Blue Medicare Advantage (PPO)

Group Master Agreement

SECTION 1: INTRODUCTION

This Blue Medicare Advantage Group Master Agreement (this "Agreement") describes the rights and obligations which you and Missouri Valley Life and Health Insurance Company (MVLH) MVLH, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City, have with respect to the group Blue Medicare Advantage (PPO) and/or Blue Medicare Advantage Prescription Drug Plan (hereinafter, "Medicare Plan(s)") coverage to be provided by us to your Covered Retirees and Covered Dependents.

References to "we", "us", "our," and MVLH throughout this Agreement refer to Missouri Valley Life and Health Insurance Company, in its capacity as a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. In exchange for your payment of the Premium, we agree to provide the coverage and/or benefits specified in the Evidence of Coverage for the Medicare Plan(s) ("Evidence of Coverage"), a copy of which is attached to this Agreement (Exhibit A). The coverage to be provided by us under the Group Plan which you have established is described in the Evidence of Coverage.

SECTION 2: DEFINITIONS

Certain terms defined in the Agreement are also used and defined (for the convenience of Covered Persons) in the Evidence of Coverage. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. The following defined terms apply to this Agreement:

Anniversary Date means the date one year after the Effective Date of coverage and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Appeal means a request submitted by or on behalf of a Covered Person for a review of our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs.

CMS means the Centers for Medicare and Medicaid Services.

CMS Requirements means the provisions of Parts C and D of Title XVIII of the Social Security Act, CMS Medicare Part C and D regulations at 42 C.F.R. Parts 422 and 423, the CMS Managed Care and Prescription Drug Benefit Manuals, other CMS instructions and guidance and the provisions of the MVLH contracts with CMS to offer the Medicare Plans.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Retiree.

Covered Person means a Covered Retiree or a Covered Dependent.

Covered Retiree means an Eligible Retiree, who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Dependent.

Effective Date for the Group means 12:01 a.m. on the date specified on the last page of this Agreement and for Covered Persons means 12:01 a.m. on the date coverage will begin as specified in the Evidence of Coverage.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Evidence of Coverage.

Eligible Retiree means an individual who meets and continues to meet all of the eligibility requirements set forth in the Evidence of Coverage and is eligible to enroll as a Covered Retiree. An Eligible Retiree is not a Covered Retiree until actually enrolled and accepted for coverage as a Covered Retiree by us.

Enrollment Forms means those forms, electronic or paper, which are approved by us and used to maintain accurate enrollment files under the Agreement.

Grace Period means the sixty (60) calendar day period beginning on the date the Premium is due.

Grievance means a type of complaint submitted by a Covered Person (or other person eligible under CMS Requirements to submit a Grievance) about us or one of our network providers or pharmacies, including a complaint concerning the quality of care. This type of complaint does not involve coverage or payment disputes.

Group means the employer, labor union, association, partnership, corporation, department, other organization or entity through which coverage and benefits are issued by us.

Note: References to "you" or "your" throughout the first part of this Agreement also refer to the Group. References to "you" or "your" in the Evidence of Coverage refer to Eligible Retirees, Eligible Dependents, Covered Retirees and/or Covered Dependents depending on the context and intent of the specific provision.

Group Master Agreement or Agreement means the written document which is evidence of the entire agreement between the Group and MVLH whereby coverage and benefits are provided to Covered Persons.

Late Enrollment Penalty ("LEP") means an amount added to the Part D Premium of an individual who did not have Part D coverage or other creditable prescription drug plan when the individual first became eligible for Part D or who had a break in Part D or other creditable prescription drug coverage for at least 63 days.

Low Income Subsidy ("LIS") means the premium subsidy amount paid to us by CMS for qualifying Covered Persons with Medicare Part D coverage.

Medicare Plan means the group Medicare Advantage Plan and/or Medicare Advantage Prescription Drug Plan that you select.

Premium means the amount required to be paid by the Group to us for coverage under this Agreement.

Service Area means a geographic area where a Medicare Plan accepts members.

SECTION 3: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

A. Eligibility Determination

Determination of whether an individual is an Eligible Retiree or Eligible Dependent is as follows:

1. You will determine whether the individual is eligible to participate in the retiree group health benefit plan that you sponsor. You are responsible for complying with all applicable laws and regulations, including but not limited to the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, in making this eligibility determination. You must also comply with all eligibility guidelines included in the Evidence of Coverage.
2. After receiving a complete application or an electronic enrollment, we will process the application or electronic enrollment in accordance with CMS Requirements. Enrollment must be accepted by CMS for an individual to be enrolled in a Medicare Plan.

B. Distribution of Enrollment Materials

You may only distribute materials describing the Medicare Plan that we have provided to you or that we have approved in writing. You will distribute any pre-enrollment materials that we provide to you to each potential enrollee before facilitating enrollment. Nothing in this Section will preclude you from making additional disclosures about your group health benefit plan as applicable to comply with ERISA, such as a wrap-around summary plan description or other plan document. If applicable, you are solely responsible for compliance with ERISA disclosure requirements in connection with the Medicare Plan(s).

C. Group Disenrollment

If you decide to disenroll all Covered Persons from a Medicare Plan, you must:

1. Notify all beneficiaries that you intend to disenroll them from the Medicare Plan. You will provide this notice at least twenty-one (21) calendar days before the disenrollment. This notice will explain how to contact Medicare for information about other plan options that may be available. You will include language provided by MVLH in this notice to meet specific CMS Requirements for notice contents.
2. Provide us with all information necessary to submit a complete disenrollment request transaction to CMS in accordance with CMS Requirements.
3. In the event of termination of this Agreement, provide advance notice in accordance with Section 4 of this Agreement.

D. Individual Covered Person Disenrollment

Covered Persons may be disenrolled from a Medicare Plan by MVLH if they become ineligible for continued enrollment. Covered Persons may also be disenrolled if this Agreement terminates or if you inform us that they are no longer eligible to participate in your retiree group health plan. If MVLH determines that a Covered Person is ineligible for continued enrollment or if you instruct us to disenroll an individual, you must:

1. Provide us with at least thirty (30) calendar days advance notice of the ineligibility or disenrollment election of an individual; and
2. Provide the Covered Person(s) who will be disenrolled with at least twenty-one (21) calendar days advance notice of the termination and of other insurance options that are available to them. You will include language provided by MVLH in this notice to meet specific CMS Requirements for notice contents.

The Covered Person will have the opportunity to elect another plan offered by us or by you, join Original Medicare, or join another carrier's Medicare Plan (by submitting an enrollment request to that organization).

SECTION 4: TERM AND TERMINATION

A. Term of Agreement and Renewal Process

This Agreement shall become effective as of the Effective Date provided: (1) that we agree to provide coverage; and (2) that you pay the required initial Premium specified by us.

This Agreement shall continue in effect until the first Anniversary Date following the Effective Date unless terminated earlier as permitted by its terms. After the initial term, this Agreement shall renew upon written mutual consent each succeeding year on the Anniversary Date for an additional one-year period unless it is terminated as permitted by its terms.

At least ninety (90) calendar days before each Anniversary Date, we will provide you with notice of changes in Premium and benefits under the Medicare Plan for the upcoming year (the "Renewal Notice").

If this Agreement renews as specified above, all of its terms and provisions (including the Premium due) shall be amended to include the terms of the Renewal Notice, and the amended Agreement shall govern coverage as of the Anniversary Date. Payment of the new charges shall constitute acceptance of the change in Premium rates. This Agreement is conditionally renewable. This means that it automatically renews each year on your Anniversary Date unless terminated earlier in accordance with its terms.

B. Termination by Group

The Group may cancel this Agreement on its Anniversary Date by giving written notice to us at least sixty (60) calendar days in advance, unless we have initiated a termination for any of the reasons stated below.

C. Termination by MVLH

We may terminate this Agreement or refuse to renew for the following reasons:

1. **Failure to Pay Premiums**. You do not pay Premiums in accordance with its terms or we have not received timely Premium payments prior to the end of the Grace Period. Termination of this Agreement for failure to pay premiums shall be effective as of the end of the Grace Period. In the event of such termination, you are obligated to pay the following:
    a. Any portion of the Premium due for coverage provided by us prior to termination; and
    b. Any amounts otherwise due us.
2. **Fraud or Intentional Misrepresentation of Material Fact.** You perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact.
3. **Group Contribution and Participation and CMS Rules.** You do not comply with: (1) a material provision which relates to rules for Group contributions or Covered Person participation; or (2) any provision in this Agreement which relates to LIS or other CMS Requirements.
4. **Termination or Non-renewal of the CMS Contract.** We will provide you with at least ninety (90) calendar days' notice upon termination or non-renewal of our contract with CMS.

Except as specifically provided in this Subsection 4.C, if we decide to terminate or not renew the Agreement based on one or more of the circumstances mentioned above, we will give you at least forty-five (45) calendar days advance written notice.

D. Notification of Termination to Covered Retirees

It is your obligation to immediately notify each Covered Person of any such termination of this Agreement for any reason, consistent with the requirements of Section 3 of this Agreement.

E. Representations Made By, and Obligations of, the Group

In agreeing to provide coverage in accordance with the terms of this Agreement, we rely on the representations you made when you applied for coverage with us and your representation that you have authority to act on behalf of all Covered Persons with respect to this Agreement. Consequently, every act by, agreement with, or notice given to, you

will be binding on all Covered Persons. You agree that you shall offer to all Eligible Retirees the opportunity to become a Covered Person under this Agreement.

SECTION 5: PAYMENT PROVISIONS

A. Monthly Invoice

We will prepare a monthly invoice of the Premium due on or before the due date. This monthly invoice will also reflect any prorated charges and credits resulting from changes in the number of Covered Persons and changes in the types of coverage that took place in the previous or current month.

If you become aware that a Covered Person will become ineligible, you must provide us with written notice of such ineligibility as described in Section 3 of this Agreement. You shall be liable to us for the Premium due for each individual enrolled in a Medicare Plan under this Agreement until the effective date of disenrollment, which is set by CMS Requirements.

You must pay the total amount of the invoice. Do not add names to an invoice, change coverage or pay for a retiree or dependent whose name does not appear on the invoice. Payment shall be for the total amount of the Group invoice.

B. Payment Due Date

Each payment is due monthly unless you agree with us in writing on some other method and/or frequency of payment. The Premium is due and payable on or before the first day of each succeeding calendar month to which such payments apply.

C. Grace Period

This Agreement has a sixty (60) calendar day Premium payment Grace Period, which begins on the date the Premium payment is due. If we do not receive the required Premium payment on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, we may terminate this Agreement and proceed with the disenrollment of Covered Persons as described in Section 3 of this Agreement.

D. Changes in Premium

Premium rates may be changed on your Anniversary Date as described in Section 4.A above regarding renewal.

E. Other Rules Regarding the Payment of Premiums

1. CMS rules govern the effective date of any disenrollment of a Covered Person under this Agreement, and we are not required to retroactively terminate this Agreement or coverage for any Covered Person.
2. If full payment of the Premium is not paid when due, this Agreement may be terminated as described in Section 4 of this Agreement.

F. Premium Subsidization

You may subsidize Premium amounts charged to Eligible Retirees. You are responsible for compliance with all applicable laws and regulations relating to your subsidy of Premiums, including ERISA and CMS Requirements, as applicable. You acknowledge and agree that Premium subsidization may vary for different classes of Eligible Retirees only if such classes are reasonable and based on objective business criteria. You represent and warrant that you will not vary Premium subsidization based on any Covered Person's eligibility for LIS. Further, you will not vary Premium

subsidization for individuals within a given class of Eligible Retirees. In no case will you charge an Eligible Retiree more than the sum of the monthly Premium that we charge you for the Medicare Plan benefits.

G. Low Income Subsidy

You will comply with the following requirements in connection with LIS:

1. You are required to pass through any LIS payments received from CMS to reduce the Premium amount that the Covered Retiree pays. You will first apply any LIS amounts to a Covered Person's share of Premium. You may not benefit from any LIS amount until the Premium for a Covered Person (including amounts for the non-drug benefits in a combined Medicare Advantage Prescription Drug Plan) paid by a Covered Retiree is reduced to zero ($0.00).

2. You are responsible for reducing up-front Premium contributions that you collect from Covered Retirees for any Covered Persons eligible for LIS. In limited situations where you are unable to reduce the up-front Premium contribution (e.g., if LIS is awarded retroactively), you will directly refund the LIS amount to the Eligible Retiree within fifteen (15) calendar days of the date you receive the LIS amount from MVLH.

H. Late Enrollment Penalty (LEP)

The Premium for an individual Covered Person may be higher if the Covered Person is assessed an LEP for not enrolling in Part B in a timely manner. This higher Premium will be reflected on the bill you receive from us.

I. Premium Billing

You will be responsible for the payment of the "Total Monthly Premium per Covered Retiree" of all Group members. The Total Monthly Premium may be less for Covered Persons who qualify for LIS as defined by CMS. You will also be responsible for any LEP charges that Group members have been assessed by CMS. The first Premium charge is payable before the Effective Date of this Agreement. Monthly charges are payable on the first day of each following month during the time this Agreement is in effect.

J. Retroactive Premium Adjustment

The monthly charge will be determined from our records by the number of Covered Retirees who have been confirmed through the CMS enrollment transaction process. Retroactive adjustments will be made for additions and terminations of Covered Retirees and for Covered Retirees who have been confirmed through the CMS enrollment transaction process after the initial billing statement. Any refund that is owed to a Covered Retiree must come from the Group, unless the Covered Retiree is billed directly by us. MVLH will only adjust the amount due of a Group and will not refund Premium(s) paid to a Covered Retiree, unless we mutually agree that a Covered Retiree is to be directly billed by MVLH. You must refund to Covered Retirees any amounts received from us that are due to Covered Retirees in a timely manner.

SECTION 6: HOST BLUE PLANS

A. Out of Area Services

We have relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Medicare Advantage Program." When Covered Persons access healthcare services outside of the Service Area, the claim for those services will be processed through the Medicare Advantage Program and presented to us for payment in accordance with the rules of the Medicare Advantage Program policies then in effect. The Medicare Advantage Program available to Covered Persons under this Agreement is described generally below.

B. Covered Persons Liability Calculation

The cost of the service on which the Covered Person's liability is based, will be either:

1. The Medicare allowable amount for covered services; or
2. The amount we negotiate with the provider of the Host Blue negotiates with its provider on behalf of our Covered Persons, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

SECTION 7: GENERAL PROVISIONS

A. Administration and Record Retention

You must provide us with any information we need to administer the coverage and/or benefits to be provided or needed to compute the Premium due. While this coverage is in force, we have the right, at any reasonable time, to examine your records on any issues necessary to verify information provided by you. You must retain all records relating to this Agreement, including but not limited to those relating to LIS administration, for the current calendar year plus an additional ten (10) years.

B. Assignment and Delegation

You may not assign, delegate, or otherwise transfer this Agreement and the obligations hereunder without our written consent. Any assignment, delegation, or transfer made in violation of this provision shall be void. We may assign, delegate, or otherwise transfer this Agreement to our successor in interest or an affiliated entity only with your written consent and after written notice has been provided to you a minimum of sixty (60) days prior any requested assignment, delegation, or other transfer. You shall not unreasonably withhold, condition, or delay your consent to any such assignment by us.

C. Authorization

Where this Agreement requires that an act involving the administration of coverage and/or benefits be authorized or approved by us, such authorization or approval shall be considered given when provided in writing by a duly authorized officer of MVLH or his or her designee.

D. Evidence of Coverage

We will provide an Evidence of Coverage and ID Card for each Covered Retiree. The Evidence of Coverage will describe the coverage and benefits to be provided to Covered Persons by us.

E. Grievance and Appeals Process

We have established and will maintain a process for hearing and resolving Grievances and Appeals raised by Covered Persons in accordance with CMS requirements. Details regarding this process are provided in the Evidence of Coverage.

F. Changes to the Agreement

MVLH may make any changes to this Agreement that are necessary to meet CMS Requirements ("CMS Mandated Amendments") with sixty (60) calendar days advance written notice to you. Such changes shall become effective as amendments to this Agreement upon expiration of this sixty (60) calendar day notice period.

Except in the case of (a) CMS Mandated Amendments or (b) Renewal Notices as described in Section 4.A., no person may change, modify, or revise the written terms or provisions of this Agreement unless such change is made by a

written amendment signed by one of our duly authorized officers. For example, no Eligible Retiree or agent of MVLH or the Group can change or waive the written terms or provisions of this Agreement except as stated in the first sentence of this paragraph.

G. Furnishing and Maintaining Enrollment Records

You must provide any information required by us for the purpose of creating and maintaining enrollment records, processing terminations, and recording changes in family status. All enrollment record information which is relevant to the eligibility or coverage status of any individual must be made available to us for inspection and copying upon request.

H. Confidential Information and Requested Disclosures of Data

a. Confidential Information means all proprietary, non-public information disclosed to you by us under this Agreement. Confidential Information includes but is not limited to: the terms of this Agreement (including all exhibits); the identity of health care providers participating in the network; health care provider fee schedules and discounts; the provisions, terms and conditions of agreements and contracts with health care providers; our coverage policies; and all information relating to our business methods, processes, policies, finances, strategies, budgets, pricing terms or other financial information, records, notes, memoranda, summaries or other materials in whatever form maintained, whether prepared by us or others, that contain or otherwise reflect or are based upon, in whole or in part, any of our proprietary, non-public information. The term Confidential Information does not include information which: (a) is or becomes generally available to the public other than as a result of disclosure by; (b) becomes available to you on a non-confidential basis from a third party; provided, that you are not aware that such third party is bound by a confidentiality agreement with respect to the Confidential Information; or (c) is identified by us as not being Confidential Information. You acknowledge and agree that you may receive our Confidential Information during the term of this Agreement and that such Confidential Information may not be utilized by you, your affiliates, or any of your employees, officers, directors, trustees, owners, agents or representatives except as specifically authorized by us. You shall limit your use or disclosure of Confidential Information consistent with this Agreement and shall return or destroy all of our Confidential Information upon termination of this Agreement, to the extent permitted by ERISA. Confidential Information disclosed pursuant to this Agreement is and shall remain our property. If, in the opinion of your counsel, disclosure of Confidential Information is required by any federal or state law, rule, regulation or court order, you may only make such disclosure after notifying us (if allowed by law) of your intention to disclose the Confidential Information prior to making such disclosure. The terms of this Section shall survive the termination of this Agreement. Notwithstanding anything herein to the contrary, no provision of this Agreement shall be interpreted as prohibiting any provision, access, use, or disclosure of information to the extent required by applicable law.

b. The parties acknowledge they are "covered entities" in an "organized health care arrangement" subject to obligations under the Health Insurance Portability and Accountability Act of 1996 and implementing regulations found at 45 C.F.R. Parts 160 to 164, as amended ("HIPAA"). The parties recognize that HIPAA imposes limitations on the use and disclosure of information by us to you and vice versa. The parties warrant that they will not request that the other party use or disclose "protected health information" ("PHI") in any

manner not permitted by HIPAA.

a. Disclosures to Broker. You will designate a broker of record ("Broker") who is permitted to received information, data, and reports ("Data") on your behalf for treatment, payment, and health care operations. You hereby direct us to provide Broker with our regular reports for you. Broker may request additional Data on your behalf through submission of a Request for Release of Business Information to a Third Party form similar to the form attached as Appendix A ("Request Form") to us. By designating Broker, you:

   i. Have executed a Business Associate Agreement with Broker consistent with requirements of HIPAA;

   ii. Agree that Broker will be required to execute a Data Extract Agreement or similar agreement with us related to Data;

   iii. Recognize that if Broker refuses to execute a Data Extract Agreement, Company may refuse to provide Data to Broker; and

   iv. Will ensure that, prior to allowing Broker to provide any Data to you containing PHI, you will comply with requirements of subsection (d) below.

b. Initiation of Request. You or Broker may perform or may engage additional third party companies ("Contractors") to perform certain administrative services on behalf of your health plans related to the treatment, payment and healthcare operations of the plans. Where you or Broker desires for us to disclose any data or reports ("Data") to you or a Contractor, you will complete a copy of the Request for Release of Business Information to a Third Party form similar to the form that is attached as Appendix A ("Request Form").

c. Designation of Representative. You will complete a Designation of Representative, a copy of which is attached hereto as Appendix B, to designate individuals employed by you who i) provide administrative functions on behalf of the health plans and are authorized to receive PHI from us for such functions or ii) are authorized to receive enrollment, disenrollment or summary plan information from us on your behalf. You will update the information on the Designation of Representative within five (30) business days of any such change or when verification is requested by us.

d. Warranties Prior to Request. You recognize that by requesting PHI from us be disclosed to you, Broker, or Contractor that is more than enrollment and disenrollment information or summary plan information, you trigger additional obligations under HIPAA. You warrant that you will only request that we provide PHI to you, Broker, or Contractors where:

   1. The plan documents include substantially all language required by 45 C.F.R. 164.504(f)(2)(ii) to permit the disclosure of PHI to you;

   2. You have implemented necessary separation under 45 C.F.R. 164.504(f)(2)(iii) and 164.314(b) to permit the disclosure of PHI to you;

   3. You, on behalf of your health plan, have executed necessary agreements with

Contractor or Broker to permit the disclosure, including but not limited to a Business Associate Agreement;

4. The request is for a permitted purpose for functions on behalf of the health plan as described on any applicable Request Form and you have determined that the disclosure to you, Broker, or Contractor is permitted under HIPAA and other applicable law;

5. If the disclosure is not related to treatment, payment or health care operations of the health plan and authorizations are required under HIPAA or other applicable law, you have obtained authorizations from its participants and beneficiaries to permit the disclosure to the Broker or Contractor;

6. If information that is received by us from a substance abuse treatment program and identifies an individual as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person is included in the ("Data"), you have obtained necessary authorizations from individuals to allow disclosure of this information under 42 C.F.R. Part 2. You recognize that general authorization for the release of medical or other Information is not sufficient for this purpose (see 42 C.F.R. § 2.31);

7. You have determined that the amount of PHI to be disclosed to you, Broker, or Contractor is the minimum amount of PHI necessary for the services to be performed by you, Broker, or Contractor; and

8. You, Broker, and Contractor will not utilize the PHI for the purpose of an employment related action, in connection with any other benefit or employee benefit plan that is not a health plan; or any improper, unlawful, or otherwise unauthorized purpose or to identify any individual for such a purpose.

9. You recognize that any Contractor or Broker (and any subcontractor of Contractor who will receive Data) engaged by you will be required to enter into a data extract agreement with us prior to receiving any Data. If Contractor or Broker refuses to accept terms agreeable to us related to a data extract agreement, we may refuse to provide Data to Contractor or Broker.

e. Denial of a Request. We have the right, in our reasonable business judgment, to decline to provide Data to you, Broker, or Contractor or to limit the Data extracted for any particular request. We will discuss any proposed refusal or limitation of Data for extraction with you, Broker, and Contractor.

f. Limited Use. You recognize that Data provided by us may contain our confidential or proprietary information as well as PHI. As such, the parties agree:

1. You, Broker, or Contractor will only use Data for the purpose identified on Request Form and permitted by applicable state and federal law;

2. The parties will report to the other party, as soon as reasonably practicable, any security incident or impermissible or unauthorized acquisition, access, use or

disclosure of a Data not provided for in this Agreement or not permitted under HIPAA, including, but not limited to, breach of unsecured PHI, as defined by 45 C.F.R. § 164.402 (Breach). Such notification is in addition to any other notifications required of your health plan under applicable state or federal law. Your health plan is solely responsible for your own notification obligations to individuals or other third parties as may be required under 45 C.F.R. 164 Part Dor any other state or federal law and we assume no responsibility for these notifications.

3. We provide Data to you for the sole purpose of performing administrative functions on behalf of your health plans. We hereby grant to you a nonexclusive, non-transferable right and license to use, reproduce, adapt, perform, compile, display, incorporate and modify the Data for the purpose of performing functions on behalf of your health plans.

4. You warrant that, if you permit any Contractor or Broker to combine Data with any other such data received from other sources for use as a benchmark or other similar purpose or to perform broader analysis for the health plan, due to wide variations among our plans in covered benefits, enrollment demographics, claims experience, allowable amounts, and other variables, you will not permit the Contractor or Broker to identify or represent the Data as pertaining to a specific plan of ours, nor indicate or imply that the Data is representative or typical of us or our plans. Further, notwithstanding the foregoing, you, Broker, and Contractor are prohibited from combining any elements of the Data related to pricing, allowed amounts, or other Confidential Information of Company with other such data received from other sources or to extract Confidential Information from any Data.

5. If Data, any extract or portion thereof, or any method of collection thereof, becomes the subject of any claim or action that it violates the patent, trade secret, copyright, or other proprietary right of any other person or entity, then we, at our option and expense, may either: (i) procure for you the right to continue using the Data; (ii) modify the Data to render it non-infringing; or (iii) replace the Data or any portion thereof with equally suitable, functionally equivalent, compatible, non-infringing data. If none of the foregoing is, in our sole discretion, commercially infeasible, we may terminate the provision of the Data to you. This paragraph states our total liability with respect to any claim that the Data, any extract or portion thereof, or any method of collection thereof violates the patent, trade secret, copyright, or other proprietary right of any other person or entity.

6. The parties shall not sell or authorize Contractor, Broker, or any third party to sell the Data or any extract of the Data.

7. The license to use Data provided to you, Broker, or Contractor under this Section is personal to you, Broker, or Contractor and cannot be assigned, delegated, or otherwise transferred to any third party without the express prior written consent of Business Associate.

g) Limitation of Liability. You understand and agree that we provide all information

and data to you, Broker, or Contractor "as is". Except as otherwise expressly provided in this Agreement, we disclaim all representations and warranties of any kind or nature, express or implied, arising out of or related to this Agreement, the data, and/or any extracts therefrom, including, without limitation, any warranties regarding quality, correctness, accuracy, completeness, comprehensiveness, non-infringement, suitability, merchantability, fitness for a particular purpose, title or otherwise (irrespective of any course of dealing, custom or usage or trade). You also understand and agree that we make no representations or warranties as to whether your, Broker, or Contractor's anticipated uses of any PHI complies with applicable law, the applicable notice of privacy practices, or with the plan document(s).

h. Indemnification. The parties shall defend, indemnify, and hold the other party (as well as any of its parent companies, affiliates, directors, officers, employees, agents, subsidiaries, successors and assigns) harmless from and against all claims, demands, causes of action, penalties, fines losses, damages, costs, and attorneys' fees, and all legal and equitable liability whatsoever arising out of or relating to (i) its own breach of this Section H; or (ii) its own, Broker's, or Contractor's negligent, improper, unlawful, or otherwise unauthorized or impermissible access, use, release or disclosure of the Data, including but not limited to a "breach" as defined by HIPAA, or other information acquired from the other party.

i. Audit. You will provide us with reasonable access to your internal practices, books, policies, procedures and records relating to your use and disclosure of the Data you receive from us as necessary to demonstrate your compliance with the terms of this Section H.

j. Obligations on Termination. Upon termination of this Agreement, the parties, Broker, and the parties' Contractors shall return or destroy all of our Confidential Information and, upon request, provide certification of such return or destruction. If Confidential Information cannot reasonably be returned or destroyed, the parties shall continue the protections applicable to Confidential Information under this Agreement for so long as the parties, Broker, or the parties' Contractors maintain such Confidential Information.

I. Errors or Delays

Clerical errors or delays by us in maintaining enrollment records regarding Covered Persons will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated, provided you have furnished us with timely and accurate enrollment information. Errors or delays by you in furnishing accurate enrollment information to us will not affect our right to strictly enforce any and all eligibility requirements.

J. Entire Agreement

This Agreement sets forth the exclusive and entire understanding and agreement between the parties and shall be binding upon the Covered Persons, the parties, and any of their subsidiaries, affiliates, successors, heirs, and permitted assigns. All prior negotiations, agreements, and understandings are superseded hereby. No oral

statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Agreement, which includes the terms of coverage and/or benefits set forth in the Evidence of Coverage, the Schedule of Benefits, and any other attachments, amendments, or riders.

K. Financial Responsibilities of the Group

We reserve the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Our recovery efforts may relate to benefit payments made for health care services rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination is required to be made by you. Your cooperation with and support of such recovery efforts is required.

In the event that you do not comply with the notice requirements set forth in Subsection 5.A (Monthly Invoice), you shall be solely liable to us for Premium due until the effective date established by CMS for a Covered Person's disenrollment.

L. Relationship of Parties

We are not an agent or representative of you, for any purpose. You are not an agent or representative of us, for any purpose.

M. Indemnification

You shall hold harmless and indemnify MVLH, against all claims, demands, liabilities, or expenses (including reasonable attorney fees and court costs), which are related to, arise out of, or are in connection with any of your acts or omissions, or acts or omissions of any of your employees, retirees, or agents, in the performance of your obligations under this Agreement. We are not your agent, nor are you our agent, for any purpose.

N. Representations

We rely on the information you and your Eligible Retirees provide to determine whether to issue coverage; the appropriate Premium and financing method; and eligibility for coverage. All such information must be accurate, truthful, and complete.

We may cancel, terminate, or void this Agreement if the information which you provide is fraudulent, or if you make an intentional misrepresentation.

O. Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due, under this Agreement.

P. Service Mark

You, on behalf of the Group and its Covered Retirees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and MVLH, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. Blue Cross and Blue Shield of Kansas City 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 us to use the Blue Cross and Blue Shield Service Mark in our service area and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Agreement.

Q. Third Party Beneficiary

This Agreement was entered into solely and specifically for the benefit of MVLH and the Group. The terms and provisions of the Agreement shall be binding solely upon, and inure solely to the benefit of, MVLH and the Group, and no other person shall have any rights, interest or claims under this Agreement, including the Evidence of Coverage, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. MVLH and the Group hereby specifically express their intent that health care providers that have not entered into contracts with MVLH to participate in our Medicare Advantage PPO provider network shall not be third-party beneficiaries under this Agreement, including the Evidence of Coverage.

R. Inspection and Audit

You shall permit CMS, the U.S. Department of Health and Human Services, the Comptroller General, or their designees, to inspect, evaluate, and audit any of your books, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to coverage by providing records to MVLH, which will submit the records to CMS. This right to inspect, evaluate, and audit shall extend ten (10) years from the expiration or termination of the Agreement or completion of final audit, whichever is later, unless otherwise required by applicable law.

S. Member Communications and Campaigns

We may send CMS required or MVLH member communications without your consent. Samples of all required materials are available upon request for informational purposes.

T. COBRA

You are solely responsible for determining when individuals are eligible for coverage under a Medicare Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). You will notify us promptly of any COBRA elections.

U. Governing Law

This Agreement shall be construed and enforced in accordance with the laws of the State of Missouri (without regard to the legislative or judicial conflicts of laws/rules of any state), except to the extent superseded by federal law.

****

In consideration of the payment of Premiums when due and subject to all of the terms of this Agreement, Missouri Valley Life and Health Insurance Company hereby agrees to provide each eligible retiree of **Jackson County MO** the benefits of this Agreement as set forth in the attached Evidence of Coverage beginning on each enrollee's effective date.

The Group has selected the following plans and premiums:

Product	**Rate**
Blue Medicare Advantage (PPO) for Jackson County MO	$230.00

The Group's Agreement is effective as of January 1, 2024.

IN WITNESS WHEREOF, the parties have executed this Agreement as of March 26, 2024.

MISSOURI VALLEY LIFE AND HEALTH INSURANCE

BY: Rachel Arnett

PRINTED NAME: Rachel Arnett

ITS: Vice President, Sales

DATED: Apr 3, 2024

Jackson County MO

BY: Frank White, Jr.

PRINTED NAME: Frank White, Jr.

ITS: County Executive

DATED: 3.22.2024

APPROVED AS TO FORM

County Counselor

ATTEST:

Clerk of the County Legislature

EXHIBIT A

2024 EOC for Blue Medicare Advantage (PPO) for Jackson County MO