ASA HMO
R. 21730

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement (this "Agreement") is entered into effective as of January 1, 2025 (the "Effective Date"), by and between Blue Cross and Blue Shield of Kansas City ("BCBSKC") and Jackson County, on behalf of itself and the Plan (as defined below) (collectively, the "Plan Sponsor").

WHEREAS, Plan Sponsor is the plan sponsor and/or plan administrator of one or more employee welfare benefit plans for certain of its employees and other eligible individuals (collectively, the "Plan"); and

WHEREAS, Plan Sponsor desires to engage BCBSKC to provide certain services with respect to the Plan, and BCBSKC desires to provide such services, on the terms and conditions set forth in this Agreement.

NOW, THEREFORE, in consideration of the premises and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, Plan Sponsor and BCBSKC agree as follows:

1. **Definitions**. Capitalized terms used in this Agreement and not otherwise defined shall have the following meanings:

"BCBSA" means the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

"BlueCard Program" means the program established by BCBSA to allow for the payment of a Plan Participant's claim by a local/host Blue Cross and/or Blue Shield Licensee when the Plan Participant is outside of such Plan Participant's Blue Cross and Blue Shield Plan's service area.

"CAA" means the Consolidated Appropriations Act, of 2021, as amended.

"COBRA" means those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, which require certain employers to offer continuation of health care coverage to employees and dependents of employees who would otherwise lose coverage.

"Confidential Information" means all proprietary, non-public information disclosed to a party to this Agreement by the other party. Confidential Information includes but is not limited to: the terms of this Agreement (including all exhibits); all HMO Participant information; all information relating to the disclosing party's 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 the disclosing party or others, that contain or otherwise reflect or are based upon, in whole or in part, any of the disclosing party's 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 the owner of the Confidential Information; (b) becomes available to either party on a non-confidential basis from a third party; provided, that the receiving party under this Agreement is not aware that such third party is bound by a confidentiality agreement with respect to the Confidential Information; or (c) is identified by the disclosing party as not being Confidential Information.

FILED
JAN 3 1 2025
MARY JO SPINO
COUNTY CLERK

"Discount" means the amount of the initial reduction from a provider's billed charges which a provider has agreed to accept as payment in full at the time of claim payment for covered services provided to HMO Participants. "Discount" does not mean or include any affiliation fees, administration fees, network management fees, provider and pharmaceutical rebates, incentive arrangements, or any other reductions or credits a provider may periodically give BCBSKC or any other amount that a provider may pay BCBSKC for services such as administration, marketing, managed care or quality improvement programs performed by BCBSKC for the provider. BCBSKC retains these amounts and they are not included in the Discount that BCBSKC makes available to Plan Sponsor.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Fiduciary" as used in this Agreement means "fiduciary" as defined at 29 U.S.C. 1002 (21)(A).

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO Plan" means the self-insured HMO Plan which is made available to Plan Participants as part of the Plan adopted by Plan Sponsor and set forth in the Plan and any amendments (as provided to BCBSKC).

"HMO Participants" means those Plan Participants who elect coverage under the HMO Plan.

"HMO Provider" means any health care provider that has entered into a contract with BCBSKC to provide health care services as part of a Health Maintenance Organization (HMO) utilized by the Plan. The HMO for which this Agreement extends Discounts is Blue-Care.

"MHPAEA" means The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and related regulations and guidance, as amended.

"MVLH" means BCBSKC's wholly-owned subsidiary, Missouri Valley Life and Health Insurance Company.

"Paid Claims" means the amounts paid to a provider, which the provider has agreed to accept as payment in full at the time of claim payment, for delivery of covered services provided to HMO Participants (including capitation payments and Medical Value Payments, as defined in Section 3.5; provided, that capitation payments and Medical Value Payments will not accumulate toward any *specific* attachment points under Plan Sponsor's stop-loss policies, if issued by MVLH). A claim shall be deemed to be paid when a valid draft for payment has been issued, even if issued after the Initial Term or Renewal Term in which the claim was incurred. Paid Claims are not reduced by any affiliation fees, administration fees, network management fees, incentive arrangements, or any other reductions or credits a provider may periodically give BCBSKC, or any other amounts that a provider may pay BCBSKC, for services such as administration, marketing, managed care or quality improvement programs performed by BCBSKC for the provider. BCBSKC retains these amounts and they do not reduce the amount of Paid Claims.

"Plan Administrator" as used in as used in this Agreement means "administrator" as defined at 29 U.S.C. 1002(16)(A).

"Plan Document" means the written agreement adopted and executed by the Plan Sponsor to provide the Plan.

"Plan of Benefits" means the Benefit Booklet provided by BCBSKC to Plan Sponsor which reflects BCBSKC's understanding of the benefits offered under the HMO Plan.

"Plan Participants" means employees of Plan Sponsor and certain other individuals eligible to participate in the Plan (which may include dependents of employees and retirees).

"Plan Sponsor" as used in as used in this Agreement means Plan Sponsor as defined at 29 U.S.C. 1002(16)(B).

"PPACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

"Runout Claims" means claims for covered services incurred by HMO Participants prior to the termination of this Agreement but payable during the Runout Period. For purposes of clarification, Runout Claims do not include claims incurred after termination of this Agreement.

"Runout Period" means the first twelve (12) months following termination of this Agreement.

"Runout Services" means the services provided by BCBSKC for Runout Claims after termination of this Agreement.

"Runout Services Fee" means the fee payable by Plan Sponsor to BCBSKC for Runout Services, which is equal to the sum of: (a) a percentage of Runout Claims; plus (b) a percentage of Discounts, as set forth in Exhibit B.

"Service Area" means the area served by and the HMO, and includes the following counties in Missouri: Buchanan, Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte; Ray and St. Clair; and Johnson and Wyandotte Counties in Kansas, and any other counties which may later be added.

"Services" means the services BCBSKC shall provide to Plan Sponsor under this Agreement, as set forth in Exhibit A.

"Services Fees" means the amount of money to be paid by Plan Sponsor to BCBSKC for the Services, as set forth in Exhibit B.

"Statutory Assessments" means any and all of the fees, taxes, surcharges and/or assessments on employer-sponsored health coverage assessed by any governmental entity. These may include, but are not limited to, state and/or local premium taxes and other assessments.

"Stop-Loss Insurance" means the insurance procured by Plan Sponsor, if applicable, that insures Plan Sponsor against the financial exposure of claims made in excess of certain amounts.

"TCR" means the Transparency in Coverage final rule of 2020 as amended.

2. **Services; Out of Scope**. BCBSKC will provide the Services set forth in Exhibit A. BCBSKC shall not perform any services other than those expressly stated in this Agreement. If Plan Sponsor desires to have BCBSKC perform any services that are not included in the Services set forth in Exhibit A, Plan Sponsor shall submit a request to BCBSKC for such services, and, if BCBSKC, in its sole discretion, desires to provide such services, the parties shall determine the services to be performed and

the additional fees to be charged for such services. In conjunction therewith, the parties may amend Exhibit A and Exhibit B to reflect such additional services and fees.

3. **Fees; Benefit Payments; Deposit**.

3.1 Services Fees. Plan Sponsor shall pay to BCBSKC the Services Fees, as set forth in Exhibit B, as compensation for providing the Services under this Agreement. Unless otherwise specifically stated, Plan Sponsor agrees to pay the Services Fees on the first day of each month. The Services Fees are described in detail as follows:

A. **Administrative Fee.** The amount of money to be paid by Plan Sponsor to BCBSKC for certain services under this Agreement, including but not limited to such services as claims processing and investigation, production and distribution of member identification cards, and other general services. Administrative Fees shall equal the amounts set forth in the Administrative Fees section of Exhibit B for each coverage class and product type combination, multiplied by the number of such coverage class and product type combinations in effect as of the first day of such month. This Administrative Fee may include all BlueCard Program-related fees except for fees for provider directories and the BlueCard Program access fees (where applicable), as described below. If the BlueCard Program access fee is included in the Administrative Fee, then any BlueCard Program access fees charged do not exceed $2,000 for any claim. This fee also includes any fees related to the processing of claims for Non-Participating Providers outside the Service Area.

B. **Access Fee.** A per covered employee, per month fee

This fee may also include the BlueCard Program access fee, which is an amount that may be charged separately each time a claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential BCBSKC receives from the Host Blue, based on the current rate in accordance with the BlueCard Program's standard procedures for establishing the access fee rate. The BlueCard Program access fee will not exceed $2,000 for any claim.

"Savings" are calculated by taking the total amount of providers' billed charges for covered services and subtracting the total of the benefits payable for claims incurred in that same period, after applying the applicable Discounts. Total benefits payable are the amounts paid by BCBSKC plus the deductible, coinsurance and copayments owed by the HMO Participant.

C. **Statutory Assessments**. Statutory Assessments are as described in more detail in Section 3.4 and are billed to Plan Sponsor when paid by BCBSKC (or MVLH, as applicable).

D. **Recoveries**. Recoveries are as described below and are set forth in more detail in Exhibit A:

i. Subrogation and Overpayments. A percentage of subrogation or overpayment amounts recovered, payable when such recoveries are made.

ii. Group Litigation Fee. A percentage of amounts recovered. Court costs, non-contingent attorneys' fees and other expenses incurred in respect of third-party litigation are not included in the Group Litigation Fee and will be deducted from any gross recovery and will be payable when such recoveries are made.

iii. Retroactive Terminations. A percentage of amounts recovered, payable when such retroactive termination recoveries are made.

E. **Runout Services Fees.** See Section 7.2 of this Agreement (applicable only during the Runout Period).

F. **COBRA** A percentage of COBRA premiums.

3.2 Changes in Services Fees. BCBSKC has the right to change the Services Fees after this Agreement has been in effect for one (1) year. BCBSKC will give Plan Sponsor written notice of any such change. The notice will state the amount of the new charges and the effective date of the change. The notice will be made no less than thirty (30) days before the effective date of the change. Notwithstanding the foregoing, BCBSKC has the right to change the Services Fees upon the occurrence of any of the following:

A. On the date a change is made in the Plan which materially increases BCBSKC's duties or obligations under this Agreement; or

B. On the date the number of employees covered by the HMO Plan has changed by ten percent (10%) or more since the date the then current charges were effective; or

C. On the date any change in law or regulations imposes greater duties or obligations on BCBSKC then contemplated by the Agreement in force at the time of such change.

3.3 Mindful by Blue KC. The Mindful by Blue KC initiative provides a set of tools and resources to promote whole person wellness, including a limited number of well-being resource visits and access to Mindful Advocates. The well-being resource visits help with major life events (divorce, adoption, loss), stress, financial issues, childcare, and other everyday challenges through lifestyle coaching. These visits are limited to 3 per issue for each BCBSKC member every calendar year. Well-being resource visits are not considered Covered Services and will not be billed (or paid) as claims. Mindful Advocates are licensed clinicians and social workers who match members to providers and guide care plans. They act as a single point of contact for listening, connecting, crisis management, benefits guidance, navigating care, and follow-up. Mindful initiatives include improved network access to providers trained in crisis support, employer education focused on mental health first aid, and resources to support behavioral health integration into our primary care provider practices.

3.4 Statutory Assessments. To the extent BCBSKC is required to pay any Statutory Assessments related to the HMO Plan, Plan Sponsor will pay BCBSKC an amount equal to the Statutory Assessments based upon BCBSKC's determination of such amounts. If Plan Sponsor elects to purchase Stop-Loss Insurance from MVLH, such Statutory Assessments may include any premium taxes payable by MVLH on premiums paid or payable by Plan Sponsor for such Stop-Loss Insurance. BCBSKC will (i) coordinate with MVLH, and (ii) collect such amounts on behalf of MVLH. Plan Sponsor shall pay such Statutory Assessments to BCBSKC in accordance with this Agreement. If BCBSKC determines, in its sole and reasonable discretion, that the payment of any Statutory Assessments was incorrect, resulting in an underpayment or overpayment by Plan Sponsor of the Statutory Assessments, then BCBSKC shall notify Plan Sponsor of the shortfall or excess, and: (a) Plan Sponsor shall promptly pay to BCBSKC such shortfall; or (b) BCBSKC shall reimburse Plan Sponsor for such excess (which may include, at BCBSKC's option, applying a credit to subsequent Plan Sponsor invoices), as applicable.

3.5 Benefit Payments. Plan Sponsor authorizes BCBSKC to pay HMO Plan benefits in accordance with the terms of the HMO Plan and this Agreement, after sufficient funds are provided by Plan Sponsor and in accordance with the following procedures. BCBSKC shall, on Tuesday of each week (unless Tuesday is a holiday recognized by BCBSKC, in which case it shall be the next business day), send via facsimile, secure electronic transmission, via standard postal service or other mutually-acceptable means of transmission to Plan Sponsor, a Weekly Claims Report which lists all claims processed during the preceding week; provided, that BCBSKC may choose to report pharmacy claims information on a monthly basis. For purposes of the report, the preceding week shall be defined as Wednesday through Tuesday. Following receipt of the facsimile, secure electronic transmission, mailed or otherwise transmitted Weekly Claims Report, Plan Sponsor shall have Plan funds transferred via debit authorization or via wire transfer to a bank account designated by BCBSKC so that claims payments may be released. The total amount of such funds transferred must equal or exceed the total amount of processed claims pending as reported on the Weekly Claims Report. BCBSKC shall not be required to bear any risk or responsibility for the funding of benefit payments.

3.6 Medical Value Payments. Plan Sponsor acknowledges that BCBSKC may have value-based payment arrangements with providers participating in certain health care delivery programs, including patient-centered medical homes, accountable care organizations or episode-based medical management. These providers are known as "Blue Distinction Total Care Program" providers. Pursuant to such health care delivery programs, Blue Distinction Total Care Program providers may be eligible for alternative payments, in lieu of or in addition to, traditional fee-for-service reimbursement, including but not limited to, withholds, bonuses, incentive payments, provider credits and member management fees (collectively, "Medical Value Payments"). The amount of Medical Value Payments Blue Distinction Total Care Program providers receive is specific to the Blue Distinction Total Care Program and/or provider and may or may not be directly related to Plan Sponsor, any HMO Participant, or any other group or individual. Plan Sponsor acknowledges that Medical Value Payments payable to any one or more Blue Distinction Total Care Program providers may: (a) be included in Paid Claims (provided, that Medical Value Payments will not accumulate toward any *specific* attachment points under Plan Sponsor's stop-loss policies if issued by MVLH); (b) may include compensation for services that are related to HMO Participants, including, but not limited to, coordination of care; and (c) may include compensation in recognition of Blue Distinction Total Care Program providers' achievement of stated performance objectives, including, but not limited to, quality of care, patient outcomes or cost.

Plan Sponsor acknowledges that the exchange of clinical and laboratory data between BCBSKC and Blue Distinction Total Care Program providers may occur in the course of administering Medical Value Payments and other value-based care programs. Such data may be used and retained to assist in the delivery of certain health care delivery programs, including patient-centered medical homes, accountable care organizations or episode-based medical management, by BCBSKC and Blue Distinction Total Care Program providers .

A. Outside of BCBSKC's Service Area. The provisions below apply to Blue Distinction Total Care Programs outside of BCBSKC's service area. When such amounts are billed in addition to the claim, they may be billed as follows:

i. Per Member Per Month (PMPM) Billings: PMPM billings for incentives/shared-savings settlements to accounts are outside of the claim system. BCBSKC will pass these charges from other Blue Cross and/or Blue Shield licensees

("Host Blues") through to Plan Sponsor as a separately identified Medical Value Payment amount on the group billings.

ii. Where Host Blues pass on the costs of Blue Distinction Total Care Programs to BCBSKC as PMPM amounts not attached to specific claims, BCBSKC will pass these amounts to Plan Sponsor in the same manner as Medical Value Payments inside BCBSKC's Service Area.

The amounts used by Host Blues to calculate either the supplemental factors or PMPM billings may be estimates. This means that Host Blues cannot determine final amounts for these arrangements at the time when Employees incur claims for covered services. Consequently, Host Blues may hold some portion of the amounts Plan Sponsor pays under such arrangements until the end of the applicable Blue Distinction Total Care Program payment and/or reconciliation measurement period.

B. Reconciliation. At the end of the Blue Distinction Total Care Program payment and/or reconciliation measurement period for these arrangements, Host Blues may take one of the following actions:

i. Use any surplus in funds to fund Blue Distinction Total Care Program payments or reconciliation amounts in the next measurement period.

ii. Address any deficit in funds through an adjustment to the per-member-per-month billing amount or the reconciliation billing amount for the next measurement period.

The measurement period for determining these surpluses or deficits may differ from the term of this Agreement. Such surpluses or deficits may eventually be exhausted through prospective adjustment to the settlement billings in the case of Blue Distinction Total Care Programs. *Some Host Blues may retain interest earned as part of their negotiated compensation with their providers, if any, on funds held that are associated with these Programs.*

C. Care Coordinator Fees. For certain Blue Distinction Total Care Programs, Host Blues may also bill BCBSKC for Care Coordinator Fees which BCBSKC will pass on to Plan Sponsor. Based on the methods that Host Blues use to pass these fees on to BCBSKC, BCBSKC bills Plan Sponsor via:

i. PMPM billings passed through to Plan Sponsor as a separately identified Medical Value Payment amount on the group billings; or

ii. 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 US Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, BCBSKC and Plan Sponsor will not impose employees cost sharing for Care Coordinator Fees Employees .

3.7 Deposit

A. Advance Deposit. Upon the execution of this Agreement, Plan Sponsor shall pay BCBSKC an advance deposit if requested by BCBSKC. The amount of such deposit, if any, is set forth in Exhibit B. The funds will be used to establish a HMO Plan reserve to facilitate prompt payment of HMO Plan benefits, expenses and fees. The Plan Sponsor authorizes BCBSKC to pay HMO Plan benefits, expenses and fees on an account maintained by BCBSKC. BCBSKC shall account for all receipts and disbursements to and from Plan Sponsor's reserve. The initial deposit amount shall be maintained at all times. Plan Sponsor shall forward additional funds as necessary to maintain the minimum deposit and to cover payment of HMO Plan benefits, expenses and fees. Plan Sponsor shall make such payments within 10 days after written notice from BCBSKC that additional funds are required. Funds will be transferred via debit authorization or via wire transfer.

B. Subsequent Deposit. If BCBSKC did not request an advance deposit under paragraph A. above, BCBSKC may subsequently request a deposit from Plan Sponsor and Plan Sponsor shall promptly pay to BCBSKC the requested deposit; provided, that the deposit shall not be required to exceed the sum of: (i) an estimated one (1) month of Paid Claims; plus (ii) an estimated two (2) months of Services Fees.

C. Restoration of Deposit. Plan Sponsor agrees to pay BCBSKC within 10 calendar days of receipt of the notification ("due date") of the amount necessary to restore to its full amount the deposit as stated in either paragraph A. or B. above. Failure of Plan Sponsor to restore the deposit in such time may cause termination of this Agreement. Such terminations shall be effective on the due date of the restoration of the deposit.

3.8 Failure to Pay. If BCBSKC fails to receive payment: (a) for Paid Claims by 11:59pm Kansas City time on Friday of the week that the Plan Sponsor receives the Weekly Claims Report; or (b) for any Services Fees or other amounts as required under this Agreement within five (5) calendar days of the due date of such payment, then in addition to any other remedies available to BCBSKC in this Agreement or otherwise, BCBSKC may: (a) apply any deposit to any outstanding amount due; (b) stop processing HMO Participants' claims; (c) deny or pend HMO Participants' claims; (d) assess a late payment fee as set forth in Exhibit B; and (e) terminate this Agreement.

4. **Term and Termination.**

4.1 Term. This Agreement shall be effective as of the Effective Date stated herein and shall continue in force for a period of one year (the "Initial Term"). It shall be automatically renewed for successive one-year periods (each a "Renewal Term") unless terminated in accordance with the provisions of this Agreement. BCBSKC will determine the Services Fees for each Renewal Term.

4.2 Termination.

A. Without Cause. Either party may terminate this Agreement without cause by giving the other party thirty (30) days' written notice of its intent to terminate this Agreement upon the expiration of the Initial Term or any Renewal Term, as applicable.

B. With Cause. Either party may terminate this Agreement for cause upon written notice if the other party materially defaults in the performance of a provision of this Agreement and such default continues for a period of thirty (30) calendar days after written notice to the defaulting party from the aggrieved party stating the default (or such shorter time as set forth in this Agreement in the event of

Plan Sponsor's failure to pay amounts due hereunder). Further, BCBSKC may immediately terminate this Agreement upon the occurrence of any of the following:

i. Plan Sponsor amends the Plan without prior written acknowledgment of BCBSKC;

ii. The HMO Plan or the Plan of Benefits subject to this Agreement are terminated;

iii. Plan Sponsor becomes insolvent or bankrupt or subject to liquidation, receivership or conservatorship; or

iv. Upon written notice from either party of the enactment or interpretation of a law or regulation, or an action or investigation by any regulatory body, which would prohibit or adversely or materially affect this Agreement, the relationship between the parties, or the operations of either party with regard to this Agreement; provided, however, that the parties first shall attempt in good faith for a period of 30 calendar days to modify this Agreement so that this Agreement is not prohibited by law.

Plan Sponsor acknowledges that the performance by Plan Sponsor of the obligations set forth in this Agreement is essential for the adequate protection of BCBSKC . As further consideration for the Services provided by BCBSKC , Plan Sponsor agrees that in the event of a proceeding under Title 11 of the United States Bankruptcy Code commenced by or against Plan Sponsor, Plan Sponsor will not object to any motion by BCBSKC for relief from the automatic stay of 11 U.S.C. § 362(a).

5. **Plan Sponsor's Duties and Responsibilities**. Plan Sponsor shall have the following duties and obligations:

5.1 Plan Interpretation. Unless Plan Sponsor elects to have BCBSKC serve as Claims Fiduciary (as expressly set forth in Exhibit A), Plan Sponsor, as claims administrator, has the full, final, binding and exclusive discretion to interpret the terms of the HMO Plan as may be necessary in order to make claims determinations, and BCBSKC is not a Fiduciary.

5.2 Plan Operation. Plan Sponsor retains the final authority and responsibility for the HMO Plan and its operation. Plan Sponsor grants BCBSKC the authority to act on behalf of Plan Sponsor in connection with the HMO Plan, but only as expressly stated in this Agreement.

5.3 Eligibility.

A. Plan Sponsor is responsible for the determination of those persons who are eligible for benefits under the HMO Plan, and shall forward all enrollment material to BCBSKC on or prior to the date required by the HMO Plan. Such determination shall be made pursuant to the terms of the Plan Document. Plan Sponsor shall notify BCBSKC on a monthly basis of all changes in participation, including terminations, changes in classification, utilization of continuation options, or any other changes in eligibility.

B. Plan Sponsor shall notify BCBSKC and verify all changes in eligibility and enrollment involving HMO Participants, including but not limited to adding and terminating coverage for employees and dependents. In determining any person's right to benefits under the HMO Plan, BCBSKC

shall rely on eligibility information furnished by Plan Sponsor prior to submission of the claim. It is mutually understood that the effective performance of this Agreement by BCBSKC will require that it be advised by Plan Sponsor periodically, but not less frequently than monthly, during the term of this Agreement of the identity of individuals eligible for benefits under the HMO Plan, the effective date or termination date (as the case may be) of their eligibility and the extent of the benefits to which they are entitled. Plan Sponsor shall also cause to be furnished to BCBSKC such other information as may reasonably be required for the proper administration of the HMO Plan.

C. It is mutually agreed that BCBSKC shall not be responsible for delay in the performance of this Agreement or for the non-performance of this Agreement which delay or non-performance is caused or contributed to by the failure of Plan Sponsor to furnish any such information.

D. Notwithstanding the foregoing, BCBSKC shall not be required to adhere to Plan Sponsor's eligibility rules or determinations to the extent they would violate any applicable law, rule or regulation, including, without limitation, any regulations promulgated under PPACA.

5.4 Changes to Plan. Plan Sponsor shall provide BCBSKC all revisions or changes to the Plan at least thirty (30) days prior to the date any such revision or change is to become effective. All revisions or changes are subject to the approval of BCBSKC, because changes may affect the services provided by BCBSKC under this Agreement.

5.5 Provide Information. Plan Sponsor will furnish all information needed by BCBSKC to perform its duties under this Agreement, including but not limited to executed copies of the Plan Documents (including Trust Agreements) if requested by BCBSKC.

5.6 Forward Claims. In the event Plan Sponsor receives claims for benefits from HMO Participants, Plan Sponsor will forward all claims to BCBSKC within three days after receipt of the claims, so that the claims can be reviewed and processed in accordance with the Plan's claims procedure.

5.7 Payment. Plan Sponsor will promptly provide funds for payment of HMO Plan benefits and expenses as set forth in this Agreement and will promptly pay BCBSKC the compensation agreed upon in this Agreement.

5.8 Compliance with Laws. Plan Sponsor is responsible and liable for providing Plan benefits and operating the Plan in accordance with its terms and all applicable state or federal laws, including but not limited to, CAA, TCR, MHPAEA, ERISA, PPACA and HIPAA. Plan Sponsor is the Plan Administrator and is responsible for complying with the various requirements of ERISA, HIPAA, CAA, MHPAEA and any other applicable laws. Plan Sponsor is responsible for any required non-discrimination testing.

5.9 Reimburse Printing Costs. Plan Sponsor will reimburse BCBSKC for the expense of any printed materials prepared for the Plan except for expenses specifically assumed by BCBSKC in this Agreement.

5.10 BCBSKC Approval. Plan Sponsor will secure BCBSKC approval of all documents provided to HMO Participants after the execution date of this Agreement which describe arrangements with HMO Providers or that can be expected to substantially affect when claims are filed.

5.11 Confidentiality. Plan Sponsor acknowledges and agrees that all details regarding the HMO Provider network including but not limited to the identity of health care providers, health care provider fee

schedules and Discounts, and the provisions, terms and conditions of agreements and contracts with health care providers are proprietary and Confidential Information of BCBSKC and may not be utilized by Plan Sponsor, its affiliates, or any of its or their employees, officers, directors, trustees, owners, agents or representatives to directly or indirectly either establish its own preferred provider or HMO network or solicit or contract or negotiate preferred provider or HMO agreements or arrangements, or Discounts with any health care provider who participates or has participated in the HMO Provider network at any time during the term of this Agreement. Plan Sponsor shall limit its use or disclosure of BCBSKC's Confidential Information consistent with Section 11 of this Agreement and the Business Associate Agreement attached hereto as Exhibit D and shall return or destroy all Confidential Information of BCBSKC upon termination of this Agreement. After termination of this Agreement, the provisions of this paragraph shall not prohibit Plan Sponsor from contracting with a preferred health provider or HMO network sponsored by any other entity.

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.

5.12 Transparency. Nothing in this Agreement shall directly or indirectly restrict the parties from (1) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the Plan Sponsor, Plan Participants, or individuals eligible to become Plan Participants; (2) electronically accessing deidentified claims and encounter information or data for each Plan Participant, upon request and consistent with the privacy regulations promulgated pursuant to HIPAA, the amendments made by the Genetic Information and Nondiscrimination Act of 2008 ("GINA"), and the Americans with Disabilities Act of 1990 ("ADA"); or (3) sharing information or data described in items (1) or (2) above, or directing that such data be shared, with a Business Associate, consistent with the privacy regulations promulgated pursuant to section 264(C) of HIPAA, the amendments made by GINA, and the ADA. The confidentiality provisions of this Agreement shall apply to the fullest extent allowed by law and in a manner consistent with the Consolidated Appropriations Act of 2021.

5.13 Amendment or Termination. Plan Sponsor shall make all decisions regarding amendment or termination of the Plan.

5.14 Participant Communications. Plan Sponsor shall be responsible for communicating to Plan Participants all information required by ERISA and other applicable law, whether requested by HMO Participants or otherwise, concerning the Plan, including, without limitation, Summary Plan Descriptions, Summaries of Material Modifications, notices of material benefit reductions and Summary Annual Reports.

5.15 Government Reporting. Plan Sponsor shall be responsible for making and filing all Form 5500 reports and any other returns and reports concerning the Plan required by ERISA, the Internal Revenue Code and any other applicable law.

5.16 Summary of Benefits and Coverage. Plan Sponsor will:

A. Promptly provide to BCBSKC the information necessary to complete the Summary of Benefits and Coverage ("SBC");

B. Distribute the SBC to HMO Participants as required under PPACA.

C. Provide confirmation to BCBSKC of distribution of the SBC as required under PPACA upon request;

D. Ensure that electronic access shall be restricted to a "read-only" or similar basis; and

E. Replace any hard-copy SBC that is modified by BCBSKC.

The hard-copy SBC on file with BCBSKC shall control in the event of any discrepancy. Plan Sponsor remains solely responsible for the content of the SBC and all other legal requirements related to the SBC. To the extent that BCBSKC incurs any liability as a result of the preparation or distribution of the SBCs to HMO Participants, Plan Sponsor shall fully indemnify BCBSKC. Plan Sponsor's failure to provide information in a timely manner may substantially delay and/or jeopardize the timely delivery of the SBC.

5.18 COBRA. Plan Sponsor will:

A. Complete a COBRA initial notification form (which shall be provided by BCBSKC) within ninety (90) days of any new employee's date of hire and within thirty (30) days of a qualifying event;

B. Determine the amount of contributions required for COBRA continuation coverage and notify BCBSKC of such amount;

C. Inform BCBSKC of continuation rights, by use of the COBRA notification form or other electronic means upon the occurrence of a qualifying event; and

D. Notify BCBSKC upon receipt of notification of any second qualifying event.

For purposes of this Section, references to BCBSKC shall mean either BCBSKC or, if applicable, its contracted COBRA Administrator.

6. BCBSKC's Duties and Responsibilities; Limitations.

6.1 Performance of Services. BCBSKC will use reasonable care and diligence in the exercise of its powers in the performance of its duties under this Agreement. BCBSKC will not be liable for any mistake of judgment or other actions made in good faith with reasonable care and diligence. Clerical errors or normal variations in claim processing made without intent to defraud and absent willful misconduct are recognized in this Agreement as possible. When such errors or variations are made and discovered, they will be corrected, adjusted and otherwise made right to the extent such is both possible and recoverable. Where not adjustable, such errors will be treated as an expense of the Plan. Plan Sponsor and BCBSKC will make a diligent effort to recover any incorrect excess payment made. BCBSKC is not required to institute any court proceedings. EXCEPT AS EXPRESSLY SET FORTH HEREIN, BCBSKC MAKES NO OTHER WARRANTIES, EXPRESS OR IMPLIED, AS TO THE SERVICES OR ITS OBLIGATIONS UNDER THIS AGREEMENT, INCLUDING, WITHOUT LIMITATION, ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

6.2 Provider Relationships. BCBSKC has entered into contracts with health care providers to develop provider networks to serve HMO Participants. These contractual relationships are not intended to interfere with or influence the exercise of a provider's independent medical judgment. Participating

Providers may contract with BCBSKC under many different types of financial arrangements, which include, but are not limited to: discounted fee-for-service payments; fixed monthly payments for each member ("capitation"); on a per day basis ("per diem"); and fixed fees for each case ("case rate"). Some providers may be compensated by a physician-hospital organization (PHO), or a similar provider organization that is compensated by BCBSKC on a capitated or other basis. Certain HMO Providers may also be eligible to receive additional payments for effectively managing their patients' care. These payments may be in the form of financial incentives for those providers who meet specific standards for the quality of care they provide. The categories of criteria used to evaluate providers for these incentives may include, without limitation, quality of care, patient access, utilization protocols, pharmacy prescriptions and office administration. Examples of specific criteria used to evaluate providers may include, but are not limited to: immunization and preventive screening services; patient satisfaction; availability for appointments; cost effective utilization of specialists, hospitals, or other services; and, use of electronic claims submission. BCBSKC expressly reserves the right to modify, suspend, or terminate, at any time, provider incentive plan. Nothing in any provider incentive plan is intended to limit the provider's obligation to provide medically necessary services to HMO Participants.

6.3 Not a Plan Sponsor/Administrator. BCBSKC is not a plan sponsor or plan administrator with respect to the Plan, nor is BCBSKC a trustee of any assets associated with the Plan.

6.4 Not a Fiduciary. Except to the limited extent that BCBSKC is serving as a limited, Claims Fiduciary of the HMO Plan, if applicable, BCBSKC is not a Fiduciary of the Plan, does not have discretionary authority or control over the management of the Plan, and shall not exercise discretion or control with respect to the management or disposition of plan funds.

6.5 Claims Payments. BCBSKC shall not be liable for the payment of claims under the Plan. BCBSKC does not guarantee payment of any benefits due under the Plan. Plan Sponsor shall have full responsibility and liability for payment of claims in accordance with the provisions of the Plan.

6.6 Plan Compliance With Laws. BCBSKC is not responsible for qualification or compliance of the Plan with ERISA, the Internal Revenue Code, or any other applicable federal, state or local law, rule or regulation.

6.7 Payment of Plan Expenses. BCBSKC is not responsible for payment of any expense of the Plan, including, but not limited to, attorneys', accountants' and other persons' fees that provide services to the Plan.

7. **Runout**.

7.1 Runout Claims and Services. Notwithstanding the termination of this Agreement, and upon termination of this Agreement, except in the event of Plan Sponsor's material breach of this Agreement (including non-payment), BCBSKC shall provide Runout Services for Runout Claims.

7.2 Runout Services Fee and Claims Obligation. Payments for Runout Claims and the Runout Services Fee are due and payable by Plan Sponsor during the Runout Period in the same manner as set forth in Section 3 regarding payment for Paid Claims and Services Fees. If Plan Sponsor has purchased Stop-Loss Insurance for the Runout Period from MVLH, BCBSKC may coordinate with MVLH in the manner provided in Section 3.

7.3 Statutory Assessments for Runout Claims and/or Runout Services. To the extent that any Statutory Assessments apply to Plan Sponsor's payment obligations under this section, as determined by BCBSKC in its sole and reasonable discretion, then the payment of such Statutory Assessments shall be administered in the manner set forth in Section 3.

8. **Inter-Plan Arrangements**. Plan Sponsor acknowledges that Exhibit C specifies additional/alternative provisions that apply to Plan Sponsor with respect to claims that are processed under the BlueCard Program. Plan Sponsor further acknowledges that BCBSKC is required by the BCBSA to disseminate to Plan Sponsor BlueCard disclosure language, which BlueCard disclosure language is included in Exhibit C. Plan Sponsor hereby further agrees to include any BlueCard language that is required to be included in Plan Sponsor's Summary Plan Description ("SPD") delivered to HMO Participants, in its entirety, so that HMO Participants are made aware of the additional/alternative provisions that apply to them with respect to claims that are processed under the BlueCard Program.

9. **Audit Rights**. During the term of this Agreement, -Plan Sponsor may, without charge by BCBSKC, perform an audit once during the calendar year while this Agreement is in effect and once within the two- (2-) year period following termination of this Agreement for the sole purpose of auditing BCBSKC's performance of certain of its obligations under this Agreement. To the extent an audit occurs, BCBSKC agrees only to the following two audit methodologies:

A. Testing up to a statistically valid random sample, based upon a 95% confidence level (plus or minus 3% precision) and 97% expected performance; or

B. Testing a targeted sample, up to a number of sample items equivalent to that which would result from the above random sample approach.

Whether the audit is performed during the term of the Agreement or following termination and regardless of the methodology used, referenced in A and B above, such samples may only include those claims that were processed by BCBSKC no more than six months prior to the date the sample was selected. For example, if a sample is drawn on June 30 of a given year, it could only include claims processed between June 30 and January 1 of the same year. Plan Sponsor may engage a third party to perform any or all of the audit on its behalf upon BCBSKC's prior written consent, not to be unreasonably withheld. Any such third party may not be reimbursed by Plan Sponsor on a contingency or other method based on identification or value of errors. If Plan Sponsor engages a third party to perform all or any part of an audit, such third party shall, upon BCBSKC's request (and Plan Sponsor shall cause such third party to), enter into a confidentiality and non-disclosure agreement with BCBSKC prior to, and as a condition of, conducting any function of the audit. Plan Sponsor shall provide BCBSKC with at least thirty (30) business days' notice of its desire to conduct an audit, and the parties (including the third party engaged by Plan Sponsor, as applicable) shall execute a Records Audit Agreement, which will set forth in detail the terms and conditions of the audit. Notwithstanding anything to the contrary in this Agreement or the Records Audit Agreement, in no event will provider reimbursement or other proprietary information under the control of BCBSKC be subject to audit unless BCBSKC, in its sole discretion, permits access to such information.

10. **Indemnification; Limitation of Liability**.

10.1 Indemnification by Plan Sponsor. Plan Sponsor hereby agrees to indemnify and hold harmless BCBSKC and its officers, directors, employees, affiliates, agents and representatives (collectively

the "BCBSKC Indemnitees") from and against any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, expenses and taxes, including but not limited to, reasonable attorneys' fees and court costs (collectively, "Damages") resulting from or arising directly or indirectly out of, or in connection with, any governmental agency or third party (including HMO Participants) claim relating to this Agreement, the Plan or the Plan of Benefits, including, without limitation, arising out of any tax or similar assessment (federal or state) which: (a) BCSBKC Indemnitees may incur with respect to Plan benefits which are the obligation and liability of Plan Sponsor; or (b) would have been levied on any charges or fees payable by Plan Sponsor to BCBSKC Indemnitees under this Agreement; provided, that the foregoing shall not apply: (i) to BCBSKC's attorney fees and court costs incurred in defending a claim for benefit denial if BCBSKC is serving as Claims Fiduciary (as expressly set forth in this Agreement); or (ii) to the extent that Damages result from the reckless, fraudulent, or criminal acts of BCBSKC.

In addition, Plan Sponsor acknowledges and agrees that BCBSKC must rely on oral and/or written representations of Plan Sponsor's officers, directors, trustees, owners, employees, HMO Participants, Plan fiduciaries, and agents, insurers, and other service providers of the Plan and Plan Participants, and that BCBSKC has no duty to verify or independently audit such information. Plan Sponsor Parties agree to indemnify and hold harmless BCBSKC Indemnitees from and against any loss or damage to the Plan, Plan Sponsor or BCBSKC due to its good faith reliance on any such representations.

10.2 Indemnification by BCBSKC. BCBSKC hereby agrees to indemnify and hold harmless Plan Sponsor and its officers, directors, employees, affiliates, agents and representatives from and against Damages resulting from or arising out of any third-party claim relating to the reckless, fraudulent or criminal acts of BCBSKC.

10.3 Limitation of Liability. Neither party to this Agreement shall be liable to the other party for any consequential (including lost profits), punitive, special or exemplary damages that result from any breach of this Agreement or any party's performance under this Agreement. Further, in no event will a party's liability to the other party under this Agreement exceed an amount that is two (2) times the amount of Services Fees paid by Plan Sponsor to BCBSKC during the twelve (12) months preceding the date of the event giving rise to the Damages. Notwithstanding the foregoing, the limitation on Damages contained in this Section does not apply to (i) claims by either Plan Sponsor or BCBSKC for indemnification under this Section 10 which result from claims brought by third parties, or (ii) claims related to or arising from a breach of the Business Associate Agreement attached hereto as Exhibit D.

11. **Confidentiality; HIPAA**. The parties agree that each will keep the other party's Confidential Information confidential and will only use the disclosing party's Confidential Information for purposes contemplated under this Agreement; provided, however, that BCBSKC may use Plan Sponsor's Confidential Information in the ordinary course of its business as long as it maintains the confidentiality of such information. Neither party will use the Confidential Information in any manner, other than as provided in this Agreement. Confidential Information disclosed pursuant to this Agreement is and shall remain the disclosing party's property. If, in the opinion of counsel for the receiving party, disclosure of Confidential Information is required by any federal or state law, rule, regulation or court order, the receiving party may only make such disclosure after notifying the disclosing party (if allowed by law) of the receiving party's intention to disclose the Confidential Information prior to making such disclosure. The terms of this Section shall survive the termination of this Agreement.

Additionally, because BCBSKC is a Business Associate (as such term is defined in HIPAA) of the Plan Sponsor pursuant to this Agreement, the Business Associate Agreement attached hereto as Exhibit D is incorporated herein and made a part hereof.

12. **General.**

12.1 Relationship Between Parties. The parties hereto are independent contractors and are not, and shall not be deemed for any purpose, to be joint venturers. No party shall hold itself out as the partner or agent of the other party or make representations or warranties on behalf of the other party, except as otherwise expressly agreed. BCBSKC shall not be designated nor deemed the Plan Administrator with respect to the Plan for purposes of ERISA or any other federal or state law of similar nature. Plan Sponsor, on behalf of itself and its HMO Participants, hereby expressly acknowledges its understanding that this constitutes an agreement solely between Plan Sponsor and Blue Cross Blue Shield of Kansas City, that Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement with BCBSA permitting Blue Cross and Blue Shield of Kansas City to use the Blue Cross and Blue Shield service marks in a portion of the States of Missouri and Kansas, and that Blue Cross and Blue Shield of Kansas City is not contracting as the agent of BCBSA. Plan Sponsor further acknowledges that it has not entered into this Agreement based upon representations by any person other than Blue Cross and Blue Shield of Kansas City and that any person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall not be held accountable or liable to Plan Sponsor for any of Blue Cross and Blue Shield of Kansas City's obligations to Plan Sponsor created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas City other than those obligations created under other provisions of this Agreement.

12.2 Severability. If any part, term or provision of this Agreement is held by a court of competent jurisdiction to be illegal or unenforceable, validity of the remaining provisions of this Agreement shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this Agreement did not contain the particular part, term or provision held to be invalid. It is provided, however, that the basic purposes of this Agreement must be achieved through the remaining valid provisions.

12.3 Trademarks and Symbols. Plan Sponsor and BCBSKC reserve the right to control the use of their respective names and any of their respective symbols, trademarks and service marks, presently existing or subsequently established. Plan Sponsor and BCBSKC agree not to use words, symbols, trademarks, service marks and other devices including the corporate name of the other in advertising, promotional materials or otherwise, without the prior written consent of the other. Plan Sponsor and BCBSKC will cease any previously approved usage immediately upon termination of the Agreement. Plan Sponsor and BCBSKC further agree that any advertising, promotional materials or other items which include the name of Plan Sponsor or BCBSKC are the property of the appropriate namesake and will be returned to the owner either upon request or at termination of this Agreement.

12.4 Waiver. Failure by Plan Sponsor, BCBSKC or both to insist upon compliance with any term or provision of this Agreement at any time or under any set of circumstances will not operate to waive or modify that provision or render it unenforceable at any other time whether the circumstances are or are not the same. No waiver of any of the terms or provisions of this Agreement will be valid or of any force or effect unless in each instance the waiver or modification is contained in a written memorandum expressing such alteration or modification and executed by Plan Sponsor and BCBSKC.

12.5 Assignment. BCBSKC shall have the right to assign or delegate its duties and obligations under this Agreement to its affiliated companies. Any other assignment of this Agreement or, of any rights contained in this Agreement, by either party, will be void and of no force or effect, unless agreed upon in writing by the parties.

12.6 Complete Agreement. This Agreement and any attachments, Exhibits, schedules and addenda to it, constitute the entire Agreement between the parties. The representations, warranties, covenants, and agreements set forth herein constitute all the representations, warranties, covenants, and agreements between the parties and upon which the parties have relied. All prior agreements, either oral or written, relating to the subject matter of this Agreement, not expressly set forth herein, are of no force or effect.

12.7 Amendment. This Agreement may be amended at any time by written agreement between Plan Sponsor and BCBSKC. In addition, BCBSKC may amend this Agreement if BCBSKC's performance of the Services under this Agreement would violate any law, rule or regulation.

12.8 Notices. All notices required to be given hereunder shall be made in writing and shall be deemed sufficiently given if delivered or mailed by first class registered or certified mail.

12.9 Governing Law. This Agreement shall be governed by and construed and interpreted in accordance with the laws of the State of Missouri, except to the extent preempted by ERISA or other applicable federal law.

12.10 Survival. All terms and provisions of this Agreement that are, by their nature, intended to be observed and performed after the termination hereof, including, without limitation, the provisions of Section 7, shall survive such termination and continue in full force and effect.

12.11 Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Agreement.

12.12 Force Majeure. Except for Plan Sponsor's payment obligations and the obligations contained in Section 11 of this Agreement, neither Plan Sponsor nor BCBSKC shall be liable or responsible to the other for any delay or failure to perform any of its obligations under this Agreement due to events of force majeure, including, without limitation, acts of God or of the public enemy, riots, acts of terrorism, wars or hostilities, fires, floods, storms, earthquakes, epidemics, or any other causes beyond the reasonable control of the party claiming the event of force majeure. If a force majeure event occurs, the party claiming the force majeure shall promptly give notice thereof to the other party (stating with reasonable particularity the event of force majeure claimed) and use its commercially reasonable efforts to perform its obligations under this Agreement despite the force majeure event. Further, the party receiving notice of such force majeure event shall cooperate with the other party to permit such efforts.

IN WITNESS WHEREOF, the parties hereby execute this Agreement effective as of the Effective Date.

BLUE CROSS AND BLUE SHIELD OF KANSAS CITY (BCBSKC)

By: Eric Whitten
Eric Whitten (Jan 7, 2025 15:09 CST)

Name: Eric Whitten

Title: Underwriting Team Lead

Jackson County - (PLAN SPONSOR)

By: ____________________

Name: Frank White, Jr

Title: County Executive

Exhibits to this Agreement:

- Exhibit A – Services
- Exhibit B – Fees / Deposit
- Exhibit C – InterPlan Arrangements
- Exhibit D – Business Associate Agreement

APPROVED AS TO FORM

____
County Counselor

ATTEST:

____
Clerk of the County Legislature

Exhibit A
Services

Optional Services/Provisions

Service	Selected?
Subrogation (not available if third-party stop-loss insurance)	Yes
Wellness (A Healthier You™)	Yes
MVLH Stop-Loss Insurance	No
BCBSKC as Claims Fiduciary	Yes
2nd Level Appeal (Mandatory or Voluntary)	Voluntary
Alight	No
COBRA Billing	No
Retiree Health Billing	No
Health Reimbursement Arrangement	No
TCR/CAA Price Comparison Tool (Available for non-carveout benefits)	Yes
TCR-mandated Files (Available for non-carve-out benefits)	Yes

1. **Claims Administration.**

1.1 Claims Processing. BCBSKC will review and process claims for benefits submitted by HMO Participants, in accordance with the terms of the HMO Plan and BCBSKC's established claims rules and procedures (including utilization review requirements) which may change from time to time. If the terms of the HMO Plan conflict with BCBSKC's established claims rules and procedures, BCBSKC's established claims rules and procedures (including utilization review requirements) shall control. Such review and processing shall include confirming the eligibility of such persons for benefits; determining if charges are in accordance with the data and guidelines used by BCBSKC as part of its established rules and procedures; determining the amount due and payable under the HMO Plan; and, providing explanations of benefits to participants. Claims shall be processed within a reasonable period of time after receipt of all necessary information.

1.2 Claims Investigation. BCBSKC will communicate with health care providers when necessary to investigate claims.

1.3 Claims Payments. BCBSKC will make disbursements to HMO Participants or their health care providers for covered benefits due under the terms of the HMO Plan and in accordance with the terms of this Agreement. Such disbursements shall be on behalf of Plan Sponsor or the trustee of the plan trust, if applicable, from funds provided by Plan Sponsor.

1.4 Denials. BCBSKC will notify HMO Participants in writing if a claim for benefits is denied, in whole or in part, and the reason for the denial.

1.5 Claims Fiduciary. In the event Plan Sponsor elects to have BCBSKC serve as claims fiduciary (as indicated above), Plan Sponsor delegates to BCBSKC discretionary authority to construe, interpret, and apply the Plan of Benefits for purposes of processing claims and appeals which are not related to pharmacy benefits. BCBSKC, as claims fiduciary, has the full, final, binding and exclusive discretion to interpret and apply the terms of the Plan of Benefits as may be necessary in order to process claims and make determinations on appeal of claims. BCBSKC, as claims fiduciary, is acting as an independent contractor. BCBSKC is a limited, claims fiduciary with respect to its exercise of discretionary authority. BCBSKC shall determine the extent of the benefits (if any) to which any HMO Participant is entitled under the Plan of Benefits. In doing so, BCBSKC will rely on the Plan and will rely on eligibility data provided by Plan Sponsor. BCBSKC shall have no liability for alleged or actual misinterpretations of the Plan of Benefits. Decisions by BCBSKC shall be complete, final, and binding on all parties. If Plan Sponsor elects to have BCBSKC serve as claims fiduciary but also elects to offer benefits under the Plan of Benefits that are inconsistent with applicable law, Plan Sponsor shall retain claims fiduciary status with respect to those benefits. If Plan Sponsor does not elect to have BCBSKC serve as claims fiduciary, then the foregoing shall not apply.

1.6 Processing Order. Claims will be processed in the order received by BCBSKC and will not be reprocessed due to out of sequence dates of services. Claims will be processed in the timeframes set forth in the Plan of Benefits without regard to Stop-Loss Insurance.

1.7 Appeals.

A. First-Level Appeals. First-level appeals will be required, and BCBSKC will process all first-level appeals.

i. If Plan Sponsor elects to have BCBSKC serve as claims fiduciary, then BCBSKC will determine whether benefits are payable in accordance with the Plan of Benefits for first-level appealed claims.

ii. If Plan Sponsor does not elect to have BCBSKC serve as claims fiduciary, then BCBSKC will make a recommendation to Plan Sponsor or its designee as to whether benefits are payable under the Plan of Benefits. Plan Sponsor shall promptly communicate its decision to BCBSKC, and BCBSKC shall finalize the appeal administration process, including notifying the member of such determination. If Plan Sponsor or its designee decides benefits for the first-level appealed claim are payable under the terms of the HMO Plan, BCBSKC shall make disbursements as instructed by and on behalf of Plan Sponsor.

B. Second-Level Appeals. Plan Sponsor shall determine (as set forth above) whether second-level appeals will be mandatory or at the member's option.

i. If Plan Sponsor elects to have BCBSKC serve as claims fiduciary, then BCBSKC will determine whether benefits are payable in accordance with the Plan of Benefits for second-level appealed claims.

ii. If Plan Sponsor does not elect to have BCBSKC serve as claims fiduciary, then BCBSKC will not process second-level appeals. Rather, BCBSKC will notify Plan Sponsor, or the party specified by Plan Sponsor, if a HMO Participant requests a second-level appeal in accordance with the HMO Plan's appeal procedures. If Plan Sponsor or

appropriate party decides benefits for the second-level appealed claims are payable under the terms of the HMO Plan, BCBSKC shall make disbursements as instructed by and on behalf of Plan Sponsor.

C. External Review. Where required by the Plan of Benefits or applicable law, BCBSKC will engage an independent external review organization and will bear the costs of such independent external review.

1.8 Stop-Loss Insurance.

A. If Purchased from MVLH. If Plan Sponsor purchases Stop-Loss Insurance from Missouri Valley Life and Health Insurance Company ("MVLH"), then the following shall apply:

i. Premiums. BCBSKC shall collect from Plan Sponsor the Stop-Loss Insurance premiums payable to MVLH, and shall pay such premiums to MVLH.

ii. Claims Billing and Payment. BCBSKC will bill Plan Sponsor up to any applicable specific, aggregating specific, and/or aggregate attachment points (in accordance with the terms of the Agreement). For claims that exceed specific, aggregating specific, and/or aggregate stop-loss attachment points, BCBSKC will not bill Plan Sponsor for such amounts. Rather, BCBSKC will coordinate with MVLH to submit claims for amounts covered by such stop-loss policy and will receive payment of such stop-loss claims directly from MVLH.

iii. Reporting. BCBSKC will provide Plan Sponsor with monthly reports regarding specific, aggregating specific, and/or aggregate stop loss made to MVLH.

B. If Purchased from Another Carrier. If Plan Sponsor purchases Stop-Loss Insurance from another carrier, then BCBSKC will reasonably coordinate with such stop-loss carrier to assist Plan Sponsor in ensuring proper administration of such stop-loss policy. BCBSKC will not collect Statutory Assessments, including premium taxes on behalf of another carrier. Such assistance will consist of sending data as is needed for such stop-loss carrier to determine coverage under the policy. The fee payable by Plan Sponsor for such service is set forth in Exhibit B.

1.9 Coordination of Benefits. BCBSKC will administer the coordination of benefits provisions of the HMO Plan. BCBSKC, may, without consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information which is necessary for the purpose of coordinating HMO Plan benefits.

1.10 Recoveries

A. Subrogation and Overpayments. If BCBSKC becomes aware of a subrogation, reimbursement or workers' compensation claim or an overpayment that may arise from anti-fraud and abuse audits, pre- or post-pay provider/hospital audits, utilization review refunds, or other means (hereinafter collectively referred to as "subrogation"), BCBSKC shall use its standard processes and procedures to attempt to recover the subrogation claim. BCBSKC shall charge an additional fee based on a percentage of the subrogation amount recovered (hereinafter the "Subrogation Fee"). The Subrogation Fee is listed on Exhibit B and is in addition to any other fee described herein. BCBSKC, in its sole discretion, shall settle and resolve all such

claims on any basis it determines as reasonable, including collection of less than the entire amount of such claim and contributions to the HMO Participant's attorneys' fees. Notwithstanding the foregoing, BCBSKC is not required to initiate court proceedings to comply with this section. However, if Plan Sponsor believes that litigation is necessary to recover a subrogation, reimbursement or workers' compensation claim or overpayment, Plan Sponsor will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees.

B. Third Party Liability. Plan Sponsor and BCBSKC recognize that BCBSKC or Plan Sponsor may receive notice of a pending class action (for which BCBSKC may, in its sole discretion, join the class or elect to opt out on its own behalf, or on behalf of Plan Sponsor, or both, to attempt to maximize recovery of funds), mass tort or other type of litigation that seeks recovery of funds based on third party liability (hereinafter collectively referred to as a "Group Litigation"). BCBSKC has no duty or obligation to notify Plan Sponsor (or the Plan) of BCBSKC's receipt of any notice of such Group Litigation. BCBSKC has no duty or obligation to participate in such Group Litigation on behalf of Plan Sponsor (or the Plan). However, BCBSKC may, in its sole discretion, elect to participate in such Group Litigation, on its own behalf, or on behalf of Plan Sponsor, or both, in order to obtain recovery of funds. In the event BCBSKC decides to participate in such Group Litigation on behalf of Plan Sponsor, BCBSKC is authorized by Plan Sponsor to recover claims expenses or other amounts on Plan Sponsor's behalf, either during or subsequent to the term of this Agreement, that relate to claims incurred and paid during the term of this Agreement. BCBSKC, in its sole discretion, may settle and resolve such Group Litigation claims on its own behalf, or on behalf of Plan Sponsor, or both, on any basis it determines as reasonable, including collection of less than the entire amount of such claim. BCBSKC shall charge an additional fee for participation in such Group Litigation based on a percentage of the amount recovered (hereinafter the "Group Litigation Fee"). The Group Litigation Fee does not include court costs, non-contingent attorneys' fees and expenses charged by outside counsel in pursuit of these cases. BCBSKC and Plan Sponsor agree and acknowledge that court costs, non-contingent attorneys' fees and expenses and the Group Litigation Fee will be deducted from the gross recovery obtained by BCBSKC. The Group Litigation Fee is listed on Exhibit B and is in addition to any other fees described herein.

Either during or subsequent to the term of this Agreement, with regard to claims incurred and paid during the term of this Agreement, BCBSKC is authorized to represent the interests of Plan Sponsor in litigation or settlement discussions undertaken by BCBSKC to protect BCBSKC's own interests, including in instances in which Plan Sponsor and BCBSKC may both have or allege claims against a third party or parties relating to, sounding in or alleging violations of law relating to: antitrust, deceptive trade practices, false or fraudulent advertising, consumer fraud, breach of fiduciary duty, breach of contract, breach of covenant of good faith and fair dealing, torts (including fraud, negligence, and product liability), breach of warranty, false claims, kickback, conversion, theft and/or the Racketeer Influenced Corrupt Organizations Act (RICO). BCBSKC shall control any recovery strategy and decisions related to such claims, including decisions to mediate, arbitrate, litigate, and shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.

C. Retroactive Termination Recoveries. BCBSKC will pursue retroactive termination recoveries in accordance with BCBSKC's established rules and procedures, or engage third parties to provide such services on behalf of the HMO Plan. The applicable fees are listed on Exhibit B

and netted against the recovery. Any recovery amounts, net of such fees, if any, will be returned to the HMO Plan. BCBSKC has no obligation to pursue recovery.

BCBSKC shall have the right to retain any net recovery not exceeding $500 if three (3) years have elapsed since this Agreement terminated. If a recovery is made and part or all of such recovery relates to amounts paid by MVLH under a Stop-Loss Insurance policy between MVLH and Plan Sponsor, then BCBSKC shall return to MVLH and, if applicable, Plan Sponsor, net of any fees set forth above, a pro rata portion of such recovery based upon the amounts paid by MVLH and, if applicable, Plan Sponsor, for the claims related to such recovery. Any amounts recovered by BCBSKC shall not apply to and shall not be used to satisfy any Stop-Loss Insurance attachment points.

2. **Identification Cards; Benefit Booklets; Other HMO Participant Documentation.**

2.1 Identification Cards. BCBSKC will prepare HMO Participant identification cards and will distribute them to HMO Participants. BCBSKC will handle the re-issuance of identification cards that are lost or if a HMO Participant's coverage under the HMO Plan changes (e.g., divorce, birth of a child, etc.). BCBSKC will make identification cards available on its website behind member log in. BCBSKC reserves the right to charge for reissuing identification cards as a result of an action caused by Plan Sponsor.

2.2 Benefit Booklets. BCBSKC will prepare the Benefit Booklet describing the Plan of Benefits and will distribute the Benefit Booklet to Plan Sponsor electronically. The Plan of Benefits contained in the Benefit Booklet is not an SPD (defined below). Plan Sponsor is responsible for: (i) reviewing the Plan of Benefits, (ii) determining whether the Plan of Benefits meets all of Plan Sponsor's legal and business obligations (and advising BCBSKC of any necessary revisions); and (iii) distributing the Plan of Benefits to Members.

2.3 Summary Plan Description. Plan Sponsor is responsible for preparing the Summary Plan Description ("SPD"), if applicable. Plan Sponsor is also responsible for distribution of the SPD in accordance with applicable law, and BCBSKC has no responsibility therefore.

2.4 Summary of Benefits and Coverage. Unless otherwise informed by Plan Sponsor, BCBSKC will prepare the Summary of Benefits and Coverage ("SBC") and will distribute the SBC to Plan Sponsor electronically (and, if requested by Plan Sponsor, via hard copy).

2.5 Other Member Documentation. BCBSKC will provide necessary enrollment forms and claim forms for use by HMO Participants.

3. **Reporting; Maintenance of Records.**

3.1 Reports for Plan Sponsor. BCBSKC will provide periodic reports to Plan Sponsor regarding the financial status of the HMO Plan and the utilization of benefits by the HMO Participants. Such reports shall be limited to data readily available to BCBSKC, and will include reconciliation of Plan funds including receipts and disbursements; benefit payments and insurance premium and fees, if any.

3.2 Reporting Assistance. BCBSKC will furnish Plan Sponsor an annual report of information available to BCBSKC which may be needed by Plan Sponsor to satisfy ERISA, CAA, MHPAEA, or any

other applicable state or federal requirements (e.g., information needed for Plan Sponsor to complete a Form 5500 or information needed for Plan Sponsor to satisfy CAA reporting requirements). Such information and reports shall be limited to information readily available to BCBSKC. BCBSKC shall not be responsible for determining when, or whether, government filings are required, or completing or filing any report or return.

3.3 Records Maintenance. BCBSKC will maintain for the duration of this Agreement and for seven (7) years thereafter adequate books and records of all transactions in which BCBSKC engages with insurers, the Plan, Plan Sponsor, and HMO Participants in connection with the HMO Plan. Plan Sponsor is entitled to continuing access to these books and records. BCBSKC may fulfill requirements of this provision upon termination of the Agreement by delivering to the successor administrator, or, if there is not a successor administrator, to the insurer, the Plan, or Plan Sponsor, either electronic copies of such books and records or hard copies of same upon payment by Plan Sponsor of the reasonable duplication costs. To the extent copies of such books and records contain confidential information of BCBSKC as defined by Section 5.13 of the Administrative Services Agreement, BCBSKC may require the successor administrator, insurer, Plan, or Plan Sponsor execute a data extraction agreement or similar document and make release of such books and records contingent upon execution of such agreement.

4. **Plan Design and Administration.**

4.1 Plan Design. BCBSKC will provide Plan Sponsor services and assistance in connection with the design and development of the HMO Plan, including revisions thereto. Service and assistance includes: underwriting and actuarial services; estimates of initial HMO Plan costs; cost projections of any proposed HMO Plan revisions; and assisting Plan Sponsor in the administration of the HMO Plan as requested and authorized from time to time. Such services are limited to those within the scope of BCBSKC's professional ability and the terms of this Agreement.

4.2 Medical/Case/Disease Management. BCBSKC will provide or contract with independent providers of medical management, case management and/or disease management services to provide such services pursuant to the terms of the Plan and as set forth in this Section.

A. Medical Management Services. Medical Management Services may include the following services in accordance with the terms of the HMO Plan:

i. Prior Authorization. Prior Authorization is the review of care before services are performed. The prior authorization process begins when the HMO Participant, the physician or hospital contacts BCBSKC. Managed care personnel review facts regarding the HMO Participant, , that individual's medical history and the proposed treatment plan. Prior Authorization of an inpatient admission examines the medical necessity of inpatient care and the length of stay if hospitalization is required. Prior Authorization also reviews alternative methods of treatment, which may result in a less expensive but equally effective treatment.

ii. Concurrent Review and Discharge Planning. Concurrent Review and Discharge Planning are a follow-up to Prior Authorization whenever an HMO Participant is admitted as an inpatient. While the HMO Participant is hospitalized, managed care personnel actively monitor the medical process to ensure that ongoing treatment is medically necessary and appropriate, and that the hospital continues to be the proper

treatment setting. Comprehensive Discharge Planning begins during the inpatient stay and includes assistance in coordinating ongoing care outside the hospital, such as home health care or care in a skilled nursing facility, if appropriate.

B. Case Management – Alternative Benefits. Case Management is a method of review whereby an individual's catastrophic, chronic or complex health problem(s), or general health, is evaluated and a plan of care is developed and implemented which meets that individual's particular needs and is the most cost effective. Case Management services are used to ensure the provision of medically necessary care in the most appropriate setting within the HMO Participant's benefits package. However, Case Management may also provide for reimbursement for alternative methods of care even if the HMO Participant does not have benefits for the alternate care or setting. It may also include any plan of care set forth to promote health and prevent illness and injury of the HMO Participant. Case Management does not extend benefits for alternative methods of care to persons who do not meet the plan standards and criteria.

In addition to the benefits specified in the Plan of Benefits, additional benefits may be offered for services furnished by any provider pursuant to an approved alternative treatment plan for Case Management which has been coordinated with the HMO Participant's physician.

Benefit payment will be provided for the alternative methods of care only when and for so long as it is determined that the alternative services are medically necessary and cost effective. Such benefit payments shall count toward an individual's calendar year maximum (if applicable) and the lifetime benefit maximum (if applicable).

The implementation of alternative benefits shall require the approval of the affected individual or the individual's legal representative and the affected person's physician.

If alternative benefits are provided for an individual in one instance, it shall not obligate providing the same or similar benefits for any individual in any other instance, nor shall it be construed as a waiver of the right to thereafter administer the HMO Plan in strict accordance with its express terms.

C. Disease Management. Disease Management is intended to enhance members' self-management skills to minimize or prevent complications from their diseases. BCBSKC's nurse coaches work together with members to develop an individualized plan and goals that comply with national standards of care. Evidence-based medicine guidelines form the foundation of the program for the following chronic conditions, including but not limited to: diabetes; depression; coronary artery disease; heart failure; chronic obtrusive pulmonary disease; asthma; metabolic syndrome; and hypertension. Following identification, BCBSKC utilizes a predictive modeling process to stratify members into one of three risk levels. The higher the stratification level, the more frequently BCSBKC engages with a member and the higher the intensity of the collaboration.

4.3 Pharmacy Benefit Management. BCBSKC contracts with a pharmacy benefit manager ("PBM") for certain prescription drug administrative services, including prescription drug rebate administration and pharmacy network contracting services.

Under the agreement, PBM obtains rebates from drug manufacturers (or via its GPO, if applicable) based on the utilization of certain prescription products by HMO Participants, and PBM retains the

benefit of the rebate funds prior to disbursement. In addition, pharmaceutical manufacturers may pay administrative fees to PBM in connection with PBM's services of administering, invoicing, allocating, and/or collecting rebates, and the PBM retains the benefit of such amounts prior to disbursement. PBM may also receive other service fees from manufacturers as compensation for various services unrelated to rebates or rebate-associated administrative fees.

In addition, BCBSKC and the PBM also contract with pharmacies to provide prescription products at discounted rates for HMO Participants. The discounted rates paid by PBM and BCBSKC to these pharmacies differ among pharmacies within a network, as well as between networks. For pharmacies that contract with the PBM, in the aggregate, BCBSKC pays a fixed discount rate under BCBSKC's contract with the PBM regardless of the various discount rates PBM pays to the pharmacies. Thus, where BCBSKC's rate exceeds the rate the PBM negotiated with a particular pharmacy, the PBM will realize a positive margin on the applicable prescription. The reverse may also be true, resulting in negative margin for the PBM. In addition, when the PBM receives payment from BCBSKC before payment to a pharmacy is due, the PBM retains the benefit of the use of these funds between these payments. BCBSKC is guaranteed a minimum level of discount whether through the PBM or where BCBSKC directly contracts with network pharmacies, which could result in the amount paid by Plan Sponsor being more or less than the amount PBM and/or BCBSKC pay to pharmacies.

BCBSKC is not acting as a fiduciary with respect to rebate administration, pharmacy network management, or the prescription drug plan. BCBSKC receives rebates from the PBM and may receive positive margin in connection with the pharmacy network, as well as other financial credits, administrative fees and/or other amounts from network pharmacies, drug manufacturers or the PBM (collectively "Financial Credits"). BCBSKC retains sole and exclusive right to all Financial Credits, which constitutes BCBSKC's property (and are not plan assets), and BCBSKC may use such Financial Credits in BCBSKC's sole and absolute discretion, including, for example, to help stabilize BCBSKC's overall rates and to offset expenses, and BCBSKC does not share Financial Credits with Plan Sponsor.

Without limitation to the foregoing, the following ("Financial Credit Rules") apply: (1) Plan Sponsor has no right to receive, claim or possess any beneficial interest in any Financial Credits; (2) applicable drug benefit Copayment, Coinsurance, OPD, Deductible and/or maximum allowable benefits (including without limitation Calendar Year Maximum and Lifetime Maximum benefits) are in no way adjusted or otherwise affected as a result of any Financial Credits, except as may be required by law; (3) any OPD, Deductible and/or Coinsurance that HMO Participants must pay for prescription drugs is based upon the Allowable Charge at the pharmacy, and does not change as a result of any Financial Credits, except as may be required by law; and (4) amounts paid to pharmacies or any prices charged at pharmacies are in no way adjusted or otherwise affected as a result of any Financial Credits.

4.3.1 <u>Pharmacy Carve-In Credits.</u> BCBSKC agrees to provide Plan Sponsor with pharmacy carve in-credits as provided in this section. The carve-in credit shall be $50.00 per member per month, and shall be paid on a quarterly basis through a credit against amounts invoiced and due from Plan Sponsor. The number of members shall be determined from the .

BCBSKC has the right, upon notice, to make an equitable adjustment to the carve-in credit amount in the event there is:

(a) a material change in the conditions or assumptions utilized in providing the carve-in credit;
(b) a material change in the size or demographics of the Plan Sponsor's membership;
(c) Plan Sponsor takes an action that has the effect of lowering the amount of Financial Credits available to BCBSKC; or

(d) A material change in law or the pharmacy benefit industry that adversely impacts BCBSKC's ability to obtain Financial Credits.

To be eligible for and receive the Carve-In Credits, this Agreement must be in effect at the time payment of such Carve-In Credits are to be made.

Plan Sponsor agrees to fully and accurately disclose and report pharmacy carve-in credits and any other discount, rebate, or other credit received by Plan Sponsor or retained by BCBSKC and/or its PBM, as required by law.

4.4 Out-of-Area Services. BCBSKC will contract with other Blue Cross Blue Shield plans to provide emergency services for HMO Participants who are outside BCBSKC's Service Area.

4.5 Discounts. BCBSKC will extend to Plan Sponsor the Discounts, if applicable, BCBSKC has negotiated with HMO Providers which are granted at the time of claim payment. BCBSKC will also extend to Plan Sponsor the Discounts, if applicable, other Blue Cross and/or Blue Shield plans have negotiated with providers and agree to extend to HMO Participants, if applicable, subject to the terms of the Agreement.

4.6 Provider Listing. BCBSKC will maintain a current listing of HMO Providers.

5. **Customer Service.** BCBSKC will:

A. Respond to all customer service-related inquiries, including telephone, fax, e-mail and standard mail inquiries from members, member representatives, providers and HMO Plan representatives;

B. Correspond with the initial inquirer through appropriate means (email, letter, call, etc.);

C. Properly identify and respond to member grievances related to benefits, network or other issues, including (i) investigation and information gathering, (ii) resolution, (iii) member notification as appropriate, and (iv) documentation of actions and correspondence; and

D. Identify and respond to provider complaints, issues and/or disputes related to provider claims payments.

6. **HMO Participant Education.** BCBSKC will assist Plan Sponsor with presentations and educational meetings with HMO Participants when reasonably possible to explain the operation of an HMO and how participants may maximize health care benefits by proper utilization of a HMO. BCBSKC will also advise HMO Participants as to the benefits available under the HMO Plan.

7. **COBRA Billing.** In the event Plan Sponsor purchases COBRA billing services from BCBSKC (as indicated above), BCBSKC will:

A. Monitor the appropriate continuation of coverage period for each beneficiary and disenroll the beneficiary at the end of the period of continued coverage;

B. Send conversion notices to eligible COBRA beneficiaries to the extent and within the period prescribed by applicable law, provided that a conversion option is included in their Plan of Benefits;

C. Bill and collect the initial premium payment covering the period during which coverage would have normally ended to the date the beneficiary elects COBRA continuation; and

D. Bill and collect the monthly premiums from the COBRA beneficiaries who elected continuation of coverage beginning with the first monthly premium due after notice of continuation coverage is made by the beneficiary;

Notwithstanding the foregoing, if Plan Sponsor elects "Group Billing" instead of "Direct Billing", then paragraphs C and D shall not apply; instead, Plan Sponsor shall be responsible for billing all premium amounts and will pay to BCBSKC the applicable fees for COBRA Services provided herein.

BCBSKC shall not be responsible for providing notice to COBRA continuants of any open enrollment periods, available benefit Plan options and/or applicable premium rates for such periods.

BCBSKC shall be entitled to rely on any information provided to it by Plan Sponsor, shall base certain eligibility, coverage and other determinations in the performance of its responsibilities under this Agreement in reliance on the information so provided, and shall not be required to confirm or verify the accuracy, authenticity or completeness of any information so provided. BCBSKC's only obligation hereunder shall be to compile such information accurately and to utilize such information in performing its responsibilities under this Agreement.

For purposes of this Section, references to BCBSKC shall mean either BCBSKC or, if applicable, its contracted COBRA Administrator.

8. **Retiree Benefits Billing Services.** In the event Plan Sponsor purchases Retiree Benefits Billing Services from BCBSKC, BCBSKC will:

A. Send monthly billing statements to members;

B. Collect premiums from members and forward the premiums collected for the current billing cycle to Plan Sponsor on a monthly basis; and

C. Provide a toll-free telephone number for access to a customer service representative.

For purposes of this Section, references to BCBSKC shall mean either BCBSKC or, if applicable, its subcontractor.

9. **Wellness Program.** If Plan Sponsor elects to have BCBSKC provide its employee wellness program, A Healthier You™ (as indicated above), the following shall apply. Program structure and offerings include a wellness portal, digital coaching and health risk assessments, and are set forth in greater detail in separate materials provided by BCBSKC to Plan Sponsor. Plan Sponsor may also purchase

additional special programs, including smoking cessation, on-line health challenges and health promotion campaigns ("Special Programs"). The terms of any such Special Programs, including the applicable costs and fees, will be set forth in separation documentation. BCBSKC will also make available to Plan Sponsor a stipend in the amount of $75,000 ("Wellness Stipend") that may be used by Plan Sponsor for enhancing employees' health and wellness, including increasing the awareness of health risks and supporting behavioral changes. Plan Sponsor will submit a request to BCBSKC for funds, including the amount of funds requested and how the funds will be used. If acceptable to BCBSKC, in its reasonable discretion, BCBSKC shall distribute such funds to Plan Sponsor (but in no event shall distributions, alone or in the aggregate, exceed the balance of Plan Sponsor's Wellness Stipend). Plan Sponsor represents and warrants that it will use any and all funds distributed from its Wellness Stipend for the purpose specified in its request for distribution. Further, Plan Sponsor will submit receipts and other evidence of use of distributed funds. Permissible uses of Wellness Stipend funds include: (a) establishing biometric screening events; (b) providing health and wellness educational programs (e.g., smoking cessation); and (c) on-site exercise classes and/or equipment. Wellness Stipend funds remaining at the end of the term of this Agreement may not be carried over to a subsequent year, or, in the event that Plan Sponsor will not renew its relationship with BCBSKC at the end of the term of this Agreement, may not be paid out to Plan Sponsor.

10. **Alight.** If Plan Sponsor elects to have BCBSKC provide Alight services (as indicated above), then the following shall apply. Alight is a healthcare concierge service which allows covered members to compare doctors and facilities, review medications, get assistance with medical bills, schedule appointments and coordinate preventive care.

11. **Health Reimbursement Arrangement.** If Plan Sponsor purchases health reimbursement arrangement services from BCBSKC, the terms of such arrangement will be set forth in a separate agreement between the parties.

12. **Third-Party Data Extracts**. At Plan Sponsor's request, BCBSKC will send various data extract files, including medical claims, prescription claims, membership and wellness, to third parties. Any one or more of such data extract files may be done on an as-requested basis, or may be set up on a weekly or monthly recurring basis. BCBSKC may require a data extract agreement among BCBSKC, Plan Sponsor and/or such third party (or such other documentation as BCBSKC deems necessary or advisable) prior to sending any such extract file. The fees for any such data extract files are set forth in Exhibit B.

Exhibit B
Fees / Deposit

Plan Sponsor agrees to pay BCBSKC, in accordance with the terms of the Administrative Service Agreement, the following:

Administrative Fees

Medical
Employee $24.08
Employee +1 $60.19
Family $70.41

Other Fees

Fee Type	Amount/Description
Access Fee	Monthly Cumulative Access Fee = $21.01 PEPM
BlueCard Fee	Included in Administration/Access Fees
Pass-through amounts (e.g., Statutory Assessments)	Amounts payable by Plan Sponsor = amounts paid by BCBSKC* **BCBSKC will bill Plan Sponsor when such amounts are paid by BCBSKC (or MVLH, as applicable)*
Subrogation (claims greater than $500, in most cases)	30% of recoveries
Stop-Loss Coordination Fee	$2.50 PEPM
Group Litigation Fee	30% of recoveries ** percentage of recovery may vary depending on the vendor engaged by BCBSKC to pursue recovery*
Retroactive Termination Recoveries (60-day grace period)	30% of recoveries
Runout Services Fee	10% of Runout Claims and/or 10% of Discounts (capped at $2,000 per Claim) and/or Monthly Cumulative Runout Services Fee = Applicable PEPM
COBRA	N/A
Wellness Special Programs	As set forth in separate documentation, if applicable $75,000 wellness fund
Third-Party Data Extracts	Fees for data extract files will vary based on factors such as source, type, and frequency. Following Plan Sponsor's request for any data extract files, BCBSKC will communicate applicable fees to, and obtain consent of, Plan Sponsor prior to implementing the data extract. Such fees also apply to any data extract request made by, or on behalf of, Plan Sponsor following termination of this Agreement.
Late Fee	$761.00
Advance Deposit	N/A

Jackson County -

By: [signature]
Name: Frank White
Title: County Executive
Date: 12-12-2024

Blue Cross and Blue Shield of Kansas City
(Plan Sponsor)

By: Eric Whitten
Eric Whitten (Jan 7, 2025 15:09 CST)
Name: Eric Whitten
Title: Underwriting Team Lead
Date: Jan 07, 2025

APPROVED AS TO FORM
[signature]
County Counselor

ATTEST:
[signature]
Clerk of the County Legislature

Exhibit C
Inter-Plan Arrangements

1. **Out-of-Area Services.**

1.1 BlueCard Program Procedures: BCBSKC has a variety of relationships, referred to generally as "Inter-Plan Arrangements", with other Blue Cross and/or Blue Shield licensees. These other licensees are referred to generally as "Host Blues". Whenever HMO Participants access emergency services outside the Service Area, the claim for those services may be processed through one of these arrangements and presented to BCBSKC for payment in conformity with the rules of the Inter-Plan policies then in effect.

Typically, when accessing care outside the Service Area and the complete service area of Blue Cross and Blue Shield of Kansas City,HMO Participants will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield licensee in that other geographic area ("Host Blue"). In some instances, HMO Participants may obtain care from non-participating healthcare providers. BCBSKC's payment practices in both instances are described below. The only services BCBSKC covers outside the Service Area are emergency services and services provided through the Away From Home Care program. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

2. **BlueCard Program.**

2.1 Program General Procedures: Under the BlueCard program, when HMO Participants access emergency services within the geographic area served by a Host Blue, BCBSKC will remain responsible to Plan Sponsor for fulfilling BCBSKC's contractual obligations. However, in accordance with applicable Inter-Plan Program Policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

2.2 BlueCard Program Liability Calculation Method Per Claim: The calculation of HMO Participants' liability on claims for emergency services incurred outside the Service Area and the complete service area of BCBSKC that are processed through the BlueCard program, if not a flat dollar copayment, will be based on the lower of the participating provider's billed charges or the negotiated price made available to BCBSKC by the Host Blue.

The calculation of the Plan Sponsor's liability on claims for emergency services incurred outside BCBSKC's Service Area and the service area of BCBSKC that are processed through the BlueCard program will be based on the negotiated price made available to BCBSKC by the Host Blue. Sometimes this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g. per case or per day amount) for specific health care services.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's provider contracts. The negotiated price made available to BCBSKC by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

i. an actual price. An actual price is a negotiated payment without any other increases or decreases, or

ii. an estimated price. An estimated price is a negotiated 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 incentive ("Estimated Price"), or

iii. an average price. An average price is a percentage of billed charges for emergency services representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers, and other claim- and non-claim related transactions ("Average Price"). Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either the Estimated Price or Average Price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the HMO Participants and the Plan Sponsor is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard program requires that the price submitted by a Host Blue to BCBSKC is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an Estimated Price or an Average Price on a claim, it may also hold some portion of the amount that the Plan Sponsor pays in a variance account, pending settlement with its participating providers.

Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from the Plan Sponsor. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

In some instances, federal law or the laws of a small number of States may require Host Blues either (i) to use a basis for determining HMO Participants' liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the law of the State in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate HMO Participants' and Plan Sponsor's liability in accordance with applicable law.

2.3 BlueCard Program Return of Overpayments: Under the BlueCard program, recoveries from a Host Blue or its participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis. Unless otherwise agreed to by the Host Blue, BCBSKC may request

adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if the recovery conflicts with the Host Blue's state law or healthcare provider contracts or would jeopardize its relationship with its healthcare providers.

2.4 BlueCard Program Fees and Compensation: Plan Sponsor understands and agrees to reimburse BCBSKC for certain fees and compensation which BCBSKC is obligated under the BlueCard program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to the BlueCard program vendors as described below. Fees and compensation under BlueCard may be revised in accordance with the program's standard procedures for revising such fees and compensation, which do not provide for prior approval by Plan Sponsor. Such revisions typically are made annually as a result of program policy 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 Plan Sponsor's benefit period under the agreement. Some of these fees and compensation are charged each time a claim is processed through BlueCard program and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Other program-related fees that BCBSKC may charge include, but are not limited to, a toll-free number fee, and a fee for providing provider directories. All these fees are included in the Agreed-upon percentage of all Paid Claims paid by the Plan during the preceding calendar month fee except for the BlueCard program access fee and fees for provider directories (where applicable), which are charged separately. If charged, the access fee will be a percentage of the discount/differential BCBSKC receives from the Host Blue, based on the current rate in accordance with the BlueCard program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. See Exhibit B of this Agreement.

3. Non-Participating Provider Arrangements.

3.1 Non-Participating Providers Outside BCBSKC's Service Area -- Allowable Charge. When emergency services are provided by Hospitals, other institutional health care facilities, Physicians, or suppliers of medical goods and services outside of the Service Area and the service area of BCBSKC which are non-participating providers, generally, the payments that BCBSKC will make on behalf of the Plan Sponsor will be either (a) the Allowable Charge, as defined below, or (b) the pricing arrangements required by applicable state law.

The Allowable Charge is the lesser of:

i. The amount, based on the local payment or rate, that the Host Blue passes on to BCBSKC for claims from hospitals, other institutional health care facilities, physicians, or suppliers of medical goods and services; or

ii. An amount that is based on the nationally recognized fee schedule to which BCBSKC currently subscribed if the claim is not submitted to BCBSKC by the Host Blue. If no allowable charge is available because the service provided does not have a specific code, BCBSKC will apply the same methodology used to establish an allowable charge for a participating provider; or

iii. The amount the provider has agreed to accept as payment in full at the time of claim payment, as, for example, when, with a Host Blue's consent, BCBSKC may negotiate a special payment for a specific situation on a case-by-case basis; or

iv. The provider's billed charges.

In these situations, the HMO Participant may be responsible for the difference between the amount that the non-participating health care provider bills and the payment BCBSKC will make for the emergency services as set forth in this paragraph.

3.2 Non-Participating Providers Outside BCBSKC's Service Area – Fees and Compensation. All applicable Inter-Plan arrangement fees, including any administrative expense allowance fees, for processing claims from non-participating providers for emergency services received by HMO Participants outside BCBSKC's Service Area and the complete service area of BCBSKC, are included in the agreed-upon percentage of all Paid Claims paid by the Plan during the preceding calendar month fee. See Exhibit B of the Agreement.

Exhibit D

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is incorporated into and made part of any and all primary agreements ("Primary Agreement"), as defined below, in existence as of the effective date of this Agreement or entered into in the future, by and between (Jackson County) Group Health Plan ("Covered Entity") and Blue Cross and Blue Shield of Kansas City d/b/a Preferred-Care, Preferred-Care Blue and Blue-Advantage, on behalf of itself and its subsidiary, Good Health HMO, Inc., d/b/a Blue-Care, as applicable (each a "Business Associate"). This Agreement replaces and supersedes any previous Business Associate Agreements entered into between the parties.

Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")(which includes the "Privacy Rule" and the "Security Rule"), and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) impose certain obligations upon Covered Entity to maintain the security and confidentiality of Protected Health Information (hereinafter called "PHI" for convenience). Specifically, the "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Part 160 and Part 164. The HIPAA Privacy Rule is the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R., part 160 and part 164, subparts A and E. The HIPAA Security Rule is the HIPAA Security Standards (45 C.F.R. Parts 160, 162, and 164). The HIPAA Breach Notification Rule is the Notification in the Case of Breach of Unsecured Protected Health Information, as set forth at 45 C.F.R. Part 164 Subpart D. Because Covered Entity discloses PHI to, or receives PHI from, Business Associate under one or more of the following Primary Agreements (**check all that apply**):

_X_ Administrative Services Agreement (for a self-funded health plan)

Each a ("Primary Agreement") between (Jackson County), as Plan Sponsor, and Business Associate, HIPAA requires that Covered Entity enter into a written agreement with Business Associate that includes specific provisions for the protection of PHI by Covered Entity's Business Associates. To comply with HIPAA requirements, Covered Entity and Business Associate mutually agree to adopt this Agreement. Business Associate recognizes and agrees that it is obligated by law to meet the applicable provisions of the HIPAA Rules.

A. Privacy of Protected Health Information ("PHI")

1. Permitted Uses and Disclosures. Business Associate is permitted or required to use or disclose PHI it creates or receives for or from Covered Entity only as follows, consistent with the Privacy Rule:

a) Functions and Activities on Covered Entity's Behalf. Business Associate is permitted to request the minimum necessary PHI from Covered Entity or on Covered Entity's behalf and to use and to disclose the minimum necessary PHI it creates or receives from or on behalf of Covered Entity to perform its obligations under the Primary Agreement.

b) Business Associate's Operations; Data Aggregation. Business Associate may *use* or *disclose* the minimum necessary PHI it creates or receives for or from Covered Entity

as necessary for data aggregation. Business Associate may create, *use* or *disclose* limited data sets or de-identified data consistent with the requirements and limitations in 45 C.F.R. 164.514(a)-(e). Business Associate may *use* the minimum necessary PHI it creates or receives for or from Covered Entity as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities. Business Associate may *disclose* the minimum necessary of such PHI to other third parties as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only if:

a) The disclosure is required by law; or

b) Business Associate obtains reasonable assurance, evidenced by written agreement, from any other person or organization to which Business Associate will disclose such PHI that the person or organization will:

a. Hold such PHI in confidence and use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as required by law; and

b. Notify Business Associate (who will in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

2. **Minimum Necessary and Limited Data Set.** Business Associate's use, disclosure or request of Protected Health Information shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will, in its performance of the functions, activities, services, and operations specified in Section A.1 above, make reasonable efforts to use, to disclose, and to request of a Covered Entity only the minimum amount of Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request. In addition, Business Associate also agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under this addendum.

3. **Prohibition on Unauthorized Uses and Disclosures.** Business Associate will neither use nor disclose PHI it creates or receives for or from Covered Entity or from another business associate of Covered Entity, except as permitted or required by this Agreement or as required by law or as otherwise permitted in writing by Covered Entity.

4. **Sale of PHI:** Business Associate shall not directly or indirectly receive remuneration in exchange for PHI except where permitted by the Agreement and consistent with applicable law.

5. **Marketing:** Business Associate shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where permitted by the Agreement and consistent with applicable law.

6. **Information Safeguards.**

a) Privacy of Covered Entity's Participants' Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative,

technical, and physical safeguards to protect the privacy of Covered Entity's Participants' PHI. The safeguards must reasonably protect Covered Entity's Participants' PHI from any intentional or unintentional use or disclosure in violation of the Privacy Rule, 45 C.F.R. Part 164, Subpart E and this Agreement, and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.

b) Security of Covered Entity's Participants' Electronic Protected Health Information. Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that protect the confidentiality, integrity, and availability of Electronic PHI that Business Associate creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and as required by the HITECH Act. Business Associate also shall develop and implement policies and procedures and meet the Security Rule documentation requirements. as of the compliance date for such obligations as applied to Business Associates. Business Associate also shall develop and implement policies and procedures and meet the Security Rule documentation requirements.

7. **Subcontractors and Agents.** Business Associate will require any of its subcontractors and agents, to which Business Associate is permitted by this Agreement or in writing by Covered Entity to disclose any of the PHI Business Associate creates or receives for or from Covered Entity, to provide reasonable assurance, evidenced by written agreement, that subcontractor or agent will comply with the same privacy and security obligations as Business Associate with respect to such PHI.

B. Compliance with Transaction Standards. If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which DHHS has established Standards, Business Associate will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Transaction Rule, 45 C.F.R. Part 162. Business Associate will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions on behalf of Covered Entity that:

1. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;

2. Adds any data element or segment to the maximum defined data set;

3. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or

4. Changes the meaning or intent of the Standard Transaction's implementation specification.

C. Individual Rights

The HIPAA regulations give individuals covered under Covered Entity health benefits plans certain rights in the PHI that is maintained by Covered Entity about those individuals. Since Business Associate will have possession of PHI about Covered Entity's participants, Covered Entity requires Business Associate's cooperation in ensuring that the following rights are given to the individual:

1. Access. Business Associate will promptly upon Covered Entity's request make available to Covered Entity or, at Covered Entity's direction, to the individual (or the individual's personal representative) for inspection and obtaining copies of any PHI about the individual which Business Associate created or received for or from Covered Entity and that is in Business Associate's custody or control, consistent with the requirements of 45 C.F.R. § 164.524, so that Covered Entity may meet its access obligations under 45 C.F.R. § 164.524

2. Amendment. Business Associate will, upon receipt of notice from Covered Entity, promptly amend or permit Covered Entity access to amend any portion of the PHI which Business Associate created or received for or from Covered Entity, so that Covered Entity may meet its amendment obligations under 45 C.F.R. § 164.526.

3. Disclosure Accounting. So that Covered Entity may meet its disclosure accounting obligations under 45 C.F.R. § 164.528:

> 1. Disclosure Tracking. Business Associate will record the following data as required by the HIPAA Privacy Rule for each disclosure, except those listed under Section B.3(c) immediately below as not requiring an accounting, that Business Associate makes to Covered Entity or a third party of PHI that Business Associate creates or receives for or from Covered Entity, (i) the disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the disclosure (items i-iv, collectively, the "disclosure information").
>
> 2. Repetitive Disclosures. For repetitive disclosures Business Associate makes to the same person or entity (including Covered Entity) for a single purpose, Business Associate may provide (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. Business Associate will make this disclosure information available to Covered Entity promptly upon Covered Entity's request.
>
> 3. Exceptions from Disclosure Tracking. Business Associate need not record disclosure information or otherwise account for disclosures of PHI that this Agreement or Covered Entity in writing permits or requires (i) for the purpose of Covered Entity's treatment or payment activities, or health care operations, (except where such recording or accounting is required by the HITECH Act, and as of the effective dates for this provision of the HITECH Act), (ii) to the individual who is the subject of the PHI disclosed or to that individual's personal representative; (iii) to persons involved in that individual's health care or payment for health care; (iv) for notification for disaster relief

purposes, (v) for national security or intelligence purposes, or (vi) to law enforcement officials or correctional institutions regarding inmates or other persons in lawful custody.

4. Availability of Disclosure Information. Unless otherwise provided by applicable law, Business Associate must have available for Covered Entity the disclosure information required by Section B.3(c)immediately above for the 6 years preceding the date of Covered Entity's request for the disclosure information. Business Associate will make the Disclosure Information available to Covered Entity within fifteen (15) days following Covered Entity's request for such Disclosure Information to comply with an individual's request for disclosure accounting.

D. Privacy Breaches; Security Incidents

1. Reporting.

a) Mitigation and Corrective Action. Promptly upon learning of any access, use or disclosure that is or may be a Breach under this Agreement, and in addition to the reporting required by the Section D, Business Associate will take steps to mitigate the Breach to the extent possible, including taking corrective action to attempt to cure the Breach as promptly as possible.

b) Breach Reporting. Business Associate will report to Covered Entity any Security Incident, Use or Disclosure of PHI not permitted by this Agreement that is a Breach of "Unsecured Protected Health Information". Business Associate will make the report to Covered Entity's Privacy Office without unreasonable delay following discovery of such Breach consistent with obligations under 45 C.F.R. 164.410. Business Associate shall cooperate with Covered Entity in investigating theBreach and in meeting Covered Entity's obligations under the Breach Notification Regulation and any other federal or state security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach. Business Associate's report will at least:

(i) Identify the nature of the non-permitted access, use or disclosure, including the date of the Breach and the date of discovery of the Breach;

(ii) Identify the PHI accessed, used or disclosed in the Breach, to include the identification (if known) of each individual whose PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired or disclosed during such Breach (e.g., full name, social security number, date of birth, etc.);

(iii) Identify who made the non-permitted or violating access, use or received the non-permitted or violating disclosure;

(iv) Identify what corrective action Business Associate took or will take to prevent further non-permitted access, uses or disclosures;

(v) Identify what Business Associate did or will do to mitigate any harmful effect of the non-permitted access, use or disclosure; and

(vi) Provide such other information, including a written report, as Covered Entity may reasonably request.

c) Other Reporting. For Security Incidents that *do not* result in unauthorized access, use, disclosure, modification or destruction of information or interference with Business Associate's system operations or that pose low probability of compromise to the PHI ("Unsuccessful Security Incidents"), each party agrees that this paragraph constitutes notice from Business Associate to Covered Entity of types of such Unsuccessful Security Incidents. Business Associate will document and provide reports, including risk assessment, of any access, use or disclosure of PHI that poses a low probability of compromise to the PHI to the Covered Entity upon request. The parties consider the following to be illustrative, but not inclusive, of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of e-PHI or interference with an information system:

1. Pings on Business Associate'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)

d) Notice. For purposes of notifying Covered Entity of Breaches or other notices required under this Agreement, notices shall be deemed given when properly addressed to a party's privacy contact, upon the date of receipt if hand-delivered or e-mailed, or three (3) business days after deposit in the U.S. mail if mailed by registered or certified mail, postage prepaid, or one (1) business day after deposit with a national overnight courier for next business day delivery, or upon the date of electronic confirmation of receipt of a facsimile transmission.

e) Breach Notification. In the event a notification provided by Business Associate to Covered Entity under this Section D.1. is a Breach requiring notification to affected individuals, Business Associate (or its delegate) will prepare and deliver such notification to individuals on Covered Entity's behalf. Such notifications to individuals will be consistent with the notification content requirements established in HIPAA.

If Business Associate notifies Covered Entity of a Breach that is not limited to Covered Entity's data and requires notification to media, regulators, or other third parties, Business Associate will provide such notification on behalf of itself and Covered Entity. Such notification will indicate that it is made on behalf of entities other than Business Associate, but is not required to specifically name Covered Entity to satisfy obligations under this section. Covered Entity approves of Business Associate's provision of notification under this section and agrees to avoid duplication in the event of a Breach.

f) Confidentiality and Privilege. Covered Entity and Business Associate acknowledge that in the event of an unauthorized use or disclosure or security incident requiring notification under this Section D.1., Covered Entity and Business Associate have a common interest in investigating and resolving the incident. Covered Entity and Business Associate recognize that each may seek legal advice related to an incident. To the extent

Covered Entity and Business Associate instruct their respective legal counsel to communicate regarding an incident, including, but not limited to a Breach, it is intended that such communication is for the common interest of Covered Entity and Business Associate and that such communication does not waive any privilege as to third parties. Notwithstanding the foregoing, nothing in this subsection (f) requires either party to disclose any information to the other or to waive any privilege Covered Entity or Business Associate may hold.

E. Obligations of Covered Entity

1. **Notice of Privacy Practices.** Covered Entity will notify Business Associate of any provision in the Covered Entity's Notice of Privacy Practices that may limit Business Associate's use of PHI in a manner not specifically addressed in this Agreement.

2. **Agreed Upon Restriction.** In the event Covered Entity agrees to a restriction requested by an individual under 45 C.F.R. 164.522 that affects Business Associate's use of PHI of that individual, Covered Entity will notify Business Associate of such restriction.

3. **Requested Disclosures.**

a) Generally. Covered Entity will not request that Business Associate use or disclose PHI in a manner not permitted by the HIPAA Rules.

b) Disclosures to Broker. Covered Entity will designate a broker of record ("Broker") who is permitted to receive information, data, and reports ("Data") on behalf of Covered Entity for treatment, payment, and health care operations. Covered Entity hereby directs Business Associate to provide Broker with Business Associate's regular reports for Covered Entity. Broker may request additional Data on behalf of Covered Entity 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 Business Associate. By designating Broker, Covered Entity:

(i) Has executed a Business Associate Agreement with Broker consistent with requirements of HIPAA;

(ii) Agrees that Broker will be required to execute a Data Extract Agreement or similar agreement with Business Associate related to Data

(iii)Recognizes that, if Broker refuses to execute a Data Extract Agreement, Business Associate may refuse to provide Data to Broker; and

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

c) Disclosures to Third Parties. Covered Entity or Broker may engage additional third party companies ("Contractors") to provide services to Covered Entity related to its treatment, payment and health care operations. Covered Entity or Broker will submit a

Request for Release of Business Information to a Third Party form, similar to the form that is attached as **Appendix A ("Request Form")**, to describe any Data to be provided to a Contractor. Covered Entity or Broker will only request that Business Associate provide PHI to Contractors where:

(i) Covered Entity has executed necessary agreements to permit the disclosure, including but not limited to a Business Associate Agreement;

(ii) Covered Entity has determined that the disclosure to the Contractor is permitted under HIPAA and other applicable law;

(iii) Contractor has agreed to limit is use of the Data to the purposes described on the Request Form;

(iv) If the disclosure is not related to treatment, payment or health care operations of Covered Entity and authorizations are required under HIPAA or other applicable law, Covered Entity has obtained authorizations from its participants and beneficiaries to permit the disclosure to the Contractor; and

(v) Covered Entity has determined that the amount of PHI to be disclosed to the Contractor is the minimum amount of PHI necessary for the services to be performed by the Contractor;

(vi) Contractor will not provide any PHI to Covered Entity unless requirements of subsection (d) below are satisfied.

Covered Entity recognizes that any Contractor (and any subcontractor of Contractor who will receive Data) engaged by Covered Entity will be required to enter into a data extract agreement with Business Associate prior to receiving any Data. If Contractor refuses to accept terms agreeable to Business Associate related to a data extract agreement, Business Associate may refuse to provide Data to Contractor.

d) Disclosures to a Plan Sponsor. Prior to receiving or requesting any Data that may contain PHI from Business Associate, Broker, or Contractor, Covered Entity will ensure:

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

(ii) Plan sponsor has implemented necessary separation under 45 C.F.R. 164.504(f)(2)(iii) and 164.314(b) to permit the disclosure of PHI to the plan sponsor;

(iii) The request is for a permitted purpose for functions on behalf of the Covered Entity and has been limited to the minimum amount of Data necessary to accomplish such purpose; and

(iv) That the plan sponsor will not utilize the PHI for the purpose of an employment related action or in connection with any other benefit or employee benefit plan that is not a health plan.

Covered Entity warrants that PHI disclosed to the Covered Entity or plan sponsor will only be used for purposes of the treatment, payment or health care operations of the Covered Entity as described on any applicable Request Form and will not be used, accessed, released or disclosed for any improper, unlawful, or otherwise unauthorized purpose or to identify any individual for such a purpose.

e) 42 C.F.R. Part 2. Federal rules prohibit Business Associate from making any further disclosure of information that is received 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 unless further disclosure is permitted by 42 CFR Part 2. Covered Entity warrants that it will ensure that any authorizations required under 42 C.F.R. Part 2 have been obtained from individuals to allow Covered Entity, Broker, or Contractor to receive any information subject to 42 C.F.R. Part 2.

f) Designation of Representative. Covered Entity will complete a Designation of Representative, a copy of which is attached hereto as **Appendix B**, to designate individuals employed by plan sponsor who provide administrative functions on behalf of Covered Entity and are A) authorized to receive PHI from Business Associate for such functions or B) authorized to receive enrollment, disenrollment or summary plan information from Business Associate on behalf of the plan sponsor. Covered Entity will update this information within five (5) business days of any such change or when verification is requested by Business Associate.

g) Business Associate Discretion. Business Associate has the right to decline, in its reasonable business judgment, to provide Data to Plan Sponsor, Broker, or Contractor or to limit the Data extracted for any particular request. BCBSKC will discuss any proposed refusal or limitation of Data for extraction with the Covered Entity, Broker, and Contractor.

h) Limitations on Use and Disclosure of Data. Covered Entity recognizes that Data provided by Business Associate may contain confidential or proprietary information of Business Associate as well as PHI of Covered Entity's participants and beneficiaries. As such, Covered Entity agrees:

(i) Covered Entity will report to Business Associate, 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 Covered Entity under applicable state or federal law. Except as described in Section D, above, Covered Entity is solely responsible for its own notification obligations to individuals or other third parties as may be required under 45 C.F.R. 164 Part D or any other state or federal law and Business Associate assumes no responsibility for these notifications.

(ii) Business Associate provides Data to Covered Entity, its plan sponsor, Broker, or Contractor for the sole purpose of performing administrative functions on behalf of

Covered Entity, as described on any applicable Request Form. Business Associate hereby grants to Covered Entity and its plan sponsor a non-exclusive, non-transferable right and license to use, reproduce, adapt, perform, compile, display, incorporate and modify the Data only for the purpose of performing functions on behalf of Covered Entity and consistent with limitations and requirements described in this E.3 and any data extract agreement between Business Associate, Broker, and Contractor.

(iii) Covered Entity warrants that, if it permits its plan sponsor, Broker, or any Contractor 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 Covered Entity, due to wide variations among Business Associate's plans in covered benefits, enrollment demographics, claims experience, and other variables, Covered Entity will not permit the plan sponsor, Broker, or Contractor to identify or represent the Data as pertaining to a specific plan of Business Associate, nor indicate or imply that the Data is representative or typical of Business Associate or its plans. Further, notwithstanding the foregoing, Covered Entity, Broker, Contractor and plan sponsor are prohibited from combining any elements of the Data related to pricing, allowed amounts, or other confidential and proprietary information of Business Associate ("Pricing") with other such data received from other sources or to extract, duplicate, modify, decompile or reverse engineer Pricing from any Data without the express prior written consent of Business Associate.

(iv) Covered Entity will not sell or authorize Broker, Contractor or any third party to sell the Data or any extract of the Data

(v) The license to use Data provided to Covered Entity, Broker, Contractor or plan sponsor under this Section E.3 is personal to Covered Entity, Contractor or plan sponsor and cannot be assigned, delegated, or otherwise transferred to any third party without the express prior written consent of Business Associate.

i) Limitation of Liability. COVERED ENTITY UNDERSTANDS AND AGREES THAT BUSINESS ASSOCIATE PROVIDES ALL INFORMATION AND DATA TO COVERED ENTITY, CONTRACTOR, OR PLAN SPONSOR "AS IS". EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS AGREEMENT, BUSINESS ASSOCIATE DISCLAIMS 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 OF TRADE).

COVERED ENTITY ALSO UNDERSTAND AND AGREE THAT BUSINESS ASSOCIATE MAKES NO REPRESENTATIONS OR WARRANTIES AS TO WHETHER COVERED ENTITY, BROKER'S, CONTRACTOR'S OR PLAN SPONSOR'S ANTICIPATED USES OF ANY PHI COMPLIES WITH APPLICABLE

LAW, THE APPLICABLE NOTICE OF PRIVACY PRACTICES, OR WITH THE PLAN DOCUMENT(S).

j) Intellectual Property. Subject to the limitations of subsection (h), above, 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, privacy, publicity, or other proprietary right of any other person or entity, then Business Associate, at its option and expense, may: (i) procure for Covered Entity 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 Business Associate's sole discretion, commercially feasible, Business Associate may terminate the provision of the Data to Covered Entity parties will coordinate on alternative means Business Associate disclaims any warranty of non-infringement as to the Data and assumes no liability or responsibility for Covered Entity, Broker's, or Contractor's costs or expenses associated with any claim that the Data, any extract or portion thereof, or any method of collection thereof violates the patent, trade secret, copyright, privacy, publicity, or other proprietary right of any other person or entity.

2. **Termination of Primary Agreement.** The following provisions govern terminations related to Business Associate's breach of its privacy obligations under this Agreement. The terms and conditions of the Primary Agreement governing all other rights of termination shall remain in full force and effect.

1. Right to Terminate for Breach.

a) Covered Entity reserves the right to terminate this Agreement and/or the Primary Agreement if it determines, in its sole discretion, that Business Associate has breached any provision of this Agreement and upon written notice to Business Associate of the breach, Business Associate fails to cure the breach within thirty (30) days after receipt of the notice; provided, however, that if a cure for the breach is underway and cannot reasonably be completed within thirty (30) days following receipt of notice of breach, the parties may mutually agree to extend such time for cure. Covered Entity may exercise this right to terminate this Agreement and/or the Primary Agreement by providing Business Associate written notice of termination, stating the failure to cure the breach of the Agreement that provides the basis for the termination. Any such termination will be effective immediately or at such other date specified in Covered Entity's notice of termination. If for any reason Covered Entity determines that Business Associate has breached the terms of this Agreement and such breach has not been cured, but Covered Entity determines that termination of the Primary Agreement is not feasible, Covered Entity may report such breach to the U.S. Department of Health and Human Services.

b) Business Associate may terminate this Agreement if it determines that Covered Entity has breached any material provision of this Agreement and upon written notice to Covered Entity of the breach, Covered Entity fails to cure the breach within thirty (30) days after receipt of the notice; provided, however, that if a cure for the breach is underway and cannot reasonably be completed within

thirty (30) days following receipt of notice of breach, the parties may mutually agree to extend such time for cure. Business Associate may exercise this right to terminate this Agreement by providing Covered Entity written notice of termination, stating the failure to cure the breach of the Agreement that provides the basis for the termination. Any such termination will be effective upon such reasonable date as the parties mutually agree. If Business Associate reasonably determines that Covered Entity has breached the terms of this Agreement and such breach has not been cured, but Business Associate and Covered Entity mutually determine that termination of this Agreement is not feasible, Business Associate may report such breach to the U.S. Department of Health and Human Services.

2. Termination of Agreement on Conclusion of Primary Agreement. This Agreement will terminate upon termination or other conclusion of all underlying Primary Agreements into which it has been incorporated by reference.

3. Obligations upon Termination.

a) Return or Destruction. Upon termination, cancellation, expiration or other conclusion of this Agreement or the Primary Agreement, Business Associate will as promptly as possible, either return all PHI to Covered Entity (if feasible) or destroy all PHI, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Covered Entity, including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of the PHI.

b) When Return or Destruction is Not Feasible. Business Associate will identify any PHI that Business Associate created or received for or from Covered Entity that cannot feasibly be returned to Covered Entity or destroyed, and will maintain such PHI consistent with obligations under this Agreement and limit its further use or disclosure of that PHI to those purposes that make return or destruction of that PHI infeasible.

c) Continuing Privacy and Security Obligation. Business Associate's obligation to protect the privacy and safeguard the security of the PHI it created or received for or from Covered Entity will be continuous and survive termination, cancellation, expiration or other conclusion of this Agreement and the Primary Agreement.

d) Other Obligations and Rights. All other obligations and rights given to Business Associate and Covered Entity upon termination, cancellation, expiration or other conclusion of the Primary Agreement will be those set out in the Primary Agreement.

e) Protection of Business Associate Information. To the extent that Covered Entity, its Contractor or plan sponsor have any Data, as defined in Section E below, that includes confidential and proprietary information of Business

Associate at the termination of this Agreement, Covered Entity will either destroy or return such Data to Business Associate or continue to comply with the terms of Section E as to such Data.

f) Survival. The terms of this Section 3 shall survive termination of the Agreement.

Indemnification. Each party ("Indemnitor") will indemnify and hold harmless the other party ("Indemnitee") and Indemnitee's officers, employees, affiliates and agents from and against all expense, loss, penalties, liability, damages, settlement, attorney's fees, costs of litigation, fees and awards or other obligations resulting from or arising out of claims, fines, demands or cause of action of any kind or character, including those made by and to individuals, their dependents or any other party, which may be asserted against or imposed upon Indemnitee in connection with Indemnitor's improper, illegal or unauthorized receipt, use or disclosure of PHI.

F. General Provisions

1. **Definitions.** Unless otherwise provided in this Agreement, capitalized terms and phrased that are used herein shall have the same meanings as set forth in "the HIPAA" Rules, which definitions are incorporated into this Agreement by reference.

2. **Amendment to Agreement and Primary Agreement.** Upon the effective date of any final regulation or amendment to final regulations promulgated by the U.S. Department of Health and Human Services with respect to the Privacy or Security of PHI or Standard Transactions, this Agreement and the Primary Agreement of which it is part will automatically amend such that the obligations they impose on Business Associate remain in compliance with these regulations.

3. **Inspection of Books and Records.** Business Associate will make its internal practices, books, policies, procedures and records, relating to its use and disclosure of the PHI it creates or receives for or from Covered Entity, available to Covered Entity and to the U.S. Department of Health and Human Services Office for Civil Rights as necessary to determine compliance with the Privacy Rule, the Security Rule, 45 C.F.R. Parts 160-164 or this Agreement. Further, Covered Entity will provide Business Associate with access to internal practices, books, policies, procedures and records of Covered Entity related to its use and disclosure of Data it receives from Business Associate under Section E.3. of this Agreement as necessary to demonstrate Covered Entity's compliance with the terms of this Agreement.

4. **Assumption of Obligations.** To the extent Business Associate undertakes to perform any of Covered Entity's obligations under the HIPAA Privacy Rule, Business Associate will comply with the requirements imposed on the Covered Entity in the performance of such obligations.

5. **Conflicts.** The terms and conditions of this Agreement will override and control any conflicting term or condition of the Primary Agreement that addresses privacy and confidentiality of confidential medical information. All nonconflicting terms and conditions of the Primary Agreement remain in full force and effect.

IN WITNESS WHEREOF, Covered Entity and Business Associate execute this Agreement in multiple originals to be effective on the last date written below.

Jackson County on behalf of the Plan **Blue Cross and Blue Shield of Kansas City**

By: [signature]

Its: County Executive

Date: 12-12-2024

By: Drew Hatten
Drew Hatten (Jan 7, 2025 13:18 CST)

Drew Hatten
Director, Underwriting

Date: Jan 07, 2025

APPROVED AS TO FORM

[signature]

County Counselor

ATTEST:

[signature]

Clerk of the County Legislature

Jackson County Executed ASA HMO 2025

Final Audit Report 2025-01-07

Created:	2025-01-07
By:	Kelly Rowland (kelly.rowland@bluekc.com)
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