentist has agreed to accept as full payment for Covered Services.

(ii) **Out-of-Network Dentist** – Please refer to Plan Summary/Summary Plan Description for criteria used to establish the Out-of-Network Allowable Charge.

2.3 **"Alternative Compensation Arrangement Payments"** means additional payments made to Network Providers for Covered Services for which no formal Claim form may be submitted, including, but not limited to, capitation payments, performance based reimbursement payments, care coordination payments, and other alternative funding arrangements as set forth in Claim Administrator's arrangement with the Network Provider.

2.4 **"Certificate of Creditable Coverage"** means a document which is generated for Covered Persons terminating coverage under the Plan. The certificate is provided to Covered Persons as evidence for credit of health coverage held under the Plan during the term of this Agreement.

2.5 **"Claim"** means notification in a form acceptable to the Claim Administrator 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, the date of service, applicable diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection for such service.

2.6 **"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.

2.7 **"Claim Payment"** means the benefit calculated by the Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan. All Claim Payments shall be calculated on the basis of the Provider's Allowable Charge for Covered Services rendered to the Covered Person. Claim Payment also includes Employer's pro rata share of Alternative Compensation Arrangement Payments.

2.8 **"Covered Employee"** shall have the same meaning as defined in the Employer's Plan.

2.9 **"Covered Person"** shall have the same meaning as defined in the Employer's Plan.

2.10 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided.

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

2.12 **"Fee Schedule"** means the specifications setting out certain particulars of this Agreement as set forth in Exhibit 5 – ASO BPA of this Agreement including, but not limited to, the Administrative Charge and other service charges; or any such other subsequent set of specifications supplied by the Claim Administrator as set forth in a subsequent ASO BPA as replacement to the initial Exhibit 5 – ASO BPA. The specifications or items of 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 such Exhibit 2's "COMPENSATION TO CLAIM ADMINISTRATOR" provisions.

2.13 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of this Agreement.

2.14 **"Group Health Plan"** means, as applied to this Agreement, the self–insured employee health benefit plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996.

2.15 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.16 **"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 the Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option health benefits coverage program, if applicable to the Plan under this Agreement.

2.17 **"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.

2.18 **"Supplemental Charge"** means a charge for costs due and payable to the Claim Administrator by the Employer that is separate and apart from the service charges detailed in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of this Agreement. 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 Fee Schedule specifications of the most current Exhibit 5 – ASO BPA. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in writing prior to the Claim Administrator's performance and/or provision of such.

2.19 **"Surcharges"** means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to World Access Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or alternate program amounts) (the "Reinsurance Contribution"), paid by the Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

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

a. With respect to all payments due the Claim Administrator by the Employer under this Agreement, within ten (10) calendar days of notification of the Employer by the Claim Administrator; or

b. With respect to all information due the Claim Administrator by the 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 the Claim Administrator by the 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.

2.21 **"World Access Fee"** means the Surcharge imposed upon the Claim Administrator under the BlueCard® Worldwide program for the administration of an international Claim.

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR

3.1 ***Subcontractors.*** During the continuance of this Agreement, the Claim Administrator will perform such services as set forth in Exhibit 1 of this Agreement, attached hereto and made a part hereof. The Claim Administrator, at its sole discretion, may contract with other entities for performance of any of the services to be performed by the Claim Administrator hereunder; provided, however, the Claim Administrator shall remain fully responsible and liable for performance of any such services to be performed by the Claim Administrator but delegated to other entities.

3.2 ***Subsidiaries.*** Any of the services to be performed by the Claim Administrator under this Agreement may be performed by the Claim Administrator, or any of its subsidiaries (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written approval by the Employer. Any reference in this Agreement to the Claim Administrator shall include its directors, officers and employees as well as the directors, officers and employees of any of its subsidiaries and the Claim Administrator shall be responsible and liable for all performance or failure to perform by such subsidiaries in connection with this Agreement.

SECTION 4: CERTAIN RESPONSIBILITIES OF THE EMPLOYER AND THE CLAIM ADMINISTRATOR

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

4.2 ***Claim Administrator responsibility.*** The 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 the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by Employer or by or through Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

4.3 ***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. The Employer shall undertake the defense of such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. 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.

4.4 ***Claim overpayments.*** The Employer acknowledges that unintentional administrative errors may occur. When the Claim Administrator becomes aware of a Claim overpayment, the Claim Administrator will make a diligent attempt to recover any such payment. The Claim Administrator will be required to reimburse the Plan for overpayment of claims in the amount of $10,000 or greater per claim which arise due to gross negligent acts by the Claim Administrator. The 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 the Claim Administrator be required to reimburse the Plan, except for gross negligence or intentional acts by the Claim Administrator.

4.5 ***Required Plan information.*** The Employer shall furnish on a Timely basis to the Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by the Claim Administrator for the performance of its duties including, but not limited to, the following:

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

b. All data as may be required by the Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

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

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

4.7 ***Claim information disclosure.*** The Claim Administrator will disclose Claim information in accordance with HIPAA privacy regulations and the Business Associate Agreement entered into by the parties.

4.8 ***Electronic exchange of information.*** In the event the Employer and the Claim Administrator exchange various data and information electronically, the Employer agrees to transfer on a Timely basis all required data to the Claim Administrator via electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, the Employer is responsible for maintaining any enrollment applications and change forms completed by Covered Persons and to allow the Claim Administrator reasonable access to this information as needed for administrative purposes.

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

SECTION 5: THIRD PARTY DATA RELEASE

5.1 ***Types of Data.*** In the event the Employer directs the Claim Administrator to provide data directly to its third party consultant and/or vendor and the Claim Administrator accepts, the Employer acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

a. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 5, "Confidential Information").

b. Release of the Confidential Information may also reveal the Claim Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 5, "Proprietary Information").

c. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 5, collectively, "Information").

d. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.

5.2 ***Third party obligations.*** The third party consultant and/or vendor shall:

a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Employer.

b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Employer.

c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.

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

e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.

f. Execute the Claim Administrator's then–current confidentiality agreement.

5.3 ***Employer obligations.*** The Employer shall:

a. Designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

b. Provide the Claim Administrator with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

As provided in this Agreement, the Claim Administrator will receive eligibility information, review and process Claims, and respond to customer inquiries; however, the Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan. Therefore, in certain instances, the Claim Administrator may refer certain Claims to the Employer for review and final decision. Such referral shall be at the sole discretion of the Claim Administrator.

SECTION 7: CLAIM DISPUTE RESOLUTION

7.1 ***Claim Appeals.*** After exhaustion of all remedies offered by the Claim Administrator, a Covered Person may appeal all adverse determinations with the Employer. The Claim Administrator will cooperate in providing Claim information pursuant to Section 4.7 above.

7.2 ***Claim Reviews.*** On occasion the Claim Administrator may deny all or part of submitted Claims. The Claim Administrator will provide a full and fair review of any determination of a Claim, any determination of a request for pre–notification, and any other determination made in accordance with the benefits and procedures detailed in the Plan.

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES

Employer delegates to Claim Administrator the discretion to interpret Plan language related to benefits, to make all claim determinations concerning the availability of benefits, and to conduct all administrative internal appeals involving the approval or denial of claims payments. In delegating claims processing and payment services, Employer acknowledges and agrees that Claim Administrator shall have full and final authority with respect to final review and benefit determinations for appealed claims and that Employer shall have no discretionary authority with respect to review, appeal, or determination of such claims; that Claim Administrator shall allow no exceptions to benefit determinations, except as such exceptions are applied consistently to all *Covered Persons*; that Claim Administrator shall not determine eligibility of participants to enroll as *Covered Persons*; eligibility shall be determined by Employer and provided to Claim Administrator in accordance with Section 4 of the Agreement; and Claim Administrator shall have no responsibility or fiduciary duty except as set forth in this Agreement, and no responsibility or fiduciary duty with respect to services performed by Employer, Employer' other vendors and Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contractors and subcontractors of any type.

8.1 ***Employer authority and responsibility.*** The Employer retains the final authority and responsibility to establish and construe the terms and conditions of the Plan and to determine Covered Persons' eligibility.

8.2 ***Referrals to Employer.*** Certain claims and/or inquiries will be referred to the Employer for final review and determination in the following instances:

a. When Claims for services do not appear to qualify for payment under the Plan, claims or inquiries where there is a question of eligibility, claims where there is a question as to the amount of payment due, and claims involving litigation or the threat of litigation; and

b. When a Covered Person chooses to appeal adverse determinations with the Employer after exhaustion of all remedies offered by the Claim Administrator.

SECTION 9: COOPERATION OF THE PARTIES

The parties shall use their best efforts to cooperate with and assist each other, as applicable, in the performance of their duties under this Agreement.

SECTION 10: HIPAA/CERTIFICATE OF CREDITABLE COVERAGE

10.1 ***HIPAA requirement.*** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the preparation and distribution of a Certificate of Creditable Coverage to individuals who terminate coverage under the Employer's Group Health Plan.

10.2 ***Responsible party.*** In accordance with the Employer's election indicated on the most current Exhibit 5 – ASO BPA of this Agreement:

a. ***If the Employer elects the Claim Administrator to issue certificates,*** the Claim Administrator shall issue a Certificate of Creditable Coverage consistent with the requirements under HIPAA. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of this Agreement and information provided to the Claim Administrator by the Employer.

b. ***If the Employer does not elect the Claim Administrator to issue certificates,*** the Employer acknowledges that the Claim Administrator is not the Group Health Plan issuer offering group coverage under the Group Health Plan nor the plan administrator and, therefore, the Claim Administrator has no obligation to prepare or distribute a Certificate of Creditable Coverage. The Employer further acknowledges that the obligation to provide such Certificate of Creditable Coverage is the obligation of the Employer.

SECTION 11: INDEMNIFICATION AND LIABILITY

11.1 ***Claim Administrator indemnifies Employer.*** The Claim Administrator hereby agrees to indemnify and hold harmless the Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to the Plan or this Agreement resulting from or arising out of any acts or omissions of the Claim Administrator or its directors, officers or employees which have been adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment errors by the Claim Administrator.

11.2 ***Indemnification and Liability.*** As between the parties, each party acknowledges that it will be responsible for claims or damages arising from personal injury or damage to persons or property to the extent they result from gross negligence of that party's employees performing the parties' responsibilities and obligations set forth in this agreement. The liability of the parties will be subject in all cases to the immunities and limitations of the New Mexico Tort Claims Act, Sections 41-4-1 et seq. NMSA 1978, as amended. The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator

11.3 **Examples of actions brought against Claim Administrator.** The following list is intended to exemplify types of actions related to design and administration of the Plan(s), but not to allocate indemnification responsibility with respect to such examples, which shall be determined in accordance with Section 11.1 or 11.2, as applicable.

a. Any claim in connection with a claim for benefits under the Plan.

b. Any claim based upon the disclosure of any information regarding a Covered Person by the Claim Administrator to the Employer.

c. Any claim in connection with un–Timely and/or inaccurate eligibility data or Claim information data provided by the Employer to the Claim Administrator, or any such data provided by the Employer in a format not approved by the Claim Administrator.

d. Any claim arising from the Employer's use or posting of electronic files on the intranet and/or internet pursuant to Section 17 below.

e. Any claim that may arise from or in connection with the Claim Administrator's suspension of Claim Payments due to the Employer's failure to pay when due any amounts owed the Claim Administrator under this Agreement and/or the termination of this Agreement in accordance with Section 13.2 below.

f. Any claim arising from the Employer's directive to the Claim Administrator to print Employer–assigned unique identification numbers on membership identification cards or to otherwise use such assigned numbers in violation of any applicable federal, state and local rules, laws and regulations.

g. Any claim based upon Medicare Secondary Payer ("MSP") laws or regulations including, but not limited to, the untimely and/or inaccurate provision by the Employer to the Claim Administrator of Employer Acknowledgment Forms ("EAFs") as and when requested by the Claim Administrator.

h. Any claim that may arise from or in connection with the Claim Administrator's issuance of Certificate(s) of Creditable Coverage, if elected on the most current Exhibit 5 – ASO BPA, based upon un–Timely and/or inaccurate data provided by the Employer to the Claim Administrator with respect to individuals whose coverage under this Agreement terminates.

i. Any claim arising from the Employer's directive to the Claim Administrator to include mutually agreed upon Employer Summary Plan Description information in Claim Administrator prepared benefit booklets for distribution to Covered Persons.

j. Any claim arising from Plan documentation and compliance with reporting and disclosure requirements of federal regulations applicable to the Plan Document and Summary Plan Description.

k. Any claim that may rise from or in connection with the Claim Administrator's issuance of written statements of creditable coverage and/or the filing of electronic reports to the Massachusetts Department of Revenue, if elected on the most current Exhibit 5 – ASO BPA, based upon untimely and/or inaccurate data or certification provided by the Employer to the Claim Administrator with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS

12.1 ***Employer audits Claim Administrator.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Employer or an authorized agent of the Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to the 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 and the benefits specified in the Plan(s). The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are deemed to have an inherent conflict of interest and will not be supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) randomly selected Claims. The Claim Administrator will be responsible for mutually agreed upon audit costs up to 50%, not to exceed a total of $25,000, in the only situation where the parties agree that an audit is appropriate and necessary. 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 the Claim Administrator's current external audit policy and procedures, a copy of which shall be furnished to the Employer upon request to the 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 twenty-four (24) consecutive-month period, except as required by state or federal government agency or regulation. The Employer and such agent that have access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary information authorized agent of the Employer shall hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with the Claim Administrator that sets forth the terms and conditions of the audit.

12.2 ***Errors identified.*** The Claim Administrator shall be responsible only for the correction of errors identified in specific Claim Payments subject to the terms and conditions of the Agreement and shall not be responsible for errors calculated to exist in a population of Claim Payments on the basis of a sample drawn from that population. Further, the Claim Administrator has the right to implement reasonable administrative practices in the administration of this Agreement.

12.3 ***Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Claim Administrator may, upon at least thirty (30) days prior written notice to the Employer, conduct reasonable audits of Employer's membership records with respect to eligibility.

SECTION 13: TERM AND TERMINATION OF AGREEMENT

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

13.2 ***Termination.*** This Agreement may be terminated as follows:

a. By either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA 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 either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Agreement, upon written notice as provided under Section 22 below; or

d. By the Claim Administrator, upon the Employer's failure to pay 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 Exhibit 5 – ASO BPA.

13.3 ***Notification of Covered Employees.*** If this Agreement is terminated pursuant to this Section 13, the Employer agrees to notify all Covered Employees. The parties agree that the Employer will give such notice because the Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 14: RELATIONSHIP OF PARTIES

14.1 ***Regarding the parties.*** The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

14.2 ***Regarding non-parties.*** It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of the Employer and their dependents.

14.3 ***Exclusivity.*** The Employer agrees not to engage any other party to perform the same services that the Claim Administrator performs hereunder while this Agreement is in effect, unless the Employer gives notice of termination pursuant to the terms of this Agreement.

14.4 ***Assignment.*** Except as otherwise permitted by Section 3 above, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Claim Administrator's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment under this Agreement.

SECTION 15: NON ERISA GOVERNMENT REGULATIONS

15.1 *In relation to the Plan.* Although the Employer is exempt from ERISA, the Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other plan document of the Employer is effective with respect to or accepted by the Claim Administrator.

15.2 *In relation to the Plan Administrator/Named Fiduciary(ies).* The Claim Administrator is not the plan administrator of the Employer's separate employee benefit plan and is not a fiduciary of the Employer, the plan administrator or of the Plan.

15.3 *In Relation to the Claim Administrator's Responsibilities.* The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Employer's plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer's employee benefit plan. The Employer acknowledges and agrees that the Claim Administrator may render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer's benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's employee benefit plan.

SECTION 16: PROPRIETARY MATERIALS

16.1 ***Types of materials as used by the parties.*** The parties acknowledge that each party has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). Neither party shall use or disclose to any third party

Business Proprietary Information without prior written consent of the other party. 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 the Claim Administrator may include the Employer in its list of clients.

16.2 ***Claim Administrator/Association ownership.*** The Employer acknowledges that the Claim Administrator's Proprietary Marks and Business Proprietary Information are the sole property of the Blue Cross and Blue Shield Association or of the Claim Administrator and agrees not to contest the Blue Cross and Blue Shield Association's or the Claim Administrator's ownership or the license granted to the Claim Administrator for use of such Proprietary Marks.

16.3 ***Infringement.*** The Claim Administrator agrees not to infringe upon, dilute or harm the Employer's rights in its Proprietary Marks. The Employer agrees not to infringe upon, dilute or harm the Blue Cross and Blue Shield Association's ownership rights or the Claim Administrator's rights as a licensee in its Proprietary Marks.

16.4 ***Disclosures in Account Contracts.*** The Employer on behalf of itself and its participants hereby expressly acknowledges its understanding this agreement constitutes a contract solely between the Employer and the Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Cross Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting the Claim Administrator to use the Blue Cross and Blue Shield Service Mark ,and that the Claim Administrator is not contracting as the agent of the Association. The Employer on behalf of itself and its participants further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than the Claim Administrator and that no person, entity, or organization other than the Claim Administrator shall be held accountable or liable to the Employer for any of the Claim Administrator's obligations to the Employer created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Claim Administrator other than those obligations created under other provisions of this agreement.

16.5 ***Administrative Services Only, Network Only.*** The Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to claims liability; and disclose the nature of the services and/or network access the Claim Administrator is providing. Such disclosures must be made to the account, the account's covered individuals, and providers and must include, at a minimum, disclosure on identification cards, benefit booklets, account contracts and explanation of benefits documentation.

SECTION 17: ELECTRONIC DOCUMENTS

17.1 ***Employer consent/intended use.*** The Employer consents to receive via an electronic file or access to an electronic file any document the Employer requests from the Claim Administrator describing the benefits under, or the administration of, the Plan.

17.2 ***Employer acknowledgement/responsibilities.*** The Employer further acknowledges and agrees that it is responsible for providing employees access, via the intranet, internet, or otherwise, to the most current version of any electronic file provided to the Employer by the Claim Administrator at the Employer's request. In addition, in all instances, the electronic file of the most current document issued to the Employer by the Claim Administrator for use by the Employer is the legal document used to administer the Employer's Plan and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from the use or posting of the electronic file on the intranet and/or internet.

SECTION 18: RECORDS

All Claim records, excluding any and all of the Claim Administrator's Business Proprietary Information, in the possession of the Claim Administrator are and shall remain the property of the Employer upon termination of this Agreement. The Claim Administrator shall return such property upon request in a form as agreed upon by the parties at the cost of preparing such property for transmittal to be borne by the Employer. All such Claim records shall be retained by the Claim Administrator

until the Claim Administrator receives a request from the Employer for transmittal or for a period of ten (10) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 19: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of New Mexico without regard to any state choice–of–law statutes, and any applicable federal law. All disputes arising out of this Agreement will be resolved in New Mexico.

SECTION 20: ENTIRE AGREEMENT

20.1 ***Definition.*** This Agreement, including all Exhibits and Addenda, represents the entire agreement and understandings of the parties hereto and all prior agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof, including any proposal document submitted by the Claim Administrator to the Employer pursuant to this Agreement, are and have been merged herein to the extent applicable. In the event of a conflict, the provisions of this Agreement and the Exhibits and Addenda of this Agreement shall prevail.

20.2 *Components.* The Exhibits and Addenda of this Agreement as of the Agreement's effective date are:

- Exhibit 1 - Claim Administrator Services
- Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- Exhibit 3 – Recovery Litigation Authorization
- Exhibit 4 - COBRA Health Benefits Continuation Coverage (if elected on the ASO BPA)
- Exhibit 5 - ASO Benefit Program Application (ASO BPA).
- Exhibit 6 – Stop Loss
- Exhibit 7 – Performance Guarantees
- Exhibit 8 – Proposed Costs and Pricing

20.3 ***Amending.*** This Agreement may be amended or altered in any of its provisions, including the addition or deletion of any Exhibits and/or Addenda as provided herein, by the parties hereto and any such change shall become effective when reduced to writing and signed by an authorized representative of the parties or at such time as said amendment may provide.

SECTION 21: LIMITATIONS

No civil action shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA.

SECTION 22: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement, the Employer and the Claim Administrator agree to give one another written notice (pursuant to Section 26 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) 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.

SECTION 23: LIMITATION OF LIABILITY

Liability for any errors or omissions by the Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this

Agreement, shall be limited to the maximum benefits which should have been paid under this Agreement had the errors or omissions not occurred (including the Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence or intentional breach of a duty under this Agreement by the Claim Administrator.

SECTION 24: DISPUTE RESOLUTION/ARBITRATION

24.1 ***Initial negotiation.*** Any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 24, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 24 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

24.2 ***Deferring to arbitration/selecting an arbitrator.*** In the event the parties fail to agree with respect to any matter covered herein, the question in dispute shall be submitted for arbitration in New Mexico. The arbitrator shall be selected as follows:

a. Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;

b. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of $200, the American Health Lawyers Association shall recommend an arbitrator; or

c. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is $200 or less, the Claim Administrator shall select an independent third party to be the arbitrator.

24.3 ***Expectations.*** The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Health Lawyers Association then in effect.

SECTION 25: OBLIGATION TO CONTINUE PERFORMANCE

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

SECTION 26: NOTICES

26.1 ***How to notify.*** All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current Exhibit 5 - ASO BPA of this Agreement.

26.2 ***Change of address.*** Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party.

SECTION 27: SEVERABILITY

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.

SECTION 28: ENFORCEMENT

Any delay or inconsistency in the enforcement of any part of this Agreement shall not constitute a waiver of any rights with respect to the enforcement 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.

SECTION 29: FORCE MAJEURE

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 or restraints of government.

SECTION 30: ELIGIBILITY FOR PARTICIPATION IN GOVERNMENT PROGRAMS

Each party represents that neither it, nor any of its management or any other employees or independent contractors who will have any involvement in the services or products supplied under this Agreement, have been excluded from participation in any government healthcare program, debarred from or under any other federal program, or convicted of any offense defined in 42 U.S.C. Section 1320a-7, and that it, its employees, and independent contractors are not otherwise ineligible for participation in federal healthcare programs. Further, each party represents that it is not aware of any such pending action(s) (including criminal actions) against it or its employees or independent contractors. Each party shall notify the other party immediately upon becoming aware of any pending or final action in any of these areas.

SECTION 31: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

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

SECTION 32: CLAIM ADMINISTRATOR USE OF THIRD PARTY RECOVERY VENDOR

Recoveries from healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, data mining, utilization review refunds, and unsolicited refunds. The 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 the Claim Administrator's refund recovery policies, which generally require correction on a Claim-by Claim basis. Third parties' audit fees associated with such audits and the Claim Administrator's fee for its related administrative expenses to support such third party audits will be paid by the Employer.

SECTION 33: NOTICE OF ANNUAL MEETING

The 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. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Agreement, 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.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

  Examination of Claims and determination of payment levels, including data entry of Claims by Claims departments, maintenance of Claims experience files, use of medical consultants, review of utilization and reasonable and customary charges; and, if dental benefits coverage is elected on the most current Exhibit 5 – ASO BPA, use of dental consultants and review of Usual and Customary Fees and Coordination of Benefits (COB).

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

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

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in other performance based reimbursement and alternative provider compensation arrangements as applicable based on Covered Person criteria established by Claim Administrator. Employer agrees that certain benefits will be covered at 100% when a Covered Person meets these criteria and participates in a medical home program, and will make any necessary benefit plan changes.

- **ENROLLMENT SERVICE**

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

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

  e. ***Medical Pre–certification Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require pre–certification, advance Claim Administrator review of medical necessity of such services covered under the Plan; access to toll–free medical pre–certification helpline for Covered Persons and their health care providers to call for assistance.

- **MEMBERSHIP VALIDATION**

  Verification of membership by wire, listing, electronic on–line query or other method prior to or during adjudication.

- **MEMBERSHIP FILE UPDATES**

  Maintenance of membership status files, processing of inter–plan transfers and processing of contract changes.

- **OTHER MEMBERSHIP SERVICES**

  Contact Employer and/or Covered Employees regarding adding, changing or renewing coverage.

- **STANDARD REPORTS**

  Make available Claim data, Claim Settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased 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 by the Plan for those services.

- **ACTUARIAL AND STATISTICAL**

  Determination of claims projections and pricing of administrative services and stop–loss coverage.

- **FINANCIAL SERVICES**

  Financial functions such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlement and wire transfers.

- **UNCASHED CHECKS**

  Regarding outstanding checks that are or become "stale" (over 365 days old), issue notification letters to payees and upon completion of notification process, reissue such checks to payees based upon payee response, if any. When check reissuance is not possible and unless stated otherwise in the Agreement, escheat such checks to state of payee's last known residence on behalf of Employer or escheat amounts pursuant to such checks to Employer, as elected by the Employer, less any amount(s) owed by payee to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud; address any related recovery litigation as set forth in Exhibit 3 of the Agreement.

- **BLUE ACCESS® FOR EMPLOYERS**

  Provides Employer on–line access to conduct a variety of secure membership, enrollment, reporting, administrative and billing transactions faster, more accurately and in real–time.

- **BLUE ACCESS® FOR MEMBERS**

  An on–line resource for personalized information about a Covered Person's health care coverage, including, but not limited to, Claims status, email notification when a Claim has been finalized, access to health and wellness information, verification of dependents covered on their plan and health risk assessment and such other services as become 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 within the designated service area.

- **CERTIFICATE OF CREDITABLE COVERAGE** ***(If elected on the most current Exhibit 5 – ASO BPA)***

  At the direction of Employer, issuance of Certificates of Creditable Coverage.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING** ***(If elected on the most current Exhibit 5– ASO BPA)***

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

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 2, Section 15 entitled "MEDICARE SECONDARY PAYER ("MSP") 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.

- **BLUE CARE CONNECTION® PROGRAM** ***(If elected on the most current Exhibit 5 – ASO BPA)***

  A program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by the Employer.

- **DISEASE/CARE MANAGEMENT PROGRAM(S)**

  Any disease and/or care management program(s) as elected on the most current Exhibit 5 - ASO BPA.

- **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.

EXHIBIT 2

FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current Exhibit 5 – ASO BPA of the Agreement. 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; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA; and iii) the date the Agreement is terminated.

Inter-Plan Program Fees:

i. **BlueCard® Program/Network Access 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);

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

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

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 2 AGREEMENT DEFINITIONS of the Agreement.

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

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

2.3 **"Employer Payment"** means the amount owed or payable to the Claim Administrator by the Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit.

2.4 **"Employer Payment Method"** means the method elected in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement by which Employer Payments will be made.

2.5 **"Employer Payment Period"** means the time period indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement.

2.6 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 15 of this Exhibit titled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING.")

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

2.8 **"Run–Off Period"** means the time period immediately following termination of the Agreement, as indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement, during which the Claim Administrator will accept Run–Off Claims submitted for payment.

2.9 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule of the most current Exhibit 5 – ASO BPA of the Agreement that is required by the Claim Administrator upon termination of the Agreement, including any services that may be performed by the Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** The Employer will pay service charges to the Claim Administrator, in accordance with the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement, as compensation for the processing of Claims and administrative and other services provided to the Employer.

3.2 ***Determining service charges.*** The service charges, which are guaranteed for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement, have been determined in accordance with the Claim Administrator's current regulatory status and the Employer's existing benefit program.

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

a. At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement, provided that sixty (60) days prior written notice is given by the Claim Administrator;

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

c. On any date changes imposed by governmental entities increase expenses incurred by the 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 (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate; or

f. On any date an affiliate, subsidiary, or other business entity is added or dropped by the 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, the Employer will pay to the Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement.

3.5 ***Identifying service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement, the Claim Administrator may charge the Employer for:

a. Any applicable Supplemental Charge(s);

b. Reasonable fees for the reproduction or return of Claim records requested by the 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 the Employer and/or any other fees for services mutually agreed upon by the parties in writing.

3.6 ***Effect of Plan enrollment.*** Administrative Charges will be paid based upon information the 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 the Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed the Claim Administrator by the Employer.

SECTION 4: CLAIM PAYMENTS

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

4.2 ***Employer's liability.*** Any reasonable determination by the 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 the Employer to the Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

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

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

SECTION 5: EMPLOYER PAYMENT

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

5.2 ***Confirmation or notification of amount due and payment due date.*** The Employer shall confirm with the Claim Administrator or the Claim Administrator shall notify the Employer's Financial Division, of the Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with the Employer Payment Method elected in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement and the following:

a. ***If the Employer Payment Method is by check,*** the Claim Administrator shall issue the Employer a settlement statement to include the Claim Administrator's mailing address for check remittance and the date payment is due.

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

5.3 ***Federal Regulation of Employer.*** Beginning in 2014 (or such other date required by law), Employer will be responsible for contributing to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. In no event will Claim Administrator be responsible for the reinsurance contribution. If required by applicable law, Employer will promptly forward to Claim Administrator all such contributions (or successor or alternate program amounts) and all information necessary for the calculation or administration of such contributions (or successor or alternate program amounts).

Late payments are subject to the penalties outlined in Section 7 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining what Employer owes.*** A Claim Settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA of the Agreement. The Claim Settlement shall reflect the sum of the following:

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

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

c. The Administrative Charges and Credits and other applicable service charges as indicated in the Fee Schedule specifications of the most current Exhibit 5 – 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 the Employer Payments, the Employer will pay the difference to the Claim Administrator. The Claim Settlement will be determined within thirty (30) days from the last day of the Claim Settlement Period. The Claim Administrator will notify the Employer in writing of the results of the Claim Settlement. Any sums due the Claim Administrator will be paid Timely by the Employer.

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

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer fails to pay.*** If the Employer fails to pay when due any amount required to be paid to the Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to the Employer, the 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 28 ENFORCEMENT of the Agreement, the Claim Administrator's failure to provide the 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 the Employer.

7.3 ***Late charge.*** If the Employer fails to make any payment required by the Agreement on a Timely basis, the Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to the Claim Administrator by the 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 the 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 the Claim Administrator to the Employer (including any and all contractual obligations of the Claim Administrator to the Employer) may be offset and/or recouped and applied toward the payment of the Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run-Off Claims.*** The 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 13 of the Agreement, 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 the Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Claim Administrator ("Run–Off Claims"). The 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 the Claim Administrator, as of the date of termination, including, but not limited to, Claim Payments made in accordance with Medicare Secondary Payor (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 Exhibit 5– ASO BPA of the Agreement and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date.

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

8.3 ***Final Settlement.*** A Final Settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This Final Settlement shall compare the 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 the Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the Final Settlement, the Claim Administrator shall pay such difference to the Employer after applying the difference against amounts, if any, then owed to the Claim Administrator by the Employer.

8.4 ***Uncashed checks.*** As of the date of termination of the Agreement, any outstanding checks that are or become "stale" (over 365 days old) will be escheated by the Claim Administrator, on the Employer's behalf, less any amount(s) owed by such checks' payees to Claim Administrator, in accordance with the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

The Employer represents that it acknowledges and has communicated the provisions stated in each of the following Sections to its Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim payment assignment.*** All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or Provider furnishing Covered Services. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***Claim dispute.*** Once Covered Services are rendered by a Provider, the Covered Person has no right to request the 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, the Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

10.3 ***Plan coverage assignment.*** Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non–assignable or non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the 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 the Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing a Provider.*** The choice of a Provider is solely the choice of the Covered Person and the Claim Administrator will not interfere with the Covered Person's relationship with any Provider.

11.2 ***Claim Administrator's role.*** It is expressly understood that the Claim Administrator does not itself undertake to furnish hospital, medical or dental service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by the Claim

Administrator. Any contractual relationship between a Provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional service.

11.3 ***Intent of terminology.*** The use of an adjective such as Approved, Administrator, Participating, In-Network or Network in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Approved, Administrator, Participating, In-Network, Network or any similar modifier or the use of a term such as Non-Approved, Non-Administrator, Non-Participating, Out-of-Network or Non-Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

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

SECTION 12: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

12.1 All amounts payable to the Claim Administrator by the Employer for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required Copayment, deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Outpatient Prescription Drug Program Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Claim Administrator, whichever is less.

12.2 The Claim Administrator hereby informs the Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("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 the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual network savings achieved by the Employer will vary. Some rates are currently based on Average Wholesale Price ("AWP"), which is determined by a third party and is subject to change.

12.3 The Employer understands that the Claim Administrator may receive such discounts during the term of the Agreement. Neither the Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be passed-through to the Employer for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator (and ultimately to the Employer as described above). For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which is reflected in the administrative fee charged by Claim Administrator to the 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. The allowable amount reimbursed for prescriptions obtained at out-of-network pharmacies is determined by the Employer's benefit design, but is usually based on 75% of the cost of the prescription if it were obtained at an in-network pharmacy.

12.4 "Weighted paid claim" refers to the methodology of counting claims for purposes of determining the Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, Claim Administrator pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which Claim Administrator funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by Claim Administrator, may include rebates and retail spread. Claim Administrator's net fee owed to Prime for core services

will be offset by the Funding Levers. Claim Administrator pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

12.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to the Employer as expenses, or accrue to the benefit of the Employer, unless otherwise specifically set forth in the Agreement. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and other Blue Plan operating divisions.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

13.1 The Claim Administrator hereby informs the Employer and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC and that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC 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 the 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. Pharmacy Benefit Managers may share a portion of those rebates with the Claim Administrator.

13.2 The Claim Administrator has estimated that drug rebates credited to the Employer during the policy year would be based on an average dollar amount per prescription ("Expected Rebate"). One-hundred percent (100%) of the Expected Rebate is shared with Employer based upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Employer is determined by multiplying the minimum guaranteed rebates by channel, times the expected number of annual prescriptions dispensed, then divided by the expected number of Covered Employees, then divided by twelve months. The total Rebate amount is reflected as a prescription drug rebate credit per Covered Employee per month.

The greater of 100% of the rebate credit based on the total claim counts times the minimum guarantees, stated below, shall be credited to the Employer on a PEPM basis, monthly, via BARS bill.

Not more than 120 days after the end of each calendar year, BCBSNM shall determine the actual amount of the prescription drug rebate for the Employer for the prior calendar year ("Actual Rebate"). The Actual Rebate shall be determined by multiplying the actual rebate per claim for the prior calendar year, as determined by the Pharmacy Benefit Managers, times the number of prescriptions dispensed for Covered Persons for the prior calendar year. No later than 180 days after the end of the prior calendar year, BCBSNM shall perform a true-up to reconcile the minimum guaranteed Monthly pepm rebates with the Actual Rebate amounts so that the Actual Rebate only is applied to administrative fees for the prior calendar year. Any additional credits or charges resulting from such reconciliation shall be credited to the designated UNMH account. BCBSNM will pay UNMH all rebates received within 24 months after the termination of the agreement.

13.3 The Employer understands that the Claim Administrator may receive such rebates during the term of the Agreement. Neither the Employer nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

SECTION 14: INTER-PLAN ARRANGEMENTS

14.1 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 Programs." Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to Claim Administrator for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this Agreement are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Program policies in effect during the term of this Agreement.

Typically, Covered Persons, when accessing care outside the geographic area Claim Administrator serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating healthcare providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Persons may obtain care from non-participating healthcare providers. Claim Administrator's payment practices in both instances are described below.

14.2 BlueCard® Program

Under the BlueCard® Program, when Covered Persons access Covered Services within the geographic area served by a Host Blue, Claim Administrator will remain responsible to Employer for fulfilling Claim Administrator's contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially 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, our action will be consistent with the spirit of this description.

a. Liability Calculation Method Per Claim

The calculation of the Covered Person's liability on Claims for Covered Services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Claim Administrator by the Host Blue.

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 be greater than or equal to billed charges. Examples of this are (i) when a Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services, and (ii) when such negotiated price is necessary or appropriate, as determined by the Host Blue, to provide for a Host Blue's geographic access or availability of particular types of health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to Claim Administrator by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

(1) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(2) an estimated price. An estimated price is a negotiated payment 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 covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for Claims already paid to providers or anticipated to be paid to or received from providers). However, 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. The BlueCard Program requires that the price submitted by a Host Blue to Claim Administrator is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a Claim, the Host Blue is required to hold any difference between the amount paid to the provider and the amount that Employer pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Employer. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

In some instances federal law or the laws of a small number of states require Host Blues either (i) to use a basis for determining Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or (ii) to add a surcharge.

Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Claim Administrator would then calculate Covered Person's liability and Employer's liability in accordance with applicable law.

b. Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. 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 the Employer. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis.

Unless otherwise agreed to by the Host Blue, Claim Administrator may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original Claim. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or healthcare provider contracts or would jeopardize the Host Blue's relationship with its healthcare providers.

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 Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by Employer. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Employer's benefit period under this Agreement.

Claim Administrator will charge these fees as follows:

It is expected that, unless the number of Employer's Blue enrolled contracts falls below 50,000, that the access fee and all other BlueCard Program-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

In the event that the number of Employer's Blue enrolled contracts falls below 50,000, only the BlueCard Program access fee may be charged separately each time a Claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Claim Administrator receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any Claim. In this situation the access fee is set forth in the Agreement's Fee Schedule. All other BlueCard Program-related fees will then be factored into Claim Administrator's determination of its general administrative fee, also set forth in the Agreement's Fee Schedule.

(1) BlueCard Program Access Fees

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, copayments, and/or coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

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

14.3 Negotiated National Account Arrangements

As an alternative to the BlueCard Program, some of Employer's Covered Persons' Claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue. Pursuant to such negotiated arrangements, the Host Blue(s) [has/have] agreed to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of the Employer receiving Covered Services in the state and/or service area of the Host Blues. Pursuant to the agreement between the Claim Administrator and the Host Blues, the Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on the Claim Administrator's behalf for those Covered Persons of the Employer receiving Covered Services in the state and/or service area of such Host Blue.

If Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's negotiated National Account arrangement(s) with such Host Blue(s) shall apply, unless otherwise agreed in the Agreement's Fee Schedule. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Group Health 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 covered charges or negotiated price (refer to the description of negotiated price under 16.2.a., BlueCard Program) made available to Claim Administrator by the Host Blue 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 14.2.a. BlueCard Program).

Employer also acknowledges that pursuant to the Host Blue's contracts with Host Blues' participating Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' participating Providers with respect to services rendered to such persons for which the Host Blue was initially obligated to pay the Host Blues' participating Providers, (ii) may pay Host Blues' participating Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' participating 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 Providers on other than a fee for services basis which include, but are not limited to, incentive payments and capitations.

The 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 the 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 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 Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by Employer. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Employer's benefit period under this Agreement.

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. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard Program.

Claim Administrator will charge these fees as follows:

It is expected that the access fee and all other Negotiated National Account Arrangement-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

Employer acknowledges that Host Blues may have contracts with certain Providers in their service areas ("Host Blues' participating Providers") for the provision of, and payment for, health care services. As a result of these contracts with their Providers, Host Blues are able to make provider networks available to persons and entities, including Claim Administrator, entitled to health care benefits under various health policies and contracts to which the Host Blue is a party. Such network availability extends to Covered Persons covered under the Agreement.

All other Inter-Plan Program fees related to this negotiated National Account arrangement are factored into Claim Administrator's determination of its Administrative Charge, also set forth in the Agreement's Fee Schedule.

The Claim Administrator hereby informs the Employer, and the Employer acknowledges, that the Claim Administrator's, the Host Blues' participating Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers and the Host Blues' participating Providers may result in minor deviations in Claim processing and/or pricing of Claims for some services. From time-to-time, Claim Administrator, Host Blues and their respective vendors may receive compensation in connection with services provided by Claim Administrator to our group customers, which are not necessarily passed on to our group customers or to members. Additional information about these types of fees, the amount of these fees and the sources of these fees is available upon request.

14.4 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 healthcare providers, the amount(s) a Covered Person pays for such services will be based on the Host Blue's local payment rate made available to the Claims Administrator. The Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating healthcare providers.

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 Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by Employer. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Employer's benefit period under this Agreement.

In addition, Claim Administrator must pay an administrative fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such administrative fee as set forth below.

Claim Administrator will charge these fees as follows:

All fees related to Claims for Covered Services delivered by non-participating healthcare providers outside Claim Administrator's service area are factored into Claim Administrator's determination of its Administrative Charge, which is set forth in the Agreement's Fee Schedule.

SECTION 15: MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING

15.1 Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan ("GHP") arrangements. The parties agree that the Claim Administrator as the Responsible Reporting Entity ("RRE") under these new requirements is required to report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and the Claim Administrator can effectively coordinate health care payments consistent with the Medicare Secondary Payer ("MSP") rules.

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

15.3 The Employer agrees that the Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Claim Administrator's files concerning Covered Persons and the number of individuals employed by the Employer. The Employer agrees to use its best efforts in responding promptly and accurately to the Claim Administrator's requests for information including, but not limited to, information contained on the Employer Acknowledgement Form ("EAF") to be provided to the Claim Administrator by the Employer on at least an annual basis, and more frequently if the information provided on the last EAF received by the Claim Administrator changes, or as requested by the Claim Administrator; and to require and facilitate its Covered Persons' cooperation in responding promptly and accurately to such requests.

15.4 Further, to assure the continuing accuracy of the Claim Administrator's files, the Employer agrees that it is the Employer's responsibility to notify the Claim Administrator promptly via submission of an EAF and such other means as may be required for such continuing accuracy of any change in the number of individuals employed by the 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 the Employer that place it in, or take it out of, the scope of the MSP statute. If the Claim Administrator does not receive such information from the Employer, the Claim Administrator will assume that all relevant factors remain unchanged and will process Claims accordingly. The Employer acknowledges and agrees that the Claim Administrator will be using the information provided by the Employer and Covered Persons to update the Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

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

SECTION 16: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 5 – ASO BPA.

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

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

16.2 The Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which the 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 the 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 17: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by the Plan, or, if Covered Person does not reside in the Plan 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 the Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Employer offers to, a Covered Person, if the Covered Person does not reside in the Plan's service area, the Plan 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, the Employer may (1) communicate directly with the Covered Persons and/or (2) provide the Host Blues whose service area covers the geographic area in which a Covered Person resides, with a Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which the Employer has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

ATTACHMENT 1

To Exhibit 2, Fee Schedule, Financial Responsibilities & Required Disclosures

FEE SCHEDULE

Fee Schedule specifications in this Attachment 1 are to apply for the period(s) of time indicated below and shall continue in full force and effect until the earlier of: (i) the end of the Fee Schedule Agreement Period noted below; or (ii) the date the Agreement is terminated.

A. FEE SCHEDULE AGREEMENT PERIOD

Fee Schedule specifications in this Attachment 1 are for the **Fee Schedule Agreement Period** commencing on August 1, 2014 and ending on July 31, 2015 and apply to Claims Payments from August 1, 2014 through July 31, 2015 and to Incurred Claims incurred from August 1, 2005 through July 31, 2015.

B. ADMINISTRATIVE CHARGES AND OTHER PAYMENTS

1. The **Administrative Charge**, calculated monthly, shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category by the appropriate factors shown below.

Medical/Drug*

$30.90 For each Covered Employee Per Month

* Applies to Standard, Extended and Out of State PPO Plans.

2. The **Termination Administrative Charge, if applicable,** shall be $13.66 per covered Employee per month (PEPM).

The Run-Off Period during which the Claim Administrator will accept Run-Off Claims submitted for payment shall be twelve (12) months from the date of termination.

3. Refer to Exhibit VII for proposed costs for contract years 2014-2017.

C. CLAIMS FOR MENTAL HEALTH & CHEMICAL DEPENDENCY OR SUBSTANCE ABUSE TREATMENT BENEFITS UNDER UNM HOSPITALS' PLAN(S) AND OUTPATIENT IMAGING MANAGEMENT SERVICES

1. Effective January 1, 2011, Claim Administrator will in-source behavioral health treatment benefits which includes claims processing, network management, and customer service, for which a fee of $0.80 per Employee per month (PEPM) and is included in the base Medical/Rx Administrative Fee listed under item B. 1 of this Attachment 1.

D. REPORTS

The Claim Administrator will make available to Employer Standard Reports and other Reporting Services in accordance with the reporting policy of the Agreement as set forth in Exhibit I – CLAIM ADMINISTRATOR SERVICES and at no additional charge. Any additional reports required by Employer must be mutually agreed upon in writing by the parties and may be subject to a Supplemental Charge.

E. CHARGES FOR ADDITIONAL SERVICES

The following **Additional Services** shall be furnished:

1. Reimbursement/Subrogation identification & recovery: 25% of any recovered amounts*

**This charge does not apply to recoveries received as a result of or associated with any Workers' Compensation Law.*

2. BlueCard® Program/Network access fees
(Applies to Out of State PPO Plan): The lesser of up to 10% of the discount or $2,000 per Claim
3. Disease Management fees (optional): N/A

F. NOTICE MAILING AND TRANSMISSION INFORMATION

For the issuance of notices in accordance with Section XVII of the Agreement, each party's address and facsimile number are shown below:

For the Claim Administrator:

Blue Cross and Blue Shield of New Mexico
5701 Balloon Fiesta Pkwy NE
Albuquerque, New Mexico 87113

PO Box 27630
Albuquerque, New Mexico 87125-7630

Attention: Lynn Weeks

FAX: 505 -816-2101

For Employer:

933 Bradbury Drive, SE, Suite 3002
Albuquerque, NM 87106

Contact Person: James Pendergast - Administrator, Human Resources
FAX: 866-809-0488

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

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

1.1 The Claim Administrator shall have the right to select and retain legal counsel.

1.2 Any lawsuit filed or arbitration initiated by the Claim Administrator will be done in the name of the Claim Administrator for its own benefit, as well as on behalf of the Employer and possibly other parties. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Employer and/or the Plan without the Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Employer and/or the Plan with attorneys identified as counsel for the Employer or in the name of two or more parties, including the Employer and the Claim Administrator, with attorneys identified as counsel for the Employer, the Claim Administrator and possibly other parties.

1.3 The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including providing appropriate authority to communicate with the Employer concerning issues pertaining to any class actions and pursuant to which the Employer specifically declines representation by class litigation counsel.

1.4 The Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

1.5 The Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.

1.6 Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Claim Administrator on any reasonable basis it deems appropriate.

1.7 Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The 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. The 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 the Claim Administrator.

1.8 The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

1.9 Nothing in the provisions of this Exhibit shall require the Claim Administrator to assert any claims on behalf of the Employer and/or the Plan.

1.10 Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, the Employer acknowledges that the efforts of the Claim Administrator may not result in recovery or in full recovery in any particular case.

1.11 The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Claim Administrator to assert any claims on the Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Claim Administrator has asserted a

claim on behalf of the Employer and/or the Plan but before any recovery, the Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

1.12 If the Employer should desire to participate in a class or multi–district settlement rather than defer to the Claim Administrator, the Employer may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 26 NOTICES of the Agreement.

1.13 The Employer further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Section 26 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Employer and/or the Plan, consistent with Section 1.2 above, to:

a. Pursue claims that the Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, 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 the Employer and/or the Plan in the class, if the Claim Administrator believes it is in the best interest of the parties to do so;

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

1.14 The Employer further acknowledges and agrees that the Claim Administrator's decision to pursue recovery in connection with particular claims shall be in the Claim Administrator's sole discretion and the 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 the Employer and/or the Plan when, as, and if, the Claim Administrator determines that such claims may be pursued in the common interest of the parties.

1.15 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.

EXHIBIT 4
COBRA HEALTH BENEFITS CONTINUATION COVERAGE

Employer has elected to not include COBRA administration services as part of the fees associated and services defined in the ASO BPA

EXHIBIT 5

BENEFIT PROGRAM APPLICATION ("ASO BPA") - Provided under separate cover

EXHIBIT 6

STOP LOSS

Effective Dates: August 1, 2014 through July 31, 2015

I. EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit 6 are contained in Section 2. AGREEMENT DEFINITIONS of the Agreement.

"Aggregate Stop Loss (ASL)" The maximum aggregate percentage of total expected Payments in any one Agreement period for which Employer is liable before stop loss benefits become payable under this Exhibit 6. The ASL percentage forms the basis for the calculation of the cumulative MCL.

"Individual Stop Loss (ISL)" The maximum amount of Claims Payments for a Covered Person in any one Agreement period for which Employer is liable before stop loss benefits become payable under this Exhibit 6.

"Maximum Claims Liability (MCL)" The maximum monthly amount which Claim Administrator can collect from Employer for payment of Claims Payments. The MCL is determined monthly by multiplying the number of Covered Employees in each membership category for any given month (including Covered Employees or Persons with COBRA coverage) times the applicable rates in the STOP LOSS APPLIATION - Provided under separate cover. The MCL is determined based on the numbers available at the time of billing. Retrospective changes in enrollment numbers, and the resulting change in the MCL, will be reflected in succeeding determinations of MCL during the Agreement period. The cumulative MCL is the total of all monthly MCL amounts in any Agreement period and is equal to the ASL. The MCL rates are calculated by Claim Administrator at the beginning of each Agreement period to cover claims paid during the current Agreement period. Incurred Claims which have not been paid or processed by Claim Administrator at the end of such period shall be carried forward into the succeeding Agreement period or as set forth in the termination Run-Off administrative option selected by Employer.

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

"Run-Off Period" means the time period immediately following termination of the Agreement, as specified in the most current Fee Schedule specifications of Exhibit 5, during which the Claim Administrator will accept Run-Off Claims submitted for payment.

"Terminal Stop Loss (TSL)" The maximum aggregate amount of Claims Payments for which Employer is liable during a termination Run-Off Period before the terminal stop loss benefits may become payable under this Exhibit 6.

"Termination Administrative Charge" means the consideration that is required by the Claim Administrator upon termination of the Agreement, including any services that may be performed by the Claim Administrator during the Run-Off Period.

II. SCHEDULE OF REINSURANCE

A. Stop Loss Coverage. Employer hereby agrees to transfer, and Claim Administrator agrees to accept, liability for Claims Payments under the Agreement on the following basis:

> **XX Individual Stop Loss.** Once the amount of Paid Claims for any *Covered Person* during an Agreement period exceeds the Individual Stop Loss level, BCBSNM will reimburse EMPLOYER 100% of the amount of paid Claims in excess of the Individual Stop Loss level for that Covered Person, subject to the limitations in Section C of this Part and Part III below. BCBSNM's reimbursement shall be made promptly and in no event later than the end of the month following the month in which EMPLOYER has paid for the Claims.

B. Stop Loss Levels. See Attachment to Exhibit 6 - STOP LOSS APPLIATION - Provided under separate cover

C. Recapture of Amounts Paid by Third Party. No payment will be made by Claim Administrator to Employer for any amount which exceeds the amount of any Claims Payments, after any recapture, recovery, or coordination

of benefits on such claim. If Employer or Claim Administrator receives any recapture, recovery or payment from a primary insurer or other third party, there shall be an adjustment of the amount owed under this Exhibit 6. If Claim Administrator has already paid under this Exhibit 6 before such adjustment has been made, Employer will remit any recapture, recovery or coordination benefit received after Claim Administrator payment under this Exhibit 6 to Claim Administrator; this obligation of Employer, shall extend through any termination claim continuation period applicable to Employer.

III. EXCLUSIONS AND LIMITATIONS

The following shall be excluded from the calculation of Claims Payments and shall not be subject to stop loss benefits under this Exhibit 6:

A. Expenses or salaries paid to nonprofessional or professional employees of Employer.

B. Any amount paid by Employer or the Plan in settlement of or as part of a judgment rendered on a claim (exclusive of the cost of the Covered Service), such as compensatory and/or punitive (exemplary) damages.

C. Any statutory or regulatory penalty imposed upon the Plan or Employer.

D. Any administrative expenses of Employer (other than amounts defined as Claims Payment) or the Plan or expenses defined as non-reimbursable elsewhere in this Exhibit 6.

E. Any liability assumed by Employer in excess of the obligations of Employer as set forth in the Plan Directives, including any amounts paid for any service or supply which is not a Covered Service or which is not provided to a Covered Person.

F. Any liability, expense, or loss which is based upon noncompliance or violation of federal or state statute, rule, or regulation.

IV. PREMIUM RATES AND PAYMENT

A. Premium Rate. The total monthly premium for ISL and/or ASL benefits shall be determined by multiplying the respective premium rate in Attachment 1 to Exhibit 6 times the respective number of Covered Employees in each of the membership categories for the month. The premium for TSL shall be equal to a percentage of the claims processed during the Run-Off Period. See STOP LOSS APPLIATION - Provided under separate cover.

B. Premium Payment. The premiums to be paid by Employer to Claim Administrator for ISL and/or ASL benefits under this policy must be received within ten (10) days of the date of billing. Failure to pay premiums may be cause for termination of this coverage. The late payment fee as set out in Exhibit 5 shall also apply to any late payment under the provision.

C. Modifications to Premiums. The amount of premium charged per Covered Employee for ISL and ASL shall remain unchanged during any Agreement period, except that the premium shall be subject to change by Claim Administrator under the same conditions as specified in Exhibit 5. The amount of premium for each succeeding Agreement period shall be renegotiated annually, no later than thirty (30) days prior to the end of each Agreement Period. If the parties cannot reach agreement regarding a modification to the premium by the last day of the Agreement period, this coverage shall terminate on such date.

V. TERM AND TERMINATION

A. Term. This Stop Loss Coverage shall be and continue in effect for the same term as the Agreement, unless sooner terminated as set forth below.

B. Termination. This Stop Loss Coverage may terminate prior to the termination of the Agreement under the following circumstances:

1. Upon failure of Employer to pay the stop loss premiums owed hereunder within ten (10) days of notice of default and demand for payment from Claim Administrator.
2. On the last day of an Agreement Period, by either party giving thirty (30) days advance written notice of intent not to renew this Stop Loss Coverage.
3. By either party giving thirty (30) days advance written notice of intent to terminate.

C. **Effect of Termination.** Termination of this Stop Loss Coverage shall not terminate the rights or liabilities of either Employer or Claim Administrator arising during any period in which this Stop Loss Coverage was in effect; provided, however, that nothing herein shall be construed to extend Claim Administrator's liability for reimbursement under this Stop Loss Coverage for any claim incurred after the date of termination of this Stop Loss Coverage.

D. **Termination Run-Off.** This Stop Loss Coverage shall apply to any claims paid during any Termination Run-Off option elected by Employer in Exhibit II to the Agreement only if Employer elects Terminal Stop Loss benefits in Section II.A above. The premium for TSL shall be paid as set forth in STOP LOSS APPLIATION - Provided under separate cover

VI. GENERAL PROVISIONS

A. **Assignment.** This Stop Loss Coverage shall not be assigned by Employer without the express written consent of Claim Administrator.

B. **Amendment.** This Stop Loss Coverage may be amended only by the mutual consent of the parties, as evidenced by the execution of a written amendment. Any such amendment shall be binding upon Claim Administrator and Employer and deemed an integral part of this coverage.

C. **Subrogation Rights.** With respect to any payment made by Claim Administrator under this Stop Loss Coverage, Claim Administrator shall be subrogated to all of Employer's rights to recover payment against any Covered Person, person, or organization, and Employer shall execute and deliver any required documents or instruments and do whatever is necessary to preserve and secure such rights. Any recovery made by Employer after payment under this Stop Loss Coverage by Claim Administrator shall be paid to Claim Administrator in accordance with Section II.C above.

D. **Governing Law.** This Stop Loss Coverage shall be governed by and construed in accordance with applicable federal and/or New Mexico law.

E. **Claim Administrator Reinsurance.** Nothing in this Policy shall preclude Claim Administrator from obtaining reinsurance from a third party insurer to cover any of its obligations hereunder.

EXHIBIT 7

PERFORMANCE GUARANTEES - Provided under separate cover

Exhibit 7

EXHIBIT-PG
EMPLOYER NAME: University of New Mexico Hospitals
Employer Group Number(s): N11003; N11004, and N12188
Effective for the Settlement Period beginning **8/1/2014** and ending **7/31/2015**

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **4,000** Covered Employees. Performance measurement will begin **8/1/2014**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	**Defined Performance Guarantees**	**Performance Guarantee**	**Percentage of the Administrative Charge at Risk 8/1/13-7/31/14**
Claims Processing Turnaround Time – All Claims	**Claims Processing Turnaround Time** means the period beginning on the date the Claim Administrator or Host Blue Plan receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Claim Administrator. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days. Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on Employer-specific Claims.	95.0% - 100% 90.0% - 94.9% 0% - 89.9%	0% 1% 2%
Claim Processing Accuracy	**Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Claim Processing Accuracy refers to Claims without processing errors such as: 1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period.	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk 8/1/13-7/31/14
	A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.		
Claim Financial Accuracy	**Claim Financial Accuracy** means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically random ratio stratified sample audit of all Dollars paid during the Settlement Period. Calculated as the total audited paid dollars minus the absolute value of overpayments and underpayments, divided by the total audited paid dollars. Measurement is based on an audit of Employer-specific Claims.	99.0% - 100% 97.0% - 98.9% 0% - 96.9%	0% 1% 2%
Customer Service	**Average Speed of Answer of Telephone Calls,** calculated over the complete business day, is defined as the time a caller spends on hold until a Customer Advocate becomes available. Method of measurement: The average speed of answer will be calculated by dividing the total length of time for all calls, measured from the time a call is queued by the automated telephone system for the next available Customer Advocate until the time the caller is connected with a Customer Advocate, by the total number of calls connected with a Customer Advocate during the Settlement Period. The Average Speed to Answer is provided by telephone reports that compute the average number of seconds that Callers spend on hold waiting for their Call to be answered. Standard is measured using member calls on an Employer-specific basis. **Abandoned Calls** are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a Customer Advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls on an Employer-specific basis.	0-30 seconds 31-60 seconds 61 seconds or more 0%-3.5% 3.6%-7.0% 7.1%-100%	0% 1% 2% 0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk 8/1/13-7/31/14
Account Management	**NM Account Management** means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Report Card or through a web-based survey. Performance will be measured in the following areas: 1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner.	Composite Score 3.0 - 5.0 0 - 2.9	 0% 3.5%
ID Card Processing	**ID Cards Processing** is defined as ID cards being mailed within 10 business days after receipt of eligibility file by the Claim Administrator.	99.0%-100.0% 97.0%-98.9% 0%-96.9%	0% 0.5% 1.5%
Reports	**Standard Monthly/Quarterly/Annual Reports** will be delivered within 30 days of the end of the reporting period. Delivery of Standard reports.	Met Not Met	$50 per late report delivered after report submission date
Customer Satisfaction	**Overall Satisfaction** is defined as the percent of the enrolled members who respond to the Continuous Tracking Study, rating the overall performance of their health plan as Excellent, Very Good, or Good. Standard is measured based on statistically valid sample of Covered Persons under the Claim Administrator's PPO program. Standard is measured on a Unit basis.	85%-100% 80%-84.9% 0%-79.9%	0% 1% 2%
Total Medical			**17%**

MEDICAL MANAGEMENT	**Defined Performance Guarantees** **Requirements:** Performance Guarantees are applicable if the following occurs: 1. Employer must have a documented communication strategy (at least 4 communications per year) and offer incentives to members that support engagement with the clinical programs for which fees are at risk. 2. Documentation of the communication strategy and incentives must be provided, and mutually agreed upon by both parties, prior to the beginning of the settlement period. If the requirements are not met, these guarantees will not be in effect. 3. Performance measurement will begin **August 1, 2014.**	**Performance Guarantee**	**Percentage of the BCC Fee At Risk**
Care Management Participation	**Care Management** - is defined as the percentage of targeted members who are actively engaged in a care management program. Actively engaged means the member or member's provider is actively participating in bi-directional communication with the claim administrators designated clinician/member care coordinator. The measurement will exclude members who were identified as not appropriate for the program or have missing/invalid phone numbers.	30% or more 15% - 29.9% 0% - 14.9%	0% 3% 6%
Total Medical Management	The level of performance guarantee is based on results at the HCSC level.		**6%**

EXHIBIT 8

PROPOSED RATES AND FEES - Provided under separate cover

Exhibit 8

UNM Hospitals

ASO & SL Renewal
for the period
August 1, 2014 - July 31, 2015

FEE / RATE COMPARISON**

ASO Fees	08/01/2013	08/01/2014	Increase	ASO FEE GUARANTEE 08/01/2015	08/01/2016	08/01/2017
Subscribers	4,943	4,990	1.0%	TBD	TBD	TBD
Scenario 2 - UNMH retains Rebates and MAFs						
Traditional						
Base Medical Fee	$31.97	$34.25		$34.55	$35.43	$36.35
Behavioral Health	$1.34	$0.80		$0.80	$0.80	$0.80
BCC - Blue Care Connection	Incl in Base	$3.60		$3.60	$3.60	$3.60
Pharmacy Rebate(Traditional)		($7.75)		($8.12)	($7.87)	($7.63)
Total Administration Fees	$33.31	$30.90	-7.2%	$30.83	$31.96	$33.12
Individual Stop Loss $430,000	$5.70	$7.18	26.0%	TBD	TBD	TBD

**See Conditions and Caveats Exhibit