**CITY OF MARYSVILLE AGENDA BILL**

**EXECUTIVE SUMMARY FOR ACTION**

## CITY COUNCIL MEETING DATE:

| **AGENDA ITEM:** | |
|---|---|
| Administrative Service Contract between Premera Blue Cross and City of Marysville | |
| **PREPARED BY:** | **DIRECTOR APPROVAL:** |
| Teri Lester | |
| **DEPARTMENT:** | |
| Human Resources | |
| **ATTACHMENTS:** | |
| 1. Premera Blue Cross contract. | |
| **BUDGET CODE:** | **AMOUNT:** |
| | |

**SUMMARY:** With Marysville becoming self-insured for health benefits, the City needs to execute agreements with insurers and service providers.

Premera Blue Cross was selected as the City's self-insured claims administrator effective January 1, 2020.

WHEREAS, the City of Marysville has established an employee benefit plan which provides for payment of certain welfare benefits to and for certain eligible individuals as defined in writing by the City, and,

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

WHEREAS, the City of Marysville desires to engage the services of Premera Blue Cross as the Claims Administrator to provide administrative services for the Plan.

**RECOMMENDED ACTION: Staff recommends the council authorize the Mayor to execute the agreement with Premera Blue Cross.**

# ADMINISTRATIVE SERVICE CONTRACT

# BETWEEN

# PREMERA BLUE CROSS

# AND

# CITY OF MARYSVILLE

## EFFECTIVE JANUARY 1, 2020 THROUGH DECEMBER 31, 2020 (THE "CONTRACT PERIOD")

This Contract is effective by and between the group named above (hereinafter referred to as the "Plan Sponsor"), and Premera Blue Cross (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.

**City of Marysville**

BY: _____ DATE: _____

_____
Title

ADDRESS: _____

_____

**Premera Blue Cross**

BY:  DATE: January 1, 2020

**Jeffrey Roe**
**President and Chief Executive Officer**

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

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# 1. DEFINITIONS

**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** 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 and emergency services. These rules are shown below the general rules.

**a. General Rules**

1. **Providers In Washington and Alaska Who Have Agreements With the Claims Administrator**

   For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between the Claims Administrator and the provider.

2. **Providers Outside The Service Area Who Have Agreements With Other Blue Cross Blue Shield Licensees**

   For covered services and supplies received outside the Service Area, Allowed Amounts are determined as stated in "Attachment A – Out-of-Area Services."

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

   The Allowed Amount for providers in the Service Area that don't have a contract with the Claims Administrator is the least of the three (3) amounts shown below. The Allowed Amount for providers outside the Service Area that don't have a contract with the Claims Administrator or the local Blue Cross and/or Blue Shield Licensee is also the least of the three (3) 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 the Claims Administrator

   - 125 percent of the amount allowed by Medicare, if available
   - The provider's billed charges. Note: 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**

1. **Providers Who Have Agreements With the Claims Administrator Or Other Blue Cross Blue Shield Licensees**

   For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable agreement between the Claims Administrator and the provider.

2. **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.

**c. Emergency Care**

Consistent with the requirements of the Affordable Care Act, the Allowed Amount will be the greatest of the following amounts:

1. The median amount that Heritage Network Providers have agreed to accept for the same services
2. The amount Medicare would allow for the same services
3. The amount calculated by the same method the Claims Administrator uses to determine payment to Non-Contracted Providers

Note: Non-Contracted Ambulances are always paid based on billed charges.

In addition to any deductible, copays and coinsurance, Members are responsible for charges received from Non-Contracted Providers above the Allowed Amount.

**Claims Administrator** Premera Blue Cross.

**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.

**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, 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** City of Marysville.

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

**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. Plan Sponsor's Fiduciary Authority

The Plan Sponsor shall have final discretionary authority to determine the benefit provisions and to construe and interpret the terms of the Plan.

The Plan Sponsor shall have final discretionary authority to determine eligibility for benefits and the amount to be paid by the Plan.

## 2.3. Defense of the Plan

Except as stated in subsection 4.3, the Plan Sponsor shall be responsible for defending any legal action brought against the Plan, including a claim for benefits by or on behalf of any individual or entity, including but not limited to any Member or former Member, any fiduciary or other party. This responsibility includes the selection and payment of counsel. The Plan Sponsor shall not settle any legal action or claim without the prior consent of the Claims Administrator if the action or claim could result in the Claims Administrator being liable, including for example, any liability for contribution to or indemnification of the Plan Sponsor or other third party either directly or indirectly.

## 2.4. 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 most 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 most 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 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 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.

## 2.5. 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.

## 2.6. 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
  - The Affordable Care Act.
  - 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)
  - 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.

    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) arising out of or connected to the Claims Administrator's administration of any benefit design authorized by the Plan Sponsor. 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.

## 2.7. Appeals

If an adverse decision on a Member appeal results from the Plan's internal appeal process, the Plan shall offer the Member a review by an Independent Review Organization (IRO) as described in subsection 3.2.

## 2.8. 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. Administrative Duties

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. The Plan Sponsor's rebate payment shall be made 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.

   The Plan Sponsor is responsible for all costs charged by the IRO to perform its review. If the Plan Sponsor chooses to share that cost with Members to the extent allowed under the Affordable Care Act, the Plan Sponsor is responsible to charge and collect any such fee from a Member.

## 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 shall be determined by the 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 2.8 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

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. 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 to any group hereunder 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 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 for such errors unless they resulted from its gross negligence or willful misconduct. The Plan Sponsor agrees to defend, indemnify and hold harmless the Claims Administrator from all claims, damages, liabilities, losses and expenses arising out of the Claims Administrator's performance of administration services under the terms of this Contract, so long as they did not arise out of the Claims Administrator's gross negligence or willful misconduct. In the event that Claims Administrator becomes aware of an inaccurately priced claim, Claims Administrator shall ensure that Plan Sponsor's funding obligation is limited to the accurate price of such claim.

## 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 and which relate to a random, statistically valid number of

claims 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.

## 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.

## 8.6. Plan Sponsor Liability Upon Termination

In the event this Contract is terminated, the Plan Sponsor shall remain liable to the Claims Administrator for all delinquent sums together with interest thereon as provided for in subsection 5.2.c. above.

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 health care service contractors.

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 Washington, unless federal law applies. Any and all disputes concerning this Contract shall be resolved in King County Superior Court 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" 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 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 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, 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 hereof 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 2.8 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

## 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 E – BUSINESS ASSOCIATE AGREEMENT

ATTACHMENT F – CARECOMPASS360°

ATTACHMENT G – EXTENDED POST-PAYMENT RECOVERY SERVICES

ATTACHMENT H – PREMERA-DESIGNATED CENTERS OF EXCELLENCE

ATTACHMENT I – PREMERA VALUE-BASED PROVIDER ARRANGEMENTS

# 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, 2020, are based on the following:

**Number of Active and Retired Members: 654**

| | Employee | Dependents |
|---|---|---|
| Medical | 265 | 389 |

**Number of COBRA Members: 3**

| | Employee | Dependents |
|---|---|---|
| Medical | 3 | 0 |

**Other Carriers Offered: None**

# 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**
**and**
**City of Marysville**
**Group Number: 4018895**
**Effective: 1/1/2020 through 12/31/2020**

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:**

$51.72 per employee per month

**Administration Fee Breakdown:**

| | |
|---|---|
| Administration Fee (Medical/Rx) | $51.72 |
| Total | $51.72 |

**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.

## 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. The fee shall be a proportionate share of $10,000, 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.

## Premera-Designated Centers of Excellence

In addition to claims for the foregoing services, Plan Sponsor shall pay Claims Administrator a care coordination and support fee of $3,000 per case. The fee is charged to the Plan Sponsor as a claims expense. See Section 2.8 for more information.

See Attachment H – 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 Appendix 2) | Not included in Administration Fee. $245 per actively engaged Member per month of active engagement. | |
| **BestBeginnings Maternity** (See Appendix 3) | Engagement fee: | $50 one-time fee per Member when the Member registers for the program and downloads the mobile application |
| | High Risk Maternity Case Management | $350 additional one-time fee for Members engaged in high-risk case management |
| **Neonatal Intensive Care Risk Assessment & Case Management** (See Appendix 4) | Fee waived | |

## 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.<br>25 percent if, after Claims Administrator has worked a subrogation case, the Plan Sponsor takes over responsibility for the case and settles directly.<br>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 |

# ATTACHMENT E – BUSINESS ASSOCIATE AGREEMENT

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

PREMERA | BLUE CROSS

# BUSINESS ASSOCIATE AGREEMENT
# FOR GROUPS NOT SUBJECT TO ERISA
# BETWEEN
# PREMERA BLUE CROSS
# AND
# CITY OF MARYSVILLE
# EFFECTIVE JANUARY 1, 2020

This Business Associate Agreement (the "Agreement") shall be entered into by and between Premera Blue Cross (the "Claims Administrator"), and the group named above (the "Plan Sponsor" and the " Health Plan (HP)" (as defined below). The Agreement shall be effective on the date shown above and shall be made part of the Administrative Services Contract (the "Contract") between the Claims Administrator and the Plan Sponsor.

**Recitals.**

1. In 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"), which required, among other things, the promulgation of privacy rules governing the use and disclosure of protected health information ("PHI") (as defined below), and the protection of electronic protected health information ("EPHI") (as defined below).

   In February 2009, Congress enacted the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which amended HIPAA and its implementing regulations codified at 45 CFR Parts 160 and 164.

2. In pertinent part, the implementation regulations for HIPAA, codified at 45 C.F.R. Parts 160, 162 and 164, and as amended (collectively referred to as the "HIPAA Rules") require covered entities, such as the HP, to maintain a written agreement with specific provisions concerning PHI and EPHI with its Business Associates (as defined in 45 C.F.R. 160.103 and as amended).

3. In addition to being the business associate of the HP, the Claims Administrator is also a covered entity, as defined in the HIPAA Rules, and has policies, procedures and practices in place to ensure compliance with the HIPAA Rules as well as other state and federal privacy laws, which protect personal financial, health and other information, that apply to the Claims Administrator (collectively referred to as the "Privacy Laws").

4. The Claims Administrator has adopted the term "protected personal information" or "PPI" (as defined below) to encompass PHI and the additional information protected by the Privacy Laws, and will apply the requirements of the HIPAA privacy rules to PPI.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan Sponsor, the HP and the Claims Administrator hereby agree as follows:

1. **Definitions.** The following definitions shall apply in interpreting this Agreement. Capitalized terms used, but not otherwise defined herein, shall have the same meaning as those terms in the HITECH Act or the HIPAA Rules

   1.1 EPHI. "EPHI" (Electronic Protected Health Information) shall mean any and all PHI transmitted by or maintained in electronic media.

   1.2 Health Plan or HP. The HP shall be defined consistent with 45 CFR 160.103, and as amended.

   1.3 Individual. "Individual" shall mean the person who is the subject of the PPI or their personal representative (as defined in 45 CFR 164.502(g)).




ORIGINAL

1.4 PHI. "PHI" (Protected Health Information) shall mean information that meets the requirements in 45 CFR 160.103, or as amended.

1.5 Protected Personal Information or PPI. "PPI" shall mean PHI and any and all information created or received by the Claims Administrator from or on behalf of HP that identifies or can readily be associated with the identity of an Individual, whether oral or recorded in any form or medium, that directly relates to: the past, present or future finances of an Individual, including, without limitation, an Individual's name, address, telephone number, Social Security Number, subscriber number or wage information.

1.6 Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his duly appointed designee.

1.7 Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 CFR 164.304, including any subsequent modifications thereto.

2. **HP.** The Claims Administrator and the Plan Sponsor and HP all agree that the HP shall be added as a party to the Contract and acknowledge that the HP's obligations under the Contract are contained completely in this Agreement. The signature of the Plan Sponsor to this Agreement shall be agreed to be the signature of the HP and binding on behalf of both the Plan Sponsor and the HP.

3. **Permitted Uses and Disclosures of PPI by the Claims Administrator.**

3.1 Functions and Activities on the HP's Behalf. The Claims Administrator shall be permitted to use and disclose PPI for (a) the management, operation and administration of the HP and (b) as otherwise necessary to provide the services set forth in the Contract ("Services"), including, but not limited to activities related to Payment and Health Care Operations, including Data Aggregation Services, as defined in 45 CFR 164.501. The Claims Administrator may also de-identify PPI in the course of providing Services to the HP.

3.2 Disclosures to the Plan Sponsor, the HP or other Business Associates of the HP. Except as allowed by applicable law and HP governing documents, the Claims Administrator will not disclose PPI to the Plan Sponsor, the HP or to another business associate of the HP. The Claims Administrator may disclose PPI only to those individuals employed by the HP or business associates of the HP, including, without limitation, the HP's producer, identified in writing by the HP as individuals to whom PPI can be disclosed. The HP must provide this written directive to the Claims Administrator as soon as possible but in any event no later than the effective date of the Contract. The HP must promptly notify the Claims Administrator of any changes to the written directive.

3.3 Functions and Activities on the Claims Administrator's Behalf. The Claims Administrator shall be permitted to use PPI as necessary for the Claims Administrator's management and administration or to carry out its legal responsibilities as permitted or required by law. The Claims Administrator shall also be permitted to disclose PPI to its Business Associates, subcontractors or other third parties as necessary for proper management and administration of the Claims Administrator, or to carry out the Claims Administrator's legal responsibilities (a) if the disclosure is required by law or (b) if before the disclosure is made, the Claims Administrator, obtains a contract from the entity to which the disclosure is to be made containing reasonable assurances that the entity will also comply with the HIPAA Rules' business associate requirements.

4. **Minimum Necessary.** The HP and the Plan Sponsor will make reasonable efforts to request from the Claims Administrator only the minimum amount of PPI necessary for its needed purpose. In addition, the HP and the Plan Sponsor will make reasonable efforts to only disclose to the Claims Administrator the minimum amount of PPI necessary for the Claims Administrator to perform the services identified in the Contract and other functions and activities referenced in Section 3 of this Agreement. Finally, the Claims Administrator will make reasonable efforts to use, disclose, or request only the minimum amount of PPI necessary from any third party to perform the services identified in the Contract and other functions and activities referenced in Section 3 of this Agreement. When feasible, as determined by the party maintaining PPI, the HP, Plan Sponsor and Claims Administrator shall create, use or disclose a Limited Data Set.

5. **Other Privacy Obligations of the Claims Administrator.** The Claims Administrator shall:

5.1 Not use or further disclose PPI other than as permitted or required by the Contract, the Agreement, HIPAA Rules or Privacy Laws and use appropriate safeguards to prevent any unauthorized use or disclosure of PPI;

5.2 Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the EPHI that the Claims Administrator creates, receives, maintains, or transmits on behalf of the HP;

5.3 Report to HP any actual use or disclosure of PPI concerning HP's members not permitted or required by the Contract, the Agreement or law of which it becomes aware;

5.4 Notify the HP of any Security Incident of which it becomes aware; provided, however, the obligation to report a Security Incident shall not include immaterial incidents, such as unsuccessful attempts to penetrate Claims Administrator's information systems;

5.5 Ensure that any agents, including a subcontractor, to whom it provides PPI and/or EPHI received from the HP, or created, received or maintained by the Claims Administrator on behalf of the HP, agree, in writing, to the same restrictions, conditions and requirements as outlined in the HIPAA Rules that apply to a Business Associate with respect to such information;

5.6 Make available PPI in a Designated Record Set, in either paper or electronic format, as required by 45 CFR 164.524;

5.7 Make available PPI for amendment and incorporate any amendments to PPI as required by 45 CFR 164.526;

5.8 Make available the information required to provide an accounting of disclosures as required by 45 CFR 164.528;

5.9 Make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PPI or PHI and/or the protection of EPHI received from, or created or received by the Claims Administrator on behalf of, the HP available to the Secretary for purposes of determining the HP's compliance with the HIPAA Rules, including documentation sufficient to meet the administrative requirements of 45 CFR §164.414 for breach notifications described in subsection 5.11, below;

5.10 Restrict the use and disclosure of PPI in accordance with 45 CFR 164.522 and consistent with the Claims Administrator's policies, procedures and practices;

5.11 Report promptly information to the HP about any use or disclosure of Unsecured PHI of the HP's members not permitted or required by the Contract, the Agreement, or law caused by the Claims Administrator or one of its subcontractors for which it becomes aware and that Claims Administrator determines Compromises the Security or Privacy of the PHI (collectively referred to as a "Claims Administrator Breach");

5.12 Notify, or direct its subcontractor to notify, an Individual as required by 45 CFR §164.404, the media as required by 45 CFR §164.406 and the Secretary as required by §164.408(b), for a Claims Administrator Breach reported to the HP under subsection 5.11 above;

5.13 Provide the HP with the information necessary about any Claims Administrator Breach in order for the HP to include such information in the HP's log of Breaches that must be filed annually with the Secretary as required by 45 CFR §164.408(c);

5.14 Comply with the following HIPAA provisions: Subpart C of 45 CFR Part 164 (i.e., the Security Rule), and Business Associate requirements (45 CFR §164.502(e)(2) and 45 CFR §164.504(e)); and

5.15 Comply with Accounting for Disclosure (45 CFR §164.528) in the event that Department of Health and Human Services rules clarify that the HP has one or more Electronic Health Records that Claims Administrator creates, accesses, uses or maintains.

6. **The Claims Administrator's Privacy-Related Services Regarding Requests by Individuals**. Upon receipt, the HP shall immediately provide notice to and forward any and all individual requests received pursuant to 45 CFR Sections 164.522, 164.524, 164.526 or 164.528 of the HIPAA Rules (collectively

referred to as the "Requests"). Upon the Claims Administrator's receipt of the Requests, either from the HP or directly from the Individual, the Claims Administrator shall:

6.1 Evaluate each Request consistent with the HIPAA Rules and the Claims Administrator's policies, procedures and practices;

6.2 For Requests that may affect the policies, procedures or practices of the HP, coordinate with the HP about evaluation of the Requests and mutually agree on the result;

6.3 For Requests that may involve the HP's other Business Associates, request information from the Business Associates identified by the HP necessary for fulfilling the Requests;

6.4 Communicate the result of the evaluation directly to the Individual within the legal timeframes established for each type of Request;

6.5 Notify the HP of the outcome of each Request identified by the HP at the time of notice to the Claims Administrator; and

6.6 Implement each Request that is granted.

Such services shall be included in the Claims Administrator's Administration Fee set forth in Attachment C in the Contract.

**7. HP's Notice of Privacy Practices.**

7.1 Preparation of the HP's Notice of Privacy Practices. Claims Administrator will provide the HP a copy of notice of privacy practices as it relates to the Claims Administrator's functions and activities contained in the Contract and this Agreement, which the HP shall incorporate into the HP's Notice of Privacy Practices (the "Privacy Notice").

7.2 Amendment of the HP's Privacy Notice. The HP shall be responsible for modifying the Privacy Notice in the event that the HP, the Plan Sponsor or the Claims Administrator materially changes its privacy policies, procedures or practices that affect the Privacy Notice. The party necessitating the change to the Privacy Notice shall bear any reasonable costs associated with revising and distributing the Privacy Notice. The HP, the Plan Sponsor and the Claims Administrator will not institute such material change before the effective date of the HP's revised Privacy Notice.

7.3 Distribution of the HP's Privacy Notice of Privacy Practices. The HP shall be responsible for the distribution of its Privacy Notice, and any revisions to its Privacy Notice within a reasonable time.

**8. Term and Termination.**

8.1 Term. The Term of this Agreement shall begin as of the Effective Date contained herein and shall remain in effect for the duration of the Contract, including any runout period required under the Contract. This Agreement shall automatically renew for the additional terms of any Contract renewal or subsequent Administrative Services Contract between Claims Administrator and the Plan Sponsor.

8.2 Termination for Breach of Privacy Obligations. Either Party shall have the right to terminate the Contract as outlined in the Contract if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of its obligations regarding PPI under this Agreement, the Contract or law.

8.3 Effect of Termination.

a. *Return or Destruction of PPI Upon Termination of Contract.* Upon cancellation, termination, expiration or other conclusion of the Contract, the Claims Administrator will, if feasible, return to the HP or else destroy PPI, in whatever form or medium that the Claims Administrator, created or received for or from the HP, including all copies of and any data or compilations derived from such PPI that allow identification of any Individual. The Claims Administrator will complete such return or destruction as promptly as practical, but not later than sixty days after the effective date of the cancellation, termination, expiration or other conclusion of the Contract.

b. *Reimbursement.* The Plan Sponsor will reimburse the Claims Administrator's reasonable costs and expenses incurred in returning or destroying such PPI.

c. *Disposition When Return or Destruction of PPI Is Not Feasible.* In the event that returning or destroying the PPI is not feasible as determined by the Claims Administrator, the Claims Administrator will limit further use or disclosure of the PPI to those purposes that make their return to the HP or destruction infeasible and shall extend the privacy protections contained herein to that PPI for as long as the Claims Administrator retains it.

9. **Order of Precedence**. This Agreement shall supersede and replace any and all provisions in the Contract concerning confidentiality or privacy of PPI. In addition, the notice provisions of this Agreement shall prevail over the Contract only to the extent that such notice is related to the obligations contained herein. Except as otherwise provided in this section, in the event that any other terms or conditions contained in this Agreement conflict or are inconsistent with the Contract, the terms and conditions of the Contract shall prevail.

IN WITNESS WHEREOF, the parties have signed this Agreement effective as of the dates indicated above.

**PLAN SPONSOR AND HEALTH PLAN (HP)**

_____

**Its:** Mayor

**Dated:** 12/5/19

**CLAIMS ADMINISTRATOR**

_____

**Its: President and Chief Executive Officer**

# EXHIBIT 1

## NON-ERISA GROUP BUSINESS ASSOCIATE AGREEMENT

### Notification Requirements
### Privacy-Related Services Regarding Requests

All notices required under Section 6 of this Agreement shall be given in writing, delivered by facsimile or in person, and addressed as follows:

**HP:**

Name: Teri Lester

Department: Human Resources

Telephone Number: 360-363-8084

Fax Number: 360-658-4648

**Claims Administrator:**

Premera Blue Cross Complaints and Appeals Department
P.O. Box 91102
Seattle, WA 98111-9202
Telephone: 1.800.722.1471
Fax: 425.918.5592

# EXHIBIT 2

## NON-ERISA GROUP BUSINESS ASSOCIATE AGREEMENT

### Electronic Transaction Standards

This Exhibit takes effect on January 1, 2012 or on the Contract effective date, whichever is later.

To the extent that the Claims Administrator and HP conduct Standard Transactions between them regarding enrollment and disenrollment (presently denominated "834"), the HP hereby agrees that it will comply with each applicable requirement of 45 CFR Part 162. The Claims Administrator will notify the representatives designated by the HP for this purpose if an electronic transaction received by the Claims Administrator from the HP violates this obligation. The HP understands and agrees that noncompliance can result in rejection of the transaction.

The Claims Administrator will comply with and require any subcontractor or agent involved with the conduct of Standard Transactions to comply with the requirements of 45 CFR Part 162 applicable to Claims Administrator.

# 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."

## Information and Data

- For Plan Sponsors for whom the Claims Administrator does not have claims data as it determines necessary for the prior 24-month period, the Plan Sponsor will attempt to obtain such data from the Plan Sponsor's previous health plan(s), 90 days prior to the Plan Sponsor Effective Date. The Claims Administrator will cooperate with Plan Sponsor's effort in obtaining such data. All such data shall be provided by the Plan Sponsor in a mutually agreeable electronic format.
- **Inability to Provide Data.** The Parties recognize that the provision of data referenced above is critical to the success of the services. Therefore, the Plan Sponsor agrees that if any or all data referenced above is unavailable or cannot be obtained in a timely fashion, this could, at the Claims Administrator's option, affect the terms, range and availability of services available to the Plan Sponsor. In the event that at least 24 months of historical data is not available, then the Claims Administrator shall adjust reporting and measurement requirements for such Plan Sponsor accordingly.

## 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. |
| 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. |
| **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 |
| Enhanced Controlled Substances Utilization Program (Opioid Management)<br>Standard Option | Our standard program 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. |
| ePocrates | Software to provide physicians with up-to-date drug and plan formulary information. |
| Polypharmacy | Education for Members using multiple drugs to review prescriptions with their providers to decrease incidences of adverse drug interactions |
| Point-of-sale Pharmacy | Follow-up with Members and physicians to minimize inappropriate or excessive drug therapies identified when drugs are dispensed. |
| **Virtual Care – On Demand** | The Claims Administrator has contracted with one or more vendors to provide virtual care services using secure chat, text, voice or audio messaging and video chat.<br>The virtual care services do not include real-time visits between Members and their doctors via online and telephonic methods (telemedicine). |

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 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 to 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

# 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.<br>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.<br>Claims Administrator will not initiate legal action to enforce the plan's subrogation provision without prior approval from the Plan Sponsor.<br>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 process is then employed to request and recover verified overpayments. |

| Post Payment Recovery Category | Explanation of Services |
|---|---|
| **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:<br>• Service is consistent with diagnosis and billing is consistent with services.<br>• There has been no unbundling of services, diagnosis up-coding or billing maximization.<br>• Services rendered were prescribed by the physician and the doctor's notes were signed.<br>• Standardized billing and payment policies were used.<br>Calypso provides support for this vendor's efforts as well as processes all recoveries. |

# ATTACHMENT H – PREMERA-DESIGNATED CENTERS OF EXCELLENCE

The Claims Administrator has partnered with provider groups called *Designated Centers of Excellence* to provide favorable pricing for certain services to Members. Member participation is not mandatory. The program is administered by the Claims Administrator; however, the Claims Administrator's travel partner will manage the travel arrangements as explained below.

## Medical Services

The centers of excellence may differ depending on the surgeries covered. The following procedures are included:

- Total knee or hip joint replacements. In Washington, the designated centers of excellence are the following Providence hospitals:

  Swedish First Hill, Seattle and Ballard

  Swedish Edmonds, Edmonds

  Providence St. Peter Hospital, Olympia

  Providence Regional Medical Center, Everett

  Kadlec Regional Medical Center, Benton County

  Providence Sacred Heart Medical Center, Spokane

  The designated centers of excellence outside Washington are Blue Cross Blue Shield Association Blue Distinction Centers Plus.

Services provided by the Designated Center of Excellence include pre-operative services and supplies before the procedure, surgery and associated facility care. Post-surgery care is covered under this benefit for a limited period after surgery.

All other related services, including outpatient follow-up care after surgery, rehabilitation and skilled nursing facility care are not part of the Premera-Designated Centers of Excellence program. To the extent the plan covers the related services, they would be subject to standard plan cost-shares. Other procedures done by the Designated Center of Excellence, such as partial joint replacements, are not eligible for coverage under the Premera-Designated Centers of Excellence program.

## Medical Transportation

The Designated Centers of Excellence program includes benefits for travel and lodging for certain covered services as described below. The member must live more than 50 miles away from the provider performing the services, unless transplant protocols require otherwise. Please contact Customer Service to access our travel partner. **Air transportation and lodging must be booked by Premera's travel partner in order to be covered.** Prior authorization is also required.

- Travel and lodging expenses related to services covered under the Premera-Designated Centers of Excellence program.
- Travel related to the covered transplants named in the plan's ***Transplants*** benefit and subject to the ***Transplants*** benefit's travel maximum, if any. Benefits are provided for travel of the member getting the transplant and one companion. The plan also covers lodging for members not in the hospital and for their companions. The member getting the transplant must live more than 50 miles from the transplant facility unless treatment protocols require the member to remain closer to the transplant center.
- Travel for cellular immunotherapy and gene therapy. Benefits are provided for travel for the member and one companion to a designated provider outside the service area, when a designated provider is not available within Washington and Alaska. Note: The immunotherapy or gene therapy itself is not included in the Premera-Designated Centers of Excellence program.

Covered medical transportation expenses are:

- Air transportation expenses between the Member's home and the medical facility where services will be provided. Air travel expenses cover unrestricted coach class, flexible and fully refundable round-trip

airfare from a licensed commercial carrier.

- Ferry transportation from the Member's home community
- Lodging expenses at commercial establishments, including hotels and motels, between home and the medical facility where the service will be provided.
- Mileage expenses for the Member's personal automobile
- Ground transportation, car rental, taxicab fares and parking fees, for the member and a companion (when covered) between the hotel and the medical facility where services will be provided.

Travel and lodging costs are subject to the IRS limits in place on the date the expense is incurred. The mileage limits and requirements can change if IRS regulations change. Please go to the IRS website, **www.irs.gov**, for details. This Attachment is not and should not be assumed to be tax advice.

**Companion Travel** One companion needed for the Member's health and safety is covered. For a child under age 19, a second companion is covered only if medically necessary.

**Reimbursement of Travel Claims** There are some covered travel services that are not arranged by Premera's travel partner. For these services, Members must submit a Travel Claim Form. A separate claim form is needed for each patient and each commercial carrier or transportation service used.
The Medical Transportation benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, except for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior authorization
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network or that have not been designated by Premera to perform the services
- Travel insurance

## Member Eligibility And Access To Services

- Services covered under the Premera-Designated Center of Excellence benefit require prior authorization. Members or their doctors will contact the Claims Administrator's Customer Service department for the prior authorization.
- The Claims Administrator will review the prior authorization request to make sure that the Member meets the medical necessity requirements and authorize the care. If the Member wants to have the procedure done by a Designated Center of Excellence, the Claims Administrator will work with the Member to find a Center of Excellence. The Claims Administrator will help coordinate the Member's care.
- If travel is necessary, the Claims Administrator's travel partner will schedule and pre-pay the costs of airfare and lodging as needed.

# ATTACHMENT I – 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.