All information contained in the Administrative Services Agreement below constitutes a trade secret of Blue Cross Blue Shield Nebraska and contains proprietary and confidential commercial information under Nebraska Revised Statute 84-712.05(3), which if released would give advantage to business competitors and such a release serves no public purpose. As such, the Administrative Services Agreement and all attachments thereto shall not be subject to Nebraska Revised Statutes 84-712.01 or other public records disclosure laws, and such Administrative Services Agreement is provided to the City of Grand Island on the condition that such Administrative Services Agreement will not be disseminated to the public and shall remain confidential.

ADMINISTRATIVE SERVICES AGREEMENT

Plan Sponsor: City of Grand Island ("THE GROUP")

Effective date: October 1, 2022

Group No.[1]: 107158

This is an Administrative Services Agreement between City of Grand Island ("THE GROUP" or "THE PLAN") and Blue Cross and Blue Shield of Nebraska, Inc. ("BCBSNE").

This Agreement is made in and governed by the laws of the state of Nebraska, except as may be subject to federal law, including ERISA. Any contractual provision which does not conform with the laws of Nebraska or the United States is hereby amended to conform to their minimum requirements.

RECITALS

A. BCBSNE is a domestic insurance company, licensed to sell insurance in the State of Nebraska. BCBSNE is also engaged in the business of providing administrative services to entities which have self-insured, or partially self-insured, health benefit plans for eligible employees.

B. The Benefit Plan Document includes this document and Attachments, and the Summary Plan Description and Amendments thereto, all of which are incorporated herein by this reference. THE GROUP is funded by either Plan Assets or General Assets for THE GROUP's Covered Persons.[2] All coverage and benefit determinations are controlled by the Benefit Plan Document as defined in this Recital. The language of this Administrative Services Agreement shall supersede and take precedence over the language of the Summary Plan Description. **The Summary Plan Description number and the Plan or General Assets funding are indicated on Attachment 1.**

C. BCBSNE is able and willing to provide claims administrative services for THE GROUP's health benefit plan, herein called the "Plan," for Covered Persons and THE GROUP desires to employ BCBSNE to provide such administrative services.

NOW, THEREFORE, IN CONSIDERATION OF THE ABOVE, IT IS AGREED AS FOLLOWS:

DEFINITIONS

Defined terms are capitalized throughout this Agreement. In addition to the definitions stated in the Summary Plan Description, the following definitions are used in this Agreement:

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

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's healthcare needs across the continuum of care.

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[1] Group Numbers are subject to change during the term of this Agreement and shall have no effect on the responsibilities of the parties hereto.

[2] Plan Assets are amounts a participant pays to or has withheld by an employer for contribution to a Plan. Such assets become Plan Assets as of the earliest date they can reasonably be segregated from the employer's general assets, but in no event later than 90 days from receipt by the employer. Plan Assets are subject to ERISA requirements.

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

Care Coordinator Fee: A fixed amount paid by a payer to providers periodically for Care Coordination under a Value-Based Program.

Covered Person(s): All enrolled members of THE GROUP (Subscribers and their enrolled dependent spouses or children).

Employee: An individual employed by the Employer, pursuant to its employment definitions and criteria.

Employer: The employer identified in the Summary Plan Description, providing coverage to its eligible Employees and dependents under the terms of its group health plan.

ERISA: Employee Retirement Income Security Act of 1974, as amended.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

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

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

Subscribers: All enrolled Employees, COBRA qualified beneficiaries, retirees (if applicable), or other non-dependent persons.

Value-Based Program (VBP): Also known as patient-focused care, a Value-Based Program is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

I.

APPOINTMENT

BCBSNE is hereby retained and appointed to provide administrative services as herein described for THE GROUP's benefit plan for Covered Persons under BCBSNE's regular claim payment procedures and methods; provided, however, that BCBSNE shall not be, nor be considered as, the "Plan Administrator," but shall be considered a "named fiduciary" with respect to claims administration only, within the meaning of any applicable federal laws and regulations pertaining to employee benefit plans.

The Plan Sponsor shall remain solely responsible for establishing and maintaining the Plan. These responsibilities include ensuring that the Plan Document and Summary Plan Description are prepared and distributed to Participants of the Plan; preparing and filing necessary reports required under ERISA (The Employee Retirement Income Security Act of 1974), and any other requirements set forth in ERISA. BCBSNE does not assume any responsibility for any act or omission or breach of duty by THE GROUP.

The Plan Sponsor acknowledges that BCBSNE is not providing tax or legal advice and that the Plan Sponsor shall be solely responsible for determining the legal and tax status of the Plan. The Plan Sponsor is responsible for the Plan's compliance with all applicable federal and state laws and regulations, including amending Plan documents as necessary to comply with applicable law changes. The Plan Sponsor recognizes the possible legal implications of federal and state laws and takes full responsibility for any non-compliance consequences that result from any request or decision made by THE GROUP. Plan Sponsor will indemnify and hold BCBSNE harmless against any and all loss, damage, expenses, and penalties imposed by law with respect to THE GROUP's failure to provide coverage in compliance with all applicable federal and state laws that results from any request or decision made by THE GROUP.

Self-funded political subdivisions are subject to Neb. Rev. Stat.13:1601 et seq., governing provisions of the Public Health Service Act, and as otherwise determined by the governmental group. Such plans are not subject to Title 1 of ERISA.

II.

BCBSNE'S SERVICES

In carrying out the terms of this Agreement, BCBSNE agrees to:

A. Prepare the Summary Plan Description for its approval by THE GROUP. If THE GROUP prepares its own Summary Plan Description, BCBSNE will provide an initial review of the Summary Plan Description for accuracy in accordance with the benefits and information outlined in BCBSNE's internal administrative process and procedures. However, BCBSNE does not assume any responsibility for any non-compliance consequences, act or omission, or breach of duty by THE GROUP with respect to the information contained therein.

B. Prepare enrollment forms, Identification Cards and Schedules of Benefits for distribution to Subscribers who are enrolled in this Plan.

C. Prepare the Summary of Benefit Coverage (SBC) documents once annually for those benefits BCBSNE administers. BCBSNE will prepare any applicable notice of modifications of the SBC which results from legal or regulatory changes or benefit changes initiated by BCBSNE. BCBSNE will not provide translation services for any Summary of Benefit Coverage documents. Distribution of the SBC documents to THE GROUP's employees or dependents shall remain the responsibility of THE GROUP.

D. Make payments on behalf of THE GROUP for Covered Services provided to Covered Persons pursuant to the Benefit Plan Document.

   All payments for Covered Services by in-network providers will be made directly to such providers. In all other cases, payments will be made, at BCBSNE's option, to the Subscriber, to his or her estate, to the provider or as required under state or federal law, including qualified medical child support orders. No assignment, whether made before or after services are provided, of any amount payable according to this Agreement shall be recognized or accepted as binding upon BCBSNE or the Plan, unless otherwise required by state or federal law.

   All benefit payments will be made as soon as possible after the claim has been filed. Payments made in error may be recovered as provided by law.

E. Follow BCBSNE's regular claim processing procedures, including the determining of appropriate benefit amounts, with respect to the processing of claims pursuant to the Benefit Plan Document. This includes, but is not limited to, the determination of benefits pursuant to the Coordination of Benefits provisions stated in the Summary Plan Description and the determination of whether to pay or deny claims in the event that a Covered Person fails to return a Coordination of Benefits questionnaire. A service for which a bill, statement or invoice is generated is considered paid on the date appearing in BCBSNE's claim system.

F. BCBSNE shall use reasonable care and due diligence in the exercise of its powers and the performance of its duties under this Agreement, provided that a higher standard of care will be exercised where required by applicable law. With the full cooperation of THE GROUP, BCBSNE will make reasonable efforts under the circumstances, considering the chances of successful recovery and the costs thereof, to recover payment made in excess of the amount provided for a Benefit under the Benefit Plan Document ("Overpayments"), as permitted by applicable provider and member contracts. THE GROUP assigns to BCBSNE the authority to pursue recovery of Overpayments and BCBSNE will pursue reasonable means of recovery of Overpayments under the circumstances but will not be obligated to commence litigation, unless otherwise specifically agreed to by the parties. BCBSNE may, at its sole option, choose not to pursue de minimis Overpayment amounts. BCBSNE will not seek refunds that relate to a retroactive termination of membership of a Covered Person for claims incurred more than 6 months prior to the date on which BCBSNE is made aware of the termination. THE GROUP understands and agrees that due to provider contract limitations, BCBSNE will be limited in its ability to pursue Overpayments or make any needed adjustments to paid claims that were incurred or paid beyond the applicable provider lookback period.

BCBSNE will assume liability up to the amount of an unrecovered Overpayment only if and at such time as it is determined that: (a) the Overpayment was caused by BCBSNE's fraudulent or criminal activity, or was caused by BCBSNE's act or omission which was an intentional disregard of BCBSNE's obligations under this Agreement; (b) reasonable means of recovery under the circumstances have been exhausted; and (c) BCBSNE's acts or omissions were not undertaken at the express direction of THE GROUP.

Payment for a specific service or an erroneous payment made under this Agreement shall not make BCBSNE or the Plan liable for further payment for the same condition. Under certain circumstances, if BCBSNE pays a provider amounts that are the responsibility of the Covered Person, BCBSNE may collect such amounts from the Covered Person.

G. Provide facilities, personnel, procedures, forms and instructions for the administration of claims under the Benefit Plan Document. The Benefit Plan Document may be modified (1) by mutual agreement of THE GROUP and BCBSNE; or (2) at renewal at BCBSNE's discretion.

H. Accept full and exclusive discretion to determine for all parties all matters of fact or interpretation relating to any claim under the Benefit Plan Document, including interpretation of plan provisions to the extent that BCBSNE is a fiduciary for claims processing purposes. The decisions of BCBSNE regarding such claims shall be final and binding subject to appeal to BCBSNE under its review process. Benefits will be paid or denied consistent with the Benefit Plan Document based upon BCBSNE's determination. The claim appeal and review process is set forth in the Summary Plan Description. NO CLAIM EXCEPTIONS TO THE BENEFIT PLAN DOCUMENT WILL BE MADE.

I. Report to THE GROUP matters of general interest with respect to the Benefit Plan Document, including, but not limited to, problems of a recurring nature and suspected misuse of benefits.

J. Submit to THE GROUP, with each monthly billing, a monthly Claims Analysis Report which sets forth the applicable identification number, patient's name, relationship to Subscriber, age, admission or performance date, discharge date, dollar charge, type of coverage, any refunds or other adjustments, and Net Paid Claims. (See Net Paid Claims in Part VI., A.)

K. Maintain membership and claims records, as required by law. Any audit initiated pursuant to this Part and authorized by THE GROUP shall be undertaken at THE GROUP's expense and shall be subject to the audit terms and conditions in Attachment 6. The parties agree that THE GROUP shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.) which may be found by the third party in its audit. Should THE GROUP contract with a third party to perform such contingent fee audit, BCBSNE has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit.

L. Provide the following services in the development and design of any amendment, revision or modification of the Plan: Underwriting and actuarial advice, cost estimates and projections, and proposed language changes, subject to Part III., E.

M. Use its discretion to seek recovery based on subrogation or other theories, from third parties (or their carriers) who have caused Injury or Illness to a Covered Person or damages to the Plan. In addition, BCBSNE may engage a contractor to perform specialized services for recovery of funds, prepayment review, or discovery of overpayment or fraud. Such contractors may be reimbursed based on a percentage of recovery, percentage of savings, or other reasonable basis, with either (1) the net amount returned to THE GROUP; or (2) the gross amount returned to THE GROUP, with the administrative fee reflected as a charge on the summary invoice provided to THE GROUP. BCBSNE may settle or release claim to such recoveries and use its discretion to determine amounts recovered, on behalf of THE GROUP. This includes participation in consolidated or class action lawsuits alleging such injuries. Any recovery from consolidated or class action suits will be apportioned among all insured and self-insured plans or pools. The proration may be based on number of covered persons, number of injured persons, claims volume, or any other basis determined by BCBSNE. Once BCBSNE has exhausted its subrogation recovery efforts, BCBSNE will not take any further action on the claim. THE GROUP will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees. This includes participation in lawsuits in which BCBSNE has been named as a defendant.

Recoveries made in any plan year will be applied first to the appropriate Stop Loss Amount, from the applicable contract year, and subsequently, to THE GROUP's claim liability. THE GROUP agrees to cooperate with all such recovery efforts. The Subrogation and Contractual Right to Reimbursement provisions applicable to the Plan are stated in the Summary Plan Description.

Notwithstanding any prior agreement between the parties to the contrary, BCBSNE will charge a fee equal to 25% of the subrogation amount recovered by BCBSNE ("Subrogation Recovery Fee"). The 25% Subrogation Recovery Fee is not included in the Administrative Service Fees or any other fee described in this Agreement and will be deducted from any recovery amount prior to releasing funds to THE GROUP.

In the event of termination of this Agreement, in whole or in part, BCBSNE may continue to work, as outlined above, all third party liability cases within its possession as well as any additional cases identified by BCBSNE with dates of services incurred prior to the date of termination. The fees charged for the subrogation services will be at the rate listed above and on Attachment 1 at the time of termination for such subrogation services.

If THE GROUP elects to use an outside vendor to perform subrogation recovery services, BCBSNE may charge a reasonable fee for implementation and reporting services.

N. Provide its standard Case Management Programs and Utilization Management Program for Covered Services provided to Covered Persons and to perform Utilization Review in accordance with the Plan.

O. Furnish THE GROUP copies of available records of BCBSNE which may be required to satisfy the requirements of ERISA.

P. Indemnify THE GROUP and hold it harmless against any and all loss, damage, and expense with respect to the administration of the Plan resulting from, or arising out of, any act or omission which constitutes bad faith, fraudulent or criminal acts of employees of BCBSNE acting alone or in collusion with others.

Q. BCBSNE does not underwrite or insure the liability of THE GROUP under this Agreement, except as specifically provided in any Stop Loss Contract between the parties. BCBSNE provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims except as set forth in this Agreement.

R. Upon mutual agreement of BCBSNE and THE GROUP and/or Plan Sponsor, assist THE GROUP and/or Plan Sponsor with certain administrative tasks related to compliance obligations of THE GROUP and/or Plan Sponsor.

S. Provide claims reporting which provides the level of detail necessary for THE GROUP's consultant to advise THE GROUP on benefit design and funding alternatives. Provided information will include, but not be limited to the following, net paid claims, enrollment data, and a high claims report which provides diagnosis and treatment detail. BCBSNE group reporting guideline / policies will apply.

T. If applicable, provide administration for the following state assessment mandates by agreeing to:

1. Comply with New York State Health Care Reform Act, if applicable. BCBSNE shall notify THE GROUP of the amount of the required surcharge and covered lives assessment for such month and shall file appropriate reports with the New York Department of Health ("DOH") and make the required payments to the DOH in accordance with the procedure under this Agreement. For purposes of this Agreement, such surcharges and covered lives assessments shall be considered authorized expenses of the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for any surcharge or covered lives assessment payable by the Plan under section 2807-j or 2807-s of the New York Public Health Law and shall not be liable for any interest or penalties assessed against the Plan or THE GROUP as a result of late or insufficient payment of such surcharges and assessments, unless the interest or penalty is a result of BCBSNE's negligence or mistake. THE GROUP is responsible for filing election forms and reporting any changes to the New York Public Goods Pool.

2. Submit payment to the Maine Vaccine Board in accordance with 22 MRSA Sec. 1066. Payment is required in relation to the number of Covered Life Months. The assessment rate is set in advance of the beginning of each calendar year. Payment is required by all insurers, which included third-party administrators. A Covered Life Month is any month in which health benefits are provided to a child under age 19 who resides in the State of Maine. Such payments shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for any interest charge for failing to make a savings offset payment in a timely manner, unless the interest payment is a result of BCBSNE's negligence or mistake.

3. Submit payment to the Vermont Department of Taxes in accordance with Sec. 48. 32 V.S.A. Chapter 243. Payment is required in an amount equal to 0.999 of 1 percent of all health insurance claims paid by an insurer for Vermont residents in the previous fiscal year. The assessment applies to all health care and dental claims that are not financed through a federal program. The payment of such fee shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

4. Submit payment to the Vermont Department of Health in accordance with 18 V.S.A. §1130(b)(1). Payment is required in relation to the number of Vermont covered lives. The payment of such fee shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

5. Submit the required assessment to the Idaho Immunization Board in compliance with Idaho Code § 41-6005, if applicable. An assessment is required to be paid by all carriers for any child under the age of 19 residing in the State of Idaho. The payment of the assessment shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

6. Submit payment to the Massachusetts Health Safety Net Office in accordance with the Massachusetts Act Providing Access to Affordable Quality and Accountable Health Care Chapter 58 of the Acts of 2006. Payment is required by all purchasers of healthcare services who make payments to acute hospitals and to ambulatory surgical centers. The surcharge amount equals the product of the payments subjected to the surcharge and the applicable surcharge percentage. The payment of such fee shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

7. Submit payment to the Massachusetts General Fund for the Pediatric Immunization Assessment in accordance with Massachusetts General Law Section 38 of Chapter 118G. Payment is required by all health care insurers that conduct business in Massachusetts to cover the costs of purchasing and distributing childhood vaccines. The surcharge amount equals a percentage of payments made to acute hospitals and ambulatory surgical centers. The payment of such fee shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

8. Submit payment to the New Hampshire Vaccine Association in accordance with New Hampshire Revised Statutes Annotated (RSA) 126-Q. Payment is required by all insurers and third party administrators covering children residing in the New Hampshire. Payment is required in relation to the number of child covered lives. The monthly assessment rate is expected to be updated once each year. The payment of such fee shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

9. Submit payment to the Alaska Vaccine Assessment Program ("AVAP") in compliance with AS 18.09.200 et. seq. An assessment is required to be paid by all insurers, self-insured employers, and third party administrators who insure or administer or provide benefits to children or adults residing in the state of Alaska. The payment of the assessment shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

10. Submit payment to the general treasurer of Rhode Island in compliance with R.I. Gen. Laws Section 42-7.4-11, Rhode Island's Healthcare Services Funding Plan Act. An assessment is required to be paid by all insurers, self-insured employers, and third party administrators who insure or administer benefits to individuals residing in the state of Rhode Island. The payment of the assessment shall be considered authorized expenses under the Plan and shall be billed to THE GROUP. BCBSNE shall not be liable for failure to pay the fee, unless the failure to make payment is a result of BCBSNE's negligence or mistake.

THE GROUP is responsible for any state assessment on GROUP claims regardless of whether the state assessment is included in this Section.

III.
THE GROUP's SERVICES

In carrying out the terms of this Agreement, THE GROUP agrees to:

A. The Employees eligible for coverage under the Plan, and specific requirements for eligibility, are determined by THE GROUP. THE GROUP agrees to follow eligibility and effective date of coverage guidelines, as stated in THE GROUP's eligibility guidelines, and/or within the Summary Plan Description.

Enrollment for coverage under the Plan is completed through THE GROUP, pursuant to its enrollment procedures. THE GROUP shall periodically provide BCBSNE with a current list of members. THE GROUP and BCBSNE shall jointly determine the medium and timing for providing such information. THE GROUP agrees to maintain current and accurate Plan eligibility and enrollment records. Information regarding eligibility and termination of eligibility Covered Persons must be furnished to BCBSNE in a timely manner. BCBSNE will process retroactive changes, additions, and terminations for up to 6 months prior to the date notice is received by BCBSNE, subject to applicable law. BCBSNE shall not be responsible for any non-performance or delay in the performance of this Agreement that is caused or contributed to by the failure of THE GROUP to provide any of the eligibility and enrollment information required by BCBSNE.

THE GROUP's records relating to such coverage shall be open to BCBSNE for review at reasonable times. THE GROUP shall be responsible for documenting the Plan's eligibility requirements and communicating these requirements to BCBSNE and THE GROUP's employees and vendors (including stop loss carriers). THE GROUP is also responsible for verifying the accuracy of the enrollment/eligibility information provided to BCBSNE and notifying BCBSNE and THE GROUP's vendors (including stop loss carriers) of any changes to the Plan's eligibility requirements. THE GROUP understands that failure to comply with the above provisions may result in the denial of claims by BCBSNE and/or THE GROUP's stop loss carrier, and/or the inaccurate disbursement of benefits. BCBSNE shall have no liability to THE GROUP or any Covered Person as a consequence of inaccurate eligibility or enrollment information, including claims that are denied by BCBSNE and/or THE GROUP's stop loss carrier, and/or the inaccurate disbursement of benefits.

B. BCBSNE will process a retroactively dated termination of coverage and/or a coverage rescission, and refund related administrative fees, for up to 6 months prior to the date notice is received by BCBSNE, subject to the applicable legal requirements for rescission of coverage. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under the Plan, and BCBSNE will pursue refunds in accordance with the Overpayments section of this Agreement. BCBSNE will not seek refunds for claims incurred more than 6 months prior to the date on which BCBSNE is made aware of the termination. Erroneous payments not recovered will be considered as benefits paid under the Agreement and BCBSNE will not be financially responsible for such erroneous payment.

   THE GROUP is responsible for determining the eligibility status of THE GROUP's Covered Persons and will hold BCBSNE harmless and indemnify BCBSNE for any error or neglect on THE GROUP's part in providing BCBSNE with accurate eligibility or enrollment information or for any failure on THE GROUP's part to provide coverage in compliance with applicable federal and state laws. BCBSNE will not be responsible for erroneous communications or disbursement of benefits due to inaccurate eligibility information provided by THE GROUP.

   Neither the acceptance of employee contributions nor the processing of claims will constitute a waiver of BCBSNE's or the GROUP's rights to rescind coverage, as allowed by law.

C. Cooperate with BCBSNE in an audit of Covered Persons, upon request, but not more frequently than annually. The cost of such audit shall be borne by BCBSNE and shall include, but not be limited to, reimbursing THE GROUP's personnel providing support to such audit in excess of ten hours and copying expenses.

D. Notify BCBSNE immediately of any work-related accident suffered by a Covered Person for which recovery may be available under any Workers' Compensation Law or similar law. THE GROUP agrees to forward a copy of the First Injury Report to BCBSNE as soon as possible. Work-related injuries or illnesses are not Covered Services, therefore provider discounts which are available to THE GROUP under the health coverage, are not available for these services. THE GROUP also agrees to advise BCBSNE of any potential subrogation rights or other contractual rights of recovery known to THE GROUP.

E. Review the Benefit Plan Document and any changes or modifications thereto, and notify BCBSNE of any necessary changes within 30 days of receipt. Any changes or modifications to the Benefit Plan Document must be approved by BCBSNE before it is effective. Such approval will not be unreasonably withheld.

Any changes or modifications to benefits which are made by THE GROUP must be approved by BCBSNE, and may be subject to an increased charge, and any additional administrative expense involved in its implementation. This charge will be determined by BCBSNE, and shall be effective as of the effective date of the modification. Benefits cannot be decreased retroactively at any time.

Special projects, services, or benefits, including any associated fees, may be described in this Agreement, an amendment to this Agreement, or in a separate agreement (e.g., a Non-Standard Benefit or Services Agreement).

F. Grant to BCBSNE discretionary authority to determine for all parties, all matters of fact or interpretation relating to any claim under the Benefit Plan, including interpretation of Plan provisions, to the extent that BCBSNE is a fiduciary for claims processing purposes. These decisions will be final and binding subject to appeal to BCBSNE under its review process.

G. Indemnify BCBSNE and hold it harmless against any and all claim loss, damage, and expense with respect to the administration of the Plan, except that resulting from, or arising out of, any act or omission which constitutes bad faith, negligence, fraudulent or criminal acts of employees of BCBSNE, acting alone or in collusion with others, or expenses incurred by BCBSNE in the regular administration of the Plan.

THE GROUP agrees that should it fail to make payment due to insolvency or for any other reason, the provider shall have authority to collect directly for Covered Services from its Covered Persons.

H. Indemnify BCBSNE and hold it harmless, as set forth herein, for any claim, loss, damage and expense arising from the release of claims specific information to THE GROUP.

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

J. Execute and be responsible for all HIPAA related compliance, including but not limited to executing any necessary agreements or notifications.

K. Keep all information received from BCBSNE confidential. THE GROUP will not use or disclose such information except as necessary for administration of claims pursuant to the Benefit Plan Document. In the event THE GROUP discloses any such information to a contractor assisting in the administration of the Benefit Plan Document, it shall first obtain written agreement from the contractor restricting further disclosure or use for any purpose other than providing such assistance. THE GROUP will ensure that, if necessary, a Business Associate Contract is in place with respect to applicable services provided by a subcontractor.

In consideration for the benefits available under the Plan, all Covered Persons agree that he or she consents to the release of his or her medical and other personal information to BCBSNE and to THE GROUP as necessary for the purpose of determining eligibility and/or administering claims.

IV.

CONTINUATION OF COVERAGE

A. THE GROUP is responsible to provide all notices required by COBRA and Department of Labor Regulations, including but not limited to:

1. An initial COBRA Notice to Employees and their spouses upon the date THE GROUP first becomes subject to COBRA.

2. An initial COBRA notice to new Employees and their spouses within 90 days after coverage commences (or earlier, if a Qualifying Event occurs within the first 90 days of coverage).

3. A notice to the Plan Administrator when a Qualifying event occurs due to an Employee's termination or reduction in hours of employment, death or entitlement to Medicare, or due to THE GROUP filing bankruptcy, within 30 days of the Qualifying Event. THE GROUP shall also notify the Plan Administrator within 30 days of receiving notice of a Covered Person's Qualifying Event due to divorce, legal separation, or cessation of dependent status.

4. A notice of unavailability of COBRA in the event an Employee or dependent requests COBRA coverage and is determined to be ineligible.

5. A notice of early termination of COBRA coverage in the event a Qualified Beneficiary's coverage is terminated prior to the end of the maximum COBRA coverage period.

THE GROUP agrees to establish reasonable COBRA notice procedures, in accordance with federal regulations. THE GROUP agrees to indemnify BCBSNE for any losses directly related to THE GROUP's failure to establish or follow reasonable COBRA notice procedures. The experience from the continuation coverage shall be charged to THE GROUP's Plan.

The applicable Continuation of Coverage provisions are stated in the Summary Plan Description.

B. The amount of recommended monthly charges to be collected and retained by THE GROUP shall not be less than the amounts indicated on Attachment 3.

V.

FINANCING ARRANGEMENTS

The financing arrangements applicable under this Agreement are those set forth on Attachment 2.

VI.

COMPENSATION

A. Commencing with the effective date of this Agreement, and in consideration of the services and obligations herein required of BCBSNE, THE GROUP shall pay BCBSNE, monthly, the following amounts. If the number of Covered Persons increases or decreases by 10% or more, or the terms of this Agreement are changed by THE GROUP during the Term, BCBSNE reserves the right to revise the rates contained in this Section or applicable Attachment.

1. **Administrative Service Fees:** The fees for BCBSNE's services, including certain optional services, as stated in this Agreement which includes fees for all persons who have elected to continue membership in THE GROUP pursuant to COBRA continuation coverage.

   The Administrative Service Fees are indicated on Attachment 1, Section A.

2. Reimbursement for the total **"Net Paid Claims"** for the preceding month, unless reimbursement is otherwise provided in Part V., above. Claims data which is, for any reason, omitted from a particular month's billing, shall be added to the billing for a subsequent month, and the Administrative Service Fee for the subsequent month shall reflect any appropriate adjustment.

   Net Paid Claims (or "Net Effect"): This is the amount determined after subtraction of any discount and other adjustments made to the Allowable Charge for Covered Services, pursuant to the contractual provisions between BCBSNE and the Contracting Providers, or in accordance with other Contract provisions. These payments are made by BCBSNE or a Blue Cross and/or a Blue Shield plan in another state, referred to as a "Host Blue." THE GROUP's payment is made on a Net Paid Claims basis.

   Payment for Covered Services by a Contracting facility inside BCBSNE's service area is based on the Contracted Amount less the Covered Person's Deductible, Coinsurance and Copayment. Payment for Covered Services received from a Contracting facility outside of BCBSNE's service area is based on the lesser of the Contracted Amount or the billed charge less the Covered Person's Deductible, Coinsurance and Copayment. Payment for Covered Services received from a Contracting professional or noninstitutional provider is based on the lesser of the Contracted Amount or the billed charge less the Covered Person's Deductible, Coinsurance and Copayment, regardless of location. The Coinsurance is based on the lesser of the Allowable Charge or the billed charge for Covered Services.

3. **Value Based Arrangements with Contracting Providers**. BCBSNE has contracts with certain health care providers that vary from traditional fee for service arrangements. These arrangements may include case and/or per diem payments, bundled or episode of care payments, and payments to accountable care organizations ("ACOs") and patient-centered medical homes ("PCMHs") in the form of care coordination and care management payments, quality bonuses, and shared savings payments ("value based care payments" or "VBC Payments"). The VBC Payments to each ACO or PCMH will differ based on the specific contract in place with BCBSNE.

   The VBC Payment amount is based upon an assessment of THE GROUP's members who are attributed to an ACO or PCMH and is billed to THE GROUP in the same manner as claims for payment by THE GROUP. VBC Payments may be billed to THE GROUP retrospectively on a quarterly basis (care coordination payments), after the completion of the program year (shared savings or quality bonus), or through the claims system in the same manner as other fee for service claims (care management).

   The VBC Payments support practices in making fundamental changes to their care delivery. These changes are needed to provide high quality, patient-focused, whole-person care, which will result in lower total cost of care. The goal of the ACO and PCMH programs is the Triple Aim, an approach for optimizing health care delivery through the following: (a) improving the patient experience of care (including quality and satisfaction); (b) improving the health of populations; and (c) reducing the per capita cost of health care.

   In addition, Host Blue Plans may have contracts with certain health care providers that vary from traditional fee for service arrangements. Pursuant to these arrangements, Host Blues may pay providers for reaching agreed-upon cost/quality goals. The Host Blue may pass these provider payments to BCBSNE, which BCBSNE will pass directly on to THE GROUP. These arrangements and payments are described in more detail in Section VI.B.

4. **Financial Settlements with Providers**. THE GROUP acknowledges and agrees that BCBSNE may, from time to time, enter into financial settlements with Contracting Providers of BCBSNE for, among other reasons, routine claims adjustments, delayed rate adjustments, cost rate adjustments, non-claim specific compensation adjustments (such as incentive or bonus program adjustments). As such, the outcome of these settlements could result in an additional charge or credit being issued to THE GROUP during or after the applicable contract year. The parties understand and agree that any such charge or credit may not result in a corresponding adjustment to amounts paid or not paid to Covered Persons or their cost share in connection with claims relating to the settlement.

BCBSNE reviews and investigates potentially fraudulent or inappropriate billings submitted by providers and members. Whenever amounts from these investigations can be associated with a claim under the Plan and result in a claim adjustment, THE GROUP will receive a credit against future claims costs in the amount of the recovery, less a percentage fee that may be retained by BCBSNE. In addition, BCBSNE may engage a contractor to perform specialized services for recovery of funds, prepayment review, or discovery of overpayment or fraud. Such contractors may be reimbursed based on a percentage of recovery, percentage of savings, or other reasonable basis, with either (1) the net amount returned to THE GROUP; or (2) the gross amount returned to THE GROUP, with the administrative fee reflected as a charge on the summary invoice provided to THE GROUP. THE GROUP understands and agrees that not all recoveries can be reasonably tied to a particular claim resulting in its adjustment; for example, when a recovery arises from a general settlement that takes in account BCBSNE's entire book of business with insufficient information for individual claim adjustments. In such circumstances, BCBSNE may retain the recoveries and will make available details of the same on an annual basis upon written request.

5. **Subrogation Recovery Fee.** BCBSNE will charge a fee equal to 25% of the subrogation amount recovered by BCBSNE ("Subrogation Recovery Fee"). The 25% Subrogation Recovery Fee is not included in the Administrative Service Fees or any other fee described in this Agreement and will be deducted from any recovery amount prior to releasing funds to THE GROUP.

6. **The following fees are related to the BlueCard Program. Additional information about the BlueCard Program is found in Paragraph B of this Part.**

   a. Access Fee: If Contracted Provider savings are available from a Host Blue, BCBSNE may be charged a fee for Covered Persons to access the Host Blue's Contracting Provider network. This Access Fee for services incurred by a Covered Person will be passed along to THE GROUP as a claims expense under Net Paid Claims, unless otherwise indicated in Attachment 1 and Section VI.A.1. The Access Fee is a percentage of the discount the Host Blue has made available to BCBSNE, but not to exceed $2,000 for any claim. If an Access Fee credit is received, this amount will be credited to THE GROUP. The provider has agreed not to bill Covered Persons for amounts in excess of the Contracted Amount, but may bill them for Deductibles, Coinsurance and amounts for Noncovered Services.

   The amount of this fee or any credits will be used in the computation of "Net Paid Claims" charged to THE GROUP. Instances may occur when none of a claim or only a small amount of the claim is paid due to the application of the Covered Person's Deductible, Coinsurance or Copayment. If the Host Blue's arrangement with the provider allows the Contracted Amount to apply when the amount is fully or mostly a Covered Person's obligation, the Access Fee will be paid and passed to THE GROUP as a claims expense under Net Paid Claims even though THE GROUP paid little or none of the claim. This process allows the benefit of the discounted amount to be passed through to the Covered Person.

   The Access Fee is indicated on Attachment 1, Section B. 1. a.

b. Administrative Expense Allowance (AEA): The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to BCBSNE for administrative services the Host Blue provides in processing claims for THE GROUP's Covered Persons. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of THE GROUP's enrollment. An Administrative Expense Allowance (AEA) for each original claim processed through the BlueCard Program by the Host Blue, will be charged back to THE GROUP as an administrative expense, unless otherwise indicated in Attachment 1 and Section VI.A.1.

An AEA Fee Report will be provided monthly with the Claims Analysis Report.

The AEA Fees are indicated on Attachment 1, Section B. 1.b.

7. **Non-Contracted Providers**

For both physician/professional and institutional claims incurred in other plan service areas with non-contracted providers, no Access Fee applies. The AEA fee for non-contracted provider claims will be $3.00 per claim.

8. **Premium for an Individual Stop Loss.**

Premium for an Aggregate Stop Loss.

The Stop Loss premium, however stated, includes fees for all persons who have elected to continue memberships in THE GROUP pursuant to COBRA.

If applicable, the Stop Loss premiums are addressed in the Stop Loss Contract.

9. **Commissions:** If a commission to an agent of record specified by THE GROUP is payable by BCBSNE, the actual amount paid will be charged to THE GROUP each month during the Term of this Agreement.

The monthly commission is indicated on Attachment 1, Section C.

B. The following language is mandated by the Blue Cross and Blue Shield Association in order to explain the methods that are used to calculate claim liability in the various independent Blue Cross and Blue Shield Plans. The Out-of-Area Services fees and compensation costs are outlined on Attachment 1, Section B.

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

Typically, when accessing care outside the geographic area BCBSNE serves, Covered Persons obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Person obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSNE remains responsible for fulfilling its contractual obligations to you. BCBSNE payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Dental Care Benefits (except when paid as medical

claims/benefits) and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSNE to provide the specific service or services are not processed through the Inter-Plan Arrangements.

1. **BlueCard® Program**

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

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

i. Covered Person Liability Calculation

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

ii. THE GROUP's Liability Calculation

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

b. **Claims Pricing**

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

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

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

claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

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

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price THE GROUP pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Covered Person and THE GROUP is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

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

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume (number of claims processed) and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

c. BlueCard Program Fees and Compensation

THE GROUP understands and agrees to reimburse BCBSNE for certain fees and compensation which BCBSNE is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to THE GROUP are set forth in Attachment 1. BlueCard Program Fees and compensation may be revised from time to time as described in the "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" Section below.

2. Special Cases: Value-Based Programs

Value-Based Programs Overview

THE GROUP's Covered Persons may access Covered Services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global

Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

a. Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these provider payments to BCBSNE which BCBSNE will pass directly on to THE GROUP as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

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

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

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

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

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

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

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

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

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

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

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Covered Persons will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay providers under Value-Based Programs.

b. Care Coordinator Fees

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

1. PMPM billings; or

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

As part of this Agreement, BCBSNE and THE GROUP will not impose Covered Person cost sharing for Care Coordinator Fees.

c. Value-Based Programs under Negotiated Arrangements

If BCBSNE has entered into a Negotiated Arrangement/Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to THE GROUP's Covered Persons, BCBSNE will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

As part of this Agreement, BCBSNE and THE GROUP may agree to waive Covered Person cost sharing for care coordinator fees.

3. Prepayment Review and Return of Overpayments

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

arrangement is agreed upon by BCBSNE and the Host Blue, and these fees may be charged to THE GROUP.

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

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, BCBSNE will request the Host Blue to provide full refunds from participating healthcare providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of this Agreement.

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

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

5. Non-Participating Healthcare Providers Outside BCBSNE's Service Area

a. Covered Person Liability Calculation

i. In General

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

ii. Exceptions

In some exception cases, at THE GROUP's direction BCBSNE may pay claims from nonparticipating healthcare providers outside of BCBSNE's service area based on the provider's billed charge. This may occur in situations where a Covered Person did not have reasonable access to a participating provider, as determined by BCBSNE in BCBSNE's sole and absolute discretion or by applicable law. In other exception cases, at THE GROUP's direction BCBSNE

may pay such claims based on the payment BCBSNE would make if BCBSNE were paying a nonparticipating provider inside of BCBSNE service area, as described elsewhere in this Agreement. This may occur where the Host Blue's corresponding payment would be more than BCBSNE in-service area nonparticipating provider payment. BCBSNE may choose to negotiate a payment with such a provider on an exception basis.

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

b. Fees and Compensation

THE GROUP understands and agrees to reimburse BCBSNE for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to THE GROUP are set forth in Attachment 1. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in the "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" Section below.

6. Blue Cross Blue Shield Global Core Program

a. General Information

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

• Inpatient Services

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

• Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Covered Persons to pay in full at the time of service. Covered Persons must submit a claim to obtain reimbursement for Covered Services.

• Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered

Persons should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill to the service center address on the form to initiate claims processing. The claim form is available from BCBSNE, the service center, or online at www.bcbsglobalcore.com. If Covered Persons need assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

THE GROUP understands and agrees to reimburse BCBSNE for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to THE GROUP under Blue Cross Blue Shield Global Core are set forth in Attachment 1. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in the "Modifications or Changes to Inter-Plan Arrangement Fees or Compensation" Section below.

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

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

C. **Rx Nebraska Program Fees:** Prime Therapeutics, LLC, (Prime) is the Pharmacy Benefit Manager which processes pharmacy claims for the Rx Nebraska Program. For pharmacy claims, BCBSNE utilizes Prime to provide network access to network participants and to provide mail service. The Rx Nebraska Program terms and fees are described in Attachment 5.

Rebates received from manufacturers of drugs and supplies on claims that are processed through THE GROUP's medical benefits will be retained by BCBSNE.

D. BCBSNE shall provide THE GROUP with a monthly billing reflecting the amount due BCBSNE from THE GROUP, less any credits. This billing will be provided on or before the 10th business day of the following month and shall be payable within 15 days of its mailing by BCBSNE.

Interest will be charged for Net Paid Claims, Administrative Service fees, Stop Loss charges and amounts previously unreimbursed by THE GROUP, which are received more than 15 calendar days after the date notification is mailed.

Interest will be based on a rate of 12% per annum for the actual number of days which have elapsed beyond the 15-day grace period. The interest charge will be added to the next subsequent billing for claims reimbursement and will not be included in the Aggregate Stop Loss Limit. Interest charges will also be applicable on any past due interest charge.

E. In connection with the administration of this Agreement, if at any time BCBSNE shall be or become subject to the imposition of, or any increase in, a premium tax or other tax whatsoever, the amount of compensation shall be increased by a like amount. (The present premium taxes on the Stop Loss premiums are included in the costs shown above, if applicable.) Assessments by a state arising from the operation of the Plan, including but not limited to a surcharge on claims and/or an assessment on residents of that state, shall be considered a tax for purpose of this paragraph.

If a change in a law or regulation occurs during the term of this Agreement which results in additional administrative costs such increases in cost will be communicated to and incurred by THE GROUP.

F. BCBSNE may employ the services of an outside company to seek recovery of credit balances from providers and facilities. The outside company may: a) retain a percentage of the monies recovered as compensation for its services. The remaining balance will be refunded to THE GROUP; or b) charge BCBSNE a fee as compensation for its services. In that instance, the Claims Analysis Report will reflect the full amount of the recovery as a credit. Any fee associated with the collection of these recoveries will be reflected as a charge on the summary invoice provided to THE GROUP.

G. This Agreement is effective only as to expenses incurred after the effective date of this Agreement, and prior to its termination, subject to Part IX.

VII.

LITIGATION

Should suit be filed against BCBSNE or THE GROUP, or both, for damages or equitable relief, arising out of a determination of benefits, the parties agree to cooperate fully and assist one another in the defense of such claims. Should BCBSNE be named as a defendant in such a suit, BCBSNE shall maintain primary control of such litigation, including the selection of counsel; however, notice will be provided to THE GROUP. Reimbursement will be made to BCBSNE by THE GROUP for the amount of any benefits determined to be payable pursuant to the Benefit Plan Document, by way of settlement or award pursuant to judgment, and THE GROUP shall be responsible for the fees of any separate counsel retained to represent its interests independently. If Plaintiff's attorney fees or taxable court costs are a part of the settlement or award, the parties agree they will split such fees and costs evenly.

This Agreement shall be governed by and interpreted in accordance with the laws of the State of Nebraska (without regard to any conflict of laws provisions) to the extent such law shall not have been preempted by ERISA or other applicable federal law. The venue for any actions shall be a court with appropriate jurisdiction in Douglas County, Nebraska.

VIII.

TERM

This Agreement shall become effective on the date indicated herein (the "Effective Date") and shall remain in effect for a period of three years commencing on the Effective Date. It may be extended by written consent of both parties, with such modifications as shall be agreed to by the parties.

This Agreement may be non-renewed, discontinued, or terminated immediately upon written notice by BCBSNE to THE GROUP, if:

1. THE GROUP fails to meet its financial obligations;

2. there is no longer any Subscriber who lives, resides or works in a Service Area where BCBSNE is licensed;

3. THE GROUP has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage, or with respect to coverage of individual insureds, or their representatives; or

4. the headquarters of the Employer are no longer located in the State of Nebraska.

This Agreement may be terminated by either party, without cause, but any such termination shall only be effective commencing with the first day of the month at least 60 days following written notice to the other party. BCBSNE will not notify individuals in THE GROUP of THE GROUP's termination, nor will any conversion coverage be provided to such individuals. THE GROUP understands and agrees that BCBSNE may deny any claims that are processed while any amount is past due under this Agreement.

IX.

PROCESSING OF CLAIMS IN THE EVENT OF TERMINATION

In the event of termination of this Agreement, liability for unreported and pending claims as of the date of termination rests with THE GROUP. The following administrative alternatives are available and the selected option is indicated in Attachment 1, section D:

A. THE GROUP will arrange with another claims administrator for processing, handling and payment of such claims as are incurred during the Term of this Agreement, but not submitted for payment until after the termination date. BCBSNE will have no responsibility for such claims except to notify the Covered Person/Provider of the termination date. Covered Person/Provider must resubmit the claims to either the new claims administrator or THE GROUP, as instructed by THE GROUP.

or

B. THE GROUP will arrange with BCBSNE for payment of such claims. Unless the parties agree otherwise, BCBSNE will continue to process claims for services provided during the Term of this Agreement for a period of 12 months after termination of this Agreement. The advance deposit will be returned as set forth on Attachment 2, Section A., 2.

THE GROUP agrees to compensate BCBSNE as provided herein. BCBSNE will send a monthly invoice reporting the amount of claims reimbursement and Administrative Expense for Net Paid Claims during the preceding month. The Administrative Expense applicable to the processing of such claims shall be outlined in Attachment 1, Section D. BCBSNE will have no financial risk or obligation for claims incurred after the current or prior Terms of the Agreement, i.e., there is no limit to the extent of THE GROUP's liability under this paragraph B. as benefits paid pursuant to this Part IX. shall not apply to any Stop Loss coverage. BCBSNE may request THE GROUP to provide a letter of credit guaranteeing payment up to an amount determined by BCBSNE to be the estimated liability for these payments.

The alternative selected is indicated on Attachment 1, D.

The Reserve for Unreported and Pending Claims at the end of the Term of this Agreement is indicated on Attachment 4.

X.

DATA

Data contained in membership files submitted to BCBSNE by THE GROUP are the property of THE GROUP. Once files which are submitted to BCBSNE are entered into BCBSNE proprietary systems, the data produced, extracted or reported from the BCBSNE systems is the property of BCBSNE ("BCBSNE Proprietary Data"). Any requests for disclosures to third parties or uses of BCBSNE Proprietary Data by THE GROUP shall require mutual consent of the parties hereto.

When BCBSNE releases BCBSNE Proprietary Data to THE GROUP for an approved data use, THE GROUP agrees to: (1) limit the use of BCBSNE Proprietary Data strictly for the purpose for which it was disclosed; (2) only use the minimum necessary BCBSNE Proprietary Data to fulfill the purpose for which it was disclosed;

(3) not commingle BCBSNE Proprietary Data with third party information; (4) not convert aggregated BCBSNE Proprietary Data into disaggregated information so as to identify the disclosing party or a licensee of BCBSA; (5) fully protect and preserve the confidential nature of BCBSNE Proprietary Data; (6) not use, distribute or exploit (e.g., resell) BCBSNE Proprietary Data; and (7) immediately notify BCBSNE of any ownership changes. THE GROUP must obtain written consent from BCBSNE prior to sharing BCBSNE Proprietary Data with third parties. BCBSNE may request that the receiving entity execute BCBSNE's non-disclosure agreement. Additionally, when BCBSNE releases BCBSNE Proprietary Data to a third party for an approved data use, BCBSNE will require the receiving entity to execute a non-disclosure agreement that addresses these requirements.

BCBSNE may request a limited audit of THE GROUP solely for the purpose of ensuring compliance with the limitations set forth in this Section X. Such audit shall be undertaken not more than annually.

Subject to the requirements of law, this Agreement, and the Parties' business associate terms, THE GROUP agrees to destroy or return BCBSNE Proprietary Data to BCBSNE upon conclusion of the purposes for which BCBSNE Proprietary Data was disclosed. BCBSNE Proprietary Data that cannot be reasonably returned or destroyed must be maintained by the receiving Party in accordance with the confidentiality terms and conditions of this Agreement.

XI.

NONASSIGNMENT

BCBSNE may not assign its rights or obligations under this Agreement without the written consent of THE GROUP, provided, however, that any reinsurance obtained by BCBSNE shall not constitute an assignment hereunder.

XII.

STOP LOSS PROVISION

A. THE GROUP has obtained stop loss insurance through one of BCBSNE's preferred stop loss vendors and BCBSNE has identified that a member has exceeded the specific stop loss deductible, BCBSNE will not request reimbursement from THE GROUP for that member's claims above the specific stop loss deductible, provided that THE GROUP has executed a valid assignment of benefits with BCBSNE and the stop loss vendor, and the Member's claims are covered under THE GROUP's stop loss policy. Notwithstanding the foregoing, BCBSNE is not responsible for the payment of claims that are denied or disputed by THE GROUP's stop loss carrier and THE GROUP agrees to hold BCBSNE harmless for denials of claims submitted to THE GROUP's stop loss insurance carrier.

XIII.

MODIFICATION

This Agreement contains the entire agreement of the parties. No representations were made or relied upon by either party other than those that are expressly set forth herein. No agent may change this Agreement in any way. No change in this Agreement shall be valid until approved in writing by an officer of each of the parties. Any such change, however, shall be effective at the time, and with respect to the eligible Employees, therein provided.

XIV.

GENERAL PROVISIONS

A. If any term of this Agreement is declared invalid by a court, the same will not affect the validity of any other provision, provided that the basic purposes of this Agreement are achieved through the remaining valid provisions. The headings of sections and subsections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

B. Failure by THE GROUP or BCBSNE to insist upon strict performance of any provision of this Agreement will not modify such provision, render it unenforceable, or waive any subsequent breach. No waiver or modification of any of the terms or provisions of this Agreement shall be valid unless in each instance the waiver or modification is accomplished pursuant to the amendment provisions of Section XIII.

C. This Agreement (including Attachments) is the full Agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and representations between the parties, other than the separate applicable Business Associate Contract and, if applicable, the separate stop loss contract. This Agreement shall be construed, enforced, and governed by the laws of the State of Nebraska.

D. Notwithstanding any provision contained herein to the contrary, THE GROUP shall have sixty (60) days from the earlier of the date of THE GROUP's receipt of this Agreement or the date of THE GROUP's consultant's receipt of this Agreement, to review, and accept or reject, the terms of this Agreement. In the event that THE GROUP does not execute this Agreement within sixty (60) days of receipt, THE GROUP agrees that the continuation of administration payments, including administrative service fees, will be considered as acceptance of the terms of this Agreement, as determined by BCBSNE.

E. THE GROUP must provide BCBSNE with all information which BCBSNE may reasonably request with regard to any matters pertaining to the Plan, including, but not limited to, information necessary to comply with state or federal laws or regulations. BCBSNE has the right to request information at any time. THE GROUP agrees to indemnify and hold BCBSNE harmless against any and all loss, damage, expenses, and penalties imposed by law with respect to THE GROUP's failure to provide BCBSNE with requested information, THE GROUP's failure to provide accurate information, and/or THE GROUP'S failure to reasonably cooperate with BCBSNE as may be required with regard to any matters pertaining to this Agreement, including compliance with state or federal laws and regulations.

F. THE GROUP agrees that BCBSNE, along with its affiliates and/or vendors, may call or text any phone numbers THE GROUP or its Covered Persons give to BCBSNE, including a wireless number, using an automatic telephone dialing system and/or a prerecorded message. Without limit, these calls may pertain to plan administration, treatment options, special investigations pertaining to fraud, waste or abuse, health-related benefits and services, enrollment, payment, or billing.

G. BCBSNE does not engage in the practice of medicine and all Contracting Providers provide Covered Services under the terms of the Plan as independent practitioners of the healing arts. Such providers are not employees or agents of BCBSNE or the On-site plan, and BCBSNE will not be liable for any act, error or neglect of any Hospital, Physician or other provider or their agent, employee, successor or assignee.

H. BCBSNE's entire liability shall not exceed the amount of benefits provided under the Plan, regardless of the form of the action. In no event shall BCBSNE be liable for consequential, incidental, special or indirect damages regardless of whether it has been advised of the possibility of such damages.

I. No failure, delay, or default in performance of any obligation of BCBSNE under this Agreement shall constitute an event of default or breach of the Agreement to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the control and without negligence of BCBSNE including, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental agency, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors, or carriers, terrorism, disaster, strikes, civil disorder, pandemic or quarantine, curtailment of transportation facilities, fire, floods, blizzards, epidemics and/or any other cause beyond the reasonable control of BCBSNE ("Force Majeure Event"), making it impossible, illegal, or commercially impracticable for BCBSNE to perform its obligations under this Agreement, in whole or in part. Upon the occurrence of a Force Majeure Event, BCBSNE shall take action to minimize the consequences of any Force Majeure Event. If BCBSNE relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice of the facts that constitute such Force Majeure Event, when it arose, and when it is expected to cease.

J. All statements, in the absence of fraud, made by THE GROUP or the Covered Person will be deemed representations and not warranties. No such statements will void coverage or reduce the Plan benefits unless contained in the attached Summary Plan Description, or the Subscriber's enrollment information. Neither acceptance of premium nor payment of Claims will constitute a waiver of available defenses.

K. The rights and obligations of the parties as set forth in this Agreement shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein. This section shall not obligate BCBSNE to pay any claims (regardless of the dates incurred), or perform claims administrative functions, after the termination of this Agreement, for any reason whatsoever, unless otherwise agreed upon by the parties.

L. Notice shall be mailed to the following addresses:

Attn: General Counsel
BCBSNE
P.O. Box 3248
Omaha, Nebraska, 68180-0001.

The Subscriber's address is the most recent address appearing on BCBSNE records.

THE GROUP's address is shown on the Summary Plan Description.

CITY OF GRAND ISLAND
(PLAN SPONSOR / THE GROUP)

By _____
Signature

HR Director
Title

100 E 1st St
Address

Grand Island NE 68801
City State Zip Code

Date: 8/4/22

Roger G. Steele
Roger G. Steele, Mayor

Date: 9/21/2022

BLUE CROSS AND BLUE SHIELD OF NEBRASKA (BCBSNE)

By _____
Signature

Chief Revenue Officer
Title

Mailing Address: P.O. Box 3248
Omaha, NE 68180-0001

Date: 8/5/22

Stacy R. Nonhof
Assistant City Attorney

ATTACHMENT 1

ADMINISTRATIVE SERVICES AGREEMENT
SUMMARY

Group: City of Grand Island

Effective Date: October 1, 2022

Group No.: 107158

Summary Plan Description Number and revision date: _

N/A Plan Assets. X General Assets.

A. Administrative Service Fee:

1. N/A% of Net Paid Claims for health coverage.

2. N/A% of Net Paid Claims for dental coverage.

3. $12.00 per enrolled Subscriber per month under health coverage effective October 1, 2022. $12.00 per enrolled Subscriber per month under health coverage effective October 1, 2023. $12.00 per enrolled Subscriber per month under health coverage effective October 1, 2024.

4. $N/A per enrolled Subscriber per month under dental coverage.

5. $0.25 per enrolled Subscriber per month under health coverage for telehealth services through American Well.

6. $3.00 per enrolled Subscriber per month under health coverage for external reinsurer reporting services. This fee will be waived if THE GROUP chooses one of BCBSNE's preferred stop loss carriers.

7. $N/A per enrolled Subscriber per month under health coverage for external pharmacy benefit management (PBM) reporting services.

8. $N/A for external PBM implementation. $ per enrolled Subscriber per month under health coverage for external subrogation reporting services.

9. $N/A for external subrogation implementation.

BCBSNE agrees to provide THE GROUP with an **implementation reimbursement up to $30,000.** This implementation reimbursement is to cover the direct expense of THE GROUP's transition to BCBSNE. BCBSNE must receive appropriate documentation of any such expense within thirty (30) calendar days of THE GROUP's payment of the expense. BCBSNE will approve and reimburse THE GROUP within thirty (30) calendar days of receipt of the appropriate documentation.

Notwithstanding the foregoing, in the event this Agreement is terminated by THE GROUP prior to the end of the multi-year administrative guarantee ending September 30, 2025, the implementation credit shall be subject to repayment by THE GROUP, up to the amount paid by BCBSNE. The fee will be included on THE GROUP's next monthly billing statement and shall be payable to BCBSNE within 15 days of mailing by BCBSNE.

B. **Out-of-Area Service Fees**

1. **BlueCard Fees and Other Out-of-Area Services Fees:**

   a. BlueCard fees Other Out-of-Area Services fees will not be billed to THE GROUP.

   b. **For purposes of disclosure only**, actual BlueCard fees and Other Out-of-Area fees which will be paid by BCBSNE to Host Blue Plans will be as follows:

      i. Access Fee: The standard Access Fee will be the percentage listed below of the Discount not to exceed $2,000 for any claim in another plan area. (Included in Net Paid Claims)

         (1) 3.79% for period October 1, 2022, through December 31, 2022; and
         (2) 3.62% for period January 1, 2023, through September 30, 2023.

      ii. Administrative Expense Allowance (AEA): The standard AEA Fee will be $5.00 for physician/professional claims and $11.00 for institutional claims incurred in other plan areas with a Contracted Provider.

      iii. For both physician/professional and institutional claims incurred in other plan areas with non-contracted providers, the AEA will be $3.00 per claim unless an alternative fee was negotiated with the Host Blue.

      iv. For international claims, the standard AEA Fee will be $5.50 for professional claims $18.55 for institutional claims, and $4.35 for Covered Person-submitted claims.

C. **Commissions:**

1. __X__ No commission is payable to an agent of record.

2. _____ The commission payable to the agent of record is $ each month.

   a. This amount is not included in the Administrative Service Fee in A. above and will be billed additionally.

   b. This amount is included in the Administrative Service Fee in A. above.

3. ____ The commission payable to the agent of record is _____% of the total applicable Specific and Aggregate Stop loss monthly premiums charged to THE GROUP as indicated in Attachment 3, Part III. The commission amount is included in the Stop loss premium and will not be billed separately to THE GROUP.

D. **Termination Provisions:** In event of termination of this Agreement, the alternative selected by THE GROUP is:

BCBSNE agrees to adjudicate any Run-Out Claims with dates of service prior to the date of termination of this Agreement. The run-out period will be 12 months. THE GROUP agrees to pay an administrative fee equal to the average number of contracts during THE GROUP's last three (3) months of coverage ending on THE GROUP's termination date, multiplied by three (3), and then multiplied by THE GROUP's per subscriber per month health coverage administration charge at the time of termination for this service. THE GROUP will also pay any applicable Administrative Expense Allowance (AEA) or other Out-of-Area Service Fees or Bluecard Fees, as outlined in this Agreement.

BCBSNE will continue to provide standard reporting through the date of termination of this Agreement. Standard reporting includes reports that THE GROUP is receiving monthly and that require no manual intervention on behalf of BCBSNE.

BCBSNE may, at is discretion, provide custom reporting, for an additional fee of $1,000 per report. The fee will be included on THE GROUP's monthly invoice and will be payable within 15 days of the mailing of the summary invoice by BCBSNE. Custom reporting includes any reports that require manual intervention and/or are set-up to be provided on a recurring or an ad-hoc basis after THE GROUP terminates with BCBSNE.

Further terms and conditions of THE GROUP's run-out services will be set forth in a run-out Addendum to this Agreement.

E. Stop loss Guarantees: Stop loss premiums for the Contract Period, if applicable, are addressed in the Stop loss Contract. Stop loss premium guarantees for future contract year(s) have been offered and accepted by THE GROUP, subject to size variance limitations, benefit changes and/or contract changes made by THE GROUP.

1. N/A The Specific Stop loss premium for the period N/A through N/A is guaranteed not to increase more than N/A % for the contract year N/A through N/A.

2. N/A The Aggregate Stop loss premium for the period N/A through N/A is guaranteed not to increase more than N/A % for the contract year N/A through N/A .

F. Subrogation Recovery Fee: 25% of all recoveries.

G. Rx Nebraska Program: Rx Nebraska Program Fees are set forth in Attachment 5.

ATTACHMENT 2

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

SPECIAL FINANCING ARRANGEMENTS

A. _____ **No Special Financing Arrangement:** There are no special financing arrangements under this Agreement. BCBSNE shall make payments for claims out of its own funds, subject to reimbursement from THE GROUP.

1. THE GROUP shall remit to BCBSNE an advance deposit of $.

2. THE GROUP shall remit to BCBSNE an additional advance deposit of $. The current advance deposit held by BCBSNE is $ and the total amount upon receipt of the amount specified above will be $.

   BCBSNE will credit such advance deposit in the name of THE GROUP. Six months following termination of this Agreement, BCBSNE shall return 50% of THE GROUP's advance deposit. As stated at Part IX., BCBSNE will continue to pay claims for a period of 12 months (or a previously agreed-upon runout period). Within 30 days following this period, BCBSNE shall refund the balance of the advance deposit less any deficits from previous billings.

3. BCBSNE has agreed to waive the advance deposit, if daily or weekly wire transfer is made.

B. _____ **Special Financial Arrangements:** Pursuant to the following, BCBSNE has agreed to waive the advance deposit:

1. BCBSNE shall make payments for claims out of its own funds, subject to reimbursement from THE GROUP. BCBSNE shall (daily, weekly, etc.) notify THE GROUP of the amount of payments which have been made since the last previous notification. THE GROUP shall reimburse BCBSNE within 24 hours of each notification, and be responsible for all service charges made for maintenance and use of any wire transfer arrangement between its bank account and BCBSNE's account.

   At the end of each month, a summary report will be provided to THE GROUP, showing individual Net Paid Claims, refunds or other adjustments, correction entries, Stop loss adjustments, the Administrative Service Fee, AEA Fee, Stop loss premiums and Total Net Paid Claims. Any additional amount due will be payable within 15 days of the mailing of the summary invoice by BCBSNE.

2. BCBSNE employees authorized to notify THE GROUP of the amounts required are:

Dave Sederburg	Lindsay Dotson	Suzanne Hansen
Maria Mayorga	Michelle McKibbon	
Mark Schadde	Will Ozobiani	

3. THE GROUP's employees who are authorized to communicate with BCBSNE's authorized employees are:.

ATTACHMENT 3

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

FUNDING RATES

The amount of recommended monthly charges to be collected and retained by THE GROUP shall be determined by THE GROUP. THE GROUP agrees to hold BCBSNE harmless in the event of insufficient funding by THE GROUP.

ATTACHMENT 4

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

RESERVE FOR UNREPORTED AND PENDING CLAIMS AT THE END OF THE TERM OF THIS AGREEMENT

The current estimate of the potential liability, excluding Administrative Expense, of THE GROUP in the event of termination of this Agreement during, or at the end of the Term of this Agreement shall be determined by THE GROUP. THE GROUP agrees to hold BCBSNE harmless for insufficient reserving by THE GROUP.

ATTACHMENT 5

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

RX NEBRASKA PROGRAM

BCBSNE will provide pharmacy benefit management services as described herein. To the extent not specifically described in this Attachment 5, the terms of the Administrative Service Agreement shall control the administration of THE GROUP's pharmacy benefits. All references to designee throughout this Attachment 5 shall include any designee of BCBSNE or its pharmacy management vendor.

1. DEFINITIONS

Whenever used in this Attachment, the following definitions apply:

A. "Average Wholesale Price" (AWP) means the average wholesale price of a prescription drug as set forth by the Pricing Source and in accordance with the NDC-11 price at the time a Claim is processed. The price file will be updated no less frequently than once every three (3) business days through the Pricing Source.

B. "Brand Drugs" means those pharmaceuticals designated by the Pricing Source as having a multi-source indicator of M, N, or O or as otherwise defined by Pricing Source.

C. "Claim" or "Claims" means requests for payment submitted by Network Participants or Members for pharmaceutical products or services.

D. "Claims Adjudication" means the determination of whether a given Claim is entitled to reimbursement pursuant the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as concurrent (on-line at point of service) Drug Utilization Review.

E. "Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Services, calculated as a percentage of the charge for such services, which is to be paid by Members pursuant to the Member's Plan.

F. "Compound Drug" means a prescription where two or more pharmaceutical products are mixed together, and which, at a minimum, one pharmaceutical product must be a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.

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

H. "Covered Prescription Drug Services" means the managed pharmacy services/pharmaceutical products available to Members and eligible for reimbursement pursuant to the Member's Benefit Plan.

I. "Dispensing Fee" means the fee paid to Network Participants for the professional service of filling a prescription and is typically added to the submitted ingredient cost or contracted rate.

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

K. "Electronic Prescribing" or "E-prescribing" means the process of creating, storing and transmitting prescription information electronically, either by computer or hand-held device.

L. "Extended Supply Network" or "ESN" means the retail Network Participants who have agreed to provide Members more than a one month's (or as mutually agreed) quantity supply of Covered Prescription Drug Services provided that the Member's Benefit Plan has a mail service benefit and a retail quantity days' supply limit of one month (or as mutually agreed).

M. "Federal Legend Drug" means a pharmaceutical product, which is required by law to bear on its packaging, "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only".

N. "Foreign Drug Claims" means Claims submitted through the Paper Claim process for reimbursement of pharmaceutical products purchased outside of the United States.

O. "Formulary" means a list of various pharmaceutical products which is available to Network Participants, members, physicians or other health care providers for purposes of providing information about the coverage and tier status of Covered Prescription Drug Services.

P. "Generic Drugs" means all drugs that are not defined as "Brand Drugs."

Q. "Mail Service" means the services through which Members may receive prescription drugs through the mail from a mail order pharmacy that has entered into an agreement to provide such services.

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

S. "Maximum Allowable Cost" or "MAC" means the highest cost at which a Benefit Plan will reimburse Network Participants or Members for pharmaceutical products present on the MAC list at the time of service.

T. "Maximum Allowable Cost List(s)" or "MAC List(s)" means a proprietary database listing, owned and maintained by BCBSNE or its designee, of multi-source pharmaceutical drug products and supplies and the corresponding MAC.

U. "Member" means an individual who is eligible to receive Covered Prescription Drug Services at the time of service.

V. "Network" or "Pharmacy Network" means the group of pharmacies that have been accepted as Network Participants and have entered into agreements with BCBSNE or its designee to provide Covered Prescription Drug Services to Members.

W. "Network Contract" means a contract between a Network Participant and BCBSNE or its designee to provide Covered Prescription Drug Services to Members, as may be amended at any time.

X. "Network Participant" or "Participating Pharmacy" means each individual pharmacy, chain or other dispensing provider that has entered into a Network Contract with BCBSNE or its designee to provide Covered Prescription Drug Services to Members.

Y. "Open Refill Transfer File" means a data file created by the Plan's previous pharmacy benefit manager containing its members' mail prescriptions, thus enabling a subsequent pharmacy benefit manager, such as BCBSNE or its designee, to continue to fill those open mail prescriptions.

Z. "Over the Counter Drugs" or "OTC Drugs" are products classified as OTC by Medi-Span as of the fill date based on the NDC-11 dispensed.

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

BB. "Plan" or "Benefit Plan" means the processing parameters and other information entitling a Member to receive Covered Prescription Drug Services.

CC. "Pricing Source" means Medi-Span, or such other national drug database as BCBSNE may solely designate, which establishes and provides updates to BCBSNE no less frequently than once every three (3) days, or as otherwise required by law, regarding the AWP or other alternative pricing benchmark as determined by BCBSNE for Covered Prescription Drug Services. BCBSNE will provide THE GROUP with prior written notice if another Pricing Source is used.

DD. "Provider Tax" means any tax on a Covered Prescription Drug Service required to be collected or paid by a retail or mail seller for a Covered Prescription Drug Service.

EE. "Rebate(s)" means retrospective reimbursement of monetary amounts by a Manufacturer under a Manufacturer's discount program with pharmacy management vendor for pharmaceutical products of that Manufacturer dispensed to a Member, for which the conditions precedent to receiving such monetary amounts are satisfied. Rebates do not include manufacturer administration fees, which are fees or other compensation received by BCBSNE and/or a pharmacy management vendor from a Manufacturer for services relating to the administration of Rebates under an agreement.

FF. "Specialty Pharmacy" means a licensed pharmacy designated by BCBSNE, or its designee, to provide Specialty Pharmaceutical Products. The list of Specialty Pharmacies may change at any time without notice.

GG. "Specialty Pharmaceutical Product(s)" means designated complex injectable and oral drugs, generally covered up to a 30-day supply, which have very specific manufacturing, storage, and dilution requirements. Specialty drugs are drugs including, but not limited to drugs used for: multiple sclerosis; rheumatoid arthritis; hepatitis C; Crohn's disease; anemia; and hemophilia. Specialty drugs may only be available through designated Specialty Pharmacies. BCBSNE reserves the right to change designated Specialty drugs and suppliers at any time without prior notice.

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

II. "Vaccine Dispensing Fee" means the fee paid to the Network Participant for the professional service of administering a vaccine and is added to the submitted ingredient cost or contracted rate.

2. GENERAL SERVICES

A. Claims Processing. BCBSNE will process Claims for Covered Prescription Drug Services electronically submitted by Network Participants and Paper Claims received from a Member according to Plan and eligibility information and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims.

Claims are processed in accordance with the applicable Network Contract using "lesser of" pricing methodology, meaning Claims will be paid at the lesser of (i) the contracted rate (either a discount off of the applicable AWP or the MAC price) plus Dispensing Fee, Vaccine Administration Fee, and any other taxes and fees; (ii) the Network Participant's submitted ingredient cost plus Dispensing Fee, Vaccine Administration Fee, and any other taxes and fees; or (iii) the Network Participant's submitted U&C. The applicable AWP used for retail and Specialty Pharmacy will be based on the package size submitted. The applicable AWP for Mail Service will generally be based on the NDC dispensed.

B. Formulary Services. Subject to certain limitations, BCBSNE will develop, maintain, and update its Formulary or Formularies. THE GROUP acknowledges and agrees that BCBSNE may, from time to time, consistent with the Plan, promote the dispensing of pharmaceutical products in a manner consistent with the designated Formulary.

C. Rebate Management. BCBSNE will obtain Rebates for some Covered Prescription Drug Services from Manufacturers. Such Rebate arrangements are based on volume purchase discounts or other similar arrangements with Manufacturers.

D. Utilization Management. BCBSNE may provide cost containment programs in the form of utilization management programs on behalf THE GROUP. If provided, such services may be subject to additional fees as described in the Pharmacy Program Fees Exhibit, if applicable.

E. E-Prescribing. BCBSNE or its designee will support e-Prescribing transaction standards for eligibility, formulary, and medication history to allow prescribers to electronically send Members' prescriptions directly to a Network Participant from the point-of-care.

F. Special Projects. Special projects, including any additional fees, may be mutually agreed to by the parties and described in this Agreement, an amendment to this Agreement, or in a separate agreement (e.g., a Non-Standard Benefit or Service Agreement).

G. Audits. THE GROUP, or a mutually agreed upon independent third-party auditor who agrees to the terms of a confidentiality agreement, may conduct an annual audit as it relates to the administration of this agreement. The rights granted to THE GROUP by this section shall be limited to one audit or inspection during any twelve (12) month period, upon at least sixty-five (65) days' written notice to BCBSNE, and shall be subject to the terms and conditions of the audit guidelines between BCBSNE and PBM, as outlined in the attached Audit Exhibit.

The parties agree that THE GROUP shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.) which may be found by the third party in its audit. Should THE GROUP contract with a third party to perform such contingent fee audit, BCBSNE has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit.

H. Cooperation upon Termination. Should THE GROUP terminate this Agreement, BCBSNE will provide all standard industry PBM transition/data files that will be used by the new PBM to minimize member disruption, including BCBSNE agreed upon claims files, prior authorization files, accumulator files, mail open refill files, both pre and post termination date. THE GROUP will reimburse BCBSNE any fees BCBSNE's pharmacy management vendor charges BCBSNE for providing such electronic files, including the fee for sending the mail outbound refill file. Such fees will be included on THE GROUP's monthly billing and shall be payable within 15 days of mailing by BCBSNE.

I. Performance Guarantees. BCBSNE agrees to adhere to the Performance Guarantees as set forth in the Performance Guarantees Exhibit.

3. PHARMACY NETWORK SERVICES

A. Drug Pricing.

The rates paid to Network Participants (including Specialty Pharmacies and Mail Service Pharmacies) for Covered Prescription Drug Services may vary and are subject to the specific contractual arrangements. BCBSNE will establish (and amend from time to time) a uniform ingredient cost and/or Dispensing Fee for Covered Prescription Drug Services. The ingredient cost and/or Dispensing Fee may vary between Brand Drugs and Generic Drugs. THE GROUP will be invoiced for pharmacy Claims using the ingredient cost and/or Dispensing Fee ("Contract Price"), minus the Member's Coinsurance and Copayment/Deductible amounts. The ingredient cost and/or Dispensing Fee may not be the same amount as BCBSNE pays to the Network Participant. Mail Service drugs dispensed under the pharmacy program will be provided by a Mail Service Pharmacy. Although the Contract Price may be more or less than the amounts BCBSNE is required to pay to Participating Pharmacies for the Plan's drugs, THE GROUP shall pay only the Contract Price. The Performance Guarantee Exhibit provides the average annual guaranteed discounts off the Average Wholesale Price (AWP).

4. REBATE MANAGEMENT SERVICES

A. Negotiating Rebates.

On its own behalf, BCBSNE or its designee have entered into, and may in the future, enter into arrangements with Manufacturers under which a portion of prescription drug charges are rebated. Pharmaceutical Rebates may be associated with drug claims processed under the Plan's pharmacy. These Rebate amounts vary, and may change during the year, based upon the status of a drug in BCBSNE's prescription drug formulary, drug utilization, benefit coverage, unexpected Generic launches, and other factors. In addition, pharmacy management vendors may receive administrative reimbursement or fees directly from BCBSNE or drug or other companies for services they provide to BCBSNE and those companies.

As compensation for costs and services provided in connection with pharmacy benefit management and other services provided under this Agreement, BCBSNE will retain 100% of the Rebates it receives from its pharmacy management vendor(s) related to the Plan's prescription drug utilization.

THE GROUP understands and agrees that, if changes in applicable laws, regulations, executive orders, agency actions, court orders and/or legal settlements, or changes in interpretation of any law or action (collectively, "Change in Law"), has an adverse effect on the availability of rebates or has the effect of eliminating rebates on prescription drugs, BCBSNE may, correspondingly, adjust THE GROUP's administrative service fees to account for the decreased revenue. In the event of an adjustment to administrative service fees on account of a Change in Law, BCBSNE shall inform THE GROUP in writing no later than thirty (30) days prior to implementing the adjustment.

5. SHARED PHARMACY VALUE PROGRAM

BCBSNE has established an ASO Block Shared Pharmacy Value Program for the 2023 calendar year that is comprised of pharmacy rebates, discounts and dispensing fees. The Pharmacy Value Target for the 2023 calendar year is $39.00 PEPM; this Pharmacy Value Target is applicable only to the calendar year of 2023 and is subject to recalculation in following years. At the end of the 2023 calendar year, BCBSNE will compare the Pharmacy Value Target to the actual performance of the ASO Block in aggregate to determine if the Pharmacy Value Target was met for the calendar year. If BCBSNE determines that the Pharmacy Value Target is met (i.e., if total pharmacy rebates, discounts, and dispensing fees for the ASO Block are more than $39.00 PEPM for the calendar year), THE GROUP will be eligible to receive 50% of the amount (PEPM) that exceeds the Pharmacy Value Target for the contract year. For example, if the Pharmacy Value Target is $39.00 PEPM, and the total pharmacy rebates, discounts and dispending fees retained by BCBSNE is $41.00 PEPM, THE GROUP will be eligible to receive payment in the amount of $1.00 PEPM (i.e., 50% if the amount in excess of the Pharmacy Value Target). If the Pharmacy Value Target is not met for the calendar year (i.e., if total pharmacy rebates, discounts and dispensing fees related to the ASO Block are $39.00 PEPM or less for the calendar year), no payments will be made to THE GROUP. The group will also in no way be penalized for not meeting this target. Payments related to the Pharmacy Value Target will be made to THE GROUP in the second quarter following the end of the applicable calendar year and will be prorated for the number of months that THE GROUP is active (in the ASO Block) with BCBSNE during the calendar year. THE GROUP will not receive an ASO Block Shared Pharmacy Value Program payment if Agreement has been terminated for any reason before the ASO Block Shared Pharmacy Value Program payment has been issued. The Pharmacy Value Target will be recalculated each year. Plans that do not renew the Agreement on a calendar year basis, will still be treated as calendar year Plans, and will received Pharmacy Value Program payments on a prorated basis during their first year of participation in the Shared Pharmacy Value Program. For each following year, a Shared Pharmacy Value Program payment will be issued on a calendar year basis assuming the terms of this Section 5 are otherwise met.[3],

[3] For example, a new Plan with a Plan Year from June 1 through May 31 would receive a Shared Pharmacy Value Program payment at the initial Pharmacy Value Target rate of $39.00 in this Attachment 5 through December 31 of the applicable year, 2023. For each following year, the Shared Pharmacy Value Program payment will be made based upon the calendar year at the applicable Pharmacy Value Target calculated for that year.

ATTACHMENT 5
RX NEBRASKA PROGRAM

Pharmacy Benefit Program
Audit Guidelines

The following guidelines will apply to all employer group audits unless the terms and conditions of the Agreement under which Prime performs the services subject to the audit provide other guidance.

1. No more than one (1) audit during any twelve (12) month period.

2. Employer group must provide BCBSNE with a minimum of sixty-five (65) days advance written notice of intent to audit and scope of the audit.

3. A member of BCBSNE Account Management team will be designated as the lead internal contact for coordinating the audit. All coordination efforts between BCBSNE and the auditor will take place through the designated coordinator.

4. Audits will take place during normal business hours.

5. Any third-party auditor must be reasonably acceptable to Prime and BCBSNE.

6. Subject to applicable law, Prime may require that a third-party auditor perform the audit and to enter into a reasonable Confidentiality and Non-Disclosure Agreement (CDA) approved by Prime's Legal Department before any information is exchanged. The CDA will specify that information provided by Prime to the group/auditor is to be used solely for the purpose of conducting the immediate audit and the information may not be used for any other purpose.

7. The audit is limited to claims for employer group during the current year and the preceding year, unless a longer time period is mutually agreed upon by the parties.

8. The parties agree to collaborate in good faith to develop a reasonable approach to the audit that meets the needs of all parties and outlines the procedure for conducting the audit. An onsite audit agenda must be finalized no later than 10 business days prior to the desired onsite date.

9. Audits will adhere to a maximum sample size of 200-300 claims per audit. The description of claims to be audited must be provided to BCBSNE a minimum of fifteen (15) business days prior to the audit. Should initial claim review reveal errors, Prime and employer group will work collaboratively to define additional claims for auditing.

10. Only the information necessary for the auditing party to conduct a fair and valid audit will be disclosed. Any unnecessary information will be redacted before it is provided to the auditing party.

11. If access to the pharmacy network agreements or manufacturer agreements is requested, Prime will provide on-site access so long as Prime is legally or contractually able to do so *and* only the relevant page(s) or exhibits (that is not the entire contract) are provided for the auditor's review.

12. The party conducting the audit will be responsible to bear its own costs and expenses related to the audit and will be responsible for reimbursing BCBSNE and Prime for all reasonable expenses incurred by BCBSNE and/or Prime in compliance with an audit such as, for example, copying, fees, or mail expenses incurred by BCBSNE and/or Prime.

13. The auditor cannot keep or make copies of any documents provided by BCBSNE or Prime to the auditor without Prime's express written consent to do so and, if applicable, as outlined in the executed CDA.

14. The auditor may be provided with screen-shots of the claim adjudication. The auditor will not have access to the live Claims Adjudication System without prior executive approval by Prime.

15. Employer groups and/or their auditors must follow Prime's visitor security policy if they are on-site.

16. Except as may otherwise be required by law, reporting of the audit results will be restricted to employer group's internal use only.

17. Employer groups and/or their auditors will provide BCBSNE and Prime with a draft and final copy of any audit reports.

The following additional guidelines will apply to network and rebate management audits of Prime subcontractors.

1. Employer group must provide network claim samples to BCBSNE at least fifty-five (55) days in advance of the onsite audit. Employer group must provide manufacturer samples to BCBSNE at least forty (40) days in advance of the onsite audit.

2. Employer group must provide a final onsite audit agenda to BCBSNE at least fifteen (20) days in advance of the onsite audit.

3. Audit must be conducted onsite at Prime or Prime's subcontractor, as applicable, by a third-party auditor that (i) has separate, stand-alone audit division; (ii) carries commercially reasonable insurance coverage for professional malpractice; and (iii) executes a mutually acceptable confidentiality agreement with Prime's subcontractor(s).

4. Employer group audits of network contracts or manufacturer contracts maintained by Prime's subcontractor or group purchasing organization will be subject to a pass-through fee of $15,000 per audit.

5. Employer group may review rebate agreements as reasonably necessary to audit the calculation of rebates or other manufacturer revenue payment received by the employer group. Rebate audits will be based on the reconciliation data provided by Prime, with Prime subcontractors' data input. The reconciliation data will be available 210 days after the end of a quarter.

6. Employer group may review the number of rebate agreements necessary to enable Employer group to audit fifty percent (50%) of the total rebate amounts attributable to the Employer group for two (2) calendar quarters during the twenty-four- (24-) month period immediately preceding the audit.

7. Employer group (or its auditor) may take and retain notes to the extent necessary to document any identified errors, but may not copy (through handwritten notes or otherwise) or retain any manufacturer contracts (in part or in whole) or related documents provided or made available by Prime subcontractors in connection with the audit.

8. Prime will facilitate responses to draft report of any audit findings. Responses will be provided within forty-five (45) days after the draft report is received from Prime.

ATTACHMENT 5
RX NEBRASKA PROGRAM
PHARMACY PROGRAM FEES EXHIBIT

If elected by THE GROUP, THE GROUP will not be charged an additional administrative fee for THE GROUP's participation in the FlexAccess™ Program.

If elected by THE GROUP, THE GROUP will not be charged an additional administrative fee for THE GROUP's participation in the HighTouchRx™ Program.

ATTACHMENT 5
RX NEBRASKA PROGRAM

ASO Block (Traditional) Pricing Guarantees for Off Cycle 2022 Effective Dates Network C with PDL 10 or PDL 20 Formulary			
RETAIL			
Brand		**Generic**	
AWP minus		**AWP minus**	
2022	19.10%	2022	81.10%
2023	19.20%	2023	81.20%
2024	19.30%	2024	81.30%
DISPENSING FEE			
Brand		**Generic**	
2022	$0.50	2022	$0.50
2023	$0.50	2023	$0.50
2024	$0.50	2024	$0.50
EXTENDED SUPPLY NETWORK (ESN) – 90-DAY CHANNEL			
Brand		**Generic**	
AWP minus		**AWP minus**	
2022	23.90%	2022	81.10%
2023	24.00%	2023	81.20%
2024	24.10%	2024	81.30%
DISPENSING FEE:		$0.00	
MAIL			
Brand		**Generic**	
AWP minus		**AWP minus**	
2022	21.25%	2022	84.10%
2023	21.25%	2023	84.20%
2024	21.25%	2024	84.30%
DISPENSING FEE:		$0.00	
AGGREGATE SPECIALTY			
AWP Minus			
2022		17.00%	
2023		17.00%	
2024		17.00%	
DISPENSING FEE:		$0.00	

Conditions and Criteria

1. Financial guarantees are measured on the BCBSNE cohort line of business collective claims experience and will be reconciled annually on a calendar year basis (regardless of plan renewal date).
2. Financial guarantees are applied in aggregate.
3. Discount and Dispensing Fee rates exclude compound, long term care (LTC) pharmacy, home infusion (HIF) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, 340b,

Medicare/Medicaid, out-of-network, member-submitted, foreign, coordination of benefits (COB), 100% member-paid plans (i.e. discount cards), subrogation, paper, invalid quantity/unit cost, and usual and customary (U&C) claims and non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBS NE specialty drug management list) claims.

4. For non-calendar year plans, payouts for missed guarantees will be prorated based on the number of months impacted during the applicable calendar year.
5. Actual client experience may vary based on utilization and drug mix.
6. Members will pay the lower of the contracted rate, U&C, or their applicable copayment. Zero balance logic is not employed.
7. Discounts are based on the actual NDC-11 dispensed.
8. Guarantees will be reconciled annually and applied in aggregate.
9. Discounts provided do not include savings from DUR or other clinical programs.
10. Guaranteed offer is based on adoption of the BCBSNE **PDL 10 or 20 formulary** and may be amended in the event there is a change in the formulary, implementation of new clinical programs, changes to the pharmacy benefit plan design, lock-out of drug classes, unexpected market events, authorized generic launches, products launched at risk, introduction of biosimilars, products under patent litigation or new lowest cost NDC priced net of rebates from the innovator.
11. Assumes client does not have 340B pricing.
12. Guarantees are based upon the above selected BCBSNE Network of pharmacies.
13. Pricing is based upon an implemented BCBSNE Extended Supply Network (90-day retail). If not implemented, Retail rates apply.
14. Pricing is based upon an exclusive specialty network arrangement.
15. Specialty drugs dispensed through the medical benefit will not be included in this guarantee reconciliation.
16. Aggregate Specialty Discount guarantees is defined by the BCBSNE specialty drug management list.
17. Aggregate Specialty Discount guarantees do not include limited distribution drugs nor any new specialty drugs brought to market and added to the specialty list during the term of the contract.
18. BCBSNE reserves the right to revise the pricing terms and financials accordingly but only at renewal, unless otherwise allowed under the terms.
19. If changes occur within the PBM marketplace which lead to a significant deviation from the current economic environment, both parties agree to proactively amend the contract to make all parties commercially reasonably economically neutral.
20. Pricing is subject to change in the event that any law, regulation, interpretation of a law or regulation, or any change within the PBM marketplace would lead to a deviation from the current economic environment upon which these guarantees are based.
21. Unexpected generic launches, products launched at risk or under patent litigation are excluded from our generic guarantees.
22. Any drug determined to be in short supply based on published sources (including the FDA and ASHP websites) will be excluded from our generic guarantees.
23. A drug that has more than a 100% increase in cost will be excluded from the generic guarantees.
24. For purposes of AWP discount and dispensing fees calculations a brand name product is defined as an original patented product from a pharmaceutical company and bioequivalent successor product. that is available from a limited number of manufacturers.
25. For purposes of AWP discount and dispensing fee calculations, generic products are all products not defined as brand name products.
26. Covid-19 related testing, vaccines, and treatments are excluded from guarantee reconciliation.
27. In the event the number of covered members or pharmacy claims volume material changes over the course of the contract, BCBS NE reserves the right to revise guarantee terms and financials accordingly.

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

AUDIT EXHIBIT

A. Audit Agreement

Prior to commencement of any audit, THE GROUP and its audit vendor, if any, shall execute a Non-Disclosure and Audit Agreement with BCBSNE's external audit services department. BCBSNE shall in no event be required to disclose any information in violation of applicable law.

B. Access to Provider Contracts

With regard to its contracts with hospitals or other providers that are not otherwise publicly available, BCBSNE reserves the right to not provide access to the contracts or to provide access only in a manner that BCBSNE deems would protect the confidential and proprietary information contained therein. This reservation of right pertains not only to the actual contracts but also to any data, reports or other information generated, and from which the terms of the contracts could be determined.

C. Procedure

In any audit under the Agreement, THE GROUP shall give BCBSNE notice in writing of its desire to conduct an audit at least sixty-five (65) days in advance. Audits are limited to the most recently completed contract year and must be completed no later than eleven (11) months after the end of that contract year. THE GROUP shall not request more than one (1) paid claims and one (1) financial audit per contract year. THE GROUP understands and agrees that: (a) due to provider contract limitations, BCBSNE will be limited in its ability to make any needed adjustments to paid claims that were incurred beyond the applicable provider lookback period; and (b) BCBSNE's ability to obtain BlueCard® paid claims from Host Blues for audit is limited, as the provision of such paid claims is subject to the approval/discretion of the Host Blue responsible for paying a given paid claim. Unless otherwise agreed, audits shall be conducted during normal working business hours at the offices of BCBSNE. Audits shall be conducted by an auditor that is mutually acceptable to both BCBSNE and THE GROUP. Such acceptance shall not to be unreasonably withheld. THE GROUP and BCBSNE shall mutually agree on the scope and terms of the audit prior to its initiation. BCBSNE shall provide appropriate records and documents for THE GROUP to evaluate the administration of the Plan benefits pursuant to this Agreement. Audits shall not be conducted for the same scope and time frame or portion of time of a previously conducted audit unless THE GROUP is required by a governmental agency to audit a certain period.

D. Types of Audits

1. Paid Claims Audit.

a. Subject to the requirements of this Attachment, applicable laws and regulations, and BCBSNE's corporate policies, THE GROUP shall have the right to conduct an audit of paid claims for Plan benefits that were processed and paid under the terms of this Agreement. The audit shall be coordinated with BCBSNE's external audit services department and will be limited to reviews of paid claim records, membership data, benefit file summaries and other documents considered relevant and applicable by BCBSNE. Audit sampling methodology shall be mutually agreed to by the parties and must be based on the universe of paid claims under review. A preliminary draft of the audit report shall be submitted to BCBSNE prior to issuance of the final report. BCBSNE shall be provided with the opportunity to respond to the draft audit report within a reasonable period of time prior to its finalization.

b. Provided THE GROUP has one thousand (1,000) or more enrolled contract holders at the beginning of the contract year, THE GROUP may audit two hundred (200) paid claims at no cost to THE GROUP. To the extent THE GROUP has less than one thousand (1,000) enrolled contract holders at the beginning of the contract year, THE GROUP may audit up to one hundred (100) paid claims at no cost to THE GROUP. If THE GROUP elects to audit additional paid claims, THE GROUP shall reimburse BCBSNE for each additional paid claim at a rate of fifty dollars ($50) per paid claim.

c. BCBSNE shall make no adjustment or refund on the basis of statistical projections or extrapolations of actual errors. In addition, BCBSNE shall make no adjustment or refund based on industry standard claim processing guidelines or other edits that are not incorporated into BCBSNE's policies and procedures, benefits contracts, or claim processing guidelines. To that end, BCBSNE reimbursement of any overpayments found during the course of an audit will be made on an individual case basis in accordance with the Overpayment section of the Agreement. Processing of adjustments will be subject to the limitations of this Section.

2. **Financial Audits.** For purposes of this section, financial audits are audits performed by a public accounting firm to certify THE GROUP's financial statements. Subject to the requirements of this Section, applicable laws and regulations, and BCBSNE's policies, financial audits shall be limited to an examination of BCBSNE's records of provider charges, reimbursements and amounts invoiced to the Plan under this Agreement. If any financial audit requires more than fifty (50) hours of BCBSNE's time, THE GROUP shall reimburse BCBSNE for personnel time in excess of such hours at the rate of fifty dollars ($50) per hour. THE GROUP shall reimburse BCBSNE for the actual cost of any specialized reporting requested of BCBSNE as part of the audit.

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

Medical Administrative Performance Guarantees

Valid from October 1, 2022, through September 30, 2025

BCBSNE has entered into a performance-driven contract with THE GROUP. Each guarantee level will place a portion of the annual net administrative fees at risk. THE GROUP will have the opportunity to reduce their administrative costs if BCBSNE fails to provide an appropriate level of service. For example, if the performance level achieved indicates the risk charge is 1.00%, at the end of the year BCBSNE would refund 1.00% of the net administration fees paid by THE GROUP during the plan year. The table below will detail the performance levels expected and the penalty for each level.

Guarantee and Level Detail	Amount at Risk (as a % of Net Administration Fee) If Metric is not achieved
One-Time Implementation Guarantees	
Year 1 – Implementation Only	
Summary Plan Description	
• Provide first draft of SPD within 90 days receipt of signed Client Profile	2.0%
ID Cards	
• ID cards will be produced within 30 days of a complete eligibility file being received.	2.0%
Account Team Implementation Satisfaction	
• The Account Team satisfaction score will be 3.5 or better based on THE GROUP's Benefit Staff survey score of a mutually agreed upon survey.	2.0%
Total Fees at Risk for Year 1 Implementation	**6.0%**

Guarantee and Level Detail	Amount at Risk (as a % of Net Administration Fee) If Metric is not achieved
Administrative Guarantees	
Quarterly meetings	
• Within 30 business days after the effective date of the group, BCBSNE will schedule quarterly meetings to be held within 30 business days following the close of the quarter.	2%
Average Speed-to-Answer (ASA) – Average time all member service calls hold before answered	
• 30 seconds or less	2%
First Call Resolution – Percentage of member service calls handled to conclusion on the first call	
• 85% or Higher	2%
Frequency Accuracy – Percentage of Local (Nebraska) medical claims processed accurately	
• 95% or Higher	2%
Dollar Accuracy – Percentage of paid Local (Nebraska) medical gross dollars processed accurately	
• 98% or Higher	2%
Claims Turnaround Time	
• At least 97% of Clean local (Nebraska) Medical Claims Processed within 30 calendar days	2%

Guarantee and Level Detail	Amount at Risk (as a % of Net Administration Fee) If Metric is not achieved
One-Time Implementation Guarantees	
Reporting Requests	
• Standard reports generated within 7 business days of request *(within report availability timeframes)* Reporting request met 95-100%	1%
• Annual Consultative Report THE GROUP will be contacted within two months following the end of the performance period for a scheduled delivery of the annual consultative analysis for the performance period being measured, as identified at the beginning of this attachment.	1%
Total Percentage of Net Administrative Fees at Risk	**20%**

Definitions and Criteria:

a) Net Administration Fee is defined as the billed administration fee less any broker commissions or BlueCard program fees included within the fee, if applicable. Additional program fees which may be billed to THE GROUP (e.g., Disease Management, COBRA administration, etc.) are also excluded from the penalty calculation.

b) The percentage of Net Administration Fee at risk is based on the Administration Fee paid for the performance period and will be calculated within 120 days of the end of the contract.

c) For purposes of this exhibit, clean claim is defined as a claim that does not require additional information to process and contains no defects or errors. When claims are on hold at the request of THE GROUP, performance guarantees will not apply.

d) Turnaround time is measured from the date a clean medical claim is received by BCBSNE to the date it is processed (paid, denied, or pended for information).

e) Should additional information to process ID cards upon implementation be needed from THE GROUP (e.g., incomplete applications, verification of benefits, etc.), the time in which it takes THE GROUP to respond with the required information will be excluded from the ID card performance guarantee measurement upon implementation.

f) Performance Guarantees by BCBSNE are contingent on a minimum medical pass–through (auto-adjudication) rate of 75%. If this pass-through rate is not achieved, the Member/Customer Service and medical Claim Administration guarantees will become null and void.

g) First Call Resolution is measured from the time a member services call is ended until 48 hours after the call to ensure all follow-up documentation and any required mailings are completed.

h) All Claim Administration and Member/Customer Service measurements, with the exception of the Member Service average speed-to-answer (ASA) guarantee, will be based on BCBSNE's entire group block of business and are not client specific. Member Service ASA measurement will be based on combined results with other performance accounts sharing similar guarantees. Measurements exclude non-medical related dental claims as well as pharmacy claims

administered by either Prime (except as noted immediately below), or an outside pharmacy vendor.

i) If THE GROUP has pharmacy benefit administration through BCBSNE/Prime, the Claim Administration guarantees for accuracy and turnaround time measurement will include medical claims and any pharmacy claims which impact the medical deductible and accumulators.

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

Medical Provider Discount Guarantee

Guarantees Valid from October 1, 2022, through September 30, 2023

BCBSNE will guarantee the savings from total billed expenses as shown in the following schedule.

Provider Savings Corridor	Penalty as % of Net Administration Fee
40.0% or Higher	0%
37% through 39.9%	2% Penalty
34% through 36.9%	5% Penalty
Less than 34.0%	10% Penalty

Conditions

The following claims will be excluded from the Provider Savings Guarantee calculation:

- Claims when the billed amount equals the allowed amount
- Mental illness and/or substance dependence and abuse claims
- Maternity and newborn claims
- Prescription drug and dental claims (if a separate dental contract is offered)
- Claims when BCBSNE is the secondary payer (e.g., Medicare is primary)
- Catastrophic Blue Card claims greater than $150,000 in allowed amount
- Out of network claims
- Employer Group exceptions/overrides on appeals or utilization management

The guarantee is subject to consistency in group size and composition. If the group enrollment changes by more than 10% from the census provided during the quote, this guarantee is void.

Reconciliation

Within one hundred twenty (120) days after the end of the contract term, BCBSNE will provide a detailed settlement calculation. Supporting reports illustrating the actual savings will be included. If the actual total savings are **less than 40.0%**, BCBSNE will issue a credit for the penalty per the above schedule.

Note: BlueCard Program fees paid to HOST Blue Plans for claims incurred outside Nebraska are not included within the calculation of the provider savings discount nor are they part of the proposed Administrative Services fee. BlueCard Program fees include per claim fees, percentage of savings fees, and/or Per Contract Per Month fees (if applicable).

Net Administration Fee is defined as the billed administration fee less any broker commissions included within the fee, if applicable. Additional program fees which may be billed to the Group (e.g., Disease Management, COBRA administration, BlueCard Program fees, etc.) are also excluded from the penalty calculation and are not considered Net Medical Administration fees.

City of Grand Island
"THE GROUP"

October 1, 2022
Effective Date

VIRTA DIABETES MANAGEMENT PERFORMANCE GUARANTEES

For any Performance Guarantee to be in effect during any Measurement Period there must be at least 50 Attributed Patients enrolled in a Service for each BCBSNE aggregate pool (e.g., self-funded employers participating in the Virta program). For the purpose of clarity, this means that there must be at least 50 Attributed Patients enrolled in the Virta Service for the corresponding Performance Guarantee to be calculated. Non-Attributed Patients will be included in the next Measurement Period.

Performance Guarantee Reconciliations will be conducted for BCBSNE's self-funded line of business and the associated Attributed Patients as an aggregate pool.

As applicable, Virta's performance targets from baseline are as follows: A1c reduction of 1.0, weight reduction of 5%, and Diabetes-specific Rx reduction of 40%.

Performance Guarantee Models

The specific Performances for the Virta Services may be based on one of the following measurement combinations:

- If pharmacy benefit administration is with Prime Therapeutics, all three measurement components (HbA1c Reduction, Weight Loss and DM Rx Cost Reduction) with a maximum refund risk of 33.33% each will apply; or
- If pharmacy benefit administration is placed with an external vendor other than Prime Therapeutics, two components (HbA1c Reduction and Weight Loss) with a maximum refund risk of 50% each will apply.

Attributed Patients from all group sizes in BCBSNE's self-funded line of business will be included in the aggregate pool Performance Guarantee Reconciliation.

DEFINITIONS

"Attributed Patient" shall mean a Patient enrolled in the Services for at least 180 continuous days during the applicable Measurement Period, with at least one recorded baseline HbA1c greater than or equal to 6.5 (for the purposes of Diabetes Reversal Performance Guarantee), or baseline BMI greater than or equal to 30 (for purposes of Diabetes Reversal, Prediabetes Reversal, or Obesity Treatment Performance Guarantee).

"Baseline HbA1c" is a Patient's Valid HbA1c that is recorded prior to Virta accepting them from treatment into the Services.

If no Baseline HbA1c is available for a Patient such Patient will not be included in any performance guarantee calculations.

"Covered Persons" means the total membership (subscribers plus dependents) enrolled in THE GROUP's health benefit plan.

"Baseline Monthly Rx Claims Cost" is calculated by taking the average monthly Diabetes Specific Pharmacy Costs for all Attributed Patients over the twelve-month period prior to each Attributed Patient's Start Date, when claims data is provided.

"Baseline Weight" is the average of Patient's first three weight measurements recorded by Virta after their Enrollment Date.

"Diabetes Specific Pharmacy Cost" means the sum of the claims amount paid by Plan for Attributed Patients for Outpatient DM Prescription Drugs.

"Measurement Period" is defined as the 12-month period following the first Patient's Start Date and each subsequent 12 month period thereafter.

"Measurement Period Monthly Rx Claims Cost" is the sum of the Attributed Patients' Monthly Diabetes Specific Pharmacy Costs during the Measurement Period

"Performance Guarantees" or **"PGs"** are the clinical and financial targets as identified by Virta in its Statement of Work (SOW) provided to BCBSNE.

"Reconciliation" is the process after each Measurement Period of determining if any Refund is due based on achievement or lack thereof of the Performance Guarantees.

"Reconciliation Period" is the period following the end of a Measurement Period in which the Reconciliation is completed. For calculation of the DM Rx Cost Reduction Performance Guarantee, claims are required that were incurred during the Measurement Period and paid anytime up to and including 90 days after the end of the Measurement Period. The Reconciliation Period begins on the day Virta gets all the claims data necessary to calculate the Performance Guarantees. Within 60 days after the beginning of the Reconciliation Period, Virta will deliver an analysis of the Performance Guarantees to Customer. The Customer then has 60 days to accept the results and/or perform an audit of the results. Any Refund owed to Customer by Virta will be paid within 90 days of the end of the Reconciliation Period.

"Refund" is any amount of money that Virta must return to Customer based on lack of achievement of the Performance Guarantees during any Measurement Period.

"Treatment A1c" is a Patient's Valid A1c measurement that is recorded during the period between 30 days prior to the end of the Measurement Period and 60 days after the Measurement Period.

If Treatment A1c is not available for a Patient, such Patient will not be included in any performance guarantee calculations.

"Treatment Weight" is a Patient's weight that is recorded during the period between 30 days prior to the end of the Measurement Period and 60 days after the Measurement Period.

"Trend Adjustment Factor" is the annual cost increase for Diabetes Management Drugs as reported by the American Diabetes Association (ADA) on a per Patient basis. This factor adjusts for observed patterns in cost increases for a typical diabetic population driven by increased ingredient costs, increased prescribing of higher cost novel drugs, and increased in overall utilization.

"**Valid A1c**" is an A1c measurement that is recorded by (i) a qualified healthcare provider (lab and/or other healthcare professional), (ii) through an FDA approved handheld HbA1c meter; or (iii) a Patient-reported blood glucose reading(s) taken from a from an FDA-approved meter, and using Virta's correlation/prediction algorithms where an A1c cannot be obtained from (i) or (ii) above.

"Virta Error Correction" - Incrementally to the above stated definitions and formulas, if any data is unclear, missing or unable to be collected, Virta may use best efforts to resolve the calculations or analysis with alignment to the overall intentions of this Performance Guarantee.