ADMINISTRATIVE SERVICE CONTRACT

BETWEEN

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

AND

ALASKA RAILROAD CORPORATION

EFFECTIVE JANUARY 1, 2022 THROUGH DECEMBER 31, 2022 (THE "CONTRACT PERIOD")

This Contract is effective by and between the Alaska Railroad Corporation (hereinafter referred to as the "Plan Sponsor"), and Premera Blue Cross Blue Shield of Alaska (hereinafter referred to as the "Claims Administrator" or "we," "us," or "our").

WHEREAS, the Plan Sponsor has established an employee benefit plan (hereinafter referred to as the "Plan") which provides for payment of certain welfare benefits to and for certain eligible individuals as defined in writing by the Plan Sponsor, such individuals being hereinafter referred to as "Members"; and,

WHEREAS, the Plan Sponsor has chosen to self-insure the benefit program(s) provided under the Plan; and

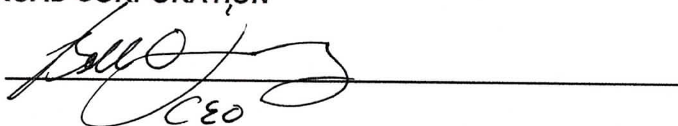
WHEREAS, the Plan Sponsor desires to engage the services of the Claims Administrator to provide administrative services for the Plan;

NOW THEREFORE, in consideration of the mutual covenants and conditions as contained herein the parties hereto agree to the provisions in this Contract, including any Attachments and endorsements thereto. The parties below have signed as duly authorized officers and have hereby executed this Contract. If this Contract is not signed and returned to the Claims Administrator within sixty (60) days of its delivery to the Plan Sponsor or its agent, the Claims Administrator will assume the Plan Sponsor's concurrence and the Plan Sponsor will be bound by its terms.

IN WITNESS WHEREOF the parties hereto sign their names as duly authorized officers and have executed this Contract.

ALASKA RAILROAD CORPORATION

BY:



DATE: 1/31/22

CEO

Title

ADDRESS: 327 W. Ship Creek Ave

Anch AK 99510-

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

BY:

DATE: January 1, 2022

Jim Grazko
President

P.O. Box 327
Seattle, WA 98111-0327

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ALASKA RAILROAD CORPORATION

BY: ______________________________ DATE: ____________________

____
Title

ADDRESS: ______________________________

____

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

BY: DATE: January 1, 2022

Jim Grazko
President

P.O. Box 327
Seattle, WA 98111-0327

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1. DEFINITIONS

Administration Fee Guarantee Period The multi-year period during which the Claims Administrator's base administration fees will not exceed amounts agreed upon by the Claims Administrator and the Plan Sponsor. The Administration Fee Guarantee Period is shown in "Attachment D – Fees Of The Claims Administrator."

Adverse Benefit Determination Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including payment that is based on a determination of the eligibility of a Member to participate in the Plan. This includes any denials, reductions, or failures to provide or make payment resulting from the application of utilization review or limitations on experimental and investigational services, medical or dental necessity, or appropriateness of care. It also includes a decision to rescind a Member's coverage unless the rescission is due to nonpayment of subscription charges.

Affordable Care Act The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowed Amount – <u>For Non-Essentials Plans</u>

The Plan provides benefits based on the Allowed Amount for covered services. The Plan Sponsor's liability for covered services is calculated on the basis of the Allowed Amount.

The Claims Administrator reserves the right to determine the amount allowed for any given service or supply unless specified otherwise in this Contract. The Allowed Amount is described below. There are different rules for dialysis, emergency care services and air ambulance services. These rules are shown below the general rules.

a. General Rules

- **Providers In Alaska and Washington Who Have Agreements With The Claims Administrator**

  For any given service or supply, the Allowed Amount is the lesser of the following:

  - The provider's billed charge; or
  - The fee that the Claims Administrator has negotiated as a "reasonable allowance" for medically necessary covered services and supplies.

  Providers that have contracts with the Claims Administrator agree to seek payment from the Claims Administrator when they furnish covered services to Members. Members will be responsible only for any applicable deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this Plan.

- **Providers Outside Alaska and Washington Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, Allowed Amounts are determined as stated in Attachment A – Out-of-Area Services."

- **Providers in Alaska Who Don't Have Agreements With The Claims Administrator Or Another Blue Cross Blue Shield Licensee**

  The Allowed Amount shall be defined as indicated below. When Members receive services from a provider who does not have an agreement with the Claims Administrator or another Blue Cross Blue Shield Licensee, the Member is responsible for any amounts not paid by the Plan, including amounts over the Allowed Amount. If applicable law requires a different Allowed Amount than the least of the three (3) amounts below, this Plan will comply with that law.

- **For Services and Supplies Received Within the Service Area:**

  In determining the Allowed Amount, the Claims Administrator establishes a profile of billed charges, using statistically credible data for a period of 12 months by examining the range of charges for the same or similar service from providers within each geographical area for which the Claims Administrator receives claims. The Allowed Amount will be no less than the 80th percentile of billed charges for that service. If the Claims

Administrator is unable to obtain sufficient data from a given geographical area, the Claims Administrator will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, the Claims Administrator will set the Allowed Amount to no less than the equivalent of the 80th percentile or no lower than 250 percent of Medicare Allowed Amounts for the same services or supplies, whichever is greater.

- **Services and Supplies from Professional Providers:** The Allowed Amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.
- **Services from Ambulatory Surgical Centers:** The Allowed Amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.
- **Services from Skilled Nursing Facilities, Extended Care Facilities, Birthing Centers, Rehabilitation Facilities, and other Sub-Acute Facilities:** The Allowed Amount will be no less than the 80th percentile of billed charges using the methodology described above.
- **Services from Hospitals (Acute Facilities):** In determining the Allowed Amount, the Claims Administrator establishes a profile of billed charges, using statistically credible data for a period of 12 months by examining the range of charges for the same or similar service from facilities within each geographical area for which the Claims Administrator receives claims. The Allowed Amount will be no less than 80th percentile of billed charges for that service. If the Claims Administrator is unable to obtain sufficient data from a given geographical area, the Claims Administrator will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, the Claims Administrator will set the Allowed Amount to no less than the equivalent of the 80th percentile or no lower than 250 percent of Medicare Allowed Amounts for the same services or supplies, whichever is greater.

- **Providers Outside of Alaska Who Don't Have Agreements With The Claims Administrator Or Another Blue Cross Blue Shield Licensee**

The Allowed Amount for providers outside of Alaska is the least of the three amounts shown below:

- An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges. Note: Non-contracted ground ambulances are always paid based on billed charges.

If applicable law requires a different Allowed Amount than the least of the three (3) amounts above, this Plan will comply with that law.

b. Dialysis Due To End Stage Renal Disease

- **Providers Who Have Agreements With The Claims Administrator Or Other Blue Cross Blue Shield Licensees**

The Allowed Amount is the amount explained above in this definition.

- **Providers Who Don't Have Agreements With The Claims Administrator Or Another Blue Cross Blue Shield Licensee**

The amount the Plan allows for dialysis during Medicare's waiting period will be no less than 125 percent of the amount allowed by Medicare and no more than 90 percent of billed charges.

The amount the Plan allows for dialysis after Medicare's waiting period is 125 percent of the Medicare-approved amount, even when a Member who is eligible for Medicare does not enroll in Medicare.

Allowed Amount – <u>For Essentials Plans</u>

The allowed amount shall mean one of the following:

- **Providers In Alaska and Washington Who Have Agreements With Premera Blue Cross Blue Shield of Alaska**

  For any given service or supply, the allowed amount is the lesser of the following:

  - The provider's billed charge; or
  - The fee that we have negotiated as a "reasonable allowance" for medically necessary covered services and supplies.

  Contracting providers agree to seek payment from Premera Blue Cross Blue Shield of Alaska when they furnish covered services to you. You'll be responsible only for any applicable deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

- **Providers Outside Alaska and Washington Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Alaska And Washington?*** section in this booklet.

- **Providers Who Don't Have Agreements With Premera Blue Cross Blue Shield of Alaska Or Another Blue Cross Blue Shield Licensee**

  The allowed amount shall be 200% of the fee schedule determined by Medicare. When you receive services from a provider who doesn't have an agreement with Premera Blue Cross Blue Shield of Alaska or another Blue Cross Blue Shield Licensee, you're responsible for any amounts not paid by Premera Blue Cross Blue Shield of Alaska including amounts over the allowed amount.

- **Dialysis Due To End Stage Renal Disease**

  Providers Who Have Agreements With Premera Blue Cross Blue Shield of Alaska Or Other Blue Cross Blue Shield Licensees

  The allowed amount is the amount explained above in this definition.

  Providers Who Don't Have Agreements With Premera Blue Cross Blue Shield of Alaska Or Another Blue Cross Blue Shield Licensee

  The amount the plan pays for dialysis during Medicare's waiting period will be no less than 200% of the Medicare-approved amount and no more than 90% of billed charges.

  The amount the plan pays for dialysis after Medicare's waiting period is 200% of the Medicare-approved amount, even when a member who is eligible for Medicare does not enroll in Medicare.

  Please see the ***Dialysis*** benefit for more details.

- **Emergency Care**

  As applicable law requires, for specified covered services received from Non-Contracted Providers or Out-of-Network Providers at facilities that have a Contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Licensee, the cost-sharing for these services shall be the same as if the services were provided by an In-Network Provider.

  Note: Non-contracted ground ambulances are always paid based on billed charges.

  Consistent with applicable laws, Members are not responsible for charges received from Non-Contracted Providers above the Allowed Amount in addition to any deductible, copays or coinsurance that may apply.

d. Air Ambulance

Consistent with the requirements of the Federal No Surprises Act, the cost-sharing for out-of-network air ambulance services shall be the same as if the services were provided by an In-Network Provider. The cost sharing amount shall be counted towards the in-network deductible, if any, and any in-network out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under the Federal No Surprises Act) or the billed amount.

Please Note: Ambulance providers that don't have agreements with Premera Blue Cross Blue Shield of Alaska or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

When you receive services from providers that don't have agreements with Premera Blue Cross Blue Shield of Alaska or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed amount, and for your normal share of the allowed amount (Please see the ***Summary of your Costs*** section for further detail).

If you have questions about this information, please call Premera Blue Cross Blue Shield of Alaska at the number listed on your Premera Blue Cross Blue Shield of Alaska ID card.

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with Premera Blue Cross Blue Shield of Alaska.

Claims Administrator Premera Blue Cross Blue Shield of Alaska.

Contract Period The period shown on the face page of this Contract. The Contract Period begins at 12:01 a.m. on the starting date shown on the face page and ends at midnight on the ending date shown on the face page.

Effective Date The date this Contract takes effect (the first day of the Contract Period). The Effective Date is shown on the face page of this Contract.

Grandfathered Health Plan A Plan benefit package that meets the requirements to be a "grandfathered health plan" set forth in the federal Affordable Care Act regulations. If the Plan consists of more than one (1) benefit package, the federal regulations on grandfathered plan status apply separately to each benefit package.

Medically Necessary Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
  - Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member A Subscriber or dependent who is eligible for coverage as stated in the Plan and who is enrolled as required in the Plan.

In-Network Provider A provider that is in one of the provider networks chosen by the Plan Sponsor for the Plan.

Non-Contracted Provider A provider that does not have a network provider contract with the Claims Administrator or, for out-of-area providers outside Washington (excepting Clark County) and Alaska, with the local Blue Cross and/or Blue Shield Licensee.

Out-Of-Network Provider A provider that is not in one of the provider networks chosen by the Plan Sponsor for the Plan.

Non-Grandfathered Health Plan A Plan benefit package that does not meet the requirements to be a grandfathered health plan set forth in the federal Affordable Care Act regulations. If the Plan consists of more than one (1) benefit package, the federal regulations on non-grandfathered plan status apply separately to each benefit package.

PEPM "Per employee per month."

Plan The employee benefit plan established and maintained by the Plan Sponsor that is being administered under this Contract. The Plan may consist of one (1) or more benefit packages.

Plan Sponsor Alaska Railroad Corporation.

Program Manager Certain vendors of Claims Administrator that provide certain of the administrative services. Claims Administrator arranges for the provision of services by Program Managers, as described in Attachments and Appendixes hereto, as well as other services which may include, based on your selections, provider quality

performance information, supplemental networks, and outcomes-driven drug utilization review and medical drug rebate programs.

Service Area The area in which the Claims administrator directly operates a provider network. This area is made up of the states of Alaska and Washington (except Clark County, Washington)

Subscriber A person who is eligible for coverage under the Plan by virtue of an employee-employer relationship or other relationship between the person and the Plan Sponsor, and who is enrolled as required in the Plan.

2. DUTIES AND RESPONSIBILITIES OF THE PLAN SPONSOR

2.1. Documentation

The Plan Sponsor shall provide the Claims Administrator with a copy of any documents describing the benefit program(s) that the Claims Administrator needs to rely upon in performing its responsibilities under this Contract.

2.2. Administrative Duties

Unless specifically delegated to the Claims Administrator by this Contract, the Plan Sponsor shall be responsible for the proper administration of the Plan including the following:

a. The Plan Sponsor shall provide the Claims Administrator a complete and accurate list of all individuals eligible for benefits under the benefit program(s) and to update those lists monthly. The Claims Administrator shall be entitled to rely on the most recent list until it receives documentation of any change thereto.

   Retroactive enrollments shall be effective on the more recent of two (2) dates:

   - The date the Member’s coverage would have been validly in force
   - The first day of the fifth full calendar month preceding the month in which the Claims Administrator receives the request for retroactive enrollment.

   Retroactive terminations of coverage shall be effective on the more recent of two (2) dates:

   - The date the Member’s coverage would have been terminated, had notification been timely
   - The first day of the fifth full calendar month preceding the month in which the Claims Administrator receives the request for retroactive termination.

b. The Plan Sponsor shall distribute to all eligible Members all appropriate and necessary materials and documents, including but not limited to benefit program booklets, summary plan descriptions, material modifications, enrollment applications and notices required by law or that are necessary for the operation of the Plan.

c. The Plan Sponsor shall provide the Claims Administrator with any additional information necessary to perform its functions under this Contract as may be requested by the Claims Administrator from time to time.

d. If the Plan Sponsor writes or revises its benefit booklet, the Claims Administrator must review and approve in advance the draft of the benefit booklet that is printed and distributed to Members.

   The Plan Sponsor must also include BlueCard (Attachment A) disclosure language approved by the Blue Cross Blue Shield Association in its booklet.

e. In order to place calls to Members, the Claims Administrator may receive Member phone numbers provided by the Plan Sponsor or by a third party (such as a producer) on the Plan Sponsor's behalf. For the Claims Administrator and its affiliates to contact Members in accordance with telecommunication-related laws and regulations, the Plan Sponsor confirms the following with respect to Member phone numbers that the Plan Sponsor has provided or will provide to the Claims Administrator:

   - The Member provided his or her phone number on his or her Plan application, or otherwise provided or updated his or her phone number with the Plan Sponsor with the expectation that it will be provided to the Claims Administrator in connection with the Member's coverage under the Plan.

- The Plan Sponsor only obtains phone numbers directly from the Member and not through a lookup service or other third party.
- The Plan Sponsor retains contact information and will furnish that information to the Claims Administrator upon request in a timely manner.

2.3. Taxes, Assessments, And Fees

The Plan Sponsor shall be responsible for all taxes, assessments and fees levied by any local, state or federal authority in connection with the Claims Administrator's duties pursuant to this Contract.

2.4. Compliance With Law

- The Plan Sponsor shall be responsible for the Plan's continuing compliance with all applicable federal, state and local laws and regulations, as currently amended. These include but are not limited to:
  - The Internal Revenue Code of 1986, as amended, including but not limited to sections 105 and 213(d), and all relevant regulations and rulings thereunder
  - The Affordable Care Act.
  - The No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021
  - The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  - The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
  - Law and regulations governing the treatment and benefits of Members covered by Medicare. These include, but are not limited to, the Medicare Secondary Payer law and regulations, the Medicare Prescription Improvement and Modernization Act of 2004 (MMA), and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

    As required by MMSEA, the Plan Sponsor agrees to provide us the following information:
    - Employer Tax Identification Number (TIN/EIN);
    - Social Security Numbers (SSNs) of all Members (employees and dependents); and
    - Medicare Health Insurance Claim Numbers (HICNs) for all Medicare-entitled Members.

    To comply with the Medicare Secondary Payer law and regulations, the Plan Sponsor also agrees to notify us promptly if the Plan Sponsor experiences a change in total employee count that would change the order of liability according to federal guidelines. Claims Administrator shall not pass along any penalties arising from compliance with Medicare Secondary Payer laws, except to the extent that the Plan Sponsor does not provide the necessary information concerning members and change in total employee count described herein.

    MMA requires groups that provide prescription drug coverage to Medicare eligible individuals to provide Medicare Part D Creditable Coverage Notices, and report creditable coverage status to the Center for Medicare and Medicaid Services (CMS).

  The Plan Sponsor, and not the Claims Administrator, is the "plan administrator" and the "plan sponsor" for purposes of all federal laws that apply to the Plan Sponsor and impose duties or obligations on such entities. The Plan Sponsor shall be responsible for determining whether it is subject to COBRA and, if so, for notifying Members of their COBRA rights both initially and upon the occurrence of a qualifying event, for calculating and collecting premiums for COBRA continuation of coverage and for promptly notifying the Claims Administrator when an individual is no longer eligible for COBRA continuation of coverage. If the Plan Sponsor is subject to ERISA, the Plan Sponsor is responsible to prepare and maintain its ERISA plan document.
- The Plan Sponsor shall defend, indemnify and hold harmless Claims Administrator and its directors, officers, employees, and agents from and against any and all costs, liabilities, damages, claims, losses or expenses (including reasonable attorneys' fees) to the extent such costs, liabilities, damages, claims, losses or expenses (including reasonable attorneys' fees) arise out of the Claims Administrator's

administration of any benefit design authorized by the Plan Sponsor, unless such costs, liabilities, damages, claims, losses or expenses (including reasonable attorneys' fees) are incurred because of Claims Administrator's own negligence. The Plan Sponsor acknowledges its sole responsibility to test and design benefits compliant with all laws.

- If the Plan Sponsor is a governmental entity that elects to opt out of compliance with certain federal mandates as allowed by federal law, the Plan Sponsor is responsible to file its opt-out with federal regulators for each contract period and to notify Members of the opt-out in accordance with federal law and regulations then in effect. The Plan Sponsor agrees to hold the Claims Administrator and the Network harmless for any and all consequences arising from the Plan Sponsor's failure to file an opt-out as required by law for a given contract period, errors in the opt-out filing, or failure to notify a Member as required by federal law.

2.5. Appeals

If an adverse decision is made in the Claims Administrator's second level of review of a Member appeal, the Plan Sponsor shall offer the Member a review by an Independent Review Organization (IRO). The Claims Administrator shall pay all charges required by the IRO to conduct the review.

IRO review is not available on dental plan appeals.

2.6. Funding

The Plan Sponsor shall be solely liable for all benefits payable to Members under the Plan that are subject to this Contract and for care coordination and support fees payable to the Claims Administrator for the Premera-Designated Centers of Excellence program. The Plan Sponsor agrees to the following:

a. **Provision Of Funds** The Plan Sponsor shall maintain adequate funds from which the total cost of all claims and fees described herein for each preceding week will be paid to the Claims Administrator by electronic funds transfer (EFT). Funds must be provided within two (2) business days of notification by the Claims Administrator to a person designated by the Plan Sponsor.

b. **Late Payments** If timely payment for the claims is not received by the Claims Administrator, the Plan Sponsor shall pay the Claims Administrator a daily late charge. This late charge is calculated from the first day following the period of two (2) business days stated above. This late charge is based on the average monthly prime rate posted by Claims Administrator's designated bank during the Contract Period, plus two (2) percent on the amount of the late payments for the number of days late. Late charges are due at the end of the Contract Period or, if earlier, upon termination of the Contract.

c. **Notices** Notices required by this subsection and subsection 3.4 shall be by secure e-mail unless another method is agreed upon in writing by the Plan Sponsor and the Claims Administrator.

3. DUTIES AND RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR

3.1. Incorporation of Response to RFP

In accordance with Section 4.02 of the Introduction & Instructions to Alaska Railroad Corporation Request for Proposals #17-17-205682 and #17-18-205684, Claims Administrator hereby acknowledges that the terms and conditions of its Response to #17-17-205682 and #17-18-205684 ("Response") are hereby incorporated in total into this Contract by reference and are attached hereto as Attachment J. To the extent that there is a conflict between the terms of this Contract and the terms of the Response, the terms of the Response shall control.

The Claims Administrator agrees to perform the following administrative services for the Plan Sponsor. The Claims Administrator shall:

a. assist in the preparation and printing of the benefit program booklets, identification cards, and other materials necessary for the operation of the Plan; and distribute identification cards to Members.

   The Claims Administrator shall be responsible to include approved BlueCard program disclosure language in the booklets it prepares. If the Plan Sponsor prepares its own booklets, the Claims Administrator shall provide approved language to the Plan Sponsor for inclusion in the booklets;

b. perform reasonable internal audits as stated in section 6 of this Contract;

c. answer inquiries from the Plan Sponsor, Members, and service providers regarding the terms of the Plan, although final authority for construing the terms of the Plan's eligibility and benefit provisions is the Plan Sponsor's;

d. prepare and provide the Plan Sponsor with reports of the operations of the Plan in accordance with "Attachment C – Reporting";

e. coordinate with any stop-loss insurance carrier;

f. when the plan makes use of one (1) or more of the Claims Administrator's provider networks, maintain a network of healthcare facilities and professionals as applicable to the plan design. Paid claims to such providers will reflect any applicable provider discounts;

g. perform care facilitation services as identified in "Attachment F – Carecompass360°."

h. manage the formulary chosen by the Plan Sponsor.

i. **Pharmacy Benefit Program** For pharmacy benefit claims, Claims Administrator will pay Plan Sponsor a prescription drug rebate payment equal to a specific amount per paid brand-name prescription drug claim. Prescription drug rebates Claims Administrator receives from its pharmacy benefit administrator in connection with Claims Administrator's overall pharmacy benefit utilization may be more or less than the Plan Sponsor's rebate payment. Claims Administrator shall make the Plan Sponsor's rebate payment to the Plan Sponsor on a calendar quarterly basis unless agreed upon otherwise.

   The allowable charge for prescription drugs is higher than the price paid to the pharmacy benefit manager for those prescription drugs.

   The parties hereby agree that the difference between the allowable charge for prescription drugs and the price paid to the pharmacy benefit manager, and the prescription drug payments received by Claims Administrator from its pharmacy benefit manager, constitutes our property, and not part of the compensation payable to Plan Sponsor under this Contract, and that Claims Administrator is entitled to retain and shall retain such amounts and may apply them to the cost of its operations and the pharmacy benefit.

   Medical Benefit Drug Program The medical benefit drug program is separate from the pharmacy program. It includes claims for drugs delivered as part of medical services. For medical benefit drug claims, the Claims Administrator may contract with subcontractors that have rebate contracts with various manufacturers. Rebate subcontractors retain a portion of rebates collected as a rebate administration fee. The Claims Administrator retains a portion of the rebate. The Plan Sponsor’s medical benefit drug rebate payment shall be made to the Plan Sponsor on an annual basis if the rebate is $500 or more. If less than $500, the Claims Administrator will retain the medical benefit drug rebate.

j. The Claims Administrator, at its sole discretion, reserves the right to delegate some or all of its duties and responsibilities under this Contract to a third party.

3.2. Appeals

a. The Claims Administrator shall review and respond to the initial appeals made by Members of Adverse Benefit Determinations (see section 1) as described in the benefit booklet provided by the Claims Administrator for this Plan.

   The Claims Administrator shall also provide a second review of adverse Member appeal decisions made after its initial review. This review will be conducted as described in the benefit booklet provided by the Claims Administrator for this Plan.

b. If an adverse decision on a Member's appeal results from the Plan's internal appeal process, the Claims Administrator agrees to facilitate a review of the appeal by an Independent Review Organization (IRO) on behalf of the Plan Sponsor. The Claims Administrator will submit all required documentation regarding the appeal to the IRO and work with the IRO as needed to complete its review.

   The external appeal process for Non-Grandfathered Plans will be offered and administered in accordance with the requirements of the Affordable Care Act.

   IRO review is not available on dental plan appeals.

   The Claims Administrator shall pay the charges required by the IRO to conduct its review.

3.3. Claims Processing

The Claims Administrator shall process all eligible claims incurred after the Effective Date of this Contract which are properly submitted in accordance with the procedures set forth in the Plan Sponsor's benefit booklet.

The Claims Administrator shall make reasonable efforts to determine that a claim is covered under the terms of the Plan as described in the benefit booklet, to apply the coordination of benefits provisions, and prepare and distribute benefit payments to Members and/or service providers. The Claims Administrator shall make reasonable efforts to identify and recover overpayments due to claim processing errors that were within its control, retroactive cancellations, or fraudulent billing practices. "Reasonable" for the purposes of this section s the standard of conduct that would be applied to a similarly situated claims administrator.

3.4. Funding Support

The Claims Administrator shall follow the steps below to facilitate the Plan Sponsor's funding of its Plan.

a. Claim payment checks will be issued on the Claims Administrator's check stock. However, as stated in subsection 2.6 above, the responsibility for funding benefits is the Plan Sponsor's and the Claims Administrator is not acting as an insurer.

b. Each week, the Claims Administrator shall notify the Plan Sponsor of the amount due for the prior week's claims. Notice will be by secure e-mail unless another method is agreed upon in writing by the Claims Administrator and the Plan Sponsor.

3.5. Participation In Class Action Suits

Subject to the limitation included in this Section 3.7, the Plan Sponsor hereby delegates to the Claims Administrator the authority to participate on behalf of the Plan Sponsor, and at the Claims Administrator's sole discretion, in class action lawsuits or settlements regarding any services or supplies covered under the terms of the Plan. Examples of such services or supplies include prescription or specialty drugs or medical devices. Claims Administrator will provide reasonable prompt notice to the Plan Sponsor of the Plan's participation in any class action lawsuit or settlement prior to Plan's participation. Such prior approval shall not be unreasonably withheld. Such participation shall be limited to those instances in which the Claims Administrator determines that it will submit a claim in the subject suit on behalf of its insured book of business. The Claims Administrator shall have no obligation to participate on behalf of the Plan Sponsor in any other lawsuit or settlement. The Claims Administrator will have no obligation to file claims on behalf of a Plan Sponsor with which the Claims Administrator does not have a contract at the time the claims for recovery are submitted.

The Plan Sponsor will recover the amount it is due under the terms of the settlement in question based upon the data submitted by the Claims Administrator. Any amounts recovered by the Claims Administrator hereunder shall be net of the Claims Administrator's fee as set forth below as well as fees paid to outside counsel in connection with the lawsuit and/or settlement.

For each class action lawsuit or settlement in which the Claims Administrator participates hereunder on the Plan Sponsor's behalf, the Plan Sponsor shall pay the Claims Administrator a fee representing a proportionate share of a fixed amount intending to compensate the Claims Administrator for its work in connection with pursuing recovery in these cases. The fixed amount is shown in "Attachment D – Fees Of The Claims Administrator." This fixed amount is subject to change on an annual basis with at least 60 days' advance notice to the Plan Sponsor. The amount of the Claims Administrator's fee payable by each Plan Sponsor shall be based on the proportion of the total amount recovered by the Claims Administrator on behalf of the Plan Sponsor compared to the amount recovered by Claims Administrator for all lines of business. The fee will be deducted from the amount of any recovery received on behalf of the Plan Sponsor and will in no event exceed the amount of such recovery.

Payment hereunder shall be made within 60 days of the Claims Administrator's receipt of the settlement funds.

The Claims Administrator shall have no obligation to forward settlement funds if the amount due to the group is less than $5.

The Plan Sponsor may elect to decline to participate in the Claims Administrator's recovery process related to class action lawsuits or settlements regarding any services or supplies covered under the Plan by providing the Claims Administrator written notice. Except as set forth below, in the event the Plan Sponsor opts out, the Claims Administrator shall have no further obligation whatsoever to the Plan Sponsor in connection with the recovery process. The Plan Sponsor may request that the Claims Administrator gather data necessary for the Plan Sponsor to submit its own claim. In any such case, the Plan Sponsor shall pay the amount shown in "Attachment

D – Fees Of The Claims Administrator" for the data-gathering services. Additionally, the Plan Sponsor shall make any such request in writing a minimum of 30 days in advance of the claim filing deadline.

4. LIMITS OF THE CLAIMS ADMINISTRATOR'S RESPONSIBILITY

It is recognized and understood by the Plan Sponsor that the Claims Administrator is not an insurer and that the Claims Administrator's sole function is to provide claims administration services and the Claims Administrator shall have no liability for the funding of benefits.

The Claims Administrator is empowered to act on behalf of the Plan Sponsor in connection with the Plan only as expressly stated in this Contract or as mutually agreed to in writing by the Claims Administrator and the Plan Sponsor.

This Contract is between the Claims Administrator and the Plan Sponsor and does not create any legal relationship between the Claims Administrator and any Member or any other individual.

4.1. Recoveries

If, during the course of an audit performed internally by the Claims Administrator as described in subsection 3.1.b. above or by the Plan Sponsor pursuant to section 6 below, any error is discovered, the Claims Administrator shall use reasonable efforts to recover any loss resulting from such error.

4.2. Independent Contractor

The Claims Administrator is an independent contractor with respect to the services being performed pursuant to this Contract and shall not for any purpose be deemed an employee or agent of the Plan Sponsor.

4.3. Limits of Liability

It is recognized by the parties that errors may occur, and it is agreed that the Claims Administrator will not be held liable to the Plan Sponsor for such errors unless they resulted from its negligence or willful misconduct.

5. FEES OF THE CLAIMS ADMINISTRATOR

5.1. Payment Time Limits

By the first of each month, The Plan Sponsor shall pay the Claims Administrator in accordance with the fee schedule set forth in "Attachment D – Fees Of The Claims Administrator."

5.2. Late Payments

a. If, for any reason whatsoever, the Plan Sponsor fails to make a timely payment required under this Contract by the thirtieth day of the month in which payment is due, the Claims Administrator may suspend performance of services to the Plan Sponsor, including processing and payment of claims, until such time as the Plan Sponsor makes the required payment, including interest as set forth in c. below.

b. In the event of late payment, the Claims Administrator may terminate this Contract pursuant to subsection 8.5 below. Acceptance of late payments by the Claims Administrator shall not constitute a waiver of its right to cancel this Contract due to subsequent delinquent or nonpayment of fees.

c. The Claims Administrator will charge interest to the Plan Sponsor on all payments received after the thirtieth day of the month in which they are due, including amounts paid to reinstate this Contract after termination pursuant to subsection 8.5 below, at the average prime rate posted by Claims Administrator's designated bank during the Contract Period plus two (2) percent on the amount of the late payments for the number of days late. Interest will be in addition to any other amounts payable under this Contract.

5.3. Customization Fees

The Plan Sponsor shall pay the Claims Administrator a "customization fee" when the Plan Sponsor requests either of the following:

a. A plan benefit configuration that the Claims Administrator has not determined to be standard for the plan type. Customization fees for nonstandard plan benefits assessed at this Contract's Effective Date are listed in "Attachment D – Fees Of The Claims Administrator."

b. An off-anniversary benefit change, regardless of whether the desired benefit is standard for the plan type. The customization fee for each off-anniversary change shall be $2,000. Customization fees for off-anniversary changes shall be invoiced separately to the Plan Sponsor.

   For purposes of customization fees, "benefits" include eligibility, termination, continuation, and benefit payment provisions, benefit terms, limitations, and exclusions, funding arrangement changes, and any other standard provisions of the Plan. Fees are computed based on current administrative costs to implement and administer the benefit.

   Customization fees for custom benefits that take effect on the Effective Date shown on the face page of this Contract are due and payable prior to that Effective Date. Customization fees for off-anniversary benefit changes are due and payable prior to the effective date of the change.

6. AUDIT

Within thirty (30) days of written notice from the Plan Sponsor, the Claims Administrator shall allow an authorized agent of the Plan Sponsor to inspect or audit all records and files maintained by the Claims Administrator which are directly pertinent to the administration of the Plan a for the current or most recently ended contract period. Such documents shall be made available at the administrative office of the Claims Administrator during normal business hours. The Plan Sponsor shall be liable for any and all fees charged by the auditor. All audits shall be subject to the Claims Administrator's audit policies and procedures then in effect. Audits will be requested no more than once in every 12 consecutive months, unless the parties agree that the additional audit is needed to address a specific issue or is required by law. To the extent that the Plan Sponsor requests data and reports that are beyond the scope of the Claim Administrator's audit policies and procedures, the Plan Sponsor shall reimburse the Claims Administrator for the additional administrative costs incurred in producing such data and reports.

Any agent or auditor who has access to the records and files maintained by the Claims Administrator shall agree not to disclose any proprietary or confidential information used in the business of the Claims Administrator.

7. TERM OF CONTRACT

7.1. Contract Period

The term of this Contract shall be the Contract Period shown on the face page of this Contract. If the Plan Sponsor and the Claim Administrator agree to extend the Contract for another contract period by means of an amendment, the term of this Contract shall be the Contract Period shown on the amendment.

Except as stated otherwise in this section and in subsection 7.2 below, the terms and conditions of this Contract and the fee schedule set forth in "Attachment D – Fees Of The Claims Administrator" are established for the Contract Period. Midyear benefit or administrative changes (other than those in 8.2.a.6.) require thirty (30) days advance written notice and the advance approval of the Claims Administrator.

The Claims Administrator reserves the right to amend this Contract at any time if needed to comply with applicable law or regulation.

7.2. Changes to Fees

The Plan Sponsor acknowledges that the fee schedule set forth in "Attachment D – Fees Of The Claims Administrator" and the services provided for in this Contract are based upon the terms of the Plan and the enrollment as they exist on the Effective Date of this Contract.

a. Any substantial changes, whether required by law or otherwise, in the terms and provisions of the Plan or in enrollment may require that the Claims Administrator incur additional expenses. The parties agree that any substantial change, as determined by the Claims Administrator after consultation with the Plan

Sponsor, shall result in the alteration of the fee schedule, even if the alteration is during the Contract Period. The phrase "any substantial change" shall include, but not be limited to:

1. a fluctuation of ten (10) percent or more in the number of Members as set forth on the census information included in "Attachment B – Census Information" which is herein incorporated by reference and made a part of this Contract;
2. the addition of benefit program(s) or any change in the terms of the Plan's eligibility rules, benefit provisions or record keeping rules that would increase administration costs by more than $2,000;
3. any change in claims administrative services, benefits or eligibility required by law;
4. any change in administrative procedures from those in force at the inception of this Contract that is agreed upon by the parties;
5. any additional services which the Claims Administrator undertakes to perform at the request of the Plan Sponsor which are not specified in this Contract such as the handling of mailings or preparation of statistical reports and surveys not specified in the Claims Administrator's standard Employer Group Reporting set.
6. A change in the third-party administrator, if any, used by the Plan Sponsor with respect to the benefits provided under this Contract. The Plan Sponsor will provide the Claims Administrator no less than 120 days' advance written notice of any such change.

b. The Claims Administrator may also adjust the fees during the Contract Period by giving thirty (30) days advance written notice to the Plan Sponsor or its agent, if the Plan Sponsor agrees with the Claims Administrator that the fees are based in whole or in part upon a mistake that materially impacts such fees.

8. TERMINATION

8.1. Termination With Notice

The Plan Sponsor may terminate this Contract at any time by giving the Claims Administrator thirty (30) days written notice.

8.2. Contract Period Expiration

This Contract will terminate on the last day of the Contract Period or the last day of any extension of the Contract Period granted by the Plan Sponsor.

8.3. Termination Due to Insolvency

Either party may terminate this Contract effective immediately by giving written notice to the other if a party becomes insolvent, makes a general assignment for the benefit of creditors, files a voluntary petition of bankruptcy, suffers or permits the appointment of a receiver for its business or assets, or becomes subject to any proceeding under any bankruptcy or insolvency law, whether foreign or domestic. A party is insolvent if it has ceased to pay its debts in the ordinary course of business; cannot pay its debts as they become due; or the sum of its debts is greater than the value of its property at a fair valuation.

8.4. Termination Due to Inability to Perform

If loss of services is caused by, or either party is unable to perform any of its obligations under this Contract, or to enjoy any of its benefits because of natural disaster, action or decrees of governmental bodies or communication failure not the fault of the affected party, such loss or inability to perform shall not be deemed a breach. The party who has been so affected shall immediately give notice to the other party and shall do everything possible to resume performance. Upon receipt of such notice, all obligations under this Contract shall be immediately suspended. If the period of nonperformance exceeds thirty (30) days from the receipt of such notice, the party whose performance has not been so affected may, as its sole remedy, terminate this Contract by written notice to the other party effective immediately. In the event of such termination, the Plan Sponsor shall remain liable to the Claims Administrator for all payments due, together with interest thereon as provided for in subsection 5.2.c. above. Notwithstanding the foregoing, this Section 8.4 contemplates that Claims Administrator has in place a Business Continuity and Disaster Preparedness Plan, which can be reviewed by Plan Sponsor upon request.

8.5. Termination For Nonpayment

The Claims Administrator may, at its sole discretion, terminate this Contract effective as of a missed payment due date in the event that the Plan Sponsor fails to make a timely payment required under this Contract and has not cured such non-payment within five business days following written notice of from Claims Administrator.

8.6. Plan Sponsor Liability Upon Termination

At the expense of the Plan Sponsor, the Claims Administrator shall make available a record of deductibles and coinsurance levels for each Member and deliver this information to the Plan Sponsor or its authorized agent.

8.7. Claims Runout

The Plan Sponsor continues to be solely liable for claims received by the Claims Administrator after the Contract terminates. For the fifteen (15)-month period following termination of this Contract, the Claims Administrator shall continue to process eligible claims incurred prior to termination, or adjustments to claims incurred prior to termination, that the Claims Administrator receives no more than twelve (12) months after the date of termination at the claims runout processing fee rate set forth in "Attachment D – Fees Of The Claims Administrator."

The runout processing charge will be due in full with the first request for claims reimbursement made during the runout period.

If the Claims Administrator receives claims for Plan benefits more than twelve (12) months after the date this Contract terminates, Claims Administrator shall deny those claims. If the Plan Sponsor wants to negotiate a different arrangement, the Plan Sponsor must contact the Claims Administrator no later than the start of the fourteenth month after the date this Contract terminates.

This "Claims Runout" provision shall survive termination of this Contract.

9. DISCLOSURE

It is recognized and understood by the Plan Sponsor that the Claims Administrator is subject to all laws and regulations applicable to Claims Administrators and hospital and medical service plans.

It is also recognized and understood by the Plan Sponsor that the Claims Administrator is not acting as an insurer and also is not providing stop-loss insurance.

10. OTHER PROVISIONS

10.1. Choice of Law

The validity, interpretation, and performance of this Contract shall be controlled by and construed under the laws of the state of Alaska, unless federal law applies. Any and all disputes concerning this Contract shall be resolved in the state of Alaska or federal court as appropriate.

10.2. Proprietary Information

The Claims Administrator reserves the right to, the control of, and the use of the words "Premera Blue Cross Blue Shield of Alaska" and all symbols, trademarks and service marks existing or hereafter established. The Plan Sponsor shall not use such words, symbols, trademarks or service marks in advertising, promotional materials, materials supplied to Members or otherwise without the Claims Administrator's prior written consent which shall not be unreasonably withheld.

The Claims Administrator's provider reimbursement information is proprietary and confidential to the Claims Administrator and will not be disclosed to the Plan Sponsor unless and until a separate Confidentiality Agreement is executed by the parties. For the purposes of this section, "provider reimbursement information" means data containing, directly or indirectly (a) diagnostic, procedures or other code sets; and (b) billed amount, allowed amount, paid amount or any other financial information for In-Network and Out-Of-Network hospitals, clinics, physicians, other health care professionals, pharmacies and any other type of facility. Such data may or may not specifically identify providers. No other provision of this Contract or any other agreement or understanding between the parties shall supersede this provision.

10.3. Parties To The Contract

The Plan Sponsor hereby expressly acknowledges, on behalf of itself and all of its Members, its understanding that this Administrative Service Contract and it's attachments constitutes a Contract solely between the Plan Sponsor and the Claims Administrator, that the Claims Administrator 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 the Claims Administrator to use the Blue Cross Service Mark in the States of Washington and Alaska, and that the Claims Administrator is not contracting as the agent of the Association.

The Claims Administrator may perform any of the services described in this Agreement through agents and subcontractors selected by the Claims Administrator. Claims Administrator shall reasonably supervise any such agent or subcontractor, and the retention of such agents or subcontractors shall not relieve Claims Administrator of its duties hereunder.

The Plan Sponsor further acknowledges and agrees that it has not entered into this Administrative Service Contract based upon representations by any person other than the Claims Administrator, and that no person, entity or organization other than the Claims Administrator shall be held accountable or liable to the Plan Sponsor for any of the Claims Administrator's obligations to the Plan Sponsor created under this Administrative Service Contract. This provision shall not create any additional obligations whatsoever on the Claims Administrator's part other than those obligations created under other provisions of this Administrative Service Contract.

10.4. Notice

Except for the notice given pursuant to the "Funding" subsection of Section 2, any notice required or permitted to be given by this Contract shall be in writing and shall be deemed delivered three (3) days after deposit in the United States mail, postage fully prepaid, return receipt requested, and addressed to the other party at the address as shown on the face page of this Contract or such other address provided in writing by the parties.

10.5. Integration

This Contract, and the Response Incorporated in Section 3.1, including any appendices, amendments or attachments incorporated herein by reference, embodies the entire Contract and understanding of the parties and supersedes all prior oral and written communications between them. Only a writing signed by both parties hereto may modify the terms.

10.6. Assignment

Neither party shall assign this Contract or any of its duties or responsibilities hereunder without the prior written approval of the other.

10.7. Survival

The following provisions shall survive the termination of this Contract:

a. The funding of claims incurred prior to termination and processed during the runout period described in 8.7 Claims Runout. The funding provisions are described in subsections 2.6 and 3.4, and the payment of runout processing fees is described in subsection 8.7.

b. The liability, hold harmless and indemnification provisions of subsection 4.3

c. The Effect on Termination section in the Business Associate Agreement

d. The provisions of subsection 8.6

e. The liability, hold harmless and indemnification provisions in Attachment H – Funding Accounts

f. The provisions of Attachment I – Allowed Amount Instructions (For **Essentials** Plans)

10.8. Independent Contractors

All health care providers who provide services and supplies to a Member do so as independent contractors. None of the provisions of the plan or this Contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between the Claims Administrator and the provider of service other than that of independent contractors.

11. ATTACHMENTS TO THE ADMINISTRATIVE SERVICE CONTRACT

The following attach to and become part of the body of this Contract and they are herein incorporated by reference.

ATTACHMENT A – OUT-OF-AREA SERVICES

ATTACHMENT B – CENSUS INFORMATION

ATTACHMENT C – REPORTING

ATTACHMENT D – FEES OF THE CLAIMS ADMINISTRATOR

ATTACHMENT D.a. – ALASKA RAILROAD RENEWAL LETTER

ATTACHMENT E – BUSINESS ASSOCIATE AGREEMENT

ATTACHMENT F – CARECOMPASS360°

ATTACHMENT G – EXTENDED POST-PAYMENT RECOVERY SERVICES

ATTACHMENT H – FUNDING ACCOUNTS

ATTACHMENT I – ALLOWED AMOUNT INSTRUCTIONS – FOR **ESSENTIALS** PLANS

ATTACHMENT J – FIDUCIARY AUTHORITY

ATTACHMENT K – ELECTIVE PROCEDURE TRAVEL SUPPORT

ATTACHMENT L – PREMERA-DESIGNATED CENTERS OF EXCELLENCE

ATTACHMENT M – PREMERA VALUE-BASED PROVIDER ARRANGEMENTS

ATTACHMENT N – PERFORMANCE GUARANTEES

ATTACHMENT O – RFP RESPONSES

ATTACHMENT A – OUT-OF-AREA SERVICES

As a Licensee of the Blue Cross and Blue Shield Association (BCBSA), the Claims Administrator has arrangements with other Blue Cross and/or Blue Shield Licensees ("Host Blues") for Members care outside the Service Area. These arrangements are called "Inter-Plan Arrangements." The Claims Administrator is required by BCBSA to disclose the information below about these Inter-Plan Arrangements to groups with which the Claims Administrator does business. The Plan Sponsor has consented to this disclosure to permit the Claims Administrator to satisfy its contractual obligations to BCBSA. This provision defines or modifies the rights and obligations of the parties under this Contract only for the processing of claims for care outside the Service Area.

The Inter-Plan Arrangements follow rules and procedures set by BCBSA. The Claims Administrator remains responsible to the Plan Sponsor for fulfilling its obligations under this Contract.

A Member's receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any eligibility requirements of the Plan.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' In-Network Providers. The Host Blue is responsible for contracting and handling all interactions with its In-Network Providers. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (Non-Contracted Providers). This Attachment explains how the Plan pays both types of providers.

Note: The Claims Administrator processes claims for the Prescription Drugs benefit directly, not through an Inter-Plan Arrangement.

BlueCard Program

Except for copays, the Claims Administrator will base the amount Members must pay for claims from Host Blues' In-Network Providers on the lower of the provider's billed charge for the covered services or the Allowed Amount that the Host Blue made available to the Claims Administrator.

Most often, the Plan Sponsor’s liability for those claims is calculated based on the same amount on which the Member’s liability is calculated. However, sometimes the Host Blue's Allowed Amount may be greater than the billed charges if the Host Blue has negotiated with an In-Network Provider an exclusive allowance (such as a per-case or per-day amount) for specific services. This excess amount may be needed to secure (a) the provider's participation in the Host Blue's network and/or (b) the overall discount negotiated by the Host Blue. Because the Member never has to pay more than the billed charge, the Plan Sponsor may be liable for the amount above the provider's billed charge even when the Member's deductible, if any, has not been satisfied.

Host Blues determine Allowed Amounts for covered services, which are reflected in the terms of their In-Network Provider contracts. The Allowed Amount can be one of the following:

- An actual price. An actual price is a negotiated amount passed to the Claims Administrator without any other increases or decreases.
- An estimated price. An estimated price is a negotiated price that is reduced or increased 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.
- An average price. An average price is a percentage of billed charges for the covered services representing the aggregate payments that the Host Blue negotiated with all of its In-Network Providers or its In-Network Providers in the same or similar class. It may also include the same types of claim- and non-claim-related transactions as an estimated price.

The use of estimated or average pricing may result in a difference between the amount the Plan Sponsor pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program

requires that the Host Blue's Allowed Amount for a claim is final for that claim. No future estimated or average price adjustment will change the pricing of past claims.

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

Variance account balances are small amounts compared to overall claims amounts and will be drawn down over time. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

Clark County Providers Services in Clark County, Washington are processed through BlueCard. However, some providers in Clark County do have contracts with the Claims Administrator. These providers will submit claims directly to the Claims Administrator and benefits will be based on the Claims Administrator's Allowed Amount for the covered service or supply.

Value-Based Programs Members might receive covered services from providers that participate in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and coordinating care when the Member is seeing multiple providers. Some of these programs are similar to those the Claims Administrator has in Washington. Types of value-based programs are accountable care organizations, global payment/total cost of care arrangements, patient-centered medical homes and shared savings arrangements.

The Host Blue may pay VBP providers for meeting standards for treatment outcomes, cost and quality, and coordinating care over a period of time called a measurement period. The Claims Administrator then passes these payments through to the Plan Sponsor. Sometimes, VBP payments are made before the end of the measurement period.

The Host Blue may bill VBP payments for Members in one of two ways:

- **In the Allowed Amount** Host Blues may adjust the Allowed Amount for VBP provider claims to include VBP payments. The actual dollar amount or a small percentage increase may be included.

  If the VBP pays a fee to the provider for coordinating the Member's care with other providers, the Host Blues may also bill these fees with claims. They will use a separate procedure code for care coordination fees.

  Members will have to pay a share of VBP payments when Host Blues include VBP charges in claims and a deductible or coinsurance applies to the claim. Members will not be billed for any VBP care coordination fees.

- **Billed Separately** Instead of adjusting claims, some Host Blues bill VBP payments as a "per Member per month" (PMPM) charge for each Member who participates in the Value Based Program. The Claims Administrator passes these PMPM amounts on to the Plan Sponsor.

Some Host Blues' claims adjustments or PMPM amounts used for VBP payments may be estimates. As a result, these Host Blues hold part of the amounts paid by the Plan Sponsor and Member in a variance account. The Host Blues will use these funds to adjust future VBP payments as explained under "BlueCard Program" above.

Taxes, Surcharges And Fees

In some cases, a law or regulation may require that a surcharge, tax, or other fee be applied to claims under this Plan. When this occurs, the Claims Administrator will disclose that surcharge, tax or other fee to the Plan Sponsor as part of its liability.

Non-Contracted Providers

When covered services are provided outside the Claims Administrator's Service Area by Non-Contracted providers, the Allowed Amount will generally be based on either the Claims Administrator's Allowed Amount for

these providers or the pricing requirements under applicable law. Members are responsible for the difference between the amount that the Non-Contracted Provider bills and this Plan's payment for the covered services. Please see the definition of "Allowed Amount" in Section 1 in this Contract for details on Allowed Amounts.

Return of Overpayments

Recoveries of overpayments can arise in several ways. Examples are anti-fraud and abuse recoveries, provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts will generally be applied on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Plan Sponsor separately. The fee is usually a percentage of the amount recovered.

Unless otherwise agreed to by the Host Blue, the Claims Administrator may request adjustments from the Host Blue for full refunds from providers due to the retroactive cancellation of Members, but never more than 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 retroactive cancellations may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or its provider contracts or would jeopardize its relationship with its providers.

Blue Cross Blue Shield Global® Core

If Members are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core. 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 helps Members access a provider network, they will typically have to pay the provider and submit the claims themselves to get reimbursement for covered services. However, if Members need hospital inpatient care, the Service Center can often direct them to hospitals that will not require them to pay in full at the time of service. These hospitals will also submit the Member's claims to Blue Cross Blue Shield Global Core.

Fees and Compensation

In-Network Providers The Plan Sponsor understands and agrees to reimburse the Claims Administrator for certain fees and compensation which the Claims Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to BCBSA, and/or to Inter-Plan Programs vendors, as described below. The fees may be revised in accordance with Inter-Plan Programs standard procedures, which do not provide for prior approval by any plan sponsor. Such revisions typically are made on January 1, but may occur at any time. Revisions do not necessarily coincide with the Plan Sponsor’s benefit period under this Contract.

Only the "access fee" can be charged separately each time a claim is processed. The access fee is charged by the Host Blue to the Claims Administrator for making its applicable provider network available to Members. The access fee will only apply to In-Network Providers' claims. If such a fee is charged, it will be a percentage of the discount/differential the Claims Administrator receives from the Host Blue. The access fee will not exceed $2,000 for any claim.

All other Inter-Plan Programs-related fees are covered by the Claims Administrator's general administration fee. See "Attachment D – Fees of the Claims Administrator."

Non-Contracted Providers All fees related to Non-Contracted Provider claims are covered by the Claims Administrator's general administration fee.

ATTACHMENT B – CENSUS INFORMATION

Administration Fees, effective January 1, 2022, are based on the following:

Number of Active, Cobra and Retired Members:

		Employee	**Dependents**
Active	Medical/Rx	528	744
	Dental	534	715
COBRA	Medical/Rx	2	1
	Dental	2	0
Retiree	Medical/Rx	37	16
	Dental	0	0

Other Medical/Rx/Dental/Vision Carriers Offered: Railroad Employee National Dental Plan

ATTACHMENT C – REPORTING

A standard package of reports covering the Contract Period will be provided to the Plan Sponsor within the fees set forth in "Attachment D – Fees Of The Claims Administrator." The reports will cover:

- Funding revenue
- Paid claims
- Census data
- Claims summaries by:
  - Provider type
  - Service type
  - Coverage type

Please note that reports, format, and content may be modified from time to time as needed.

If the Plan Sponsor requests a report that includes information not provided in our standard package of reports or a custom format for standard data, we reserve the right to charge additional fees as needed for that report.

ATTACHMENT D – FEES OF THE CLAIMS ADMINISTRATOR

ATTACHMENT D
to the Administrative Service Contract
between

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
and
Alaska Railroad Corporation
Group Number: 1038789
Effective: 1/1/2022 through 12/31/2022

Pursuant to the Administrative Service Contract, the Plan Sponsor shall pay the Claims Administrator the fees, as set forth below, for administrative services.

Administration Fees:

$59.64 per employee per month

Administration Fee Breakdown:

Administration Fee (Medical/Rx)	$50.20
Administrative Fee (Vision)	$1.05
Administrative Fee (Dental)	$3.47
Electronic EOB Credit	-$1.00
Fiduciary Fees	$1.00
Enhanced Controlled Substance Utilization	$0.12
Stop Loss Interface Fee	$4.00
Telemedicine - General Medical and Mental Health (Virtual Care Only)	$0.65
Telemedicine - Chemical Dependency (Virtual Care Only)	$0.15
Telemedicine - Outpatient Rehab (Virtual Care Only)	$0.00
Total	$59.64

Elective Procedure Travel $550 Per Case

Chronic Condition Support - Powered by Livongo		Program Fees
Full Program:	**Diabetes Management**	$67.00 per plan participant per month
	Hypertension	up to $39.00 per plan participant per month*
	Diabetes Prevention Program Service Fees:	
	Weight Management Enrollment Milestone	$300 (one-time fee)
	Weight Management 9 Week Milestone	$300 (one-time fee)
	Weight Management 5% Weight Loss Milestone	$150 (one-time fee)

Administration Fee Guarantee:

The base administration fee, not including other charges such as producer fees, is guaranteed as shown below during the period from 1/1/2022 through 12/31/2024. This period shall be known as the "administration fee guarantee period."

Year	Amount	Contract Period Begins	Contract Period Ends
Year 1	$60.64	1/1/2022	12/31/2022
Year 2	$61.25	1/1/2023	12/31/2023
Year 3	$61.86	1/1/2024	12/31/2024

Claims Runout Processing Fee:

The charge for processing runout claims is an amount equal to the active administration fee at the time of termination, times the average number of subscribers for the 3-month period preceding the termination date, times two.

BlueCard Fee Amount:

BlueCard Fees are tracked and billed monthly in addition to claims expense.

ATTACHMENT D.a. – RENEWAL LETTER

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

Effective Date: 1/1/2022
Group Name: Alaska Railroad Corporation
Group #: 1038789
Agency Name: Direct Sales

9/23/2021

Current Enrollment
Employees 567
Members 1324

Administrative Fees	PBCBSA - Current	PBCBSA - Renewal
	PEPM	PEPM
Administration Fee (Medical/Rx)	$53.16	$54.20
Network Access	Included	Included
Nurseline	Included	Included
Administration Fee (Vision)	$1.03	$1.05
Administration Fee (Dental)	$3.40	$3.47
Base Administration Fee - LWAC Stoploss Not Purchased	**$57.59**	**$58.72**
Electronic EOB Credit*	-$1.00	-$1.00
Total Billed Fee - LWAC Stoploss Not Purchased	**$56.59**	**$57.72**

*Electronic EOB percentage must remain above 20% to continue credit.

Additional Service Fees	
BlueCard Access Fees	Billed as Incurred on Monthly Basis
Calypso Extended Recovery Services	25% to 35% of amounts processed depending on services provided
Personal Health Support	$245 Per Actively Engaged Participant Per Month
Elective Procedure Travel	$550 Per Case

Multi-Year Fees*			
1/01/23 to 12/31/23 - LWAC Stoploss Not Purchased		$59.31	ACCEPT
1/01/24 to 12/31/24 - LWAC Stoploss Not Purchased		$59.90	ACCEPT

Optional Administrative Fees	PEPM	PEPM	
Fiduciary Services	$1.00	$1.00	ACCEPT
Enhanced Controlled Substance Program - Standard	$0.12	$0.12	ACCEPT
Telemedicine - General Medical and Mental Health (Virtual Care Only)	$0.65	$0.65	ACCEPT
Telemedicine - Chemical Dependency (Virtual Care Only)	$0.15	$0.15	ACCEPT
Telemedicine - Outpatient Rehab (Virtual Care Only)	$0.00	$0.00	ACCEPT
Premera Designated Centers of Excellence	25% Per Case Savings		
OP Rehab Management (Billed per case)	$35 Per Episode of Care		
Maternity Services (Billed per case)	Engagement Fee $50, Case Management $350		
NICU Case Management (Billed per case)	$1,962 (Waived if LWAC Stoploss Purchased)		

Chronic Condition Support - Powered by Livongo		Program Fees	Accept	Decline	
Full Program:	**Diabetes Management**	$67.00 per plan participant per month	☐	☐	ACCEPT
	Hypertension	up to $39.00 per plan participant per month*			
	Diabetes Prevention Program Service Fees:				
	Weight Management Enrollment Milestone	$300 (one-time fee)			
	Weight Management 9 Week Milestone	$300 (one-time fee)			
	Weight Management 5% Weight Loss Milestone	$150 (one-time fee)			
Diabetes Prevention and Diabetes Management:	**Diabetes Management**	$67.00 per plan participant per month	☐	☐	DECLINE
	Diabetes Prevention Program Service Fees:				
	Weight Management Enrollment Milestone	$300 (one-time fee)			
	Weight Management 9 Week Milestone	$300 (one-time fee)			
	Weight Management 5% Weight Loss Milestone	$150 (one-time fee)			
Diabetes Only:	**Diabetes Management**	$67.00 per plan participant per month	☐	☐	DECLINE
Hypertension Only:	**Hypertension**	$39.00 per plan participant per month	☐	☐	DECLINE

**$35 PPPM will be billed if the member is also engaged in Diabetes Management and/or Diabetes Prevention*

Personal Funding Accounts	Fee Per Plan Participant (CYC)	Accept	Decline	
Health Savings Account (HSA)	$2.25	☐	☐	ACCEPT
HSA On Demand	$0.36	☐	☐	DECLINE
Health Reimbursement Arrangement (HRA)	$2.60	☐	☐	DECLINE
Flexible Spending Account (FSA)	$2.60	☐	☐	ACCEPT
FSA & Dependent Care FSA	$2.60	☐	☐	ACCEPT
Additional or Incremental Account (each)*	$1.20	☐	☐	ACCEPT

**Limited Purpose FSA paired with an HSA, Full Purpose FSA paired with an HRA, or an HSA paired with an HRA*

Premera Pharmacy Targets	Dispensing Fee	Target Discount
Retail Brand	$0.40	18.23%
Retail Generic	$0.40	83.48%
Retail 90 Brand	$0.10	21.70%
Retail 90 Generic	$0.10	83.75%
Mail Brand	$0.00	24.02%
Mail Generic	$0.00	85.87%

Discounts are targets and not guarantees.

Premera Pharmacy Rebate Arrangement	
Pharmacy Rebates	Credited Quarterly to Group
Medical Drug Rebates	Credited Annually to Group (if more than $500)

Medical drug rebates less than $500 will be retained by Premera

The amounts provided herein are the amounts calculated for your contract with Premera, and are not designed by Premera to be used for any other purpose.

Value-Based Program Payments

Provider groups enter into agreements with Premera or other Blue Cross and/or Blue Shield Licensees (Host Blues) for value-based programs. Such programs include the Blue Distinction Total Care program, Global Outcomes Contracts, accountable care organizations, patient-centered medical homes, shared savings arrangements, and global payment/total cost of care arrangements. Premera and the Host Blues may pay value-based program providers for meeting the programs' standards for treatment outcomes, cost, quality, and care coordination. The Plan Sponsor shall pay the Claims Administrator a per-member-per month (PMPM) amount established for each value-based program provider group. The PMPM amount will be multiplied by the number of the Plan Sponsor's Members that are attributed to each provider group. The PMPM amounts differ between the provider groups, and may change during the Contract Period.

Fee For Class Action Recoveries

The Plan Sponsor shall pay the Claims Administrator a fee for its work in pursuing class action recoveries on behalf of the Plan Sponsor as described in Subsection 3.5. “Participation In Class Action Suits.” The fee shall be a proportionate share of $50,000, based on the proportion of the amount recovered on behalf of the Plan Sponsor compared to the total amount recovered by the Claims Administrator for all lines of business.

SaveOnSP Program

SaveOnSP maximizes plan savings for select non-essential health benefit specialty drugs listed at www.premera.com/saveonsp through application of drug manufacturer coupons and covers the cost-share for participating Members. To participate, Members must contact SaveOnSP at 1-800-683-1074 to enroll before filling applicable prescriptions. Costs for the SaveOnSP program are calculated as the (i) required Member cost-share of applicable coupons; (ii) Member fills in excess of manufacturer coupon funding; (iii) amounts due if member is ineligible for manufacturer program assistance, and (iv) 25% of reported plan savings, which are invoiced monthly in the Claims invoice. Amounts in (i), (ii) and (iii) will not have to be subject to reported plan savings.

Brightline Health Virtual Therapy

Brightline Health provides virtual therapy for children ages 3 through 18 needing behavioral/mental health support. Family members can participate in sessions with children as needed.

Brightline will send the Claims Administrator a monthly invoice detailing each Member and fee for use of content or engagement with coaching or therapy, if applicable. The Plan Sponsor will be billed by the Claims Administrator on their next monthly invoice according to the fees set forth here.

The fees are as follows:

- $35 Per Active Dependent Per Month (PADPM) 6-month platform membership fee.
    - “Engaged Participant” is defined by a Participant that has completed registration, accesses the Program by logging in, and completes at least two (2) activities in their entirety, such as an evaluation, assessment, exercise, coaching session, or an activity defined in a Participant’s care plan.
    - Initial Engaged Participant status lasts for a period of 6-months. After the initial 6-month period ends, the engagement episode is over and monthly fees will cease.
    - Once the initial 6-month period is exhausted, if an inactive individual re-engages with the Program by completing at least two (2) activities, such individual shall become an Engaged Participant and vendor may invoice for such individual for three (3) months from the date in which the individual completed the second activity.

- In the event an Engaged Participant stops completing activities for a period of three (3) months from the date of the last completed activity, vendor shall change such individual's status to "Inactive" and vendor will no longer invoice for such individual.

- $90 per coaching session. This fee is billed with a monthly invoice and pass through the claims call as a non-claim medical expense.

Virtual mental health therapy: Covered virtual therapy will be billed to your medical plan on a separate claim and are subject to the mental health office visit cost-shares of your plan.

Virtual speech therapy: Covered virtual therapy will be billed to your medical plan on a separate claim and are subject to the rehabilitation office visit cost-shares of your plan.

Premera-Designated Centers of Excellence

In addition to claims for the medical services, Plan Sponsor shall pay Claims Administrator a care coordination and support fee of 25 percent of per case savings, which shall be calculated by comparing bundled service fees with the Alaska average for applicable services. No member cost-share applies to these fees.

See Attachment L – Premera-Designated Centers Of Excellence for more information.

CareCompass360°

See "Attachment F – Carecompass360°" for an overview of services provided. Services are included in the Claims Administrator's Administration Fee except where stated below.

Personal Health Support (See Attachment G, Appendix 2)	Not included in Administration Fee. $245 per actively engaged Member per month of active engagement.
BestBeginnings Maternity Program (See Attachment G, Appendix 3)	Not included in Administration Fee. **Risk Assessment**: $50.00 per actively engaged member per month of active engagement. **Case Management:** $350 per actively engaged member per month of active engagement.
Neonatal Intensive Care Risk Assessment & Case Management (See Attachment G, Appendix 4)	$1,962 per billed case

Extended Post-Payment Recovery Services:

Claims Administrator will perform the services listed below on a pay-for-performance, contingent fee ("Contingent Fee") basis, which shall be calculated as a percentage of the gross amount recovered with respect to any particular claim. See "Attachment G – Extended Post-Payment Recovery Services" for an overview of services provided.

Post Payment Recovery Category	Contingent Fee
Coordination of Benefits	25 percent
Subrogation	25 percent unless Claims Administrator, in its sole option or discretion, engages outside counsel, in which case the Contingent Fee amount shall be 35

	percent, whether or not the case involves litigation or other dispute resolution process. 25 percent if, after Claims Administrator has worked a subrogation case, the Plan Sponsor takes over responsibility for the case and settles directly. In all cases, Plan Sponsor is also responsible for payment of any court costs, such as filing fees, witness fees or court reporter fees.
Provider Billing Errors	25 percent
Credit Balance	25 percent
Hospital Billing and Chart Review	35 percent

Funding Account Fees

Per Participating Employee Per Month (PPEPM) Fees:

Monthly admin fee per Participant with HRA Account (PPEPM)	$2.60
Monthly admin fee per Participant with HSA Account (PPEPM)	$2.25
Monthly admin fee per participant with Health FSA Account (PPEPM) and Dependent Care FSA Account (PPEPM)	$1.20
Runout Fees (All products except HSA) Applicable for any account(s) other than HSAs administered by Claims Administrator during the runout period. (Billed in a lump sum at the beginning of the runout period based on active participants as of the beginning of the runout period.)	150% of the applicable PPEPM fee
Trust services (HSA only)	Included
Non-discrimination testing, per testing cycle	$250 per Internal Revenue Code §125 plan plus $150 per type of account ($150 charge not required for HSA)
Custom file/interface programming, marketing or other requests (if approved)	$120 per hour
Healthcare debit card services (if offered)	Included
Charge to Participant for each additional/replacement debit card, if offered (initial card included)	No charge
Extra debit cards for family members	No charge
Charge to Plan Sponsor for each returned check/Automated Clearinghouse (ACH)	$25 per occurrence
Charge to Claims Administrator for Merchant Dispute resolution fees	As incurred

ATTACHMENT E – BUSINESS ASSOCIATE AGREEMENT

The Plan Sponsor should keep its signed business associate agreement and any signed amendments behind this page.

ATTACHMENT F – CARECOMPASS360°

Claims Administrator agrees to make available to the Plan Sponsor certain components of the CareCompass360° program, which are more particularly described in the appendices attached hereto and incorporated herein. Claims Administrator, in its sole and absolute discretion, may upgrade, change Program Managers or otherwise modify these services. Fees for these services are shown in "Attachment D – Fees Of The Claims Administrator."

General Provisions

- The parties understand, acknowledge and agree that the services provided to the Plan Sponsor hereunder are designed only for availability to the population of Plan Sponsor Members eligible for such services and not for application to each and every Member.
- **Severability.** In the event that any provision hereof is found invalid or unenforceable pursuant to judicial decree or decision, the remainder of this Attachment shall remain valid and enforceable according to its terms.

Appendix 1

Care Facilitation Services

Claims Administrator agrees to provide the following care facilitation services.

Service	Description
Care Management	
Clinical review	Prospective and retrospective review for medical necessity, appropriate application of benefits. Independent medical review and independent clinical management which may include advanced imaging (as well as member shopping tools), radiation oncology therapy, sleep studies and genetic testing are administered by the Claims Administrator's designated Program Manager(s).
Quality Programs	Includes provision of evidence-based clinical practice and preventive care guidelines to Members and providers, chart tools, and quality of care program activities.
NurseLine	Round-the-clock access for Members to registered nurses to answer questions about their health care. administered by the Claims Administrator's designated Program Manager.
Pharmacy	
Prescription drug formulary promotion	Development of formulary and access to providers and Members on-line
Physician-based pharmacy management	Physician education on cost-effective prescribing
ePocrates	Software to provide physicians with up-to-date drug and Plan formulary information.
Enhanced Controlled Substances Utilization Program (Opioid Management)	Our program, administered by the Claims Administrator's designated Program Manager, identifies and investigates Members who show signs of drug misuse or addiction. When warranted, these Members will only be able to get opioid prescriptions from a particular pharmacy and may also be restricted to one prescriber.
Point-of-sale Pharmacy	Follow-up with Members and physicians to minimize inappropriate or excessive drug therapies identified when drugs are dispensed.
Virtual Care	The Claims Administrator has contracted with one or more vendors (Program Manager(s) that uses interactive audio and video technology or using store and forward technology in real-time communication between the member at the originating site and the provider for diagnoses, consultation, or treatment. Services must meet the following requirements: • Covered service under this plan • Originating site: Hospital, Rural health clinic, federally qualified health center, physician's or other health care provider office, community mental health center, skilled nursing facility, home,

	or renal dialysis center, except an independent renal dialysis center • If the service is provided through store and forward technology, there must be an associated office visit between the member and the referring provider. • Is Medically Necessary

Appendix 2
Personal Health Support Services

Services of the Personal Health Support program may include:

- Telephonic personal health support, including a clinician designated as the participant's single point of contact for personal health support.
- Engagement team triage
- Periodic reporting on program enrollment and activities

Eligible Health Conditions

Members eligible for services include those who are classified by Claims Administrator, in its sole discretion, using its own methodology or criteria, as high-risk and/or have two (2) or more of the chronic conditions designated by Claims Administrator for the program. Claims Administrator may change the methodology for determining eligibility or terms of or criteria for eligibility, at its sole discretion, from time to time.

Active Engagement

The separate monthly program fee is charged only for Members who are actively engaged in personal health support services during the month. "Active engagement" means that a Member or their authorized designee (such as the parent of a minor child or an individual with power of attorney) has at least one (1) two-way conversation with their personal health support clinician in which health goals are discussed. The initial outreach contact to the Member does not count. No charges are made for a month in which there is no active engagement.

Appendix 3
BestBeginnings Maternity Program

The BestBeginnings Maternity program offers education and support services to pregnant Members and case management for pregnant Members identified as high risk. Member participation is voluntary. The program helps educate Members about normal symptoms of pregnancy, as well as risks and problems, including warning signs.

BestBeginnings Program Description

The BestBeginnings program has two components:

- A mobile application, administered by the Claims Administrator’s designated Program Manager, for the Member's smartphone or tablet. Members can download this mobile application from the Internet after they register for the BestBeginnings program. There is no charge to the Member. The application covers important health issues in pregnancy. It provides surveys to help identify high-risk pregnancies and post-partum depression. It also offers information, tools, milestones, alerts on pregnancy-related issues, and reminders. Content is updated quarterly as needed.
- The Claims Administrator will provide outreach to Members identified as having the potential for a high risk pregnancy. These Members can click in the mobile application to call one of the Claims Administrator's maternity specialists. These specialists are the Claims Administrator's personal health support clinicians who have specific maternity training. Maternity specialists are available from 6:00 a.m. to 8:00 p.m. on Monday through Friday and 9:00 a.m. to 1:00 p.m. on Saturday, Pacific time.

Appendix 4
Neonatal Intensive Care Risk Assessment and Case Management

The Neonatal Intensive Care Unit (NICU) Program provides case management for babies admitted to the NICU. The program is administered by the Claims Administrator's designated program manager (the "Program Manager"). The Claims Administrator and/or the hospital refers Members who are admitted the NICU or a specialty care nursery to the Program Manager. The Program Manager then contacts the parents to get consent for the newborn Member to participate in the NICU Program. Member participation is voluntary.

Services include:

- Coordination of care for newborns throughout their stays in the NICU
- Assistance with management of the baby's care from discharge to the baby's transition home
- Comprehensive booklet that educates parents about the NICU and the needs of the child in the NICU
- Measures health outcomes
- Recommends appropriate levels of care to the Claims Administrator

Appendix 5

Chronic Condition Management Program

The Chronic Condition Management program provides helps members with chronic conditions to manage them in order to live healthier lives. The Claims Administrator's Chronic Condition Management Program Manager (the Program Manager) monitors participating Members' health data and uses it to create actionable, personalized and timely coaching and reminders. The Program Manager receives Members' health data in real time via cellular technology.

The Program Manager is able to share the data with the Member's doctor or someone close to the Member if the Member requests it.

Personalized support and interaction are available during normal business hours. However, coaches are available to support acute events 24 hours a day, 365 days a year.

Covered Services

Diabetes Management:
For members who have Type 1 or Type 2 diabetes. Members receive:

- A blood glucose meter from the Program Manager that uploads blood sugar readings to the Member's personal online account. Members must use the Program Manager's meter. A carrying case comes with the meter.
- Unlimited test strips for this meter. Members can reorder test strips using the meter or online. The strips will be sent to the Member directly.
- A lancing device and lancets.
- Control solution
- Real-time reminders to check blood sugar or to take medication, and tips based on the Member's blood sugar readings that can help keep blood sugar levels within a healthy range.
- One on one live coaching and support via phone, text, e-mail, or the program manager's mobile app. Coaches are health professionals, such as dietitians or registered nurses, that are certified diabetes educators.
- Health summary reports that Members can share with their doctors
- The Program Manager's mobile application

Diabetes Prevention:

For Members who are at risk for diabetes according to the criteria followed by Centers For Disease Control:

- Must be 18 or older
- Have a body mass index (BMI) greater than or equal to 25 or greater than or equal to 23, if the Member is Asian
- No previous diagnosis of type 1 or type 2 diabetes
- Have a blood test in the last year that is within the pre-diabetes range
- Be previously diagnosed with gestational diabetes

Members receive:

- A cellular digital scale from the program manager that uploads readings to a personal online account.
- 31 on-line lessons that cover topics such as nutrition, activity and stress, and problem solving. The first 9 lessons are unlocked weekly, and the remainder are unlocked every other week.
- One-on-one live coaching and support via phone, text, e-mail or the program manager's mobile application.

High Blood Pressure:

This program is for members with a diagnosis of hypertension. It focuses on awareness and self-management through medication and lifestyle changes. Members will receive:

- A blood pressure cuff from the Program Manager that uploads blood pressure readings to the Member's personal online account. Members must use this cuff in order to participate in the program.
- Real-time reminders to check blood pressure or to take medication, and tips based on Members' blood pressure readings that can help keep blood pressure within a healthy range.
- Coaching and support via phone, text, e-mail, or the Program Manager's mobile application. Coaching provides information on such topics as reducing blood sugar, getting more active, healthy eating and weight management.
- Health summary reports that Members can share with their doctors.

Access To Services

- The Claims Administrator will work with the Program Manager to identify Members who meet the qualifications for the Diabetes Management and Hypertension programs. The Claims Administrator will transmit eligibility files weekly to the Program Manager.
- For the Diabetes Prevention program, the Program Manager will ask Members to complete a brief screening questionnaire to determine if the member meets eligibility criteria.

Billing

The Program Manager will submit medical claims for the services. Members pay nothing.

The Program Manager will contact Members who stop participating in the program by phone to engage or re-engage them. If the Member does not re-engage, the Program Manager will not bill for that Member beyond the initial period.

Members have the option to cancel the program at any time.

Appendix 6
Premera Pulse

Premera Pulse, administered by the Claims Administrator's designated Program Manager, is a digital tool designed to support booking capabilities with high value providers and deliver personalized health information in the moments members need them. Members receive timely messages that help them make informed decisions about their care.

- Leveraging third party cost and quality data to drive provider selection
- Enhanced modeling to provide care gaps and targeted outreach for engagement
- Enhanced digital tools to help drive members to high-value providers and to provide greater promotion of healthcare consumerism
- Communications package to drive awareness, engagement, and overall program value.

Members are not required to download an application. They set up an on-line account with the Premera Pulse program manager. Members do need to have a phone that can receive text messages.

ATTACHMENT G – EXTENDED POST-PAYMENT RECOVERY SERVICES

Claims Administrator, through its affiliate, Calypso, shall provide a set of Extended Post Payment Recovery Services to the Plan Sponsor as described below. Claims Administrator will perform these services on a pay-for-performance, contingent fee ("Contingent Fee") basis, which shall be calculated as a percentage of the gross amount recovered with respect to any particular claim. Contingent Fees are shown in "Attachment D – Fees Of The Claims Administrator."

Post Payment Recovery Category	Explanation of Services
Coordination of Benefits	Claims Administrator's investigators and auditors will work to identify and pursue overpayments due to Member's missing or inaccurate COB information. Claims Administrator utilizes questionnaires and interviews with providers, employers and Members to determine if Plan Sponsor's Plan is primary or secondary.
Subrogation	Claims Administrator's investigators, auditors and attorneys identify and pursue overpayments due to Subrogation opportunities. Claims Administrator's research to obtain accurate subrogation information and determine group's subrogation rights include questionnaires and interviews with providers, employers and Members. As Claims Administrator deems necessary, Claims Administrator manages attorney and Member notification, coordinates case documentation, coordinates with potentially responsible parties and provides representation for hearings. Claims Administrator will notify Plan Sponsor in the event that Claims Administrator recommends that the Plan Sponsor file suit. Plan Sponsor retains the right to authorize or deny any legal action. Claims Administrator will not initiate legal action to enforce the plan's subrogation provision without prior approval from the Plan Sponsor. If Plan Sponsor brings any legal action on its own, Plan Sponsor will be solely responsible for the case, and (1) The Claims Administrator will cooperate with the Plan Sponsor; (2) Any court costs and attorneys' fees incurred in pursuing such subrogation claims shall be the responsibility of the Plan Sponsor; and (3) If Claims Administrator had already opened a subrogation case, Plan Sponsor shall pay Claims Administrator its subrogation fee set forth in "Attachment D – Fees Of The Claims Administrator." (If Claims Administrator had not already opened a subrogation case, no fees shall be due the Claims Administrator.)
Provider Billing Errors	Claims Administrator's post-payment editing programs and investigators and auditors perform additional screens and tests where billing information is inconsistent with age/services rendered or where there appears to be up-coding or unbundling of services. A recovery

Post Payment Recovery Category	Explanation of Services
	process is then employed to request and recover verified overpayments.
Credit Balance	This service requires an on-site review of the provider's financial records and discussions with their staff. Credit balances are verified as owed to Plan Sponsor and the source of the credit is determined. The credit is reviewed with the provider and approved for payment back to Claims Administrator or the Plan Sponsor.
Hospital Billing and Chart Review	This service requires an on-site review of the Member's medical charts and interviews with provider staff by registered nurses. Calypso out-sources the on-site review work to an independent vendor who ensures that: • Service is consistent with diagnosis and billing is consistent with services. • There has been no unbundling of services, diagnosis up-coding or billing maximization. • Services rendered were prescribed by the physician and the doctor's notes were signed. • Standardized billing and payment policies were used. Calypso provides support for this vendor's efforts as well as processes all recoveries.

ATTACHMENT H – FUNDING ACCOUNTS

The Plan includes the following funding accounts, collectively referred to as "the Program" in this Attachment:

- a Health Flexible Spending Account ("Health FSA") to reimburse eligible health care expenses in compliance with Code §§§ 105, 106 and 125 and applicable IRS regulations and guidance;
- a Dependent Care Assistance Plan Flexible Spending Account ("DCAP") to reimburse eligible dependent care expenses in compliance with Code § § 125 and 129 and applicable IRS regulations and guidance;
- a Health Savings Account ("HSA") described in Code § 223

Claims Administrator, through designated Program Managers, agrees to provide those services described in the Appendices to this Attachment. Except as expressly stated in this Attachment, all other terms and conditions as set forth in the Contract shall remain in full force and effect, and shall continue to be binding on the parties hereto.

SERVICES

Administrative Services Only

Plan Sponsor understands and agrees that Claims Administrator's sole function under this Attachment is to provide administrative services in accordance with the terms of this Attachment. Under the terms of this Attachment, Claims Administrator does not render investment advice, is not an "administrator" as defined in § 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and is not a trustee or a fiduciary, as these terms or other analogous terms may be defined under applicable state, local, or federal law, and does not provide consulting, legal, tax or accounting advice with respect to the creation, adoption or operation of the Program or any portion thereof.

Discontinuance of Services Inconsistent with Role

If, based on changes in the regulations governing the Program or the interpretation of the regulations, there is a reasonable likelihood that any service being, or to be, provided under this Attachment by Claims Administrator could constitute a discretionary function and thereby subject Claims Administrator to classification as a "fiduciary" under applicable state, local, or federal law with respect to the Program, and such service could not be restructured in a manner that would not subject Claims Administrator to classification as a "fiduciary" under applicable state, local, or federal law, then Claims Administrator, upon reasonable notice to Plan Sponsor may decline to thereafter provide that service. The failure to provide any such service shall not constitute a breach of Claims Administrator's obligations under this Attachment.

Compliance Responsibility

Plan Sponsor is solely responsible for all plan documents and for ensuring that the Program complies with all applicable provisions of the Internal Revenue Code and any applicable state and local laws governing the Program.

For the Program components listed below, the Parties also agree to abide by the Business Associate Agreement attached to the Contract. The Business Associate Agreement shall apply to the following:

- The Health Flexible Spending Account ("Health FSA")

Debit Card Substantiation

Plan Sponsor agrees that, in connection with any account offering that includes a debit card made available to its employees, the following personal or health data may be shared with Claims Administrator's vendors for purposes of debit card substantiation: Program Participant ID, Prescription Number, Service Start Date, Amount Paid, Partner Routing ID, Provider Name and Sender ID.

Reliance Upon Data

All services provided by Claims Administrator hereunder shall be based on information supplied by Plan Sponsor or designee or agent of Plan Sponsor (as designated by Plan Sponsor). Plan Sponsor acknowledges that the timely provision of accurate, consistent and complete Program Data in the format specified by Claims

Administrator is essential to its delivery of services, and Plan Sponsor is responsible for ensuring such timely and accurate data is delivered to Claims Administrator in Claims Administrator's approved format. For these purposes, "Program Data" means all data and records supplied to Claims Administrator, obtained by Claims Administrator or produced by Claims Administrator (based on data or records supplied to, or obtained by, Claims Administrator) in connection with performing the services pursuant to this Attachment. Program Data includes, but is not limited to, current Program Participant names, addresses, status, and contribution amounts.

Data in Electronic Format

Plan Sponsor agrees that administrative, contribution and recordkeeping data shall be provided by the Plan Sponsor in an electronic format acceptable to Claims Administrator and will be updated by the Plan Sponsor as Claims Administrator requires for proper processing. If the data is not submitted in an electronic format or if the format of the data requires additional translation, formatting or cleansing, Claims Administrator reserves the right to approve or refuse such submission and to charge additional data-handling fees as required.

Reliance Upon Persons Designated by Plan Sponsor

Plan Sponsor will provide names and other contact information to identify persons authorized by Plan Sponsor to take actions for, or provide information with respect to, the Program. Until notified of a change, Claims Administrator may reasonably rely upon this information and may act upon instructions received from and/or on information provided by these named persons. Claims Administrator has the right to assume that those persons continue to be authorized until notified otherwise.

Customer Service

Customer service representatives will be available at a toll free telephone number to assist Plan Sponsor and Program Participants.

Claims Administrator will provide access to the Claims Administrator’s Web site as described in "Benefit Information Portals" below to allow Program Participants and Plan Sponsor to access certain account information and for Program Participants to file claims.

Program Participants will have access to their accounts through Claims Administrator's Web site as described below in this Attachment.

Benefit Information Portals

Program Participant Portal

Claims Administrator will provide Program Participants with access to Claims Administrator's portal system. This system will allow online claim filing. Program Participants will also have online access to the following:

- Real-time history of claim submission and payment processing;
- Account management with transaction history and account balance; and
- Contribution data.

Employer Portal

Claims Administrator will provide Plan Sponsor and Plan Sponsor’s designated administrator with access to Claims Administrator's employer portal system. The Plan Sponsor portal system provides Plan Sponsor with the ability to upload contributions data, generate reports, and perform other administrative functions with respect to the Program.

COMPENSATION

In consideration for its services provided hereunder, Plan Sponsor shall pay Claims Administrator or its designee in accordance with the Fee Schedule provided in Appendix 1 of this Attachment I. Claims Administrator may amend the schedule for services not yet rendered upon giving notice in writing under the same conditions specified in "Termination For Cause" below in this Attachment. Fees are invoiced and payable monthly. The monthly invoice will include:

- Fees related to the initial setup or periodic renewal of the Program, as soon as practicable after the setup

or renewal date.

- Administration fees, based on the number of Program Participants in the Program (depending on the components of the Program in which they participate) as of the first day of the month. Eligibility is based on information provided by Plan Sponsor to Claims Administrator, and must be received by Claims Administrator by the first business day of the month.
- Additional optional services agreed upon by Plan Sponsor and Claims Administrator.
- Miscellaneous direct costs that Claims Administrator will pass through to Employees.

Invoices will be sent on or about the 20th day of each month. Monthly charges are based on participation as of the first day of the month and will not be adjusted for any Employees who terminate during the month. After the month in which termination of employment occurs, the Plan Sponsor is no longer responsible to pay fees for employees who terminate from employment.

All fees are due at the time they are invoiced and Plan Sponsor agrees to pay all fees due within 30 days after the invoice date ("Grace Period"). As set forth in "Duration; Termination; Successor Recordkeeper" below in this Attachment, late payment may result in termination of the Funding Account.

USE OF AGENTS OR SUBCONTRACTORS

Claims Administrator may perform any of the services described in this Attachment through agents and subcontractors selected by Claims Administrator. Claims Administrator shall reasonably supervise any such agent or subcontractor, and the retention of agents or subcontractors shall not relieve Claims Administrator of its duties hereunder.

CLAIMS ADMINISTRATOR NOT LEGAL COUNSEL

Plan Sponsor understands and agrees that it shall review with its legal and/or tax counsel all documents provided to it by Claims Administrator and that Plan Sponsor should consult such counsel on any questions concerning Plan Sponsor responsibilities under this Attachment, the Program documents, and the legal sufficiency of any documents provided by Claims Administrator. Plan Sponsor understands that neither Claims Administrator nor any of Claims Administrator's affiliates, agents, or subcontractors are permitted to provide Plan Sponsor with legal or tax advice. Plan Sponsor acknowledges that it will not rely on any information provided as if it were legal or tax advice.

NOTICE OF ERRORS

All information supplied to Plan Sponsor or Program Participant will be deemed correct if notice of transactional errors is not given to Claims Administrator by the Program Participant or Plan Sponsor within 90 days of issuance of any payment, confirmation, or other information. If Claims Administrator receives timely notice, Claims Administrator will use reasonable efforts to correct transactional errors. Claims Administrator will not be liable for damages of any kind resulting from such errors.

INDEMNIFICATION

Indemnification of Claims Administrator

Plan Sponsor shall hold harmless and indemnify Claims Administrator and its employees, directors, officers, agents, and subcontractors (collectively, "Claims Administrator Indemnitees") from and against any loss, damage, liability, claims, costs and expenses, including reasonable attorneys' fees, to which the Claims Administrator Indemnitees may become subject, which result from:

- Any misrepresentation or nonfulfillment of any terms of this Attachment by Plan Sponsor, a Program Participant, or any other individual including, but not limited to, liabilities resulting from the provision of inaccurate, untimely, or incomplete information to Claims Administrator or the failure to provide Claims Administrator with clear instructions as to distributions;
- Any failure of the Plan Sponsor to provide timely and accurate Program Data;
- Any failure by Plan Sponsor, a Program Participant, or any other individual to comply with the terms of

the Program;

- Any violation by Plan Sponsor, a Program Participant, or any other individual of the requirements of applicable state, local and/or federal laws;
- The making by Claims Administrator of any payment based upon instructions that Claims Administrator reasonably believes to be authorized; and
- Any action, conduct, or activity taken by Claims Administrator, or any inaction by Claims Administrator, at the direction of Plan Sponsor, provided that Claims Administrator reasonably believes the direction to be valid and is not negligent in the execution of such directions.

Indemnification of Plan Sponsor

Claims Administrator shall hold harmless and indemnify Plan Sponsor and its employees, officers, and directors from and against any loss, damage, liability, claims, costs and expenses, including reasonable attorneys' fees, to which Plan Sponsor may become subject, which are caused directly by the gross negligence or willful misconduct by Claims Administrator. The liability of Claims Administrator (and its affiliates, agents and subcontractors) hereunder, regardless of the theory or form of action, shall not exceed the aggregate of the total amount of fees paid by Plan Sponsor hereunder.

General Conditions of Indemnification

As a condition to receiving indemnification, the party seeking indemnification shall:

- Give written notice to the indemnifying party of any indemnified claim, demand or action within 15 days after it has knowledge thereof;
- Permit the indemnifying party at its option to assume control of the defense of such claim, demand or action;
- Give full cooperation in the investigation and defense on request;
- Use its best efforts to mitigate the damages; and
- Not compromise or settle such claim, demand or action without the indemnifying party's written consent.

DURATION, TERMINATION, AND SUCCESSOR RECORDKEEPER

Duration

This Attachment will automatically terminate one (1) year from the Effective Date, unless terminated earlier by the Parties.

Termination for Cause

Claims Administrator may terminate this Attachment and discontinue services immediately upon notice to Plan Sponsor if:

- Plan Sponsor fails to transfer funds for the Program on the terms set forth in the Appendixes;
- Plan Sponsor fails to pay any invoice prior to the expiration of the Grace Period;
- Plan Sponsor's agreement with Claims Administrator to provide or administer the health coverage is terminated or discontinued for any reason;
- Plan Sponsor offers Program Participants any other funding account in conjunction with the Program or health plans being administered by Claims Administrator without prior written agreement between the Parties as provided for in "Representations and Warranties" below in this Attachment; or

Plan Sponsor may terminate this Attachment upon thirty (30) days' notice in the event that Plan Sponsor agreement with Claims Administrator to provide or administer health coverage is materially changed and services under this Attachment are no longer required.

Runout Period

If the services under the Attachment are terminated, Claims Administrator will, for the 120-day period immediately following the date of termination ("Runout Period"), continue to administer claims for expenses incurred prior to the date of termination in the manner described in this Attachment. Administrative fees during the Runout Period shall be as indicated on Appendix 1. Upon expiration of the Runout Period, all obligations of Claims Administrator to administer claims or perform any other services under this Attachment shall cease.

Successor Recordkeeper

Upon termination, the parties agree that Claims Administrator shall have no further duty or responsibility to Plan Sponsor under this Attachment except as provided by the Runout Period described above in this Attachment. However, Claims Administrator will use reasonable efforts to transfer all relevant non-proprietary information concerning the Program that Claims Administrator deems necessary for future operations, in Claims Administrator's standard format, to Plan Sponsor or to a successor service provider. Any unforeseeable costs or expenses incurred by Claims Administrator in effecting this transfer shall be paid by Plan Sponsor unless waived in writing by Claims Administrator. Plan Sponsor agrees that Claims Administrator may charge reasonable fees for the provision of requested records or reports that Claims Administrator previously provided.

Survival of Indemnification

Plan Sponsor acknowledges and agrees that the indemnification provisions of this Attachment shall survive the termination of this Attachment.

Representations and Warranties

Claims Administrator makes no statutory, express, or implied representations or warranties of any kind with respect to the services or Claims Administrator's performance of services under the Attachment, including, without limitation, those of merchantability and fitness for a particular purpose, which, without limiting the foregoing, are disclaimed by Claims Administrator. No descriptions or specifications, whether or not incorporated into the Attachment, no provision of marketing or sales materials, and no statement made by any sales representative in connection with the services shall constitute representations or warranties of any kind.

Plan Sponsor warrants that it will not use any other funding account in conjunction with the Program or health plans being administered by Claims Administrator unless otherwise agreed to in advance by the Parties in writing.

Writing and Signature; Electronic Transactions

Unless otherwise explicitly required by law:

- Any requirement for a writing under this Attachment may be rendered in any form that can reliably reproduce an accurate physical record of the communication and authenticate the source, including but not limited to facsimile transmission, electronic mail, or Internet transmission.
- Any requirement of a signature under this Attachment may be rendered in any form clearly indicated by the signatory to be a signature or which complies with instructions directly given to the signatory as to the proper form of indicating a signature in an electronic or voice response environment. Appropriate forms include, but are not limited to, personal identification numbers rendered over the Internet, and facsimile transmissions.
- Notwithstanding the above, the recipient of any writing or signature under this Attachment may require the confirmation of any writing or signature in physical form (such as hand or typewritten or the equivalent) with a manual signature.
- Plan Sponsor represents that the Program document(s) will allow for transactions to be made by electronic means. Under the Program document(s) and this Attachment together, notices, consents and other actions by or on behalf of, or with respect to, the Program, its Program Participants and their respective beneficiaries ("Program Transactions") may be affected, in whole or in part, by electronic means. Any Program Transactions relating to services provided under this Attachment may be initiated or effected by Plan Sponsor, the Program, a Program Participant or a beneficiary by use of Claims Administrator authorized electronic means, Internet access system (including Claims Administrator web

site) or telephone service line. Use of electronic means for Program Transactions is subject to the terms and conditions established by Claims Administrator and disclosed to Plan Sponsor and Program Participants, and electronic transactions shall be binding on the parties if Claims Administrator, acting in good faith, believes that such transactions are authorized by Plan Sponsor, a Program Participant, or beneficiary, as applicable.

Appendix 1
General Administration and Recordkeeping Services

Claims Administrator will provide the following administrative services under this Attachment for the following funding accounts (each, a "Program component" and collectively, the "Program"), as elected by Plan Sponsor to be offered to Program Participants under the Program:

- Health Flexible Spending Account (FSA)
- Dependent Care Assistance Program Flexible Spending Account (DCAP)

1. Enrollment and Communications: Claims Administrator will provide its standard enrollment kit with standard forms and notices necessary to implement and administer the Program, all in electronic format.

2. Administration and Recordkeeping:

a) a) Program Participant Accounts: Claims Administrator will establish Program Participant accounts for each Program Participant for whom it receives complete enrollment information. Claims Administrator is not responsible for determining if employees are eligible under the terms of the Program, but shall rely upon the Program Data provided by the Plan Sponsor.

b) Program Participant Files: Claims Administrator will maintain physical or electronic files for all program participants for whom program participant accounts have been established. These files will include enrollment forms and all other written correspondence and documents concerning each program participant's account, and if applicable, records of any such actions conducted through the Internet or electronic means.

c) Transfer of Funds: Plan Sponsor agrees to establish a payroll deduction for any Health FSA or Dependent Care FSA Program component offered, if applicable. In addition, Plan Sponsor agrees to advance an amount necessary to fund anticipated benefit payments from the Program by transferring funds to an account accessible by Claims Administrator in an amount equal to 4 percent of expected annual Program contributions, but not less than $250, this amount to be known as the Required Minimum Funding. This advance, or initial deposit, will be made prior to the Effective Date and will be used by Claims Administrator to pay claims under the Program.

   i) On a weekly basis, Plan Sponsor will allow Claims Administrator to initiate transfer via ACH EFT from Plan Sponsor's designated bank account the amount necessary to return the existing deposit balance to the Required Minimum Funding. In this manner, Claims Administrator will, each week, have available an amount equal to the Required Minimum Funding to facilitate payment of claims for the week. Plan Sponsor agrees to grant Claims Administrator authority to issue payments for allowable expenses under the Program.

   ii) As calculated on a daily basis, if current claim payments cause the existing deposit balance to fall below 4 percent of the Required Minimum Funding, Plan Sponsor will allow Claims Administrator to initiate transfer via ACH EFT from Plan Sponsor's designated bank account outside the schedule provided for in paragraph 3(c)(i) of this Appendix the amount necessary to return the existing deposit balance to 50 percent of the Required Minimum Funding to ensure that the existing deposit balance does not fall below zero.

   iii) On a monthly basis, Claims Administrator will re-calculate the Required Minimum Funding based on the expected annual Program contributions for all program participants active at that time. If the re-calculated Required Minimum Funding exceeds the previously used Required Minimum Funding by 25 percent or more, the Required Minimum Funding will be replaced by the new calculation. This adjustment to the Required Minimum Funding will be part of the weekly process provided for in paragraph 3(c)(i) of this Appendix.

   iv) In no event will Claims Administrator be obligated to issue claim payments of any kind or cause debit card payments to be approved if the existing deposit balance falls to zero or below. In no event will Claims Administrator be required to use its own funds to issue claim payments of any kind or to cause debit card payments to be approved.

   v) Plan Sponsor agrees that all amounts held under the Program will be treated as general assets of the Plan Sponsor in order to maintain the unfunded status of the Program for purposes of ERISA. Plan Sponsor will not communicate to program participants that any particular fund or funds are dedicated

exclusively for the payment of Program benefits. Accordingly, Plan Sponsor agrees that Claims Administrator will not hold amounts received from Plan Sponsor in a trust account.

d) Claims Processing:

   i) Review of Claims - Claims Administrator will make initial claims determinations in accordance with standards set forth under Program documents, applicable law, including IRS guidelines concerning eligible expenses. Plan Sponsor, and not Claims Administrator, retains exclusive authority to decide appeals of adverse benefit determinations.

   ii) Payment of Claims - Claims Administrator will process claims within five (5) business days of the date Claims Administrator receives a claim request from a Program Participant. Checks, if applicable, will be issued within two (2) scheduled weekly check payment cycles, upon receipt of claims in good order. Claims are in "good order" when the reimbursement request contains all pertinent information, including information required to substantiate the claim.

   iii) Program Components Other Than Health FSA (if offered) - Claims Administrator will not reimburse a Program Participant's claim unless the Program Participant has sufficient funds in his/her Program account(s) at the time the claim is submitted. If the Program Participant does not have sufficient funds in his/her Program account(s) at the time the claim is submitted, the reimbursement request will be held by Claims Administrator and processed in accordance with the time frame described in paragraph 3(d)(ii) starting with the date that such funds are available.

   iv) Health FSA Only (if offered) - Claims Administrator will reimburse a Program Participant's claim up to the amount the Program Participant has elected to contribute to the Health FSA for the current plan year minus any amounts previously reimbursed, whether or not the Program Participant has sufficient funds in his or her Health FSA account at the time the claim is submitted, in accordance with IRS regulations. After an account is terminated, reimbursement will also be terminated for dates of service after the termination date and the amounts reimbursed may not match the amount elected to be contributed.

   v) Unsubstantiated Claims/Ineligible Expenses - If a Program Participant is not able to substantiate a claim, the claim will be denied. If payment for an expense is advanced through the debit card and subsequently deemed ineligible for reimbursement, Claims Administrator will deny further access to the debit card after first going through a receipt request and substantiation process and will attempt to collect these amounts from the Program Participant. Where Claims Administrator is unsuccessful, Plan Sponsor will be responsible for collecting such amounts in accordance with IRS guidance. Claims Administrator will provide data to the Plan Sponsor identifying the employees and the ineligible amounts to enable Plan Sponsor to deduct an amount equal to the unsubstantiated or ineligible reimbursement from the employee's paycheck, or to add the amount to the Program Participants taxable wages, as allowed by applicable law.

   vi) Reports - Claims Administrator will provide Plan Sponsor with the ability to produce Program-level reports utilizing the information maintained on its recordkeeping system. Standard reports will summarize all transactions that occurred for each Program Participant and report new Program Participants within the specified time period.

3. Program Document:

Maintenance of a Program document for the applicable Program component(s) consistent with the Plan's operations and all legal requirements is the sole responsibility of Plan Sponsor.

a) Maintenance of Documents: Claims Administrator will provide a sample Program document to Plan Sponsor if requested. Claims Administrator will use reasonable efforts to provide updates to Plan Sponsor in a timely manner after changes in the law and regulations. Plan Sponsor will inform Claims Administrator of changes it desires to the Plans prior to the time Claims Administrator is expected to implement those changes. Any Plan Sponsor-initiated changes to the Program document(s) must be submitted to Claims Administrator prior to implementation to ensure that Claims Administrator is able to administer the provisions as drafted.

b) Preparation of Amendments: The preparation of amendments, other documentation, or systems changes to implement amendments for Plan Sponsor-initiated changes not due to changes in law and regulation will be billed at Claims Administrator's hourly service rates listed in Appendix 1.

4. <u>Claims Administrator VISA® Payment Card (Health FSA Only):</u> At Plan Sponsor's option, Claims Administrator will provide Program Participants with a VISA® debit card integrated with the Program Participant's account. The debit card will allow the Program Participant to access his or her account balance to pay for eligible expenses under the Plans. The debit card can be used at any eligible merchant provided the merchant has properly configured the VISA® merchant code to identify itself correctly. Cardholders are subject to the terms and conditions described in the VISA® cardholder agreement, which will be provided with the debit card. The payment card option may not be available with some Program component designs.

Appendix 2
Administration and Recordkeeping Services for Health Savings Account

If Plan Sponsor has elected to offer an HSA to Plan Sponsor's employees, then the terms of this Appendix shall apply to the administrative services that Claims Administrator provides in connection with the HSA.

1. Plan Sponsor agrees:

   a) The HSA is funded by a related trust, which is intended to satisfy the requirements of Code § 223 and for which UMB Bank, n.a serves as trustee ("Trustee").

   b) Claims Administrator is not a financial institution and does not hold the HSA.

   c) Claims Administrator does not act as a trustee for the HSA.

   d) Plan Sponsor will offer the HSA to its employees and operate the HSA in such a manner that it will not constitute an "employee welfare benefit plan" within the meaning of ERISA § 3(1) or an "employee pension benefit plan" within the meaning of ERISA § 3(2), and acknowledges that any services provided by Claims Administrator with respect to the HSA need not comply with ERISA requirements.

   e) Upon mutual agreement of the parties, a new trustee may be substituted for the existing Trustee. Such substitution shall not alter the obligations of the Claims Administrator or Plan Sponsor under this Agreement.

2. Claims Administrator will provide the following administrative services related to the HSA:

   a) Enrollment and Communications: Plan Sponsor's employees may elect to enroll in an HSA under the terms set forth in the HSA enrollment form and agreements. Claims Administrator will provide, to Plan Sponsor's employees, a standard enrollment kit with standard forms and notices necessary for the employees to establish and maintain an HSA account. The enrollment kit will include the HSA enrollment form, agreement, and terms and conditions, all in electronic format, necessary to implement the administration with the Trustee.

   b) HSA Administration and Recordkeeping:

      i. Program Participant Accounts with the Trustee - Each employee participating in the HSA must establish his or her own HSA account with the Trustee. The Trustee will establish and maintain a Program Participant HSA account for each employee for whom it receives complete enrollment information. Claims Administrator is not responsible for determining if employees are eligible for HSA Accounts, but relies on data provided by Plan Sponsor.

      ii. Program Participant Files - Claims Administrator maintains physical or electronic files for all Program Participants for whom HSA accounts have been established. These files include enrollment forms and all other written correspondence and documents concerning each Program Participant's account, and if applicable, records of any such actions conducted through the Internet or electronic means.

      iii. Transfer of HSA funds - Plan Sponsor agrees to establish a payroll deduction for the HSA, if applicable. After each contribution cycle is processed, Claims Administrator will notify Plan Sponsor of the cumulative HSA funds processed for that cycle. Plan Sponsor will allow Claims Administrator to initiate transfer via Automated Clearing House (ACH) Electronic Funds Transfer (EFT) from Plan Sponsor's designated bank account the cumulative HSA funds processed for that cycle. Claims Administrator will remit the funds to the Trustee for deposit into each employee's HSA.

      iv. Reports - Claims Administrator will provide Plan Sponsor with the ability to produce program-level reports utilizing the information maintained on its recordkeeping system. Standard reports will summarize all transactions that occurred for each Program Participant and report new enrollees.

   c) HSA Documents: All HSA account documents, including but not limited to, records of all deposits and withdrawals and other account statements will be provided by the Trustee to Plan Sponsor's employees in accordance with Trustee's standard policies and procedures and applicable law. Claims Administrator does not maintain, and shall not be responsible for maintaining or providing, such HSA documentation.

   d) Claims Administrator VISA® Payment Card: The Trustee will issue to each employee with an HSA account a VISA® payment card integrated with the employee's HSA account. The payment card will allow the HSA account balance to automatically transfer to the payment card. The payment card can be used at any eligible healthcare merchant provided the merchant has properly configured the VISA® merchant code to

identify itself correctly. The use of the payment card is subject to the terms and conditions described in the employee's VISA® cardholder agreement with Trustee, which will be provided with the payment card.

e) Claims Processing:

   i. Payment of Claims - Claims Administrator will process claims within five (5) business days of the date Claims Administrator receives a claim request from a Program Participant. Checks, if applicable, will be issued within two (2) scheduled weekly check payment cycles, upon receipt of claims in good order. Claims are in "good order" when the reimbursement request contains all pertinent information, including information required to substantiate the claim.

      Claims Administrator will not reimburse a Program Participant's claim unless the Program Participant has sufficient funds in his/her Program account(s) at the time the claim is submitted. If the Program Participant does not have sufficient funds in his/her Program account(s) at the time the claim is submitted, the reimbursement request will be held by Claims Administrator and processed in accordance with the time frame described in paragraph above starting with the date that such funds are available.

ii. Reports - Claims Administrator will provide Plan Sponsor with the ability to produce Program-level reports utilizing the information maintained on its recordkeeping system. Standard reports will summarize all transactions that occurred for each Program Participant and report new Program Participants within the specified time period.

This Attachment applies to the **Essentials** plans.

ATTACHMENT I – ALLOWED AMOUNT INSTRUCTIONS

Plan Sponsor's Instructions

The term "Instructions" in this Attachment shall mean specific instructions provided by the Plan Sponsor to the Claims Administrator that direct the Claims Administrator to administer the Plan as follows:

With respect to Alaska providers that do not have a network contract with the Claims Administrator or with a Blue Cross Blue Shield Licensee, the Plan Sponsor Instructs the Claims Administrator to administer the Plan with Allowed Amounts that are the least of the following three amounts:

- An amount that is no less than the lowest amount the Plan pays for the same or similar service from a comparable provider that has a contracting agreement with the Claims Administrator
- 200 percent of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges. Note: Ambulances are always paid based on billed charges.

If the Plan Sponsor wishes to modify its Instructions, this Attachment must be amended in writing. The Plan Sponsor understands that it is responsible for the compliance of the Plan design with all applicable federal, state and local laws and regulations. The Plan Sponsor has independently ascertained that its Plan design complies with the applicable federal, state and local laws and regulations. The Plan Sponsor acknowledges and agrees that the Claims Administrator has made no representations or warranties that the Plan Sponsor's Plan design or the Instructions complies with such laws and regulations.

Compliance With Instructions

The Claims Administrator agrees to administer the Plan consistent with the Instructions. The Plan Sponsor accepts full responsibility for its decision to require the Claims Administrator to provide health plan administration consistent with the Instructions.

Indemnification

The Plan Sponsor shall defend, indemnify and hold harmless the Claims Administrator and its directors, officers, employees, and agents from and against any and all costs, liabilities, damages, claims, lawsuits, penalties, losses or expenses (including reasonable attorney's fees) arising out of or connected to the Claims Administrator's compliance with the Instructions.

Term

The foregoing commitments of each Party shall survive any termination of the business relationship between the Parties.

Effect Of Invalidity, Unenforceability

If any provision of this Attachment shall be held invalid or unenforceable, such provision shall be deemed deleted from this Attachment and replaced by a valid and enforceable provision which so far as possible achieves the original intent of the Attachment.

Waivers

No failure or delay by a Party in exercising any right, power or privilege under this Attachment shall operate as a waiver of that right. Any waiver of a provision of this Attachment will not be deemed or construed to be a waiver of any other failure or delay of the same or a different provision.

ATTACHMENT J – FIDUCIARY AUTHORITY

Plan Sponsor's Fiduciary Authority

The Plan Sponsor retains complete authority and responsibility for the Plan, its operation, and the benefits provided hereunder. The Claims Administrator is empowered to act on behalf of the Plan Sponsor in connection with the Plan only to the extent expressly stated in this Attachment. Except as stated in this Attachment, the Plan Sponsor shall retain final discretionary authority to determine the benefit provisions and the amount to be paid by the Plan, and to construe and interpret the terms of the Plan.

The Plan Sponsor has the sole and complete authority and responsibility to determine eligibility of persons to participate in the Plan.

Claims Administrator's Fiduciary Authority

The Plan Sponsor and the Claims Administrator agree that the Claims Administrator will have the discretionary authority to administer, process, and determine entitlement to Plan benefits in accordance with the Plan documents for each claim received and to construe the terms of the Plan. It is agreed that the Claims Administrator has no other discretionary authority under the Plan.

Claims Administrator is not a fiduciary with respect to rebate administration or the prescription drug plan. Alaska Railroad Corporation has final authority and responsibility to select its pharmacy benefit design and formulary from available options. Current formularies are available on the Claims Administrator's website.

a. In the event of a legal, administrative or other action arising out of the administration, processing, or determination of a claim for Plan benefits, the Claims Administrator shall undertake the defense of such action at the Claims Administrator's expense and settle such action when, in its reasonable judgment, it appears expedient to do so. This section does not apply to Non-Contracted Provider arbitrations mandated by the Washington State Balance Billing Protection Act.

b. If the Plan Sponsor is also named as a party to a legal, administrative or other action, the Claims Administrator will defend the Plan Sponsor only if the action relates solely and directly to actions or failure to act by the Claims Administrator. In the event that the action relates in part to actions or failure to act of the Plan Sponsor, the Plan Sponsor shall be responsible for its own defense. This section does not apply to Non-Contracted Provider arbitrations mandated by the Washington State Balance Billing Protection Act.

c. If the legal, administrative or other action relates solely to the action or failure to act of the Plan Sponsor, the Plan Sponsor shall undertake sole defense of the action and shall defend the Claims Administrator. This includes any actions that arise from the Plan Sponsor's failure to fund claims determined to be payable under the Plan by the Claims Administrator.

d. For all actions, the Plan Sponsor agrees to pay the full amount of Plan benefits and any other damages or awards in any judgment or settlement in such action, except to the extent any judgment or settlement is based upon Claims Administrator's gross negligence or willful misconduct.

ATTACHMENT K – ELECTIVE PROCEDURE TRAVEL SUPPORT

The Plan's Elective Procedure Travel benefit provides Members the option to travel from Alaska to another state for certain elective procedures. This program assists Members who are using the benefit as follows:

- Premera has a dedicated Customer Support phone line for calls related to elective procedure travel.
- A dedicated Customer Service unit is available to provide:
  - Eligibility determinations and pre-approval for the elective procedure travel
  - Help to find high-value travel providers
  - Information on travel options and costs
- Case management also provided, including coordination of the medical care the Member needs:
  - Determine the appropriate medical provider for the covered service
  - Transfer of the Member's medical records as required
  - Help with appointment scheduling
- Premera's designated Program Manager will make the Member's travel arrangements and will provide pre-payment for some travel costs, such as airfare, on behalf of the Plan. Pre-paid amounts will be passed back to the Plan Sponsor as part of the regular request for claims payment.

ATTACHMENT L – PREMERA-DESIGNATED CENTERS OF EXCELLENCE

The Claims Administrator has partnered with provider groups called designated centers of excellence to provide bundled pricing for certain services to Members. All Members are eligible to participate in the program, but participation is not required. The program is administered by the Claims Administrator; however, the Claims Administrator's travel partner (Program Manager) will manage the travel benefits.

Medical Services

The bundled pricing applies to the following procedures:

- Total knee replacements
- Total hip replacements
- Spinal surgeries, such as cervical spinal fusions
- Gynecological surgeries: vaginal hysterectomy, uterine and adnexa procedures with or without complications

Services included in the bundled price for the procedure are:

Inpatient Procedures:

- Services provided before the procedure: Pre-surgical consultation with the professional team, X-ray, EKG if needed, and basic laboratory procedures. For joint and spinal surgeries, one physical therapy evaluation and therapy visit. For gynecological procedures, a urinary muscle study or cystometrogram if needed.
- Surgery, inpatient facility charges, and professional services provided during the inpatient stay.
- Post-discharge visit with the professional team, X-ray, and walker or cane, that are furnished prior to the patient being cleared to travel.

Outpatient Total Knee or Hip Joint Replacements:

- Services rendered on the day of the surgery
- Professional orthopedic fees for the surgeon and assistant surgeon
- Facility fees, including implants and supplies, lab and other testing, recovery and convalescence center fees.

Travel

Travel between the Member’s home and a designated center of excellence in Washington state is covered under the plan’s Medical Access Travel benefit and Elective Procedure Travel benefit. See Attachment K – Elective Procedure Travel Support for concierge services provided in connection with this benefit.

ATTACHMENT M – PREMERA VALUE-BASED PROVIDER ARRANGEMENTS

The Claims Administrator provides access for Members to provider groups that participate in Claims Administrator's value-based programs (VBPs). VBPs focus on improving treatment outcomes, cost and quality, and coordinating care when the Member is seeing multiple providers.

The Claims Administrator pays VBP providers for meeting standards for treatment outcomes, cost and quality, and coordinating care over a period of time called a measurement period. The Claims Administrator will then pass these VBP payments through to the Plan Sponsor.

ATTACHMENT N – PERFORMANCE GUARANTEES

PERFORMANCE GUARANTEE AGREEMENT

BETWEEN

Premera Blue Cross Blue Shield of Alaska

AND

Alaska Railroad Corporation

EFFECTIVE 1/1/2022 THROUGH 12/31/2022 (The "Agreement Period")

This Performance Guarantee Agreement is between Premera Blue Cross Blue Shield of Alaska ("the Company"), and Alaska Railroad Corporation ("the Group"). The Company will provide an acceptable level of service as described herein or will pay the penalties also described herein.

SECTION 1. TERM

The term of this Agreement shall only be the Agreement Period.

Provided this Agreement is executed prior to or on the Effective Date, the Company's fulfillment of the performance guarantees set forth in this Agreement shall be measured from the Effective Date.

In the event that this Agreement is not executed prior to or on the Effective Date, the Company's performance shall be measured in accordance with Section 3.C.

The performance guarantees under this Agreement are contingent on the Company receiving timely payment of administrative fees or subscription charges, as applicable, from the Group.

SECTION 2. PERFORMANCE GUARANTEES AND PENALTY AMOUNTS

The Company guarantees its performance as stated below. The maximum amount of accumulated penalties for the Agreement Period shall be $79,000.00

Performance Guarantee Metrics:

1) Account Management: Quarterly Account Management Team Satisfaction Survey

The Company will provide an online survey that measures the effectiveness of account management in providing superior service to the client. The Account Management Survey shall be distributed to appropriate members of the Group's benefits staff, and/or third party benefit consultants as selected by the Group, at the end of each quarter. The Group and its selected associates shall complete the Online Account Management Survey within thirty (30) days of receipt. The failure of the group to respond to one of the quarterly surveys shall nullify the Account Management Survey metric, and the Company will not pay the penalty.

Following the end of each quarter and receipt of the survey response(s) from the Group, the Company will calculate the Mean Score in each performance assessment category by using a mean score calculation. The Account Management Commitment will be deemed as fulfilled if Question 8 "Overall Satisfaction with Account Management Team" is equal to or greater than 3 on a 5 point satisfaction scale. Surveys with no response will be removed from our scoring computation. Only completed survey's submitted within 30 days of distribution will be used to score Account Management performance.

This metric is Corporate Standard and reporting will be Group Specific; Quarterly Survey; Annual Settlement

The estimated penalty for this metric will be $7,900.00

Performance Guarantee Metrics:

2) Claims : Claims Accuracy - Dollars

The Company guarantees that at least 99% of total benefit dollars payments shall be accurate (less than 1% to be in error) in a contract year, when overpayments and underpayments are combined, not offset against one another. Calculated as Total Dollars Paid less Total Absolute Value of Dollar Errors, divided by Total Dollars Paid, based on annual randomly selected audit sample, not less than 99%.

This metric is Corporate Standard and reporting will be Group Specific. Reported annually.

The estimated penalty for this metric will be $7,900.00

3) Claims : Claims Accuracy - Frequency

95% of the Groups clean claims shall be paid without error (payment and procedural) in a contract year. Calculated as Total Claims With No Errors divided by Total Claims Paid, and based on annual randomly selected audit sample, not less than 95%.

This metric is Corporate Standard and reporting will be Group Specific. Reported annually.

The estimated penalty for this metric will be $7,900.00

4) Claims : Claims Clean Claims Turnaround Time within 30 Days

Turnaround Time (TAT) is measured from the date a clean claim is received by the Company (either via paper or electronic data interchanges) to the date it is processed for payment, denied, or pended for external information. A clean claim is defined as one that has been received by The Company with the relevant and correct information required to process the claim. This claim will have no defects or irregularities, includes any required substantiating documentation, and can be adjudicated without interruption. The calculation for the Claim Turnaround Time percentage will be measured on the percentage of all Clean Claims processed within 30 Days of Receipt divided by Total Clean Claims Processed (*excluding Blue Card claims), not less than 97%. *Performance Standard will be tolled with respect to a claim during the period the claim is suspended for information outside The Company's claims processing system or scope of responsibility or control (i.e., review by other organizations not integrated into processing system).

This metric is Corporate Standard and reporting will be Group Specific. Reported quarterly.

The estimated penalty for this metric will be $7,900.00

Performance Guarantee Metrics:

5) Customer Service: Customer Service - Abandonment Rate

The Company guarantees that no more than 3 percent of incoming calls that are made to our toll-free customer service telephone line shall be dropped before speaking to a Customer Service Representative. Customer Service Abandonment Rate calculated as Total Abandoned Calls divided by Total Accepted Calls.

This metric is Non-Standard and reporting will be Combined score of all PG Groups in Customer Service Unit. Reported quarterly, settled using 12 mo avg.

The estimated penalty for this metric will be $7,900.00

6) Customer Service: Customer Service - Service Level within 30 seconds

The Company guarantees that 75% of all calls to their toll-free customer service telephone line will be answered in thirty seconds or less. Answered means the time from when the caller selects the option to speak with an agent until a Customer Service Representative answers the call. Results are calculated as Total Calls Answered Within 30 Seconds divided by Total Calls Received.

This metric is Corporate Standard and reporting will be Combined score of all PG Groups in Customer Service Unit.
Reported quarterly, settled using 12 mo avg

The estimated penalty for this metric will be $7,900.00

7) Vendor: Pharmacy - Claims Turnaround Time

Measured in business days from the date the prescription is received by the Vendor (either via paper, phone, fax or internet) to the date it is shipped. Calculated as the number of prescription claims requiring intervention processed within four business days divided by the total number of prescription claims received that require intervention.

This metric is Non-Standard and reporting will be Based on Book of Business; Annual Reporting.

The estimated penalty for this metric will be $7,900.00

8) Vendor: Pharmacy - Claims Turnaround Time

Measured in business days from the date the prescription is received by the Vendor (either via paper, phone, fax or internet) to the date it is shipped. Calculated as the number of “clean” prescription claims processed within two business days divided by the total number of clean prescription claims received.

This metric is Non-Standard and reporting will be Based on Book of Business; Annual Reporting.

The estimated penalty for this metric will be $7,900.00

Performance Guarantee Metrics:
9) Vendor: Pharmacy - Dispensing Accuracy The company guarantees that 100% accuracy in dispensing, according to the plan design and prescription, the correct drug, strength and dosage, unless the error is a prescriber error through the mail order delivery channel. Calculated as the total number of non-conformance events divided by the total number of prescription dispensed. This metric is Non-Standard and reporting will be Based on Book of Business; Annual Reporting. The estimated penalty for this metric will be $7,900.00
10) Vendor: Pharmacy - Patient Satisfaction Survey The Patient Satisfaction Rate for each contract year must be 90% or greater as determined by a satisfaction survey conducted by ESI on behalf of Premera. The Patient satisfaction survey will be conducted annually to assess patient satisfaction at the Premera Book of Business level. The survey must be completed by March 31 of each calendar year. This metric is Non-Standard and reporting will be Based on Book of Business; Annual Reporting The estimated penalty for this metric will be $7,900.00

SECTION 3. EVALUATION OF PERFORMANCE AND PAYMENT OF PENALTIES

A) At the end of the Agreement, the Company shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance guarantee set forth in this Agreement and make this information available to the Group.

B) If the Company fails to meet any of the performance guarantees set forth in Section 2, the Company shall pay to the Group the financial penalty based on the percentage set forth in Section 2.

C) In the event that this Agreement is not executed by the Effective Date, the Company's performance shall be measured from the first day of the month following the month this Agreement is executed. In such event the applicable penalty amounts will be pro-rated for that portion of the year for which performance guarantee metrics are in force.

D) Refer to Section 4 if the contract under which the Company provides insurance and/or administrative services to the Group is terminated prior to the end of the term of this Agreement.

SECTION 4. TERMINATION OF AGREEMENT

If this Agreement terminates prior to the last day of the Agreement Period the Group is not entitled to any penalties under Section 2 of this Agreement. This Agreement shall terminate upon the earliest of the following dates:

A) the end of the Term of this Agreement;

B) the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

C) the date upon which the Group either fails to meet its obligation to sufficiently fund the bank account from which claims are paid (if applicable), or fails to make timely payments of either administrative fees or subscription charges anytime during the plan year;

D) the date upon which the contract under which the Company provides services to the Group is terminated;

E) any other date mutually agreeable to the Company and Group.

ATTACHMENT O – RFP RESPONSES

As reflected in RFP Response Dated June 2017.