



## HUMAN RESOURCES DEPARTMENT

**DATE:** December 15, 2016

**FROM:** Robert McConnell, Director of Human Resources

*RM*

**ITEM:** 2017 Renewal Contract with BC/BS

### REQUEST

Approval of the 2017 BC/BS Administrative Service and Stop Loss Agreement contracts

Please place this item on the December 26, 2016 City Commission meeting.

### BACKGROUND INFORMATION

Blue Cross/Blue Shield of ND administers the City of Bismarck's Health Insurance and provides Stop Loss coverage for our plan. We would like to renew our contract with them for the 2017 plan year.

### RECOMMENDED CITY COMMISSION ACTION

The Human Resource Department recommends approval of the BC/BS Administrative Service Agreement and Stop Loss agreement.

### STAFF CONTACT INFORMATION

Robert McConnell, Director Human Resources, 701-355-1332, [rmcconnell@bismarcknd.gov](mailto:rmcconnell@bismarcknd.gov)



**CONTRACT REVIEW FORM**

**DEPARTMENT**

Contract between the City of Bismarck and Blue Cross Blue Shield of North Dakota

Purpose of Contract: Health Insurance: Stop Loss & Admin Service Agreement

Contract Amount: \$ \_\_\_\_\_

Contract Period: 1/1/2017 thru 12/31/2017

Funding Source: Health Insurance Reserve Fund

Project Number: (If needed, send copy to Fiscal Services) \_\_\_\_\_

Comments: Annual Renewal of our agreement

\_\_\_\_\_

\_\_\_\_\_

After Mayor's Signature, route to: Robert McConnell Date: 12/15/2016

Department Head Signature:  Date: \_\_\_\_\_

**CITY ATTORNEY**

Comments: \_\_\_\_\_

\_\_\_\_\_

City Attorney Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCE**

Comments: \_\_\_\_\_

\_\_\_\_\_

Director of Finance Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADMINISTRATION**

City Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTENTION:**  
Attach a signature flag at each place you want the Mayor to sign.  
Please send copy of completed contracts to Administration.

[Print Form](#)

# **City of Bismarck**

**January 1, 2017 through December 31, 2017**

**STOP-LOSS CONTRACT  
(INCURRED BASIS)**

This Stop-Loss Contract ("Contract") is entered into between City of Bismarck ("Insured") and Blue Cross Blue Shield of North Dakota ("BCBSND"), the terms of which are as follows:

**WITNESSETH:**

**WHEREAS**, the Insured has established and maintains a self-funded employee welfare benefit plan known as the City of Bismarck Group Plan ("the Plan"), which provides, among other things, various benefits to Members in the Plan, as set forth in the attached Exhibit "A"; and

**WHEREAS**, benefits under the Plan are paid from the general assets of the Insured, or trust assets ("the Trust"), or a combination of such general assets and trust assets; and

**WHEREAS**, BCBSND provides certain services to the Plan pursuant to the Administrative Service Agreement dated January 1, 2017, a copy of which is attached; and

**WHEREAS**, the Insured desires to protect its general assets or trust assets or a combination of such general assets and trust assets from catastrophic losses under the Plan; and

**WHEREAS**, the Insured and BCBSND intend this Contract to be between themselves and for the benefit of each other; and

**NOW, THEREFORE**, in consideration of the mutual promises and covenants contained in this Contract, the parties agree as follows:

**I. CONTRACT PERIOD**

The effective date of this Contract is January 1, 2017. The Contract will continue in effect through December 31, 2017, unless it is terminated by one of the parties as specified in Section X. TERMINATION.

**II. DEFINITIONS**

This section defines the terms used in this Contract. These terms will be capitalized throughout this Contract when referred to in the context defined.

- A. **AGGREGATE STOP-LOSS ATTACHMENT POINT** - the total dollar amount of Plan Benefits for all Members, incurred during the Contract Period, beyond which BCBSND will reimburse the Insured. A Plan Benefit is incurred on the date the service is provided to the Member by the health care provider. In no instance will the Aggregate Stop-Loss Attachment Point be less than the Minimum Aggregate Deductible. The Aggregate Stop-Loss Attachment Point is set forth in Section VII. PAYMENT OF PREMIUMS.
- B. **ERISA** - the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, et seq.
- C. **INDIVIDUAL STOP-LOSS ATTACHMENT POINT** - the total dollar amount of Plan Benefits, per Member, incurred during the Contract Period, beyond which BCBSND will reimburse the Insured. A Plan Benefit is incurred on the date the service is provided to the Member by the health care provider. The Individual Stop-Loss Attachment Point is set forth in Section VII. PAYMENT OF PREMIUMS.

- D. **MEMBER** - the Subscriber and any dependent of a Subscriber or any other person designated by a Subscriber or by the terms of the Plan who is or may become entitled to a benefit under the Plan. The term shall also include any proprietor, partner, or owner of the Insured, if any, who is designated by the terms of the Plan who is or may become entitled to a benefit under the Plan. Notwithstanding the above, in no case shall the term Member include any person not otherwise entitled to coverage under the terms of the Plan.

For the purposes of determining the various benefits and restrictions or other limitations thereto made available to a Member under the terms of the Plan, all benefits under any Plan option or tier (and any restrictions or other limitations thereto) made available to or received by a Member shall accumulate toward that Member's benefits and any restrictions and other limitations thereto.

- E. **MINIMUM AGGREGATE DEDUCTIBLE** - the minimum total dollar amount of Plan Benefits for all Members, incurred during the Contract Period, beyond which BCBSND will reimburse the Insured. A Plan Benefit is incurred on the date the service is provided to the Member by the health care provider. The Minimum Aggregate Deductible is set forth in Section VII. PAYMENT OF PREMIUMS.
- F. **PLAN BENEFITS** - the amount of benefits paid or payable pursuant to the terms of the Plan to or on behalf of a Member. A Plan Benefit is incurred on the date the service is provided to the Member by the health care provider. The term will not include a payment which BCBSND determines was made in error. The Insured will reimburse BCBSND for any Plan Benefits subsequently repaid to the Plan, the Insured and/or the Trust, if any.
- G. **SUBSCRIBER** - any employee of the Insured who is or may become eligible to receive a benefit under the Plan. The term includes all common law employees as well as any proprietors, partners, or other owners who work for the Insured, if any, and who are otherwise entitled to coverage under the Plan. Notwithstanding the above, in no case shall the term Subscriber include any person not otherwise entitled to coverage under the terms of the Plan.

### III. **STOP-LOSS COVERAGE**

- A. BCBSND agrees to reimburse the Insured for Plan Benefits that exceed the Individual Stop-Loss Attachment Point and/or the greater of the Minimum Aggregate Deductible or the Aggregate Stop-Loss Attachment Point during a Contract Period only when and to the extent the Plan Benefits are actually paid. A Plan Benefit is deemed to have been paid as of the date the payment instrument issued by the Insured is tendered for payment and subsequently honored within a reasonable time. Benefits that are incurred other than during the Contract Period are not eligible for reimbursement under this Contract.
- B. BCBSND shall not have any responsibility or obligation under this Contract to directly reimburse or pay benefits to or on behalf of a Member or to any provider of services. This Contract is solely between BCBSND and the Insured and shall not create any rights or legal relationship between BCBSND and any Member or agent or assignee thereof. BCBSND's sole liability hereunder is to the Insured, subject to the terms, conditions and limitations of this Contract. It is the Insured's intent that the Insured shall be the sole beneficiary of this Contract so as to enable the Insured to stabilize funding of the Plan against losses in excess of the Individual Stop-Loss Attachment Point and/or the greater of the Minimum Aggregate Deductible or the Aggregate Stop-Loss Attachment Point set forth herein. The Insured is the Administrator of the Plan as defined at section 2(16)(A) of ERISA, with all of the duties and responsibilities applicable to plan administrators under ERISA, including but not necessarily limited to compliance with any and all administrative, reporting, and disclosure requirements. BCBSND is not the plan administrator and is not responsible for any of the duties assigned to the plan administrator by ERISA or by the terms of the Plan unless delegated to BCBSND by the terms of the Plan.

- C. BCBSND shall not reimburse the Insured for any loss or expense caused by or resulting from any of the following:
1. Expenses incurred while the Plan is not in effect with respect to the Member and/or while a Member is not eligible for coverage under the Plan;
  2. Expenses that BCBSND, or an independent review organization pursuant to an applicable external review process under the Plan, determines are not covered under the terms of the Plan;
  3. Expenses or losses covered by amendments to the Plan that are incurred prior to the effective date of BCBSND's written consent as described in Section VI. ENTIRE STOP-LOSS CONTRACT AND MODIFICATION as to such Plan amendments;
  4. Liability assumed by the Insured under any contract or agreement other than the Plan;
  5. Expenses or losses incurred as a result of a determination by the Insured to reimburse a Member for a health care treatment or service previously determined by BCBSND, or an independent review organization pursuant to an applicable external review process under the Plan, not to be Plan Benefits covered under the terms of the Plan. If, at the time of BCBSND's or an independent external review organization's final decision under the terms of the Plan, Plan Benefits have not met or exceeded the Individual Stop-Loss Attachment Point and/or the greater of the Minimum Aggregate Deductible or Aggregate Stop-Loss Attachment Point and payment of the disputed benefits will not cause Plan Benefits to meet or exceed the Individual Stop-Loss Attachment Point and/or the greater of the Minimum Aggregate Deductible or Aggregate Stop-Loss Attachment Point, any further appeals of decisions to deny Plan Benefits shall be directed to the Insured in compliance with the procedures and time frames established by the Plan. The Insured shall render a final decision on appeal at such time as the Insured determines that the information submitted on appeal is sufficient to render a decision. As between the Member and Insured only, the Insured shall serve as the final review committee and the Insured shall have all discretion necessary to construe and interpret the terms of the Plan and the exclusive authority and responsibility to make factual determinations. All decisions by the Insured shall be final and binding on the Member. With respect to any dispute between the Insured and the Member only, any decision by the Insured must be upheld in a court of law unless it is arbitrary and capricious or an abuse of discretion. The Insured shall notify the Member and BCBSND of its final determination. To the extent that the Insured determines that a claim for benefits should be granted in accordance with the procedure outlined herein, said benefits shall not constitute Plan Benefits for purposes of determining the Individual Stop-Loss Attachment Point and/or the Minimum Aggregate Deductible or Aggregate Stop-Loss Attachment Point or for purposes of determining reimbursement under the terms of the Stop-Loss Contract.
  6. Expenses incurred as a result of the acts or omissions of the Insured, or the Trust, or other party other than BCBSND that are not otherwise payable under the terms of the Plan;
  7. Services rendered or supplies furnished which are in violation of any law or regulation;
  8. Settlements, judgments and interest on judgments; or
  9. Court costs, fines, penalties, and/or legal expenses, whether incurred in an attempt to obtain medical treatment or an attempt to recover or defend a claim for benefits under the Plan, or otherwise.

**IV. PAYMENT OF CLAIMS**

The Insured shall provide written proof of loss satisfactory to BCBSND of any claims for reimbursement under this Contract. Such proof of loss shall be provided to BCBSND as soon as is reasonably possible but no later than 31 days after Plan Benefits exceed the Individual Stop-Loss Attachment Point for any Member and/or the greater of the Minimum Aggregate Deductible or the Aggregate Stop-Loss Attachment Point and after Plan Benefits have been paid as defined in Section III.(A) above.

Where the Insured seeks reimbursement for Plan Benefits under this Contract, BCBSND shall have exclusive discretion to determine whether the benefits for which reimbursement is sought were payable under the terms of the Plan, whether the Member was eligible for benefits under the Plan, and the amount of benefits payable under the Plan, if any. In determining whether to reimburse the Insured under this Contract, BCBSND shall not be bound by any benefit determinations under the Plan made by parties other than BCBSND. Notwithstanding the preceding, BCBSND shall accept the final decision of an independent review organization made pursuant to an applicable external review process under the Plan, and any benefits provided as a result of the external review process shall be considered Plan Benefits under this Contract.

The amounts otherwise payable under this Contract shall be reduced by the amount of any other reimbursement, recovery, or indemnity which the Insured, the Plan, or the Trust, if any, may be entitled to receive with respect to any Plan Benefits.

**V. SUBROGATION AND REIMBURSEMENT**

To the extent the Insured, the Plan and/or the Trust, if any, becomes subrogated to or has a claim for restitution or reimbursement of Plan Benefits for which the Insured, the Plan and/or the Trust, if any, has obtained or seeks subrogation, restitution, or reimbursement, under this Contract, BCBSND shall be entitled to a pro rata share of any recovery by settlement, judgment, or otherwise based on the ratio of its payment under this Contract as it relates to the Plan Benefits. Any reasonable attorney fees or other reasonable legal costs incurred in the subrogation, restitution, or reimbursement recovery, if any, shall be charged to the total amount recovered prior to any pro rata apportionment between the Plan and BCBSND. Neither the Insured, the Plan nor the Trust, if any, shall be entitled to waive any portion of any subrogation, restitution, or reimbursement claim for which the Insured, the Plan and/or the Trust, if any, has obtained or seeks reimbursement under this Contract without the express written approval of BCBSND.

**VI. ENTIRE STOP-LOSS CONTRACT AND MODIFICATION**

- A. This Contract and its exhibits constitute the entire Stop-Loss Contract between the parties hereto. No promises, terms, conditions or obligations other than those contained in this Contract are valid or binding. Any prior agreements, statements, promises, negotiations, inducements or representations, either oral or written, made by either party or agent of either party that are not contained in this Contract are of no effect. Changes in this Contract or to any exhibit (except the Plan, as discussed below) may be made only by a written amendment signed by duly authorized representatives of the parties. In the case of BCBSND, such an amendment is valid only if signed by the President and Chief Executive Officer. In the case of the Insured, such an amendment is valid only if signed by the Mayor. No other employee or agent of BCBSND or the Insured shall have the authority to amend this Contract or waive any of its provisions.
- B. This Contract is based on the terms of the Plan as included in the Exhibit "A". The Insured shall notify BCBSND of any amendment to the Plan within five days. To the extent such amendment would substantially increase the duties and/or potential liability of BCBSND under this Contract, the Insured shall secure BCBSND's written consent to such amendment prior to the execution of the amendment. BCBSND agrees not to unreasonably withhold such consent. BCBSND reserves the right to adjust premiums specified in accordance with Section VII. PAYMENT OF PREMIUMS and/or to terminate this Contract in accordance with Section X. TERMINATION.

- C. If any term or provision of this Contract is held by a court to be illegal or in conflict with federal or state law, the validity of the remaining terms and provisions herein shall not be affected.

**VII. PAYMENT OF PREMIUMS**

The amount of the premiums due from the Insured is set forth below. The figures below indicate premium costs based on the expected monthly enrollment as shown:

Stop-Loss coverages are based on Plan Benefits incurred during the Contract Period and paid during or after the Contract Period. Individual Stop-Loss Attachment Point is \$50,000 per Member and the Aggregate Stop-Loss Attachment Point is 120% of expected Plan Benefits incurred during the Contract Period.

1. Expected monthly enrollment levels:

	Single Participation	Family Participation
Health	156	521

2. Aggregate Stop-Loss Attachment Point per Subscriber (x 12 for Contract Period):

	Single Participation	Family Participation
Health	\$400.81	\$1,042.55

3. Aggregate Stop-Loss Attachment Point and maximum administrative fees (net of BlueCard Fees and Compensation) per Contract Period based on the figures shown in 1 and 2 above:

Aggregate Stop-Loss Attachment Point:	\$7,268,339
Maximum administrative fees:	\$349,007
(\$42.96 per Subscriber per month)	

4. Minimum Aggregate Deductible: \$6,541,505

5. Monthly premium for stop-loss coverage (aggregate and individual):

	Single Participation	Family Participation
Health	\$106.16	\$274.02

6. Summary of estimated maximum Contract Period costs at enrollment levels in 1 above:

Aggregate Stop-Loss Attachment Point:	\$7,268,339
Maximum administrative fees:	\$349,007
Stop-Loss insurance premium:	<u>\$1,911,905</u>
Total maximum costs:	<u>\$9,529,251</u>

In addition to the Total Maximum Cost, applicable BlueCard Fees and Compensation will apply.

All premiums are payable by the Insured at the home office of BCBSND on or before the date they are due. The first premium is due on the effective date of this Contract. Subsequent premiums are due on the first of each month after the first premium is paid. If a premium is not paid on or before its due date, this Contract may be terminated.

A grace period of 31 days will be granted for the payment of every premium after the first. This Contract will be in force during the grace period. If the premium is not paid in the grace period, this Contract may terminate at the end of the grace period. To the extent the Insured files a claim for reimbursement under this Contract for Plan Benefits incurred during the grace period, the Insured must pay BCBSND a pro rata premium for the period through the date Plan Benefits are incurred. When this Contract terminates, the Insured will be liable to BCBSND for all premiums past due.

BCBSND reserves the right, upon providing at least 31 days' notice to the Insured, to change premium amounts or attachment points: (1) in response to any change in the rate of insurance premium tax assessed by any state; (2) on the effective date of any amendment to the Plan; (3) on any Contract anniversary; and (4) if the Insured should choose to offer a dual choice option.

BCBSND may agree, at its sole discretion and without prejudice to its right under this Contract, to reinstate coverage at the date of termination on receipt and approval of written application for reinstatement and any and all other material and/or information as may be requested by BCBSND. No coverage shall be reinstated until BCBSND confirms such reinstatement in writing to the Insured and all premiums due with interest have been paid.

#### **VIII. GOVERNING LAW**

This Contract shall be construed and enforced according to the laws of North Dakota except to the extent preempted by federal law, including but not limited to ERISA.

#### **IX. LEGAL AND EQUITABLE ACTIONS**

No action at law or equity may be brought to recover under this Contract prior to the expiration of 60 days after written proof of loss has been received by BCBSND. No such action shall be brought more than three years after the deadline for furnishing written proof of loss to BCBSND as specified in Section IV. PAYMENT OF CLAIMS.

#### **X. TERMINATION**

This Contract will terminate upon the earliest of the following:

- A. If any law or regulation is enacted by the United States or by any state or if any existing law is interpreted to prohibit the continuance of this Contract, it shall terminate automatically on the effective date of such law or regulation or date of interpretation.
- B. If the Plan is terminated.
- C. If the Administrative Service Agreement dated January 1, 2017, is terminated.
- D. The last day of the Contract Period.
- E. At the end of the grace period if the premium is not paid within the grace period discussed at Section VII. PAYMENT OF PREMIUMS.

#### **XI. GENERAL PROVISIONS**

- A. This Contract is between BCBSND and the Insured, and does not create any rights or legal relationships between BCBSND and any Members.
- B. No assignment of this Contract or of the Insured's rights under this Contract shall be binding upon BCBSND, without the express written consent of the President and Chief Executive Officer of BCBSND. See Section VI.(A).

- C. The Insured acknowledges that it does not have any right in, nor will it use without the written approval of BCBSND, any trademark, copyrighted, proprietary or confidential information of BCBSND. Further, the Insured agrees that it will not use information deemed to be confidential by BCBSND for any purpose unrelated to this Contract.
- D. The Insured warrants that it is a corporation, partnership, trust or proprietorship existing under the laws of North Dakota and that the signator below has the authority to bind the Insured in this Contract. BCBSND warrants that the signator below has the authority to bind BCBSND in this Contract.
- E. The Insured hereby expressly acknowledges and understands that BCBSND 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 BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND is not contracting as an agent of the Association. The Insured further acknowledges and agrees this Contract was not entered into based upon representations by any person or entity other than BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to the Insured for any of BCBSND's obligations to the Insured created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this Contract.

**XII. NOTICE**

BCBSND shall be entitled to rely upon the accuracy of any communication from authorized representatives of the Insured. BCBSND shall not be bound by any notice, direction, requisition, or request unless and until it shall have been addressed to the following person and sent by certified mail return receipt requested:

**Timothy Huckle, President and CEO**  
**BLUE CROSS BLUE SHIELD OF NORTH DAKOTA**  
4510 13th Avenue South  
Fargo, North Dakota 58121

The Insured shall be entitled to rely upon the accuracy of any communication from authorized representatives of BCBSND. The Insured shall not be bound by any notice, direction, requisition, or request unless and until it shall have been addressed to the following person and sent by certified mail return receipt requested:

**Robert W. McConnell, Director Human Resources**  
**CITY OF BISMARCK**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

**XIII. COUNTERPARTS AND BINDING EFFECT**

This Contract may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute one and the same instrument. This Contract shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed, in their names by their undersigned officers, the same being duly authorized to do so.

**CITY OF BISMARCK  
GROUP HEALTH PLAN (PLAN ADMINISTRATOR)**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

**BLUE CROSS BLUE SHIELD OF NORTH DAKOTA\***  
4510 13th Avenue South  
Fargo, North Dakota 58121



By: \_\_\_\_\_

Title: \_\_\_\_\_

Its President and CEO

Date: \_\_\_\_\_

October 25, 2016

**CITY OF BISMARCK  
(PLAN SPONSOR)**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

By: X \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Stop-Loss Contract  
01/01/2017 - 12/31/2017  
10155

\*An Independent Licensee of the Blue Cross and Blue Shield Association.

## ADMINISTRATIVE SERVICE AGREEMENT

This Administrative Service Agreement ("Agreement") is entered into between City of Bismarck ("the Plan Sponsor"), City of Bismarck ("the Plan Administrator") and Blue Cross Blue Shield of North Dakota ("BCBSND"). Throughout this Agreement, BCBSND is referred to as the "Company." The terms of this Agreement are as follows:

### WITNESSETH:

**WHEREAS**, the Plan Sponsor has established and maintains a self funded employee welfare benefit plan known as the City of Bismarck Group Plan ("the Group Health Plan")("the Plan"), which provides, among other things, various benefits to Members in the Plan, as set forth in the attached Exhibit "A"; and

**WHEREAS**, the Plan Administrator is the administrator of the Plan as defined by Section 3(16) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"); and

**WHEREAS**, the Plan Sponsor, the Plan Administrator and the Company mutually agree to comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as modified by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"). Specifically, the "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Parts 160 and 164. The HIPAA Privacy Rule is the Standards for Privacy of Individually Identifiable Health Information at 45 CFR, Parts 160 and 164, Subparts A and E. The HIPAA Security Rule is the HIPAA Security Standards (45 CFR Parts 160 and 164, Subpart C). The HIPAA Breach Notification Rule is the Notification in the Case of Breach of Unsecured Protected Health Information, as set forth at 45 CFR Part 164, Subpart D; and

**WHEREAS**, benefits under the Plan are paid from the general assets of the Plan Sponsor or trust assets ("the Trust"), or a combination of such general assets and trust assets; and

**WHEREAS**, the Plan Administrator has requested the Company to provide certain services to the Plan as more fully described herein; and

**WHEREAS**, the Company has agreed to provide certain services to the Plan, as more fully described herein; and

**WHEREAS**, the Company is a Fiduciary of the Plan only to the extent it is providing the services described herein;

**NOW, THEREFORE**, in consideration of the mutual promises and covenants contained in this Agreement, the parties agree as follows:

### I. EFFECTIVE DATE AND PLAN YEAR

The effective date of this Agreement is January 1, 2017. The Agreement will continue in effect through December 31, 2017, unless it is terminated by one of the parties as specified in Section XII. TERMINATION.

For the purposes of the costs of any and all benefits and services extended through this Benefit Plan, including the implementation of any benefit changes required under federal or state law, the Plan Administrator agrees that the Plan Year shall commence on January 1, unless it is terminated by one of the parties as specified in Section XII. TERMINATION.

## II. DEFINITIONS

This section defines the terms used in this Agreement. These terms will be capitalized throughout this Agreement when referred to in the context defined.

- A. **ACCOUNTABLE CARE ORGANIZATION (ACO)** - a group of health care providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the Total Cost of Care for their member populations.
- B. **ADMINISTRATIVE EXPENSE ALLOWANCE** - a fixed per-claim dollar amount charged by the Host Blue to BCBSND for administrative services that the Host Blue provides in processing claims for the Members. The dollar amount is normally based on the type of claim (e.g., institutional, professional, international, etc.) and can also be based on the size of the group enrollment. When charged, BCBSND passes the AEA fee on to the Plan Administrator.
- C. **BENEFIT PAYMENTS** - payments of benefits under the Plan.
- D. **CARE COORDINATION** - organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's health care needs across the continuum of care.
- E. **CARE COORDINATOR FEE** - a fixed amount paid by a Blue Cross Blue Shield Plan to health care providers periodically for Care Coordination under a Value-Based Program.
- F. **CLAIM** - notification in a form acceptable to the Company that service has been provided or furnished to a Member.
- G. **DRG** - shall mean diagnostic related groups.
- H. **DATA AGGREGATION** - the combining of Protected Health Information the Company creates or receives for or from the Plan and for or from other health plans or health care providers for which the Company is acting as a business associate to permit data analyses that relate to the Health Care Operations of the Plan and those other health plans or providers.
- I. **ERISA** - the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1001, et seq.
- J. **FEES AND CHARGES** - the amounts the Plan Administrator must pay the Company for the administrative services described in Section VII. FEES AND CHARGES.
- K. **FIDUCIARY** - means the same as the term is defined at Section 3(21)(A) of ERISA.
- L. **GLOBAL PAYMENT/TOTAL COST OF CARE** - a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.
- M. **HEALTH CARE OPERATIONS** - any of the activities of a health plan to the extent the activities relate to functions that make it a health plan.
- N. **HEALTH CARE PROVIDER** - any eligible provider that has provided care, diagnosis, or treatment to or for a Member for which benefits are sought under the Plan.
- O. **INELIGIBLE PERSON** - any person, firm, or corporation that has received benefits or on whose behalf benefits have been paid but for whom benefits are not payable under the terms of the Plan.

P. **MEMBER** - the Subscriber and any dependent of a Subscriber or any other person designated by a Subscriber or by the terms of the Plan who is or may become entitled to a benefit under the Plan. The term shall also include any proprietor, partner, or owner of the Plan Sponsor, if any, who is designated by the terms of the Plan who is or may become entitled to a benefit under the Plan. In no case shall the term Member include any person not otherwise entitled to coverage under the terms of the Plan.

For the purposes of determining the various benefits and restrictions or other limitations thereto made available to a Member under the terms of this Agreement, all benefits under any Plan option or tier (and any restrictions or other limitations thereto) made available to or received by a Member shall accumulate toward that Member's benefits and any restrictions and other limitations thereto.

Q. **PATIENT-CENTERED MEDICAL HOME (PCMH)** - a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

R. **PAYMENT** - activities undertaken to obtain premiums, determine or fulfill coverage and benefits, or obtain or provide reimbursement for health care services.

S. **PLAN ADMINISTRATOR - CITY OF BISMARCK.** City of Bismarck is the administrator of the Plan as defined at Section 3(16) of ERISA, with all of the duties and responsibilities applicable to plan administrators under ERISA, including but not necessarily limited to compliance with any and all administrative, reporting, and disclosure requirements. The Company is not the Plan Sponsor or the Plan Administrator of the Plan and is not responsible for any of the duties assigned to the Plan Sponsor or the Plan Administrator by ERISA, the terms of the Plan, or by this Agreement.

T. **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:

1. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;
2. relates to a Member's past, present or future physical or mental health or condition;
3. relates to the provision of health care to a Member;
4. relates to the past, present, or future payment for health care to or on behalf of a Member; or
5. identifies a Member or could reasonably be used to identify a Member.

Educational records and employment records are not considered PHI under federal law.

U. **PROVIDER INCENTIVE** - an additional amount of compensation paid to a health care provider by a Blue Cross Blue Shield Plan, based on the health care provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

V. **SECURITY INCIDENT** - any attempted or successful unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with the Company's system operations in the Company's information systems.

W. **SHARED SAVINGS** - a payment mechanism in which the health care provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

X. **STANDARD TRANSACTIONS** - health care financial or administrative transactions conducted electronically for which standard data elements, code sets and formats have been adopted in accordance with federal or state law.

- Y. **SUBSCRIBER** - any employee of the Plan Sponsor who is or may become eligible to receive a benefit under the Plan. The term includes all common law employees as well as any proprietors, partners, or other owners who work for the Plan Sponsor and are otherwise entitled to coverage under the Plan. Notwithstanding the above, in no case shall the term Subscriber include any person not otherwise entitled to coverage under the terms of the Plan.
- Z. **SUCCESSFUL SECURITY INCIDENTS** - Security Incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.
- AA. **UNSUCCESSFUL SECURITY INCIDENTS** - Security Incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.
- BB. **VALUE-BASED PROGRAM (VBP)** - an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local health care providers that is evaluated against cost and quality metrics/factors and is reflected in health care provider payment.

### III. **SERVICES PROVIDED BY THE COMPANY**

During the term of this Agreement, the Company will provide the following general services:

- A. Consultative assistance on plan design with corresponding cost estimates; provided, however, the Company will not provide services or advice regarding compliance with any state or federal law obligations, including, but not limited to, obligations arising out of state or federal statutes, case law, regulations, advisory opinions, and the like.
- B. Establish a membership record for existing Members containing information as arranged for or provided by the Plan Administrator.
- C. Provide identification cards for each Subscriber.
- D. Provide the Plan Administrator with assistance in drafting Summary Plan Descriptions and Summaries of Benefits and Coverage.
- E. Receive membership applications from the Plan Administrator for enrollment of Members, unless the parties agree to use an alternative method of certifying Members for coverage under the Plan.
- F. Provide managed benefits services in accordance with appropriate licensure and certification requirements.
- G. Provide toll-free service lines for Members and Health Care Providers during the Company's business hours. A toll-free managed benefits line for Health Care Providers will also be available during the Company's business hours. During nonbusiness hours, answering machine services will be available for managed benefits calls.
- H. Provide the Plan Administrator with all forms required by the Company to provide administrative services.
- I. Administer other party liability programs including, but not limited to, workers' compensation, no-fault, subrogation/reimbursement and coordination of benefits. The Company retains full discretion regarding the administration and enforcement of these programs. Such discretion includes, but is not limited to, pursuing, settling or releasing claims to any available recoveries and determining amounts recovered. The Company has no obligation to notify the Plan Administrator regarding the disposition of actual or potential subrogation/reimbursement cases. If the Company determines not to pursue a potential subrogation/reimbursement recovery, the Plan Administrator may do so at its own expense.

The Company has no obligation to participate in consolidated or class action lawsuits on behalf of the Plan. To the extent the Company participates in such actions, any recovery will be apportioned among all insured and self-insured plans in a like manner. The proration may be based on the number of covered persons, the number of injured persons, claims volume, or any other basis as determined in its sole discretion by the Company.

No additional administration costs will be charged to the Plan Administrator for the administration of these programs. Any and all legal fees and costs incurred directly in a subrogation/reimbursement recovery shall be charged against any such recovery. Such subrogation/reimbursement recoveries shall not affect the administration of this Agreement.

- J. Make available to the Plan Administrator a weekly report of claim payments.
- K. Make available to the Plan Administrator a summary of claims paid on a cumulative basis during the term of this Agreement.
- L. Provide a formal procedure for detection of fraud and unlawful activity.
- M. Provide a health conversion policy to Members when application is made within 10 days of the termination of coverage under the Plan.
- N. Provide assistance to the Plan Administrator for enrollment, customer service and education.
- O. Provide formal policy and procedure guidelines to the Plan Administrator for the conduct of external audits or reviews of the Company commissioned by the Plan Administrator. The Company will cooperate with all external audit or review teams.

The Plan Administrator shall provide the Company with the scope and requirements of any audit or review prior to the commencement of the audit or review. If a sample of claims is required, the Company will provide the Plan Administrator with a statistically valid computerized sample of claims.

All audit or review findings shall be discussed with the Company upon discovery to allow further investigation or implementation of corrective action. Dollar audit findings will be corrected through negotiations with the Plan Administrator.

All Member records shall be kept confidential and considered proprietary. Such records shall be available for audit or review only after disclosure statements have been signed by the external audit or review team to assure the information remains confidential and is utilized for the stated purpose only. If any records are removed from the Company's office for purposes of the audit or review, approval must be granted. All records will be subject to the minimum necessary requirements.

- P. Review of claims for Plan benefits. Requests for Plan benefits will be evaluated by the Company in accordance with the terms and conditions of the Plan, a copy of which is attached as Exhibit "A".
  - 1. In evaluating claims under the Plan, the Company may correspond with Members if additional information is necessary for the Company to complete processing of a claim. The Company may also consult with Health Care Providers and/or obtain professional evaluation by the Company's Medical Management Department where such consultation or evaluation is deemed appropriate by the Company. If, in the judgment of the Company, an independent medical examination of the Member is advisable, the Company may arrange for examinations to be performed by qualified independent physicians who may be certified as specialists. The costs of any consultation, evaluation, or independent medical examination shall be paid by the Plan Administrator.

2. All requests for benefits shall be submitted to the Company on forms satisfactory to the Company. The Company has the authority and discretion to determine eligibility for Plan benefits as well as the discretion to construe and interpret the terms of the Plan and to make factual determinations. The Company's decisions regarding a Member's claim for Plan benefits must be upheld in a court of law unless they are arbitrary and capricious or an abuse of discretion. Where the Company decides that a claim for benefits should be granted, it shall notify the Member and the Plan Administrator of the decision. Where the Company decides that a request for Plan benefits should be denied, in whole or in part, the Company will notify the Member and the Plan Administrator of the decision.
  3. A Member may appeal to the Company any full or partial denial of a claim for Plan benefits. The appeal must be made within 180 days after the Company's original decision. The Company has the authority and discretion to determine eligibility for Plan benefits as well as the discretion to construe and interpret the terms of the Plan and to make factual determinations. The Company's decisions on appeal must be upheld in a court of law unless they are arbitrary and capricious or an abuse of discretion. The Company shall notify the Member and the Plan Administrator of its final decision.
  4. The parties acknowledge that they have also entered into a Stop-Loss Contract with this Agreement whereby the Plan Administrator may seek reimbursement for certain extraordinary benefit payments as described in the Stop-Loss Contract. If, at the time of the Company's final decision under Section III.(P)(2) or III.(P)(3), Plan Benefits (as defined in the Stop-Loss Contract) have met or exceeded the Individual and/or Aggregate Stop-Loss Attachment Points (as defined in the Stop-Loss Contract) or payment of the disputed benefits could cause Plan Benefits (as defined in the Stop-Loss Contract) to meet or exceed the Individual and/or Aggregate Stop-Loss Attachment Points (as defined in the Stop-Loss Contract), there shall be no further appeals and the decision by the Company shall be final and binding on all parties, including the Member, and the Plan Administrator.
- Q. Where the Company or the Plan Administrator determines that a benefit is payable under the Plan, the Company will pay the Health Care Providers or other parties on behalf of the Plan and obtain reimbursement from the Plan Administrator pursuant to Section IV(E). The parties agree that benefits are funded solely from the general assets of the Plan Administrator, trust assets, or a combination thereof and that the Company has no obligation to pay benefits under the Plan. Furthermore, the parties agree that the Company's obligation to make payments to Health Care Providers or other parties on behalf of the Plan is conditioned upon full reimbursement by the Plan Administrator following such payments by the Company. In the event the Plan Administrator fails to reimburse the Company in accordance with Section IV(E) and unless the Company and the Plan Administrator mutually agree otherwise, the Company's obligation to make payments to Health Care Providers or other parties on behalf of the Plan shall be suspended until the Plan Administrator has fully reimbursed the Company. Any obligation to provide notice to Members, or other interested parties of the Plan Administrator's failure to reimburse the Company rests solely with the Plan Administrator. The Company has no obligation to provide such notice and shall not provide such notice.
- R. If the Company makes an overpayment or improper payment to any Subscriber, Health Care Provider, or an Ineligible Person, the Company shall advise the Plan Administrator of such payment and the Company shall use its reasonable best efforts to obtain reimbursement and/or restitution of the overpayment or improper payment. The Company shall report the result of such efforts to the Plan Administrator.
- S. When coverage under this Benefit Plan is terminated, BCBSND will, within a reasonable period of time, issue a notification of termination of coverage to the Subscriber. Upon notification by the Subscriber of the ineligibility of a dependent, a notification of termination of coverage will be issued to the affected Member within a reasonable period of time. Termination notices may also be obtained from BCBSND upon request within 24 months after coverage is terminated.

- T. The Company shall have no other duties or responsibilities with respect to the Plan except as expressly set forth in this Agreement. The Company is not an insurer of the Plan nor does it underwrite the risk or otherwise assume any risk for the payment of benefits under the Plan.

#### IV. DUTIES OF THE PLAN ADMINISTRATOR

During the term of this Agreement, the Plan Administrator shall be responsible for the following:

- A. The Plan Administrator shall provide to the Company periodic reports and information in order for the Company to effectively provide the services designated in this Agreement. These reports/information include:
1. A copy of all applicable Plan documents, including, but not limited to current and updated copies of the Plan and any Summary Plan Descriptions and revisions or amendments thereto as well as any summaries of material modifications;
  2. Certification/verification of eligibility of employees and/or their dependents to become Members, which information shall be provided to the Company prior to the effective date of coverage;
  3. All other membership or similar information that is required by the Company to fulfill its obligations under this Agreement and/or that may be necessary for the Company to provide cost estimates and analysis to the Plan Administrator; and
  4. Completion of the employer section of the claim forms and timely submission of claim forms.
  5. The Plan Administrator agrees to furnish the Company with any information required by the Company for the purpose of enrollment. Any changes affecting a Member's eligibility must be provided to the Company immediately, but in any event the Plan Administrator will notify the Company of any changes in a Member's eligibility within 31 days of the change. The Plan Administrator acknowledges and agrees that in the event there are premium payments made to the Company by the Plan Administrator based upon a failure by the Plan Administrator to notify the Company of any changes in enrollment or eligibility within 31 days of the change, that the Company shall retain any and all premium payments as consideration for the administrative costs and burden incurred by said failure to notify the Company of the change.
- All information shall be provided at such time as it is requested by the Company. The Company shall not be responsible for delay in the performance of the Agreement or for nonperformance of this Agreement which is caused by, or contributed to in whole or in part by, the failure of the Plan Administrator to immediately furnish required information or documentation.
- B. The Plan Administrator shall prepare and distribute Notice of Privacy Practices appropriate for the Plan so that the Plan may meet its notice obligations under federal law. The Plan Administrator authorizes the Company to disclose the minimum necessary PHI to the Plan Sponsor for plan administration functions specified in the Plan documents, as amended.
- C. The Plan Administrator agrees to abide by all underwriting requirements established by the Company as these underwriting requirements relate to, including but not limited to, rating factors, the minimum participation of eligible Members, minimum employer contributions, reporting employer contribution rates, and provider network restrictions, as permitted and restricted under federal and/or state laws.
- D. It shall be the sole responsibility of the Plan Administrator to distribute Summaries of Benefits and Coverage so that the Plan Administrator and the Plan may satisfy their obligations under federal law and to distribute Summary Plan Descriptions to Subscribers of the Plan and to advise Members of their rights under ERISA, including, but not limited to claims appeals procedures. In the event a claim is paid due to the Summary Plan Description not being distributed to the Subscriber, the Plan Administrator shall be liable for all claims, including those in excess of the individual and aggregate stop-loss maximum amounts.

- E. Upon receipt of notice from the Company, the Plan Administrator will, on behalf of the Plan, reimburse the Company for payments actually made to Health Care Providers or other parties on behalf of the Plan pursuant to Section III.(Q). This reimbursement shall be separate from any amounts payable for Fees and Charges under Section VII. FEES AND CHARGES.
- F. The Plan Administrator shall provide notice to Members if the Plan Administrator defaults in any obligation under this Agreement and/or the Plan, including, but not limited to the obligation to pay benefits under the Plan.
- G. The Plan Administrator shall pay all fees, costs, and expenses provided for herein. Such amounts shall be paid separately from Benefit Payments described in Section IV(E).

**V. BUSINESS ASSOCIATE PROVISIONS**

**A. RESPONSIBILITIES OF THE COMPANY**

**1. Privacy of Protected Health Information (PHI)**

- A. The Company will keep confidential all Claim records and all other PHI the Company creates or receives in the performance of its duties under this Agreement. Except as permitted or required by this Agreement for the Company to perform its duties under this Agreement, the Company will not use or disclose such Claim information or other PHI without the authorization of the Member who is the subject of such information or as required by law.
- B. The Company will neither use nor disclose Members' PHI (including any Members' PHI received from a business associate of the Plan) except (1) as permitted or required by this Agreement, (2) as permitted in writing by the Plan Administrator, (3) as authorized by Members, or (4) as required by law.
- C. The Company will be permitted to use or disclose Members' PHI only as follows:
  - 1. The Company will be permitted to use and disclose Members' PHI (a) for the management, operation and administration of the Plan that the Plan Administrator offers Members, and (b) for the services set forth in this Agreement, which include Payment Activities, Health Care Operations, and Data Aggregation as these terms are defined under federal law. The Company also may de-identify PHI it obtains or creates in the course of providing services to the Plan Administrator.
    - a. The Company will be permitted to use Members' PHI as necessary for the Company's proper management and administration or to carry out the Company's legal responsibilities.
    - b. The Company will be permitted to disclose Members' PHI as necessary for the Company's proper management and administration or to carry out the Company's legal responsibilities only if (i) the disclosure is required by law, or (ii) before the disclosure, the Company obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written Agreement, that the entity will hold Members' PHI in confidence, use or further disclose Members' PHI only for the purposes for which the Company disclosed it to the entity or as required by law, and notify the Company of any instance the entity becomes aware of where the confidentiality of any Members' PHI was breached.

2. The Company's use, disclosure, or request of PHI shall utilize a limited data set if practicable. Otherwise, the Company will make reasonable efforts to use, disclose, or request only the minimum necessary amount of Members' PHI to accomplish its intended purpose. In addition, the Company agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under this Agreement.
- D. Other than disclosures permitted by Section V.(A)1.C, the Company will not disclose Members' PHI to the Plan Administrator or to the Plan's business associate except as directed by the Plan Administrator in writing.
  - E. The Company will require each subcontractor and agent to which the Company is permitted by this Agreement or in writing by the Plan Administrator to disclose Members' PHI to provide reasonable assurance, evidenced by written Agreement, that such other entity will comply with the same privacy and security obligations with respect to Members' PHI as this Agreement applies to the Company.
  - F. The Company will not disclose any Members' PHI to the Plan Sponsor, except as permitted by and in accordance with Section V.(A)1.C.
  - G. The Company will not receive remuneration in exchange for PHI except where permitted by this Agreement and consistent with applicable law.
  - H. The Company will not receive payment for any use or disclosure of PHI for marketing purposes except where permitted by this Agreement and consistent with applicable law.
  - I. The Company will report to the Plan Administrator any use or disclosure of Members' PHI not permitted by this Agreement or not permitted in writing by the Plan Administrator, except for disclosures incidental to a permitted use or disclosure. The Company will make any such report to the Plan Administrator after the Company learns of such non-permitted use or disclosure. In addition, the Company will report, following discovery and without unreasonable delay, any "breach", as determined by the Company, of "unsecured PHI" as these terms are defined by the Breach Notification Rule.
  - J. The Company will report to the Plan Administrator attempted or successful unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with the Company's system operations in the Company's information systems ("Security Incident"), of which the Company becomes aware. With regard to attempted unauthorized access, use, etc., the Company and the Plan Administrator recognize and agree that the significant number of meaningless attempts to, without authorization, access, use, disclose, modify or destroy electronic PHI will make real-time reporting formidable. Therefore, the Company and the Plan Administrator agree to the following reporting procedures for Security Incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

For Unsuccessful Security Incidents, the Company and the Plan Administrator agree that this Agreement constitutes notice from the Company of such Unsuccessful Security Incidents. By way of example, the Company and the Plan Administrator consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with an information system:

1. Pings on the Company's firewall,
2. Port scans,
3. Attempts to log on to a system or enter a database with an invalid password or username,
4. Denial-of-service attacks that do not result in a server being taken off-line, and
5. Malware (e.g., worms, viruses).

For Successful Security Incidents, the Company shall give notice promptly to the Plan Administrator in the event a Member's electronic PHI was compromised.

**K. Disposition of Protected Health Information**

The parties agree that upon termination, cancellation, expiration or other conclusion of this Agreement, the Company will return or destroy all PHI received or created by the Company on the Plan Administrator's behalf as soon as feasible. Due to various regulatory and legal requirements, the Plan Administrator acknowledges that immediate return or destruction of all such information is not feasible. The Company agrees that upon conclusion of this Agreement for any reason, it will use or disclose the PHI it received or created on the Plan Administrator's behalf only as necessary to meet the Company's regulatory and legal requirements and for no other purposes unless permitted in writing by the Plan Administrator. The Company will destroy PHI received or created by the Company on the Plan Administrator's behalf that is in the Company's possession under such circumstances and upon such schedule as the Company deems consistent with its regulatory and other legal obligations.

These responsibilities agreed to by the Company and related to protecting the privacy and safeguarding the security of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and, where applicable, shall govern the Company's receipt, use or disclosure of PHI pursuant to the terms of this Agreement.

**2. Access, Amendment and Disclosure Accounting for Protected Health Information**

- A. Upon the Plan Administrator's written request, the Company will make available for inspection and obtaining copies by the Plan Administrator, or at the Plan Administrator's direction by the Member (or the Members' representative), any PHI about the Member created or received for or from the Plan Administrator in the Company's custody or control so the Plan Administrator may meet its access obligations under federal law. The Company shall make such information available in electronic format where directed by the Plan Administrator.
- B. Upon receipt of a written request from the Plan Administrator, or at the Plan Administrator's direction by the Member (or the Members' representative), the Company will amend or permit the Plan Administrator access to amend any portion of the PHI created or received for or from the Plan Administrator in the Company's custody or control, so the Plan Administrator may meet its amendment obligations under federal law.

C. So the Plan Administrator may meet its disclosure accounting obligations under federal law, the Company will do the following:

1. The Company will record each disclosure of Members' PHI which is not excepted from disclosure accounting under Section V.(A)2.C.2, that the Company makes to the Plan Administrator or to a third party.

The information that the Company must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom the Company made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure.

For repetitive disclosures of Members' PHI that the Company makes for a single purpose to the same person or entity (including the Plan Administrator), the Company may record (a) the disclosure information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

2. The Company will not be required to record disclosure information or otherwise account for disclosures of Members' PHI that this Agreement or the Plan Administrator in writing permits or requires:
  - a. for Payment Activities or Health Care Operations,
  - b. to the Member who is the subject of the PHI or to that Members' personal representative,
  - c. to persons involved in that Members' health care or payment for health care or to assist in disaster relief efforts as provided under federal law,
  - d. for national security or intelligence purposes as provided under federal law,
  - e. to law enforcement officials or correctional institutions regarding inmates,
  - f. for incidental uses or disclosures,
  - g. as part of a limited data set in accordance with federal law,
  - h. that occurred prior to the HIPAA Privacy Compliance Date,
  - i. pursuant to a valid authorization.
3. Unless otherwise provided by applicable law, the Company will have available for the Plan Administrator the disclosure information required by Section V.(A)2.C.1. for the six (6) years immediately preceding the date of the Plan Administrator's request for the disclosure information.
4. Upon the Plan Administrator's written request, the Company will make available to the Plan Administrator, or at the Plan Administrator's direction to the Member (or the Member's representative), disclosure information regarding the Member so the Plan Administrator may meet its disclosure accounting obligations under federal law.

### 3. Information Safeguards

- A. The Company will maintain reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of Member PHI. The safeguards must reasonably protect Member PHI from any intentional or unintentional use or disclosure in violation of federal law and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.
- B. The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI the Company creates, receives, maintains, or transmits on behalf of the Plan Administrator as required by federal law.

#### **4. Inspection of Books and Records**

The Company will make its internal practices, books, and records relating to its use and disclosure of PHI created or received for or from the Plan Administrator available to the Plan Administrator and to the U.S. Department of Health and Human Services to determine compliance with federal law or this Agreement.

#### **5. Information Privacy and Safeguard Provisions Survive Termination of Agreement**

These responsibilities agreed to by the Company and related to protecting the privacy of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and where applicable, shall govern the Company receipt and use of PHI obtained pursuant to the terms of this Agreement.

### **B. RESPONSIBILITIES OF THE PLAN SPONSOR**

1. The Plan Sponsor retains full and final authority and responsibility for the Plan and its operation. The Company is empowered to act on behalf of Plan only as stated in this Agreement or as mutually agreed in writing by the Plan Sponsor and the Company.
2. The Plan Sponsor will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations, including any licensing, filing, reporting, and disclosure requirements, that may apply to the Plan. The Company will have no responsibility for or liability with respect to the Plan's compliance or noncompliance with any applicable federal, state, or local law, rule, or regulation.

If the Group offers a high deductible health plan, the Plan Sponsor assumes sole responsibility for determining whether the Plan qualifies as a high deductible health plan under Section 223(c)(2) of the U.S. Internal Revenue Code. THE COMPANY MAKES NO WARRANTY, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE REGARDING THE PLAN.

If the Group offers a high deductible health plan, the Company does not provide legal or tax advice, and expressly disclaims responsibility for determining, on behalf of any individual or group, the legal and tax implications of: (1) establishing a health savings account; (2) eligibility for a health savings account; (3) the contributions made to a health savings account; (4) the deductibility of contributions to a health savings account; and (5) withdrawals from a health savings account and related taxation.

3. By executing this Agreement, the Plan Sponsor certifies to the Company that its Plan documents have been amended to incorporate the provisions required by and under federal law, and agrees to comply with the Plan Administrator's Plan documents.

The Company may rely on Plan Sponsor's certification and Plan Administrator's written authorization, and will have no obligation to verify (1) the Plan Administrator's plan documents have been amended to comply with the requirements of federal law or this Agreement or (2) the Plan Sponsor is complying with the Plan Administrator's plan document as amended.

## VI. PLAN AMENDMENT AND MODIFICATION

- A. This Agreement and its exhibits constitute the entire Agreement between the parties hereto. No promises, terms, conditions or obligations other than those contained in this Agreement are valid or binding. Any prior agreements, statements, promises, negotiations, inducements or representations, either oral or written, made by either party or agent of either party that are not contained in this Agreement are of no effect. Changes to this Agreement or any exhibit (except the Plan, as discussed below) may be made only by a written amendment signed by duly authorized representatives of the parties. In the case of BCBSND, such an amendment is valid only if signed by the President and Chief Executive Officer of BCBSND. In the case of the Plan Administrator or Plan Sponsor, such an amendment is valid only if signed by the Mayor. No other employee or agent of the Company, the Plan Sponsor or the Plan Administrator shall have the authority to amend this Agreement or waive any of its provisions.
- B. The Mayor of the Plan Administrator is authorized to amend any and all provisions of the Plan at any time, in whole or in part, in accordance with the amendment procedure set forth in the Plan. With respect to amendment of the Plan, the Plan Administrator shall notify the Company of any such amendment within five business days. To the extent such amendment would increase the duties or liabilities of the Company, the amendment shall not become effective until the Plan Administrator secures the Company's written consent to such amendment. The Company agrees not to unreasonably withhold such consent. The Company reserves the right to adjust Fees and Charges as specified in Section VII. FEES AND CHARGES and/or to terminate this Agreement. The Plan Administrator will notify Members of any amendments or modifications of the Plan in accordance with ERISA, §104 and applicable regulations. The Company is not responsible for notifying Members of any amendments or modifications to the Plan.

## VII. FEES AND CHARGES

### A. General Administrative Fee

Fees and Charges are to be paid by the Plan Administrator in the amount equal to \$42.96 per Subscriber per month for administration costs as billed.

### B. Inter-Plan Arrangements Fees

#### Standard BlueCard Fees:

Access Fees – 4.51% of discount with a \$2,000 cap.

Administrative Expenses Allowance (AEA) - \$11.00 for Institutional claims and \$5.00 for Professional claims.

Revisions to such fees are typically made annually as a result of the Inter-Plan Arrangements changes.

#### Nonparticipating Provider Claims Processing Fee:

Up to \$3.00 per claim for out-of-network claims (AEA).

Revisions to such fees are typically made annually as a result of the Inter-Plan Arrangements changes.

- C. The Company will provide a billing statement to the Plan Administrator of all Fees and Charges incurred. All such Fees and Charges shall be paid by the Plan Administrator immediately upon receipt of said billing statements.
- D. The Company reserves the right to adjust the service Fees and Charges upon giving the Plan Administrator 31 days written notice.

- E. The Plan Administrator will be liable for any taxes, charges, fees, or similar assessments made against the Plan or against the Company with respect to the Plan, which may become due as a result of a determination by any insurance department or Department of Labor, or any other federal, state or municipal body, or instrument or administrative organization thereof and this shall apply retroactively to any prior period of which these taxes or fees are applicable, it being the intent of this Agreement that the Company shall not incur any special responsibility for such items by reason of entering into this Agreement.
- F. Programming charges for specific requirements or requests of the Plan Administrator that are unique to the Company are not part of the Fees and Charges specified in Section VII.(A). The costs of such items for Systems Analyst, CPU Time, and Administrative Support Staff Time will be charged separately at the prevailing actual hourly cost rates.

These charges shall be billed on a separate statement due and payable on the first of each month following the month incurred. Upon receipt of a request from the Plan Administrator for the generation of a report, a specific software application or other administrative service requiring a program change, the Company shall document the request for review by the Plan Administrator prior to implementation. The document shall include a description of the request, including an exhibit when appropriate, and an estimate of the cost of implementation. The Company reserves the right to adjust these costs upon giving the Plan Administrator 31 days written notice prior to the end of the term of this Agreement, unless otherwise agreed to by the parties. During the term of this Agreement, any substantial change in the self-funded employee welfare benefit plan or change in coverage that requires additional programs or personnel may result in an adjustment to the fees as mutually agreed.

- G. Regarding prescription medications or drugs purchased by Members under the terms of the Plan, the Plan Administrator agrees to pay to the Company the amount due to the pharmacy (or other prescription drug retailer) under the terms of the pharmacy provider participating agreement. The amount due to the pharmacy under the terms of the pharmacy provider participating agreement is that which is due at the time the prescription medication or drug is purchased by the Member. The amount due to the pharmacy under the pharmacy provider participating agreement is calculated without regard to any subsequent, retrospective manufacturer discount that may apply to the cost of the prescription medication or drug. The Plan Administrator acknowledges and agrees that, in some cases but not all, drug manufacturers may offer retrospective discounts to the Company on prescription medications and drugs purchased under the terms of the Plan. If a drug manufacturer makes a retrospective discount payment available, the Plan Administrator acknowledges and agrees that a portion of any such rebate may be retained by an entity that performs manufacturer discount program services on behalf of the Company under the terms of this Agreement. The Plan Administrator further acknowledges and agrees that, when made available by the drug manufacturer, another portion of the retrospective discount payment is retained by the Company. In its sole discretion, the Company may periodically refund to the Plan all or part of any rebate payments received. The calculation of any refund rests in the sole discretion of the Company.

#### VIII. CALCULATION OF MEDICAL BENEFITS

BCBSND has a number of payment arrangements with Health Care Providers. Examples of these arrangements include diagnostic related groupings, per diems, and other payment arrangements. In specific cases, the payment arrangement amount may be less than, more than or equal to the amount billed to BCBSND by the Health Care Provider. In all cases, the amount charged to the Plan Administrator will be the cash or check amount paid by BCBSND to the Health Care Provider. Members' Cost Sharing Amounts, calculated on a percentage basis, will be based on the lesser of the payment amount or the amount actually billed by the Health Care Provider.

## IX. INTER-PLAN ARRANGEMENTS

BCBSND has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Member accesses health care services outside of the geographic area BCBSND serves, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to BCBSND for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits and vision care benefits (except when paid as medical claims/benefits), and those prescription drug benefits that may be administered by a third party contracted by BCBSND to provide the specific service or services.

### A. BlueCard<sup>®</sup> Program

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

#### 1. Liability Calculation Method Per Claim

- a. **Member Liability Calculation.** Unless subject to a fixed dollar copayment, the calculation of Member liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the billed charges of the Host Blue's participating health care provider or the negotiated price made available to BCBSND by the Host Blue.
- b. **Group Liability Calculation.** The calculation of the Group liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to BCBSND by the Host Blue. Sometimes, this negotiated price may be greater than billed charges in accordance with how the Host Blue has negotiated with its participating health care providers for specific health care services. In cases where the negotiated price exceeds the billed charge, the Group may be liable for the excess amount even when the Member's Deductible Amount has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the health care provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the health care provider, even when the contracted price is greater than the billed charge.

## 2. Claim Pricing

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

- a. an actual price. An actual price is a negotiated rate of payment without any other increases or decreases; or
- b. an estimated price. An estimated price is a negotiated rate of payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- c. an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Group pays on a specific claim and the actual amount the Host Blue pays to the health care provider. However, the BlueCard Program requires that the amount paid by the Member and the Group is a final price; no further price adjustment will result in increases or decreases to the pricing of past claims.

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

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

## 3. BlueCard Program Fees and Compensation

The Group understands and agrees to reimburse BCBSND for certain fees and compensation which BCBSND is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to BlueCard Program vendors, as described below.

BCBSND will charge the Group separately for only the following BlueCard Program-related fees:

- BlueCard Program access fee
- BlueCard Program Administrative Expense Allowance (AEA)

An access fee may be passed on to the Group as an additional claim liability. If one is charged, it will be a percentage of the discount/differential BCBSND receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed \$2,000 for any claim. If BCBSND receives an access fee credit, BCBSND will give the Group a claim expense credit or a separate credit.

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its participating health care provider prohibits billing Members for amounts in excess of the negotiated payment. However, a health care provider may bill for noncovered health care services and for Member's cost sharing (for example, deductible, copayments and/or coinsurance) related to a particular claim.

Alternative financial arrangements may be used to charge both the BlueCard Program access fee and the BlueCard Program AEA. These are charged either on a per contract per month (PCPM) or a per claim basis as indicated in Section VII. Fees and Charges. The alternative financial arrangement replaced both the access fee and the AEA for only those contracts or claims identified in Section VII. Fees and Charges.

All other BlueCard Program-related fees are included in the BCBSND general administrative fee. See Section VII. Fees and Charges.

## **B. Special Cases: Value-Based Programs**

Members may access Covered Services from health care providers that participate in a Host Blue's Value-Based Program. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost or Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Under Value-Based Programs, a Host Blue may pay health care providers for reaching agreed-upon cost/quality goals in a variety of ways such as Provider Incentives, share of target savings, Care Coordinator Fees and other amounts allowed by rules of the Association.

The Host Blue may pass these health care provider Value-Based payments to BCBSND, which will then be passed directly on to the Group as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

The charge to Groups for Value-Based Programs incentives/Shared Savings settlements that are part of the claim are passed to the Group via an enhanced health care provider fee schedule. Per Member Per Month (PMPM) billings for Value-Based Programs incentive/Shared Savings settlements to the Group are outside of the claim system. BCBSND will pass these Host Blue charges directly through to the Group as a separately identified amount on the Group billings.

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

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

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from Value-Based payments. If the Group terminates, the Group will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the terms of this Agreement.

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

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

Host Blues may also bill BCBSND for Care Coordinator Fees for provider services which we will pass on to the Group as follows:

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

BCBSND and the Group will not impose Member Cost Sharing for Care Coordinator Fees.

#### **C. Return of Overpayments**

Under the Inter-Plan Arrangements, recoveries from a Host Blue or from health care providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital audits, credit balance audits, utilization review refunds and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts, which generally require correction on a claim-by-claim or prospective basis. The fees of such a third party may be charged to the Plan Administrator as a percentage of the recovery.

#### **D. Federal/State Taxes/Surcharges/Fees**

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSND will disclose any such surcharge, tax or other fee to the Group and it will be the Group's liability.

#### **E. Nonparticipating Health Care Providers Outside the BCBSND Service Area**

Member Liability Calculation – When Covered Services are provided outside of BCBSND's service area by health care providers who have not entered into a "participation agreement" with a Host Blue (nonparticipating health care providers), the amount the Member pays for such services will generally be based on either the Host Blue's nonparticipating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the nonparticipating health care provider bills and the payment BCBSND will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

In certain situations, BCBSND may pay claims based on the payment BCBSND would make if the Covered Services had been obtained within the BCBSND service area, such as in situations where a Member did not have reasonable access to a participating health care provider, as determined by BCBSND in its sole and absolute discretion or by applicable state law. In other situations, BCBSND may pay such a claim based on the payment BCBSND would make if BCBSND were paying a nonparticipating health care provider inside of BCBSND's service area, (as described in the Member's Certificate of Insurance), where the Host Blue's corresponding payment would be more than BCBSND's payment to a nonparticipating health care provider within the BCBSND service area. BCBSND may also in its sole and absolute discretion, negotiate a payment with such a health care provider on an exception basis. In any of these situations, the Member may be responsible for the difference between the amount that the nonparticipating health care provider bills and payment BCBSND will make for the Covered Services as set forth in this paragraph.

Fees and Compensation - The Group understands and agrees to reimburse BCBSND for certain fees and compensation which BCBSND is obligated under applicable Inter-Plan Arrangements to pay to the Host Blues, the Association and/or to Inter-Plan Arrangement vendors.

BCBSND may pay an AEA fee to the Host Blue for processing nonparticipating health care providers' claims and the Group further agrees to reimburse BCBSND for this AEA fee, if one is charged, as set forth in Section VII. Fees and Charges.

#### **F. Blue Cross Blue Shield Global Core**

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands ("BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue.

##### **1. Inpatient Services**

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for Cost Sharing Amounts. In such cases, the hospital will submit the Member's claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services.

##### **2. Outpatient Services**

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

##### **3. Submitting a Blue Cross Blue Shield Global Core Claim**

When a Member pays for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the health care provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSND, the Blue Cross Blue Shield Global Core Service Center or online at [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com).

You understand and agree to reimburse BCBSND for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to you under Blue Cross Blue Shield Global Core are set forth in Section VII.(B). Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section IX.(G).

## **G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation**

Fees and compensation under applicable Inter-Plan Arrangements may be revised in accordance with the specific program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any Group. Such revisions typically are made annually as a result of Inter-Plan Arrangements changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with the Group's Plan Year under this Agreement.

## **X. GOVERNING LAW**

This Agreement shall be construed and enforced in accordance with federal law under ERISA, except to the extent that state law is not preempted, in which case this Agreement shall be construed and enforced in accordance with the laws of North Dakota.

## **XI. DISPUTES AND INDEMNIFICATION**

A. The Plan Sponsor and the Plan Administrator agree to indemnify the Company and hold it harmless:

1. From any and all claims, suits, interest, and expenses, including attorneys' fees and court costs, the Company may become liable for or shall pay upon or in consequence of any liability for premium taxes or other taxes by whatever name called similar to or in lieu of premium taxes, or other taxes, including penalties and interest, arising out of the performance by the Company of its services under this Agreement except as provided in Section XI.(B) hereof; and
2. As permitted by North Dakota law, against any and all losses, damages, and/or expenses, including but not limited to attorneys' fees and court costs, resulting from or arising out of claims, demands, suits or actions brought against the Company related to the Plan and/or arising out of or related to the performance of services by any party under this Agreement to recover benefit payments described by the Plan or as a result of any decision by the Plan Administrator to limit or exclude benefits under the Benefit Plan to the extent that such limitation or exclusion of benefits is ever alleged or determined to violate any state or federal law.

B. The Company agrees to hold the Plan Sponsor and the Plan Administrator harmless against any and all loss, damage, and/or expenses under this Agreement resulting from dishonest, fraudulent, or criminal acts of the Company's employees acting within the scope of their employment, provided the claim for benefits is not otherwise payable under the Plan.

C. Legal or extraordinary benefit matters shall be referred by the Company to the Plan Administrator. Where the Company is not a party to such matters, the decision to defend a legal action or a suit in equity on a claim under the terms of the Plan for benefits or otherwise, except as provided in Section XI.(B) above, shall be the responsibility of the Plan Sponsor and/or the Plan Administrator. Notwithstanding the above, if litigation is filed naming the Company as a defendant, the Company will have the right to manage the litigation and determine whether to pay, compromise, litigate, or appeal the litigation and submit all defense costs incurred to the Plan Sponsor and/or the Plan Administrator for reimbursement in accordance with Section XI.(A) of this Agreement. If the Company agrees to pay or compromise such litigation, the Plan Sponsor and/or the Plan Administrator may not seek contribution or indemnity for any additional loss, damage, and/or expenses incurred in connection with such litigation, notwithstanding Section XI.(B) above.

- D. The Company shall not be liable for any loss resulting from the performance of its duties, if such duties were performed at the direction of the Plan Sponsor and/or the Plan Administrator and contrary to the advice of the Company, or if the Company relied on information from the Plan Sponsor and/or the Plan Administrator that was inaccurate. The Plan Sponsor and the Plan Administrator acknowledge and agree there are federal and/or state laws affecting the administration of this Agreement by the Company and to comply with any and all obligations arising out of federal or state statutes, case law, regulations, advisory opinions, and other applicable legal requirements. The Company shall not be liable for any loss resulting from noncompliance with any such legal requirements where compliance is the responsibility of the Plan Sponsor or Plan Administrator, regardless of whether or not the Plan Administrator or Plan Sponsor relied on services or advice provided by the Company.

## XII. TERMINATION

- A. If any law or regulation is enacted by the United States or by any state or if any existing law is interpreted to prohibit the continuance of this Agreement, it shall terminate automatically on the effective date of such law or regulation or date of interpretation.
- B. Any party may terminate this Agreement by giving written notice to the other parties 31 days prior to the specified termination date of this Agreement. Written notice shall be sent certified mail return receipt requested.
- C. In the event of termination of this Agreement, the Company shall complete the evaluation of all requests for benefits under the Plan which are received prior to the termination of this Agreement.
- D. Both the Plan Administrator and Company will have the right to terminate this Agreement if either party determines that the other has engaged in a pattern of activity or practice that constitutes a material breach or violation of its obligations regarding PHI under this Agreement and, on notice of such material breach or violation from the complaining party, fails to take reasonable steps to cure the breach or end the violation.

If the party fails to cure the material breach or end the violation after the complaining party's notice, the complaining party may terminate this Agreement by providing the other party written notice of termination setting forth the uncured material breach or violation serving as the basis for the termination and specifying the effective date of the termination.

## XIII. GENERAL PROVISIONS

- A. This Agreement is between the Company, the Plan Sponsor and the Plan Administrator, and does not create any rights or legal relationships between the Company and any Members.
- B. If one or more provisions of this Agreement are determined to be illegal or otherwise unenforceable, such determination shall not affect the legality or enforceability of the remaining provisions of this Agreement.
- C. The Plan Sponsor and the Plan Administrator acknowledge that they do not have any right in, nor will it use without the written approval of the Company, any trademark, copyrighted, proprietary or confidential information of the Company. Further, the Plan Sponsor and the Plan Administrator agree that they will not use information deemed to be confidential by the Company for any purpose unrelated to this Agreement.
- D. The Plan Sponsor warrants that it is a corporation, partnership, or proprietorship existing under the laws of North Dakota and that the signator below has the authority to bind the Plan Sponsor in this Agreement. The Company warrants that the signator(s) below has the authority to bind the Company in this Agreement. The Plan Sponsor warrants that the signator below has the authority to bind Plan Sponsor in this Agreement. The Plan Administrator warrants that the signator below has the authority to bind the Plan Administrator in this Agreement.

- E. The Plan Sponsor and the Plan Administrator hereby expressly acknowledge and understand that BCBSND 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 BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND is not contracting as an agent of the Association. The Plan Sponsor and the Plan Administrator further acknowledge and agree this Agreement was not entered into based upon representations by any person or entity other than BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to the Plan Sponsor and the Plan Administrator for any of BCBSND's obligations to the Plan Sponsor and the Plan Administrator created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this Agreement.
- F. The Company is and shall remain an independent contractor with respect to the services being performed under this Agreement and shall not for any purpose be deemed an employee of the Plan Sponsor or Plan Administrator. Further, the Company, the Plan Sponsor and the Plan Administrator shall not be deemed partners, involved in a joint venture, or governed by any legal relationship other than that of independent contractor. The Company does not assume any responsibility for the general policy direction of the self-funded employee welfare benefit plan, the adequacy of the funding, or any act or omission or breach of duty by the Plan Sponsor or the Plan Administrator.
- G. All disputes between the parties regarding matters set forth in this Agreement that cannot be settled between the parties, may be referred to arbitration at the request of the Company, the Plan Sponsor or the Plan Administrator. The arbitration shall be conducted in accordance with commercial arbitration rules of the American Arbitration Association or in some other manner agreed to by the parties. However, where the Plan Sponsor or the Plan Administrator contend that the Company has breached this Agreement, notice of said alleged breach shall be delivered to the Company by certified mail return receipt requested; if the Company cures the alleged breach within 31 days after it receives said written notice, the Plan Sponsor or the Plan Administrator shall be barred from bringing suit or submitting the matter to arbitration. Any arbitration of any dispute covered by this paragraph shall be nonbinding and no party waives their right to pursue the matter in court by participating in such arbitration.
- H. If the Plan Administrator has a digital or online version of the Summary Plan Description or any other Plan documents, the Plan Administrator agrees that it will not alter, modify or change the language of the Summary Plan Description, and further agrees the Summary Plan Description, attached as Exhibit "A", will be the controlling document in the event of any conflict or liability that might arise as the result of any alterations, modifications or changes made by the Plan Administrator. In the event a claim is paid based on the Plan Administrator's digital or online Summary Plan Description, the Plan Administrator is liable for all such claims. The Plan Administrator further agrees that no waiver of this provision is valid unless in writing and approved by the Company.
- I. Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 and the HITECH Act and any implementing regulations applicable to this Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan Sponsor, the Plan Administrator and the Company remain in compliance with such regulations, unless the Company elects to terminate this Agreement by providing the Plan Sponsor and the Plan Administrator notice of termination in accordance with this Agreement at least thirty-one (31) days before the effective date of such final regulation or amendment to final regulations.

**XIV. NOTICE**

The Company shall be entitled to rely upon the accuracy of any communication from authorized representatives of the Plan Administrator. The Company shall not be bound by any notice, direction, requisition, or request unless and until it shall have been addressed to the following person and sent certified mail return receipt requested to:

**Timothy Huckle, President and CEO**  
**BLUE CROSS BLUE SHIELD OF NORTH DAKOTA**  
4510 13th Avenue South  
Fargo, North Dakota 58121

The Plan Administrator shall be entitled to rely upon the accuracy of any communication from authorized representatives of the Company. The Plan Administrator shall not be bound by any notice, direction, requisition, or request unless and until it shall have been addressed to the following person and sent certified mail return receipt requested to the Plan Administrator at:

**Robert W. McConnell, Director Human Resources**  
**CITY OF BISMARCK**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

**XV. SUMMARY HEALTH INFORMATION**

Upon the Plan Sponsor's written request for the purpose either (a) to obtain premium bids for providing health insurance coverage for the Plan, or (b) to modify, amend or terminate the Plan, the Company will provide Summary Health Information regarding the Members in the Plan to the Plan Sponsor.

**XVI. COUNTERPARTS AND BINDING EFFECT**

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute one and the same instrument. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed, in their names by their undersigned officers, the same being duly authorized to do so.

**CITY OF BISMARCK**  
**GROUP HEALTH PLAN (PLAN ADMINISTRATOR)**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

**BLUE CROSS BLUE SHIELD OF NORTH DAKOTA\***  
4510 13th Avenue South  
Fargo, North Dakota 58121

By: \_\_\_\_\_



Title: \_\_\_\_\_

Its President and CEO

Date: \_\_\_\_\_

October 25, 2016

**CITY OF BISMARCK**  
**(PLAN SPONSOR)**  
221 North 5th Street  
Bismarck, North Dakota 58506-5503

By:  \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Administrative Service Agreement  
01/01/2017 - 12/31/2017  
10155

\*An Independent Licensee of the Blue Cross and Blue Shield Association.

# **Exhibit "A"**