To: Rowan County

From: Blue Cross and Blue Shield of North Carolina (Blue Cross NC)

Re: Administrative Services Agreement (ASA) Contract Changes – 2022

Date: June 29, 2022

Attached is the 2022 renewal amendment for your Administrative Services Agreement (ASA) with Blue Cross NC. Below is a brief overview of the changes Blue Cross NC is proposing to the ASA for this Agreement Period.

1. Amendment re: Fiduciary and Ministerial Duties. This agreement is being amended to update language throughout the document related to finduciary and ministerial duties. This includes changes to sections in Articles 2, 4, 7 and 17, as well as Exhibit C. Changes are solely for sake of clarity; no changes have been made to processes or contracted services.

2. Amendment re: Reporting. The section in Article 5 regarding reporting has been amended and Exhibit D replaced in its entirety to ensure ongoing alignment with reporting and data integration services offered.

3. Amendment re: Health Management Programs. This section in Article 5 has been updated to reflect current terms for health management and wellness engagement programs as well as rewards programs and other wellness activities. The section addressing Blue Rewards has been deleted in its entirety.

4. Amendment re: Claims Processing. This section in Article 7 has been updated to further clarify that claims processing is per Blue Cross NC standard processes and policies and timeframes are not adjusted for stop loss coverage.

5. Amendment re Blue Cross NC Guidelines. This sction in Article 7 has been updated to further clarify that any deviation from Blue Cross NC standard policies and procedures for claims adminstration must be mutually agreed upon in writing by authorized persons of the parties to the ASA.

6. Amendment re: Notices. This provision will be updated at each renewal to ensure we have the most current contact information.

7. Administrative Fees Exhibit. The new exhibit reflects the current renewal rates as well as any other changes to this exhibit.

8. Inter-Plan Programs Arrangement Exhibit. This exhibit is being revised to include language required by the Blue Cross and Blue Shield Association.

9. Pharmacy Program Exhibit. This exhibit is being updated to clarify the terms of the Pharmacy Program.

10. Performance Guarantee Exhibit. The new exhibit reflects the Performance Guarantees for the current Agreement Period.

If you have any questions concerning the amendments listed above or to the content in the amendment, please contact your Blue Cross NC Strategic Client Consultant or Blue Cross NC ASO Contract Management via jane.park@bcbsnc.com for assistance.

Thank you.

AMENDMENT TO
ADMINISTRATIVE SERVICES AGREEMENT

This AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT ("Amendment") is made and entered July 1, 2022, by and between Rowan County ("Plan Sponsor"), Rowan County Group Health Plan ("Group Health Plan") and Rowan County ("Plan Administrator") and Blue Cross NC (each, a "Party" and collectively, the "Parties").

W I T N E S S E T H:

WHEREAS, the Parties previously entered into an Administrative Services Agreement (the "Agreement") pursuant to which Blue Cross NC provides certain services with respect to administration of the Group Health Plan;

WHEREAS, the Parties desire to amend the Agreement regarding certain matters as provided for herein;

NOW THEREFORE, in consideration of the mutual promises and covenants made herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties do hereby agree to amend and renew the Agreement effective July 1, 2022 as follows:

1. The section of Article 2 (Representations and Warranties) titled "Status of Blue Cross NC" shall be deleted in its entirety and replaced with the following:

   Status of Blue Cross NC. Blue Cross NC represents and warrants, and Plan Sponsor and Plan Administrator acknowledge and agree, that Blue Cross NC is not an insurer or underwriter of the Group Health Plan and that Blue Cross NC does not have any fiduciary responsibility with respect to the Group Health Plan, except for the fiduciary duties that Plan Sponsor and Plan Administrator expressly delegated to Blue Cross NC pursuant to this Agreement. Notwithstanding, Plan Sponsor and Plan Administrator acknowledge and agree that Blue Cross NC shall have authority with respect to the structure, payment terms, and other contract terms in connection with its Provider networks. Plan Administrator will provide Blue Cross NC with a copy of the Group Health Plan SPD, the Group Health Plan document and all amendments thereto.

2. The section of Article 4 (Obligations of Plan Administrator) titled "Administrative Discretion" shall be deleted in its entirety and replaced with the following:

   Administrative Discretion. Plan Administrator has the discretionary authority to administer the Group Health Plan, including the authority to make determinations in the administration

of the Group Health Plan, including, without limitation, determinations concerning eligibility for benefits; coverage of services, care, treatment, or supplies; and/or reasonableness of charges; and such determinations shall be final and conclusive. Prior to the Effective Date, Plan Administrator will take such internal action as is necessary to delegate to Blue Cross NC the authority to make discretionary decisions regarding claims for benefits and appeals of benefit determinations as described in Section 7.3 of this Agreement.

3. The section of Article 5 (Obligations of Blue Cross NC) titled "Program Reports" shall be deleted in its entirety and replaced with the following:

   Reports. Blue Cross NC shall provide reports as set forth in Exhibit D.

4. The section of Article 5 (Obligations of Blue Cross NC) titled "Health Management Programs" shall be deleted in its entirety and replaced with the following:

   Health Management Programs. Blue Cross NC shall make available to the Plan Administrator and Plan Sponsor health and wellness programs designed to promote healthy behaviors of Employees.

   a. Care Management Programs. Care management programs may include nurse support programs for condition care, case management, maternity, weight management, and a 24/7 nurse line. The components of the care management programs included in claims expense as care management fees are described on the Program Selection Chart, herein incorporated by reference, and further described in Exhibit C.

   b. Wellness Engagement Program. The wellness engagement program provides an integrated wellness incentive offering that includes, but is not limited to, online wellness programs, activities, resources (including a health assessment), online coaching, and telephonic coaching. The components of the wellness engagement program included in claims expense as care management fees are described on the Program Selection Chart, herein incorporated by reference, and further described in Exhibit C.

   c. Wellness Rewards Packages and Standalone Activities. Blue Cross NC offers optional Wellness Rewards Packages and stand-alone activities. These programs incentivize and reward members for engagement in a wellness program, participation in health management activities, or other activities that may be contracted for directly between the Plan Sponsor and a third-party vendor upon Blue Cross NC's approval. Rewardable activities may include engagement in care management programs and other Blue Cross NC sponsored activities. Blue Cross NC shall provide various communication tools to encourage the healthy behaviors within the designated wellness programs. Not all members may be eligible for each activity. Available wellness rewards packages are described on the Program Selection Chart, herein incorporated by reference.

      Plan Administrator shall be responsible for electing the package and/or stand-alone activity and type of the reward (within the parameters established by Blue Cross NC)

and for paying the cost of the reward. Blue Cross NC may act as an agent in transmitting payment for the rewards on behalf of the Group Health Plan. The Plan Administrator and Plan Sponsor shall be responsible for complying with all applicable federal and state laws with respect to the payment of any reward, including without limitation reporting the amount of the reward on each Employee's Form W-2. Blue Cross NC shall provide the Plan Administrator a summary of the total dollar amount of the rewards paid annually to each Employee. Blue Cross NC shall have no liability or responsibility for the activities that are contracted for directly between the Plan Sponsor and a third-party vendor.

5. The section of Article 5 (Obligations of Blue Cross NC) titled "Blue Rewards" shall be deleted in its entirety.

6. The section of Article 7 (Claims Administration) titled "Claims Processing and other Administrative Services" shall be deleted in its entirety and replaced with the following:

   Claims Processing and Other Administrative Services. Blue Cross NC shall provide administrative services under this Agreement, including processing claims and appeals filed by or on behalf of Members for Group Health Plan benefits to the extent described in this Article and in accordance with its reasonable understanding of the terms of the Group Health Plan as reflected in the Benefit Booklet(s). Blue Cross NC shall reject any claim for services incurred prior to the Effective Date, except as specifically agreed upon by Blue Cross NC and Plan Administrator. Blue Cross NC shall process all claims in accordance with its standard practices, policies, and procedures and will not adjust claims processing or claims processing timeframes for purposes of stop loss coverage or stop loss coverage administration. Blue Cross NC does not have any obligation to deviate from its normal standard practices, policies and procedures in order to ensure that claims (including claims which have been approved for payment by Blue Cross NC) or appeals which are pending at the end of the Plan Year are processed, determined and/or paid prior to the end of the Plan Year for any reason, including, without limitation, to enable a particular claim to be covered by a stop loss policy. Furthermore, notwithstanding anything in this Agreement to the contrary, Blue Cross NC shall not be liable to Plan Sponsor, the Group Health Plan and/or the Plan Administrator for any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees) arising from or relating to stop loss coverage and/or stop loss coverage administration, including without limitation the manner in which a stop loss policy covers (or fails to cover) any claim handled by Blue Cross NC.

7. The section of Article 7 (Claims Administration) titled "General Ministerial Administration" shall be deleted in its entirety and replaced with the following:

   General Ministerial Administration. To the extent that it has responsibility with respect to the processing of claims, Blue Cross NC shall among other things provide the following ministerial services:

   a. Calculate benefits, prepare checks, make benefits payments, and communicate through existing systems and in accordance with established procedures and processes;

b. Make available to Plan Administrator standard claim forms for issuance to Members;

c. Investigate claims as necessary;

d. Discuss claims, where appropriate, with Providers or Participating Blue Plans;

e. Perform internal audits of claim payments on a random sample basis;

f. Assist Plan Administrator in responding to regulatory inquiries pertaining to Member complaints, including denied claims;

g. Notify claimants of rejected claims and the reasons for the rejections and;

h. Provide claims department consultation as necessary with its health care and legal consultants in handling claims. The Plan Administrator will be responsible for seeking its own advice if more specific consultative services are required in a particular case

8. The section of Article 7 (Claims Administration) titled "Blue Cross NC Guidelines" shall be deleted in its entirety and replaced with the following:

   Blue Cross NC Guidelines. In providing the services described in this Agreement, Blue Cross NC may apply its standard practices, policies, and procedures used in its insured business and may apply its standard practices, policies and procedures used with respect to self-funded health plans subject to ERISA, to the extent not inconsistent with the terms of this Agreement unless the parties agree otherwise in a writing which is signed by an authorized individual for each party, and Plan Sponsor and Plan Administrator expressly authorize Blue Cross NC to employ such standard practices, policies. For this purpose, the authorized individual for each party shall be the person to whom any notice required by the Agreement must be given, as identified in Section 18.11 or the Authorized Signer of the current Group Application.

9. The second sentence of the section of Article 17 (Term and Termination) titled "Run-Out Services" shall be deleted and replaced with the following:

   "Blue Cross NC may elect, in writing, to continue to process Run-Out Claims and pay benefits under the terms of the Group Health Plan with respect to Run-Out Claims for a fee specified in Exhibit A."

10. The section of Article 18 (General Provisions) titled "Notices" shall be deleted in its entirety and replaced with the following:

    Notices. Any notices required to be given pursuant to the terms and provisions of this Agreement, or any Business Associate Agreement herein incorporated by reference, shall be in writing, postage prepaid, and shall be sent by first class mail or electronic mail to the Parties at the addresses below. The notices shall be effective on the date indicated on the return receipt or, if emailed, on the date the email is sent.

    To: Blue Cross and Blue Shield of North Carolina

Post Office Box 2291
Durham, North Carolina 27702
Attention: Vice President, Group Segment

To: Plan Sponsor
Rowan County
130 West Innes Street
Salisbury, NC 28144
Attention: Assistant Director-Benefits and Risk Management
Contact email: Debbie.Holshouser@rowancountync.gov

To: Group Health Plan or Plan Administrator
Rowan County
130 West Innes Street
Salisbury, NC 28144
Attention: Assistant Director-Benefits and Risk Management
Contact email: Debbie.Holshouser@rowancountync.gov

11. Exhibit A (Administrative Fees) shall be deleted in its entirety, and replaced with the attached revised Exhibit A (Administrative Fees).

12. Exhibit C, Section A.2 (Security Amount- Application of Security Amount) shall be deleted in its entirety and replaced with the following:

    Application of Security Amount. Blue Cross NC shall utilize the Security Amount to the extent necessary to make claims payments and may utilize the Security Amount to satisfy any Administrative Fees or Miscellaneous Fees that have been assessed, but that have not been timely paid, pursuant to the terms of this Agreement, as determined in good faith by Blue Cross NC.

13. The initial paragraph of Exhibit C, Section A.5 (Security Amount- Amount of Increase in Security Amount) shall be deleted and replaced with the following:

    Amount of Increase in Security Amount. Blue Cross NC may increase the Security Amount for the reasons set forth in Section A.4 above in such amount as shall be determined in good faith by Blue Cross NC, provided that the maximum increase shall not exceed the sum of: (i) 1/12 of the most recent estimated annual claims amount determined by Blue Cross NC on a monthly basis; and (ii) the amount of the most recent Monthly Administrative Fee determined by Blue Cross NC pursuant to subsection A of Exhibit A. Although Blue Cross NC shall have the authority to make exceptions, such increases shall generally be in the below described amounts in the below described circumstances:

14. Exhibit D (Blue Cross NC Reporting and Data Transfer Fees) shall be deleted in its entirety and replaced with the attached revised Exhibit D (Blue Cross NC Reporting and Data Integration).

15. Exhibit E (Inter-Plan Programs Arrangement) shall be deleted in its entirety, and replaced with the attached revised Exhibit E (Inter-Plan Programs Arrangement).

16. Exhibit G (Pharmacy Program) shall be deleted in its entirety, and replaced with the attached revised Exhibit G (Pharmacy Program).

17. Exhibit J (Performance Guarantee) shall be deleted in its entirety, and replaced with the attached revised Exhibit J (Performance Guarantees).

[EXECUTION PAGE FOLLOWS]

IN WITNESS WHEREOF, the Group Health Plan, Blue Cross NC, the Plan Sponsor and the Plan Administrator have caused their duly authorized representatives to execute this Amendment to be effective as of the date first above written.

Signed For: Plan Sponsor

By: _____
Signature of Authorized Official

Name _____

Title _____

Date _____

Signed For: Plan Administrator and the Group Health Plan

By: _____
Signature of Authorized Official

Name _____

Title _____

Date _____

Signed For: BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA

By: Tunde Sotunde, M.D.
Tunde Sotunde, M.D. (Jul 8, 2022 13:56 EDT)
Signature of Authorized Official

Name Tunde Sotunde, MD

Title President & Chief Executive Officer

Date Jul 8, 2022

EXHIBIT A

ADMINISTRATIVE FEES

In accordance with the specific rate information contained in the medical rate page(s) and, if applicable the dental rate page(s), herein incorporated by reference, and Article 10 of the Agreement, the Plan Sponsor shall pay or cause to be paid to Blue Cross NC fees for administrative services provided to the Group Health Plan during the term of this Agreement as follows:

A. MONTHLY ADMINISTRATIVE CHARGE

1. Medical Benefits

For the Agreement Period, the monthly Administrative Fee will be:

$ 46.00 per health contract per month.

The above monthly Administrative Fee includes:

- Charges for services related to claims and appeals processing services as described in the Agreement.
- The administrative expense allowances associated with Inter-Plan Programs as described in **Exhibit E**.
- The cost of the following additional programs or services provided by Blue Cross NC to the Group Health Plan:

  Claims Fiduciary Services

B. INTER-PLAN ACCESS FEES

Access fees related to the BlueCard Program, as described in **Exhibit E** (Inter-Plan Programs Arrangement), are processed in the following manner:

- Access fees are billed to the Plan Sponsor, Plan Administrator, and/or Group Health Plan separately. The calculation to determine these fees is described in **Exhibit E**, and shall not exceed $2,000 per claim.

C. RUN-OUT SERVICES ADMINISTRATIVE FEES

In accordance with the Run-Out Services provision in Article 17 of the Agreement, Plan Sponsor shall pay or cause to be paid to Blue Cross NC Administrative Fees for run-out services following the termination of this Agreement as follows:

Blue Cross NC shall continue for a period of 12 months to administer all claims that were incurred prior to the effective date of the termination in accordance with the Run-Out Services provision in Article 17. Blue Cross NC shall charge a claim processing fee for this twelve month run-out period equal to the sum of the last three (3) months of the Monthly Administrative Charge prior to the termination of this Agreement. Fifty percent (50%) of the claim processing fee shall be due upon the termination of the Agreement, and the remaining fifty percent (50%) shall be due half-way through the period during which the run-out services are being provided.

In addition, the Security Amount that Plan Sponsor is required to maintain shall be refunded after three months of the run-out period provided there have been no delinquency in the funding of the Claims Expense.

Except as specifically stated herein, Plan Sponsor shall pay Blue Cross NC for run-out services according to the method of payment described in **Exhibit C**..

D. ADDITIONAL ADMINISTRATIVE SERVICES

For the Agreement Period, the Administrative Fees for Additional Administrative Services will be as follows:

(1) Custom Reporting and Data Integration. In addition to standard reporting included as part of plan administration, Plan Administrator may request custom reporting or data integration. There will be additional fees for these services. See Exhibit D for details.

(2) External Review. The External Review Process provision, referenced in Article 7, provides a selection of services related to adverse benefit determinations. Current fees and expenses for those services are listed on the External Review Process Price List which is incorporated by reference and available upon request.

(3) Routine Vision Care. If the Plan elects to utilize Blue Cross NC routine vision care services, a network access fee will be billed in addition to the allowed amount. This network access fee related to routine eye care services shall be no more than 27% of the vision claim's allowed amount. This network access fee will be billed to the Plan Sponsor, Plan Administrator and/or Group Health Plan separately from the routine vision care medical expense, but will be included in the monthly Statement of Account.

(4) Pharmacy Program Utilization Management. Blue Cross NC agrees to perform Drug Utilization Review services as described in Exhibit G (Pharmacy Program). This includes review for benefit denials. The Fee for these services will be forty dollars ($40.00) per review.

EXHIBIT D

BLUE CROSS NC REPORTING and DATA INTEGRATION

Blue Cross NC Reporting

The following reports are standardly available to Blue Cross NC ASO clients.

Report Name	Report Frequency
Statement of Account	Monthly
Summary of Billed Charges by Product	Monthly
Schedule C to Form 5500 Data	Annually
Claims and Membership	Monthly
Detail of Paid Claims	Monthly
Monthly Claims Paid by Subgroup	Weekly
Triangulation Report	Monthly
Utilization Reports	Various
Program Reports*	Various
Online Reporting System**	On Demand

*Additional standard reporting is available for programs purchased for the Plan including, but not limited to, Specific Stop Loss, Aggregate Stop Loss, Performance Based Pricing, and Health Management Programs.

** Reports and analytics are available via the Employer Services portal.

Additional custom reporting may be available as requested by the Plan Administrator and as mutually agreed upon by Blue Cross NC and Plan Administrator. The cost of additional reporting shall be as agreed upon by the Plan Sponsor and Blue Cross NC prior to the production of reports.

Blue Cross NC Data Integration

Blue Cross NC offers a variety of data integration services to support our clients' need to integrate plan data with third party vendors. This includes Blue Cross NC transferring data to a vendor and Blue Cross NC accepting a data file transfer from a vendor. These services and associated fees are detailed in the Data Integration Fee Schedule. The following are examples of data integration services that may incur fees.

a. Third-Party Data Extract (outbound)

   i. Standard data extracts are detailed claims and/or eligibility files. Claims files can include medical and pharmacy claim-line level detail with member, service, clinical

and provider information. Eligibility files include member level detail with product, benefit and demographic information. Eligibility files are monthly snapshots of enrollment and are not intended to be used to maintain member eligibility with third-party vendors. Standard file layouts can be provided upon request.

ii. Groups should contact their client management team to complete the Data Extract Documentation Guide to initiate setup of a third-party data extract.

b. Stop Loss Vendor Integration
   i. Groups with third-party stop loss administrator vendors sending monthly reports and/or eligibility information for members who have reached the stop loss limit.
   ii. Groups should contact their client management team to complete the Third Party Admin (TPA) Stop Loss Reporting Request Form to initiate setup of reporting regarding third party stop loss reinsurers.

c. Pharmacy Vendor Integration
   i. Groups that carve out pharmacy benefits to a non-preferred vendor may choose to have pharmacy data integrated into Blue Cross NC's system for various purposes. Selected services and associated fees will be captured on the Client Intake Form, if applicable.

Any additional data integration requests will be assessed on a case-by-case basis to determine feasibility; additional setup time and fees may apply. The cost of additional integrations shall be as mutually agreed upon by the Plan Sponsor and Blue Cross NC prior to implementation.

EXHIBIT E
INTER-PLAN PROGRAMS ARRANGEMENT

DEFINITIONS

Wherever used in this exhibit, the following definitions apply:

1. "Inter-Plan Programs" means a national arrangement for extending access to cost-effective health care outside of Blue Cross NC's service area, through Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates) that have agreed to participate.

2. "Host Blue" means the independent Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates) that participate in Inter-Plan Programs and provide Provider network access and claim pricing for other independent Blue Cross and/or Blue Shield Licensees (Plans and certain Plan affiliates), including Blue Cross NC, when Members receive medical services in that Host Blue's service area.

SERVICES RECEIVED OUTSIDE OF NORTH CAROLINA

Blue Cross NC has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access health care services outside the Blue Cross NC service area, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Blue Cross NC for payment in accordance with the rules of the Inter-Plan Programs then in effect.

The options for care are as follows:

- Members may obtain care from non-Blue Cross NC service area healthcare providers that have a contractual agreement (i.e., "participating providers") with the Host Blue.
- Members may obtain care from a non-Blue Cross NC service area non-participating healthcare provider(s). These "non-participating providers" do not have a contractual agreement with the Host Blue.

The Blue Cross NC payment practices for the above two options for care are discussed below.

NOTE: A Plan Sponsor, Plan Administrator, and/or Group Health Plan may elect to cover only limited healthcare services received outside of North Carolina (e.g. in a health maintenance organization plan arrangement.) These limited services may include emergency care, urgent care, or approved follow-up care obtained outside the Blue Cross NC service area. Any other services may not be covered when processed through any Inter-Plan Programs arrangements. The specific

limited services are described elsewhere in the Benefit Booklet and/or Plan Sponsor, Plan Administrator, and/or Group Health Plan summary plan description.

1. Participating Provider(s) Outside Blue Cross NC's Service Area

As a result of Inter-Plan Programs, Plan Sponsor Member claims for covered health care services from participating healthcare providers may be processed through either the BlueCard Program or Negotiated National Account Arrangements as described below:

A. BlueCard® Program

Under the BlueCard® Program, when Members receive covered healthcare services within the geographic area served by a Host Blue, Blue Cross NC will remain responsible to Plan Sponsor, Plan Administrator, and/or Group Health Plan for fulfilling Blue Cross NC's contract obligations. However, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating Providers. When Members receive covered health care services within the geographic area served by Host Blue, Blue Cross NC's obligations under Article 7 of this Agreement with respect to those health care services arise once Blue Cross NC receives the claims information for the services from the Host Blue. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

   The calculation of Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the participating Provider's billed covered charges or the negotiated price made available to Blue Cross NC by the Host Blue.

   The calculation of Plan Sponsor, Plan Administrator, and/or Group Health Plan liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to Blue Cross NC by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, you may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge

      The methods employed by a Host Blue to determine a negotiated price may vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price made available to Blue Cross NC by a Host Blue may represent a payment that is one of the following:

(a) an actual price. An actual price is a negotiated payment without any other increases or decreases ("Actual Price"), or

(b) an estimated price. An estimated price is a negotiated payment increased or reduced by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives ("Estimated Price"), or

(c) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its 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.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Blue Cross NC pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member and Blue Cross NC is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

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

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

A small number of states may require a Host Blue to either (i) use a basis for determining Member liability for covered healthcare services that does not reflect the entire amount of realized or expected savings on a particular claim, or (ii) add a surcharge. Should any state enact a law that mandates liability calculation methods that differ from the negotiated price methodology or require a surcharge, Blue Cross NC would then calculate Member liability in accordance with applicable law.

B. Negotiated National Account Arrangements

As an alternative to the BlueCard Program, claims for covered healthcare services may be processed through a negotiated national account arrangement with a Host Blue.

If Blue Cross NC has arranged for a Host Blue to make available a custom healthcare Provider network in connection with this contract, then the terms and conditions set forth in our negotiated national account arrangement with such Host Blue shall apply. In negotiating such arrangement(s), Blue Cross NC is not acting on behalf of or as an agent for you, your group health plan or your Members.

If we have entered into a negotiated national account arrangement with a Host Blue, Member liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Blue Cross NC and that allows your Members access to negotiated participation agreement networks of specified participating providers outside of the Blue Cross NC service area.

Under certain circumstances, if Blue Cross NC pays the Healthcare Provider amounts that are the responsibility of the Member, Blue Cross NC may collect such amounts from the Member.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, Blue Cross NC may include a factor for such settlement reconciliations as part of the fees Blue Cross NC charges to you.

C. Prepayment Review and Return of Overpayments

If a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill Blue Cross NC up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by Blue Cross NC and the Host Blue, and these fees may be charged to you. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill Blue Cross NC the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by Blue Cross NC and the Host Blue, and these fees may be charged to you.

Recoveries of overpayments from a Host Blue or its participating and nonparticipating providers from post-payment review activities can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to Blue Cross NC they will be credited to your account. When a Host Blue identifies and collects these recovery amounts, the Host Blue may bill Blue Cross NC up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by Blue Cross NC and the Host Blue, and these fees may be charged to you. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. When this occurs, the Host Blue may bill the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement

arrangement is agreed upon by Blue Cross NC and the Host Blue, and these fees may be charged to you.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Blue Cross NC will request the Host Blue to provide full refunds from participating healthcare providers for a period of only 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, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of this agreement.

A. Non-Participating Providers Outside Blue Cross NC's Service Area

When covered healthcare services are received outside of Blue Cross NC's service area from non-participating healthcare Providers, the amounts a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment that Blue Cross NC will make for the covered services as set forth in this paragraph.

In some exception cases, Blue Cross NC may pay claims from non-participating healthcare Providers outside of Blue Cross NC's service area based on the Provider's billed charge, such as in situations where a Member did not have reasonable access to a participating Provider, as determined by Blue Cross NC or by applicable state law. In other exception cases, Blue Cross NC may pay such a claim based on the payment it would make if Blue Cross NC were paying a non-participating Provider for the same covered healthcare services inside of Blue Cross NC's service area, as described elsewhere in this Contract where the Host Blue's corresponding payment would be more than Blue Cross NC's in-service area Non-participating Provider payment, or Blue Cross NC may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment Blue Cross NC will make for the covered services as set forth in this paragraph.

FEES AND COMPENSATION

Plan Sponsor, Plan Administrator, and/or Group Health Plan understands and agrees to reimburse Blue Cross NC for certain fees and compensation which Blue Cross NC is obligated to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), or to Inter-Plan Programs vendors under the Inter-Plan Programs.

If, under either the BlueCard Program or a Negotiated National Account Arrangement, Blue Cross NC passes claim-based network access fees on to Plan Sponsor, Plan Administrator, and/or Group

Health Plan directly, then these fees will be up to the allowable Inter-Plan Programs' percentage of the discount (billed covered charges less negotiated price) received from a Host Blue as described above in the section entitled "Liability Calculation Method Per Claim" and will not exceed $2,000 per claim. If Blue Cross NC passes the administrative expense allowance on to Plan Sponsor, Plan Administrator, and/or Group Health Plan directly, the administrative expense allowance fee will be charged on a per claim basis. In such cases, the remaining Inter-Plan Programs-related fees are covered in the Monthly Administrative Charge.

If, under either the BlueCard Program or a Negotiated National Account Arrangement, Blue Cross NC does not charge Plan Sponsor, Plan Administrator, and/or Group Health Plan either the (i) claim-based network access fees or the (ii) administrative expense allowance fee directly, then such fee(s) will be included as part of the Monthly Administrative Charge and/or Network Performance Fees as defined under the Agreement. A listing of any fees paid directly by Plan Sponsor, Plan Administrator, and/or Group Health Plan will be provided by Blue Cross NC, on an annual basis, upon written request of Plan Sponsor, Plan Administrator, and/or Group Health Plan.

Administrative expense allowance fees for claims from non-participating Providers outside Blue Cross NC's service area will also be included as part of the Monthly Administrative Charge as defined under the Agreement.

Additional fees that are paid by Blue Cross NC each time a claim is processed through Inter-Plan Programs include, but are not limited to, Central Financial Agency Fees and ITS Transaction Fees. Other fees paid by Blue Cross NC may apply. Where applicable, these fees paid by Blue Cross NC are covered in the Monthly Administrative Charge.

Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Blue Cross NC shall provide you with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and your right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If you fail to respond to the notice and do not terminate this Agreement during the notice period, you will be deemed to have approved the proposed changes, and Blue Cross NC will then allow such modifications to become part of this Agreement.

VALUE BASED PROGRAMS

Value-Based Programs Overview:

Plan Sponsor, Plan Administrator, and/or Group Health Plan Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to Accountable Care Organizations, global payment/total cost of care arrangements, patient centered medical homes and provider shared savings arrangements.

Value-Based Programs under the BlueCard Program/Value-Based Programs Administration:

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways:

The Host Blue may pass these provider payments to Blue Cross NC, which Blue Cross NC will pass directly on to Plan Sponsor, Plan Administrator, and/or Group Health Plan as either an amount included in the price of the claim or an amount charged separately in addition to the claim. When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(a) Actual Pricing: The charge to accounts for Value-Based Programs incentives/provider shared savings settlements is part of the claim. These charges are passed to Plan Sponsor, Plan Administrator, and/or Group Health Plan via an enhanced provider fee schedule.

(b) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/provider shared savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/provider shared savings settlements to accounts are outside of the claim system. Blue Cross NC will pass these Host Blue charges directly through to Plan Sponsor, Plan Administrator, and/or Group Health Plan as a separately identified amount on the group billings.

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

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

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

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If Plan Sponsor, Plan Administrator, and/or Group Health Plan terminate, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this agreement.

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

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

Care Coordinator Fees:

Host Blues may also bill Blue Cross NC for Care Coordinator Fees for provider services which we will pass on to Plan Sponsor, Plan Administrator, and/or Group Health Plan as follows:

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

As part of this agreement, Blue Cross NC and Plan Sponsor, Plan Administrator, and/or Group Health Plan will not impose Member cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements:

If Blue Cross NC has entered into a Negotiated Arrangement/Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Plan Sponsor, Plan Administrator, and/or Group Health Plan Members, Blue Cross NC will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive Member cost sharing for care coordinator fees, the following provision will apply: As part of this agreement, Blue Cross NC and Plan Sponsor, Plan Administrator, and/or Group Health Plan may agree to waive Member cost sharing for care coordinator fees.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

You understand and agree to reimburse Blue Cross NC for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services

EXHIBIT G
PHARMACY PROGRAM

1. DEFINITIONS

Whenever used in this exhibit, the following definitions apply:

1.1 "A Rated Generics" means drugs designated by the FDA to have a therapeutically equivalent (A rated) generic equivalent.

1.2 "Average Wholesale Price" (AWP) means the average wholesale price of a covered prescription drug as set forth in the Blue Cross NC price file at the time a Claim is processed. The AWP that will be applied for prescriptions filled by a Participating Pharmacy will be based on the date dispensed and the 11-digit NDC for the product. The AWP that will be applied for prescriptions filled by the Mail Service Pharmacy or Specialty Pharmacy will be based on the date dispensed and the appropriate NDC for the product dispensed. The price file will be updated no less frequently than once every three (3) business days through Medi-Span or such other Pricing Source as designated by Blue Cross NC.

1.3 "Brand Drugs" means those pharmaceuticals designated by the Pricing Source as having a multi-source indicator of M, N or O, or as otherwise defined by Pricing Source

1.4 "Claim" means a request for payment submitted by Network Participants or Members for prescription drugs or services. A claim does not include reversals or rejects. A claim does not include an initial claim that was eventually reversed or rejected.

1.5 "Claim Adjudication" or "Adjudication" means the process which Blue Cross NC uses to apply the criteria and parameters of the Group Health Plan to determine eligibility for coverage of pharmacy benefit management services, perform concurrent (on-line at point of service) Drug Utilization Reviews and determine drug pricing reimbursement amounts.

1.6 "Claims Adjudication System" means an electronic Claims processing system providing for the Adjudication of Claims.

1.7 "Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Services, calculated as a percentage of the charge for such services, which is to be paid by Members pursuant to the Group Health Plan. Members will pay the lowest of: (i) eligible charge (discounted AWP + dispensing fee + applicable tax or MAC + dispensing fee + applicable tax); (ii) U&C; and (iii) applicable co-payment.

1.8 "Compound Drug" means a prescription where two or more medications are mixed together, and which, at a minimum, one medication must be a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not

be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.

1.9 "Copayment/Deductible" means a fixed dollar portion of the amount claimed for Covered Prescription Drug Services that is to be paid by Members pursuant to the Group Health Plan. Members will pay the lowest of: (i) eligible charge (discounted AWP + dispensing fee + applicable tax or MAC + dispensing fee + applicable tax); (ii) U&C; and (iii) applicable co-payment.

1.10 "Covered Prescription Drug Services" means the pharmacy services and/or pharmaceuticals available to Members and eligible for reimbursement pursuant to the Group Health Plan.

1.11 "Dispensing Fee" means the fee paid to Network Participants for the professional service of filling a prescription and is typically added to the AWP or MAC calculated cost.

1.12 "Drug Utilization Review" or "DUR" means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Group Health Plan.

1.13 "Electronic Prescribing" or "E-prescribing" means the process of creating, storing and transmitting prescription information electronically, either by computer or hand-held device.

1.14 “Eligible Prescription Drug Claim” is any electronically or manually adjudicated Claim paid in full or in part by the Plan Sponsor under the prescription drug benefit for a prescription drug that is covered within established benefit limits for a Member.

Eligible Prescription Drug Claims may exclude certain specialty medications, medications that have A Rated Generics, OTC medications, compounds, vaccines, biosimilars, or any paid claims where coverage is subsequently denied or claims filed on behalf of persons who do not have coverage at the time the prescription drug is filled.

1.15 "Extended Supply Network" or "ESN" means the retail Network Participants who have agreed to provide Members more than a one-month's (or as mutually agreed) quantity supply of Covered Prescription Drug Services provided that the Group Health Plan has a mail service benefit and a retail quantity days’ supply limit of three months.

1.16 "Federal Legend Drug" means a drug, which is required by law to bear on its packaging, "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only".

1.17 "Foreign Drug Claims" means Claims submitted through the Paper Claim process for reimbursement of drugs purchased outside of the United States.

1.18 "Formulary" means a list of various pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of Covered Prescription Drug Services.

1.19 "Generic Drugs" means all drugs that are not defined as “Brand Drugs”.

1.20 "Mail Service Pharmacy" means the services through which Members may receive prescription drugs through the mail.

1.21 "Manufacturer" means a company that manufactures and/or distributes pharmaceutical drug products.

1.22 "Maximum Allowable Cost" or "MAC" means the highest drug cost at which Plan Sponsor will reimburse the Network Participant or Member for a specific drug.

1.23 "Maximum Allowable Cost List(s)", "MAC List(s)", or "Blue Cross NC's MAC List(s)" means the proprietary database listing(s), owned and maintained by Blue Cross NC or its designee, of multi-source pharmaceutical drug products and supplies and the corresponding MAC. A separate MAC List may be maintained for the Mail Service Pharmacy.

1.24 "Network" or "Pharmacy Network" means the group of pharmacies that have been accepted as Network Participants and have entered into agreements with Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members.

1.25 "Network Contract" means a contract between a Network Participant and Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members, as may be amended from time to time.

1.26 "Network Participant" or "Participating Pharmacy" means each individual pharmacy, chain or other dispensing provider that has entered into a Network Contract with Blue Cross NC or its designee to provide Covered Prescription Drug Services to Members.

1.27 "Open Refill Transfer File" means a data file created by the Group Health Plan’s previous pharmacy benefit manager containing its Members’ mail prescriptions, thus enabling a subsequent pharmacy benefit manager, such as Blue Cross NC or its designee, to continue to fill those open mail prescriptions.

1.28 “Over-the-Counter Drugs” or “OTC Drugs” are products classified as OTC by Medi-Span as of the fill date based on the NDC-11 dispensed. OTCs are subject to cost share based on Brand or Generic drug designation.

1.29 "Paper Claims" means prescription drug services that are submitted to Blue Cross NC for adjudication through the use of a paper claim form, generally by a Member subsequent to the point of sale.

1.30 "Pharmacy Operations Manual" means the document to be distributed to Network Participants which describes the administrative policies and procedures of the Claims Adjudication System. The Pharmacy Operations Manual details the method for submitting Claims from the Network Participant to the Claims Adjudication System and procedures for the resolution of Claims rejected by the Claims Adjudication System.

1.31 "Pricing Source" means Medi-Span, or such other national drug database as Blue Cross NC may solely designate, which establishes and provides updates to Blue Cross NC no less frequently than once every three (3) days, or as otherwise required by law, regarding the AWP or other alternative pricing benchmark as determined by Blue Cross NC for Covered Prescription Drug Services.

1.32 "Provider Tax" means any tax on a Covered Prescription Drug Service and other services taxable in the jurisdiction required to be collected or paid by a retail or mail seller for a Covered Prescription Drug Service or the provider of the services.

1.33 "Specialty Pharmacy" means a designated pharmacy provider that provides Specialty Pharmacy Products.

1.34 "Specialty Pharmacy Product(s)" means a pharmaceutical that may be administered orally, by injection or by infusion; may be subject to limited availability or special handling, utilization management, AWP greater than six-hundred dollars, distribution or purchase arrangements from the Manufacturer; may require more support or patient educational services than commonly required for drugs obtained from retail pharmacies; or may be covered under either a medical or pharmacy Group Health Plan.

1.35 "Usual and Customary" or "U&C" means the lowest price, including any Dispensing Fee a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

1.36 "Utilization Management" or "UM" means a broad collection of standard clinical products and services that are designed to encourage proper drug utilization in order to enhance Member outcomes while managing drug benefit costs for Plan Sponsor. Such services include, but are not limited to the following, Formulary exception, prior authorization, step therapy, quantity limits, restricted access, and retrospective DUR.

2. GENERAL SERVICES

2.1 **Plan Administrator Management Services.** Blue Cross NC will provide certain account management services as set forth herein.

2.1.1 Account Management. Blue Cross NC agrees to provide account services to support the overall effectiveness of the services provided under this Exhibit, and promote the integration of such services with operations. The account team will

facilitate and plan routine meetings with Plan Administrator to provide updates on program performance, present benefit consultations, and consult on operational improvements. Benefit design consultation and analysis may consist of analysis of different benefit designs, the financial impact of Copayment differentials, Pharmacy Network options, shifts in utilization patterns, generic savings opportunities, and Formulary options. The account team will also present new Blue Cross NC products and services to Plan Administrator, to support meeting their pharmacy program objectives. Other activities may include some or all of the following:

(a) Research and propose solutions to Claims, eligibility, provider, and Member service issues;

(b) Collaboration with Plan Administrator on an annual strategic plan and supporting work plans to coordinate the activity;

(c) Attend quarterly face-to-face meetings with Plan Administrator;

(d) Provide and interpret pharmacy reports, quarterly performance reports and semi-annual program updates. Conduct financial analysis of Blue Cross NC sponsored programs and products at the Group Health Plan level; and

(e) Plan and coordinate implementation meetings for Blue Cross NC programs and services.

2.2 Claims Processing Information Management

2.2.1 Group Health Plan Information Management. Blue Cross NC or its designee will enter Group Health Plan and Pharmacy Network information as soon as practicable after receiving such information from Plan Administrator but agrees that it will enter such standard data no later than ninety (90) days after receiving the data from Plan Administrator. If Plan Administrator requests Blue Cross NC to enter such data sooner than ninety (90) days, the Parties will mutually agree on the time frame and any potential increased costs associated with such activities.

2.2.2 Adjudication of Claims. Blue Cross NC or its designee will adjudicate Claims for Covered Prescription Drug Services electronically submitted by Network Participants through the Claims Adjudication System or manually submitted by a Member as a Paper Claim, according to the Group Health Plan, Member eligibility, and other information submitted by the Plan Administrator. In adjudicating claims, Blue Cross NC will rely on the information provided to it by the Plan Administrator and will not be responsible for inaccuracies in the information. Adjudication will include eligibility and coverage determination under the Group Health Plan, including the calculation of allowable costs and applicable Copayment/Deductible,

or Coinsurance, payment of eligible claims, and notification of declined or ineligible Claims.

2.2.3 NDC File. Blue Cross NC or its designee will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC. Blue Cross NC or its designee will update the NDC File no less frequently than monthly with information provided by Pricing Source. The NDC file is provided for internal data purposes only and may not be used for pricing purposes.

2.3 **Web-based Tools, Products and Services.** Blue Cross NC or its designee shall offer several web-based products and services to Plan Administrator. Products range from communicating drug news and pipeline information, to an interactive, user-friendly Web site designed for Members.

2.4 **Contact Center Services**

2.4.1 Member Contact Center. Blue Cross NC or its designee will make available a toll-free customer service line for use by Members.

2.4.2 The Mail Service Pharmacy Contact Center. Blue Cross NC or its designee will make available a toll-free customer service line for use by Members utilizing the Mail Service Pharmacy.

2.4.3 Pharmacy Locator. Blue Cross NC or its designee will provide a means, either toll-free telephone line and/or electronic, for Members to contact to identify Network Participants in a particular area. The toll-free telephone line will be available during Pharmacy Help Desk hours.

2.4.4 Pharmacy Help Desk Service. Blue Cross NC or its designee will provide help desk service for pharmacist Claim inquiries twenty-four (24) hours a day, seven (7) days a week. This help desk service will also handle calls from Network Participants in the event they have questions concerning reconciliation reports provided to them for purposes of pharmacy payments.

2.5 **Clinical Services**

2.5.1 Formulary Management.

2.5.1.1 Blue Cross NC will provide Formulary clinical services in accordance with NCQA standards and all applicable state and federal laws.

2.5.1.2 Blue Cross NC will provide Formulary management services and will update the Formulary in a timely manner.

2.5.1.3 Blue Cross NC will coordinate Pharmacy & Therapeutics (P&T) Committee meetings at least quarterly and include developing agenda, therapeutic class

reviews, drug monographs and quarterly updates of Formulary publications available on Blue Cross NC's website.

2.5.2 Utilization Management. Blue Cross NC will provide cost containment programs in the form of Utilization Management programs on behalf Plan Sponsor and such services will be subject to additional fees as described in Exhibit A.

2.6 **E-Prescribing.** Blue Cross NC or its designee will support e-Prescribing transaction standards for eligibility, formulary, and medication history to allow prescribers to electronically send Members' prescriptions directly to a Network Participant from the point-of-care.

2.7 **Special Projects.** Special Projects may be mutually agreed to by the parties and described in an amendment to this Agreement as applicable, including any additional fees.

2.8 **Cooperation upon Termination.** Should Plan Sponsor terminate this Agreement, Blue Cross NC will provide all standard industry PBM transition/data files that will be used by the new PBM to minimize member disruption, including full historical NCPDP claims files, prior authorization files, accumulator files, mail open refill files, both pre and post termination date. Blue Cross NC reserves the right to charge a reasonable fee for these files.

2.9 **Access to Information.** Subject to the limitations in Article 15, if Plan Administrator needs pharmacy claims information from Blue Cross NC for audit or to conduct health care operations, Blue Cross NC shall give Plan Administrator access to that information if allowed by law, upon the completion of a data use agreement. Blue Cross NC reserves the right to restrict the provision of certain information it deems confidential, proprietary or a trade secret.

2.10 **Consulting Fees**. Plan Sponsor has contracted separately with Mark III Employee Benefits ("Group Consultant") for consulting services with regard to the Group Health Plan. In order to provide full consulting services, Group Consultant has contracted with Stealth Partner Group, an Amwins Company ("Pharmacy Consultant") to provide the Plan Sponsor with pharmacy consulting services specific to the Group Health Plan's pharmacy benefits. Plan Sponsor acknowledges and agrees to pay Blue Cross NC $2.00 per Prescription Drug Claim], which shall represent consulting fees (the "Consulting Fee") that Plan Sponsor has requested that Blue Cross NC or its designee pay the Pharmacy Consultant. Plan Administrator further agrees to meet in person with Blue Cross NC two times during the Agreement Period to discuss the Pharmacy Program and performance. For purposes of this section, prescription drug claim shall mean any prescription drug paid under the pharmacy benefit, including brand or generic drugs, purchased via mail or retail. Such Plan Sponsor acknowledges that it has the sole financial responsibility for the payment of the Consulting Fee. Blue Cross NC or its designee has no obligation to pay the Consulting Fee until Plan Sponsor has submitted the corresponding funds to Blue Cross NC. No amount so transferred or paid by Plan Sponsor will be considered an asset of Plan Sponsor or its Group Health Plan, and Blue Cross NC will not have any obligation to Plan Sponsor with

respect to any interest or other earnings, if any, received by Blue Cross NC with respect to such amounts.

The Parties acknowledge that this provision does not restrict Plan Sponsor from changing or removing its consultants. The Plan Sponsor understands that changing its consultants identified above shall require notice as required under Article 18 of the Agreement.

Blue Cross NC or its designee shall pay Consulting Fees to the Pharmacy Consultant from its general assets on a quarterly basis after receiving such Consulting Fees from Plan Sponsor. Flat fee payments shall be paid as part of the first quarter commission payment. Should Blue Cross NC or its designee pay any amount of Consulting Fees to Consultant that Blue Cross NC or its designee, for any reasons, did not collect or was required to return to Plan Sponsor, Blue Cross NC or its designee shall notify Consultant and Blue Cross NC or its designee shall recoup such Consulting Fees.

The Plan Sponsor represents and warrants that the Consulting Fees are reasonable and are directly related to actual services rendered by the Pharmacy Consultant to the Plan Sponsor. The Plan Sponsor further represents and warrants that the Pharmacy Consultant does not provide services to the Plan Sponsor that would make the Pharmacy Consultant a fiduciary of the Group Health Plan, as defined in the Employee Retirement Income Security Act of 1974, as amended.

3. PHARMACY NETWORK SERVICES

3.1 **Network Utilization and Pricing.** Blue Cross NC or its designee will provide and maintain Pharmacy Network(s) to provide Covered Prescription Drug Services to Members. For the Pharmacy Network selected, the rates are described in Section 3.5 of this exhibit. In the event Plan Administrator elects to have Blue Cross NC maintain or administer additional Networks, the rates will be subject to change.

3.2 **Network Establishment and Maintenance.** Through the chosen Pharmacy Network(s), Members will have access to certain Network Participants that have (a) executed a Network Contract as required by Blue Cross NC or its designee (as amended from time to time), and (b) have agreed to provide Covered Prescription Drug Services to Members in accordance with a pharmacy reimbursement schedule and the terms of the Network Contract. Blue Cross NC or its designee will maintain Network Contracts with an adequate number of Network Participants in the various geographical areas where Members reside and will comply with all applicable regulatory access requirements. Blue Cross NC or its designee will furnish each Network Participant with Group Health Plan information in such a format and media as Blue Cross NC deems appropriate for the purpose of assisting such Network Participants in providing Covered Prescription Drug Services to Members. Blue Cross NC reserves the right to periodically change Network Participants in order to maintain satisfactory compliance with Blue Cross NC's policies on pricing, quality, and operations.

3.3 **Network Contracts.** Blue Cross NC will comply, or will require its designee to comply, with all laws applicable to pharmacy network contracts, including applicable state regulatory or other governmental agencies' filings if necessary (including, but not limited to, filings regarding all Network Participant terminations).

3.4 **Blue Cross NC Maximum Allowable Cost List.** Network Pharmacies will be required to accept Blue Cross NC's MAC List(s) for Members.

3.5 **Drug Pricing.**

Plan Sponsor will be invoiced for pharmacy claims based on the contracted rate with the pharmacy minus the member's coinsurance and deductible amounts. Schedule A provides a minimum annual effective rate for each level of discount.

See Schedule A for pricing terms and conditions. Schedule A will provide the underwriting terms and conditions and will be included as an exhibit to the pharmacy exhibit.

3.6 **Pharmacy Network Audit Services.** Blue Cross NC or its designee will perform pharmacy Claims audits to promote Network Participants' compliance with contractual obligations and applicable laws. Blue Cross NC or its designee will perform its pharmacy Claims audits pursuant to the authority granted to Blue Cross NC or its designee in the applicable Network Contracts. Such audits may include:

3.6.1 Daily Claims Review. Blue Cross NC or its designee will conduct manual review of selected questionable Claims by Network Participant from a population of Claims that meet or exceed a defined dollar threshold. Blue Cross NC or its designee will contact Network Participant and instruct pharmacist to reverse and reprocess the applicable Claim using accurate Claim information, when appropriate.

3.6.2 Desktop Audits. Blue Cross NC or its designee will perform desktop audits of Network Participants identified through the pharmacy audit profile, upon request, through Blue Cross NC's compliance hotline, or as otherwise identified by Blue Cross NC. Blue Cross NC or its designee will review and verify up to twelve (12) months of Claims by Network Participant and will contact Network Participant through correspondence to address questionable Claims issues. Blue Cross NC or its designee will request a copy of prescription to verify accuracy, when appropriate.

In certain cases, inaccurate Claims will result in a chargeback to the Network Participant. During each calendar year, Blue Cross NC or its designee will perform the number of desktop audits that equals nine percent (9%) of Network Pharmacies. If additional audits are needed, the volume and associated fees will be mutually agreed upon in advance.

3.6.3 On-Site Audits. Blue Cross NC or its designee will perform on-site audits of Network Participants identified through the pharmacy audit profile, upon request,

through Blue Cross NC's compliance hotline, or as otherwise identified by Blue Cross NC. Blue Cross NC or its designee will review and verify up to twenty-four (24) months of Claims at the Network Participant's location. Blue Cross NC or its designee will also verify Network Participant is in compliance with the Network Contract and the Pharmacy Operations Manual. In certain cases, inaccurate Claims will result in a chargeback to the Network Participant. During each calendar year, Blue Cross NC or its designee will perform the number of on-site audits that equals five percent (5%) of Network Pharmacies. If additional audits are needed the volume and associated fees will be mutually agreed upon in advance.

3.7 Network Participant Interface and Payments

3.7.1 Claims Submission. Network Participants will be required to submit Claims for Covered Prescription Drug Services to Blue Cross NC or its designee in accordance with the procedures detailed in the National Council of Prescription Drug Programs (NCPDP) Online Claims Submission Telecommunication Standard.

3.7.2 Claims Quality. Blue Cross NC or its designee will perform online edits of the information contained in the Claims based upon the provisions and guidelines of the applicable Group Health Plan. Missing, illegible or erroneous information will cause such Claims to be rejected and the Network Participant will be notified online according to the NCPDP standards for communicating such rejections. All rejected Claims must be resubmitted in their entirety.

3.7.3 Payment Methodology/Network Participant Reimbursement Calculation. Blue Cross NC or its designee will pay Claims consistent with the applicable Benefit Booklet. Reimbursement to the Network Participant will be based upon the agreed-upon pricing contained in the Network Contract with the Network Participant on the date the prescription transaction is processed, referred to as the Allowed Amount. The negotiated amount, or Allowed amount for Participating Pharmacies, will be: any provider or sales taxes, where applicable; plus the lesser of: (i) U&C; or (ii) the Pharmacy Network submitted cost plus the contracted Dispensing Fee; or (iii) the sum of the MAC or AWP less the contracted discount percentage plus the contracted Dispensing Fee.

3.7.4 Material Change to AWP. If after the Effective Date: (i) material changes to the formula, methodology or manner in which AWP is calculated or reported by the Pricing Source take effect or (ii) the Pricing Source ceases to publish AWP for the Covered Prescription Drug Services under this Agreement, then the financial terms of this Agreement shall be automatically adjusted at the time of such change to return the Parties to their commercially reasonably respective economic positions as they existed under the Agreement prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Agreement shall immediately and automatically be converted to an alternative comparable pricing benchmark.

3.7.5 Provider Taxes. Blue Cross NC will bill Plan Sponsor and Plan Sponsor will pay Blue Cross NC for any federal, state or local Provider Taxes payable with respect to any sales of Covered Prescription Drug Services to a Member, and will remit to Network Participant any such taxes collected from Plan Sponsor. Network Participant is required to submit a request for tax payment at the time of an on-line claim submission. Network Participant will remit any such Provider Taxes to the appropriate taxing authority. Network Participant will be solely responsible for any other taxes or surcharges associated with its performance under the Network Contract.

4. REBATE MANAGEMENT SERVICES

4.1 Negotiating Rebates.

On its own behalf, Blue Cross NC or its designee have entered into, and may in the future, enter into arrangements with Manufacturers under which a portion of prescription drug charges are rebated. In addition, pharmacy management vendors may receive administrative reimbursement or fees directly from Blue Cross NC or drug or other companies for administrative services they deliver for Blue Cross NC and those companies. These amounts are not considered rebates as described here. Pharmaceutical Rebates may be associated with drug claims processed under the Group Health Plan's pharmacy benefit. From time to time, Rebates may be received for prescription drugs provided under the medical benefit ("medical benefit Rebates"). These Rebates amount vary, and may change during the year, based upon the status of a drug in Blue Cross NC's prescription drug formulary, drug utilization, benefit coverage, unexpected generic launches, and other factors. Plan Sponsor retains sole and complete control to (i) select and change the formularies for its Plan, and (ii) determine and amend all benefit structures and terms under its Group Health Plan.

As described below, Blue Cross NC will credit to Group Health Plan's account the allocated rebates it receives from its pharmacy management vendor(s) after deducting the applicable Pharmacy Handling Fees.

4.2 Rebate Payments.

Blue Cross NC guarantees the group that the rebate credits for pharmacy claims processed during the current Agreement Period will be as provided in Schedule A.

Although the rebate per Eligible Brand Prescription Drug Claim may be more or less than the amounts Blue Cross NC receives under this Agreement, Plan Sponsor agrees to receive only the Rebate Payment

Plan Sponsor understands that certain Manufacturers will not pay Rebates for "cash business." "Cash business" may be defined differently by Manufacturers and final authorization to pay Rebates on "cash business" Claims (as defined by such Manufacturers), resides separately with each Manufacturer. Subject to the foregoing, for

purposes of this Agreement, "cash business" means those Claims involving payment of the entire cost of the drug by the individual receiving such drug due to such individual not being covered by any prescription drug benefit which provides for payment of the entire, or any portion of, the cost of the drug; provided, however, that Claims involving payment of the entire cost of the drug by the individual receiving the drug due to exhaustion of his or her prescription drug benefit will not be considered "cash business," nor are Claims initially paid for by the Member where the Member is entitled to subsequent reimbursement from the provider of the prescription drug benefit coverage. Blue Cross NC will have the right, upon notice, to make an adjustment to the Rebates if rebate revenue is decreased because Brand Drugs lose their patent, move to generic status, or there is a change in law. Rebate payments are conditioned on Blue Cross NC processing all pharmacy claims under the Group Health Plan. Rebate guarantees are subject to change if Plan Sponsor carves out any portion of the pharmacy benefit to third party PBMs. Rebate guarantees include claims processed through in-house pharmacies, and assume hospital own-use claims are eligible for rebates (i.e. assume Plan Sponsor does not have 340b pricing). If Plan Sponsor has 340b pricing in place, rebate guarantees are subject to change.

4.3 Rebate Payment Schedule.

Rebate guarantees will be paid quarterly by Blue Cross NC within 180 days to Plan Sponsor with an annual reconciliation report of rebates received by Blue Cross NC provided to Plan Sponsor for each contract year anniversary date. Blue Cross NC will retain 50% of any overage discovered in that annual reconciliation, with such retention capped at a maximum of $5.00 PEPM. The balance of rebates shall be paid to Plan Sponsor no later than 270 days of each contract year anniversary date, however rebates will not be paid without a fully executed and signed Agreement.

Plan Sponsor agrees all payments associated with rebates and any related interest are not due and owing to the Group Health Plan until Blue Cross NC actually pays them to the Plan pursuant to this Agreement. Plan Sponsor agrees that Blue Cross NC will deposit rebates in an interest-bearing account upon receipt from pharmacy management vendor(s) until distributed to the Group Health Plan, and interest earned will be retained by Blue Cross NC as additional compensation.

4.4 Rebates Upon Termination.

In the event the Pharmacy Benefit is terminated by Plan Sponsor prior to the end of the arrangement as described in Schedule A, Plan Sponsor will forfeit any unpaid rebates earned during that year to date, and Blue Cross NC may retain such rebates as additional compensation.

5 PHARMACY SERVICES

5.1 Mail Service Pharmacy Services.

5.1.1 Mail Service Pharmacy Pricing Terms. Plan Sponsor will pay Blue Cross NC for Covered Prescription Drug Services dispensed by the Mail Service Pharmacy in an amount equal to the contracted rate for each Covered Prescription Drug Service dispensed as specified in Schedule A, less the applicable Copayment/Deductible or Coinsurance amount. The applicable AWP will be based on the package size dispensed and the appropriate NDC.

5.1.2 Mail Service Pharmacy Covered Prescription Drug Services. The Mail Service Pharmacy will provide medications under the following guidelines:

(a) The Covered Prescription Drug Services and days' supply limitation will be as set forth in the applicable Benefit Booklet.

(b) Based upon the prescription and Applicable Law, the Mail Service Pharmacy will provide a quantity of Covered Prescription Drug Services consistent with the Member's Benefit Booklet, subject to the quantity limitations written by the prescriber on the prescription, professional judgment of the dispensing pharmacist, limitations imposed on controlled substances and Manufacturer's recommendations. Prescriptions may be refilled providing the prescription so states. Prescriptions will not be filled (1) more than twelve (12) months after issuance, (2) more than six (6) months after issuance for controlled drug substances, or (3) if prohibited by Applicable Law.

5.1.3 Mail Service Pharmacy Dispensing Procedures.

(a) The Mail Service Pharmacy shall dispense Covered Prescription Drug Services to Members, and dispense Generic Drugs when authorized, in accordance with (1) Applicable Law, and (2) the terms of this Agreement.

(b) All matters pertaining to the dispensing of Covered Prescription Drug Services or the practice of pharmacy in general are subject to the professional judgment of the dispensing pharmacist.

(c) Any drug which cannot be dispensed in accordance with the Mail Service Pharmacy's reasonable dispensing protocols, which requires special record-keeping procedures, or which requires special handling, may not be dispensed by the Mail Service Pharmacy, provided that the Mail Service Pharmacy provides Members with reasonably prompt notice of any such drug.

(d) If it becomes impracticable, for reasons of force majeure or otherwise, for the Mail Service Pharmacy to dispense prescriptions to Members under the Mail Service Pharmacy Service, the Mail Service Pharmacy shall use reasonable efforts to have prescriptions dispensed from an alternative Network Participant, subject to Applicable Law.

5.1.4 Mail Service Pharmacy Postage, Mailing, and Shipping. The Mail Service Pharmacy will be solely responsible for all standard postage, mailing and shipping expenses of Covered Prescription Drug Services provided to Members pursuant to this Agreement, except in the instance when a Member requests expedited shipping, in which case the expedited shipping expenses shall be the sole responsibility of the Member. The Mail Service Pharmacy shall have discretion to waive the expedited shipping fee, but it shall remain responsible for the postage.

5.1.5 Mail Service Pharmacy Complaint Procedures. The Mail Service Pharmacy shall make commercially reasonable efforts to resolve oral or written complaints in an informal process and to keep written records of events and actions surrounding each complaint that is not resolved to the Member's satisfaction, as much as is practicable.

5.2 **Specialty Pharmacy Services.** The following provisions apply only to services provided through the Specialty Pharmacy.

5.2.1 Specialty Pharmacy Services.

(a) Blue Cross NC or its designee will use Member enrollment and benefit coverage information provided by Plan Administrator to determine Member eligibility and benefit coverage at the time of dispensing.

(b) The Specialty Pharmacy will collect from each Member their applicable Copayment/Deductible and/or Coinsurance fee for each prescription or refill in accordance with the Benefit Booklet.

(c) The Specialty Pharmacy may withhold prescription services to a Member for good cause if allowed by law including, but not necessarily limited to, Plan Sponsor's nonpayment of prescription services provided to Members; the Member's failure to pay for services rendered (e.g., Copayments/Deductibles and/or Coinsurance or other out-of-pocket costs); requests by Members for quantities of Specialty Pharmacy Products in excess of prescribed quantities or refill limitations or where, in the professional judgment of the dispensing pharmacist, the prescription should not be filled.

(d) The Specialty Pharmacy will attempt to dispense Generic Drugs in lieu of prescribed brand name Specialty Pharmacy Products if commercially available, consistent with the prescription, and consistent with the dispensing pharmacist's professional judgment and Applicable Law. In addition, the Specialty Pharmacy will comply with the Group Health Plan Formulary to the extent the Formulary applies to such Specialty Drug Products, unless the Specialty Pharmacy is otherwise directed by a prescribing provider via a prescription which contains the handwritten words "Dispense as Written" or "Brand Necessary", or such other equivalent indication as may be required by applicable laws or regulations to indicate the same intention.

(e) Upon the Specialty Pharmacy's receipt of an appropriate Specialty Pharmacy Product prescription and any required Copayment/Deductible or Coinsurance from the Member, the Specialty Pharmacy will ship the Specialty Pharmacy Product to the Member or provider, as directed by the Member, via a third party carrier or any other comparable traceable method the Specialty Pharmacy may select.

(f) The Specialty Pharmacy will make every reasonable effort to resolve oral or written complaints in an informal process and keep written records of events and actions surrounding each complaint that is not resolved to the eligible Member's or provider's satisfaction.

5.2.2 Specialty Pharmacy Dispensing Procedures.

(a) The Specialty Pharmacy will dispense Specialty Pharmacy Products to Members when authorized, in accordance with (1) Applicable Law, and (2) the terms of this Amendment and Benefit Booklet.

(b) All matters pertaining to the dispensing of Specialty Pharmacy Products or pharmacy in general are subject to the professional judgment of the dispensing pharmacist.

(c) If it becomes impracticable, for reasons of force majeure or otherwise, for the Specialty Pharmacy to dispense prescriptions to Members, Specialty Pharmacy will use commercially reasonable efforts to have Specialty Pharmacy Products dispensed from an alternative specialty pharmacy, subject to Applicable Law.

5.2.3 Specialty Pharmacy Pricing Terms.

(a) The Copayment/Deductible or Coinsurance amount for each prescription or refill dispensed through the Specialty Pharmacy will be as designated in the applicable Group Health Plan.

(b) Claims for Specialty Pharmacy Products will be processed as soon as reasonably practicable following receipt. The applicable AWP will be determined as of the date on which the Claim is processed using the most recently loaded Pricing Source data.

5.2.4 Specialty Copay Solutions – Copay Maximization.

Plan Sponsor has elected to participate in the Specialty Copay Solutions – Copay Maximization Program. This program maximizes the value of eligible manufacturer-sponsored patient assistance coupon programs (coupon program) by

adjusting Member out-of-pocket liability to reach the full value of the benefit under the manufacturer's coupon program. In addition, the value of the manufacturer coupon will not be credited to Member deductible or out-of-pocket maximum amounts. The administrative fee for this program is $125 per eligible specialty drug claim.

EXHIBIT J

PERFORMANCE GUARANTEES

A. Terms and Conditions

Blue Cross NC agrees to the following performance definitions, measures and standards ("Performance Guarantees") for a period of one year beginning July 1, 2022 through June 30, 2023 (hereinafter the "Measurement Period").

For each category described, performance will be measured by, and Administrative Fee Refunds ("AFR"), if any, will be calculated on the basis of Blue Cross NC's audits, surveys or reports as described in this Exhibit. Where Blue Cross NC fails to achieve a Performance Guarantee, applicable AFRs, expressed as a percentage of the Medical Administrative Fee collected from the Plan Sponsor and/or the Group Health Plan, will be paid by Blue Cross NC as described below.

Blue Cross NC will place a maximum of **9%** of Medical Administrative Fees at risk. The Medical Administrative Fee is the Administrative Fee payable by the Group Health Plan to Blue Cross NC for administration of health benefits. Medical Administration Fee does not include fees for dental benefits, run-out services, commissions, and/or stop loss coverage.

The Plan Sponsor and/or the Group Health Plan reserve the right to have internal or external auditors verify the accuracy of Blue Cross NC's reported results at their expense. Blue Cross NC reserves the right to replace or modify any Performance Guarantee if necessitated by the way Blue Cross NC tracks or measures the applicable Performance Guarantee. Any substitute Performance Guarantee will, to the extent reasonably possible, attempt to reflect the same underlying objective and performance level reflected in the original Performance Guarantee, consistent with this new measurement and/or tracking methodology. Blue Cross NC shall explain the reasons for the change and the substitute methodology in writing at least 30 days prior to such change.

1. The measures discussed herein are calculated based on the entire Measurement Period in accordance with Blue Cross NC's performance measurement policies and procedures. The appropriate AFRs will be paid if the result fails to meet the established standard. An annual report of Performance Guarantee performance will be prepared by Blue Cross NC and provided to Plan Administrator no later than 90 days after the conclusion of the Measurement Period and will be the basis for payment, if any, pursuant to paragraph 4 of this section, below.

2. These Performance Guarantees and AFRs apply only in regard to health care services provided directly by Blue Cross NC. It is not intended to apply to any other service or coverage,

including but not limited to dental, life insurance coverage, and carve-outs such as vision and mental health.

3. Any material failure on the part of the Group Health Plan or its designee to perform on a timely basis those responsibilities specified in the Agreement that are necessary and integral to the Performance Guarantee made by Blue Cross NC shall void the Performance Guarantee, until such time as they have been corrected and the applicable Performance Guarantee and Blue Cross NC shall be held harmless. This includes, but is not limited to, retroactive requests from the Group Health Plan or its designee.

4. Blue Cross NC shall pay any amounts due to the Plan Sponsor and/or the Group Health Plan as a result of Blue Cross NC's failure to meet the Performance Guarantee. Payment shall be made 90 days following the conclusion of the current Measurement Period.

5. AFRs shall be a percentage of the actual Administrative Fees paid by the Plan Sponsor and/or the Group Health Plan. If the Plan Administrator, the Plan Sponsor and/or the Group Health Plan are delinquent in the payment of Administrative Fees, miscellaneous fees and/or the funding of claims as stated in this Agreement, the Performance Guarantees made by Blue Cross NC shall be void for the entire month during which the delinquency occurs. If the Group Health Plan is delinquent for three consecutive months, the Performance Guarantees made by Blue Cross NC shall be void for the entire current Measurement Period.

6. Notwithstanding the above, Performance Guarantees will become effective the later of the first day of the Measurement Period or the month following the receipt of a fully executed Agreement. When calculating the payout on Performance Guarantees measured on an annual basis, the Performance Guarantee will be deemed to have been met for portions of the Measurement Period prior to the execution of the Agreement.

B. Implementation (Fees at Risk: 2.00%)

Standards	**Administrative Fee Refunds (AFR) for Failure to Meet Standard**

(Note: Applicable Administrative Fee Refunds (AFR) will be paid based on Measurement Period results.)

1. Blue Cross NC will generate and mail Member ID cards prior to the effective date.

Member ID cards mailed by the effective date	0% Refund
Member ID cards mailed 1-5 days after the effective date	1% Refund
Member ID cards mailed 6 or more days after the effective date	2% Refund

** The above standard is based on Blue Cross NC receiving accurate and complete enrollment data at least **45** days prior to the Group Health Plan's effective or renewal date to include enrollment data with addresses formatted to USPS standard.*

C. Customer Service (Fees at Risk: 4.00 %)

Standards	**Administrative Fee Refunds (AFR) for Failure to Meet Standard**

(Note: Applicable Administrative Fee Refunds (AFR) will be paid based on Measurement Period results.)

1. Average Speed to Answer will be thirty-one (31) seconds or less.

30.9 Seconds or Less	0.0% Refund
31-40 Seconds	1.0% Refund
41 Seconds or Higher	2.0% Refund

Standard: (Will be based on ASO Performance Guarantee Unit results)

2. Abandonment Rate will be 5.0% or less.

5.0 % or Less	0.0% Refund
5.01% - 7.9%	1.0% Refund
8.0% or Higher	2.0% Refund

Standard: (Will be based on ASO Performance Guarantee Unit results)

D. Claim Processing Service (Fees at Risk: 3.00 %)

Standards	**Administrative Fee Refunds (AFR) for Failure to Meet Standard**

(Note: Applicable Administrative Fee Refunds (AFR) will be paid based on Measurement Period results.)

1. Financial Accuracy Rate = 98.0%

98.0 % or Higher	0% Refund
96.0% - 97.9%	1% Refund

94.0%-95.9%	2% Refund
93.9% or Less	3% Refund

(Will be based on Administrative Services Only (ASO) Unit results)

E. Definitions

1. "Abandonment Rate" is the percentage of Member calls that hang up while waiting for a Customer Service Professional to answer the call.

2. "Average Speed to Answer" is measured beginning when a Member arrives in the Customer Service Department queue and ending when a Customer Service Professional answers the call.

3. "Business Days" are Monday through Friday that Blue Cross NC is open for business.

4. "Calendar Days" are any day of the week, including weekends and holidays.

5. "Clean Claims" are those claims that do not require external investigation in order to process. External investigation means that Blue Cross NC must obtain information from a non-Blue Cross NC agent, contractor or subsidiary to process a claim.

6. "Enrollment Data" is comprised of those applications or other forms or statements completed and submitted by potential Members or electronic eligibility information submitted by the Plan Administrator.

7. "Financial Accuracy Rate" is based on claim errors which impact the actual dollars applied to the claim. This occurs when the Blue Cross NC claims processor or claims adjudication system produces an over or under payment. Financial Accuracy Performance is determined based on review of a random sample of paid claims, including adjusted claims (exclusive of zero-paid claims). This measure is calculated by dividing the absolute dollar value of the overpaid and underpaid tested claims by the total dollar amount paid (or should have paid) for the tested claims.

8. "Member" is a covered employee, a covered employee's dependent or other eligible person who is enrolled in the Group Health Plan.

9. "Processing Time" is a measure based on the number of calendar days from the date of receipt of a claim by Blue Cross NC to either:

    (i) The date the claim has passed all edits and is paid by issuance of a check, settled by payment voucher or denial notice is sent.

(ii) Release of a response to the claimant by Blue Cross NC for those claim submissions, which do not include sufficient information for processing. These claims are closed on the date the response is issued. When the member re-submits the claim with additional information, the claim is processed as a new claim (For example, when a 'balance due' bill is submitted by the Member instead of an itemized bill, the claim would be processed again when the itemized bill is received).

Note: Blue Cross NC measures Processing Time for out-of-state claims processed through the national Blue Card program based on the time a claim is received by Blue Cross NC from the out-of-state Blue Cross Blue Shield plan that prices the claim until the claim has passed all edits and is returned by Blue Cross NC to the out-of-state Blue Cross Blue Shield plan for payment.

10. "Subscriber" is an employee who has enrolled in the Blue Cross NC Health Plan offered by their employer.

11. "Zero-paid claim" is defined as:

(i) A properly denied claim;
(ii) A Coordination of Benefits (COB) claim for which an allowed amount is determinable; or
(iii) A claim for which valid Member liability exceeds plan liability.

SCHEDULE A

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Rowan County	
Effective Date:	7/1/2022
Members:	1,361
Employees:	860

CUSTOM PASSTHROUGH PRICING	
Contract Period	**Broad Plus**
BRAND DISCOUNTS	
Retail Network	
7/1/2022 to 6/30/2023	17.75%
Extended Supply Network (ESN) - 90 Day Channel	
7/1/2022 to 6/30/2023	20.00%
Mail	
7/1/2022 to 6/30/2023	24.50%
GENERIC DISCOUNTS	
Retail Network	
7/1/2022 to 6/30/2023	82.05%
Extended Supply Network (ESN) - 90 Day Channel	
7/1/2022 to 6/30/2023	86.15%
Mail	
7/1/2022 to 6/30/2023	84.95%
BRAND DISPENSING FEES	
Retail Network	
7/1/2022 to 6/30/2023	$0.45
Extended Supply Network (ESN) - 90 Day Channel	
7/1/2022 to 6/30/2023	$0.00
Mail	
7/1/2022 to 6/30/2023	$0.00
GENERIC DISPENSING FEES	
Retail Network	
7/1/2022 to 6/30/2023	$0.45
Extended Supply Network (ESN) - 90 Day Channel	
7/1/2022 to 6/30/2023	$0.00
Mail	
7/1/2022 to 6/30/2023	$0.00
AGGREGATE SPECIALTY	
Discount	
7/1/2022 to 6/30/2023	20.50%
Specialty Pharmacy Dispensing Fee	
7/1/2022 to 6/30/2023	$0.00

Notes: UR-8912

- Discounts are based on the actual NDC-11 dispensed on the fill date.
- Guarantees are based upon the above selected BCBS NC Network.
- Guarantees are based upon an implemented BCBS NC Extended Supply Network (90-day retail). If not implemented, Retail rates apply.
- Discount and Dispensing Fee rates exclude compound, long term care (LTC) pharmacy, home infusion (HIF) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, 340b, Medicare/Medicaid, out-of-network, member-submitted, foreign, coordination of benefits (COB), 100% member-paid plans (i.e. discount cards), subrogation, paper, invalid, usual and customary (U&C) claims and non-specialty discount and dispensing fees also exclude specialty (as defined by the BCBS NC specialty drug management list) claims.
- For discount purposes, Specialty is defined by the BCBS NC specialty drug management list.
- Guarantees are based upon an exclusive specialty network arrangement.
- Aggregate Specialty Discount guarantees does not include limited distribution drugs nor any new specialty drugs brought to market and added to the specialty list during the term of each contract year.
- For discount and dispensing fees, Brand drugs are defined as drugs that have a Medi-Span multisource code field equal to “M", “N", or “O".
- For discount and dispensing fees, Generic drugs are defined as drugs available in sufficient supply that have a Medi-Span multisource code field equal to “Y”.

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Rowan County	
Effective Date:	7/1/2022
Members:	1,361
Employees:	860

CUSTOM PASSTHROUGH PRICING	
Contract Period	**Enhanced**
REBATE PER BRAND	
Retail and Extended Supply Network (ESN) - 30/90 Day Channels	
7/1/2022 to 6/30/2023	$249.03
Mail	
7/1/2022 to 6/30/2023	$708.98
Specialty	
7/1/2022 to 6/30/2023	$1,567.00

Notes:
- Guarantees are based upon the above selected BCBS NC formulary.
- For rebate purposes, Specialty is defined by the BCBS NC Specialty Rebate List.
- Compound, long term care (LTC) pharmacy, home infusion (HIF) pharmacy, veterans affairs (VA) pharmacy, Indian/tribal/urban (I/T/U) pharmacy, 340b, Medicare/Medicaid, out of network, member-submitted, foreign, coordination of benefits (COB), 100% member-paid plan (i.e. discount card), subrogation, paper, invalid, vaccine, over-the-counter (OTC), and biosimilar claims are excluded from rebate guarantees.
- For rebate purposes, Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to “M”, “N”, or “O”.
- Guaranteed rebates will be paid on all eligible claims, claims paid in full or in part by Plan Sponsor, incurred during the life of the contract.
- Pharmacy handling fees of $2.65 per retail and specialty script and $4.05 per mail script will be deducted from rebates at time of rebate settlement.
- If pharmacy coverage is terminated prior to 6/30/2023, Rowan County will forfeit any unpaid rebates.

BlueCross BlueShield of North Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

Rowan County	
Effective Date:	7/1/2022
Members:	1,361
Employees:	860

Additional Caveats:

- For the purpose of reconciliation at contract year end, all guarantees are reconciled in aggregate, as long as the contract remains in effect.
- Guarantees are based on adoption and adherence of an above BCBS NC formulary, including associated utilization management and clinical Programs. BCBS NC reserves the right to equitably adjust the guarantees in the event there is a change in the formulary implementation of new or removal of existing clinical programs, changes to the pharmacy benefit plan design, changes of lock-out of drug classes, client formulary changes, unexpected market events, authorized generic launches, products launched at risk, introduction of biosimilars, products under patent litigation or new lower cost NDC priced net of rebates from the innovator.
- Members will pay the lower of the contracted rate, U&C, or their applicable copayment. Zero balance logic is not employed.
- Assumes client does not have 340B pricing.
- Guarantees provided does not include savings from DUR or other clinical programs.
- Specialty drugs dispensed through the medical benefit will not be included in reconciliation of guarantees.
- BCBS NC reserves the right to equitably adjust the guarantees in the event the number of covered members or pharmacy claims volume changes by greater than 20% during the contract year.
- BCBS NC reserves the right to equitably adjust guarantees if changes occur in any law, regulation, interpretation of a law or regulation, or within the PBM marketplace which lead to a significant deviation from the current economic environment, both parties agree to proactively amend the contract.
- Covid-19 related testing, vaccines, and treatments are excluded from guarantee reconciliation.
- Pricing includes a $2.00 per rx fee to be paid to Amwins/Stealth by Prime Therapeutics.

SPECIFIC STOP LOSS INSURANCE CONTRACT

(With a Deductible)

THIS CONTRACT is entered into this July 1, 2022, by and between Rowan County ("Plan Sponsor"), Rowan County Group Health Plan ("Group Health Plan") and Rowan County ("Plan Administrator") and Blue Cross and Blue Shield of North Carolina, an independent licensee of the Blue Cross and Blue Shield Association, ("Blue Cross NC") (collectively, the "Parties").

RECITALS

WHEREAS, Plan Sponsor has established and maintains a self-funded Group Health Plan for certain of its employees and their dependents.

WHEREAS, the Group Health Plan and Plan Sponsor have entered into an Administrative Services Agreement with Blue Cross NC to perform services in administering the Group Health Plan ("Administrative Services Agreement").

WHEREAS, the purpose of this contract is to limit Plan Sponsor's claims liability under the Group Health Plan for an individual Member's Paid Claims, not to exceed the Specific Stop Loss Level elected during a single Contract Period. Blue Cross NC will provide limitation of Plan Sponsor liability for an individual Member's Paid Claims whenever the total Specific Stop Loss claims for all Members exceed the Aggregating Specific Stop Loss Deductible for the Contract Period.

WHEREAS, Blue Cross NC is willing to provide for assumption of a certain portion of Plan Sponsor's claims expense liability incurred under the Group Health Plan as set forth herein.

NOW, THEREFORE, in consideration of the mutual agreement and conditions contained herein, the Parties agree as follows:

1. DEFINITIONS

Wherever used in this contract, the following words and phrases shall have the following meanings, except as otherwise specifically stated or unless a different meaning is plainly required by the context.

A. Contract Period-- shall mean the Plan Sponsor's Specific Stop Loss coverage term as shown in the Notice for Stop Loss Insurance Coverage.

B. Aggregating Specific Stop Loss Deductible – shall mean that amount of additional liability elected herein for total Specific Stop Loss claims for all Members for the Contract Period.

C. Member -- shall mean employees, their dependents, or other eligible persons entitled to benefits under the terms and conditions of the Group Health Plan.

D. Paid Claims -- shall mean claims released for payment by Blue Cross NC on any day during the given Contract Period, regardless of the date incurred, unless otherwise

indicated in the Notice for Stop Loss Insurance Coverage. Paid Claims do not include those claims paid on an exception basis, where Blue Cross NC has not agreed to accept liability under this contract. Paid Claims exclude (if applicable) "Care Management Fees" as that term is defined in the Administrative Services Agreement referenced herein.

E. Specific Stop Loss -- shall mean whenever, during any one Contract Period, Paid Claims for any individual Member exceed the Specific Stop Loss Level elected herein. The Specific Stop Loss liability is determined by Blue Cross NC at the end of every month, as the amount that exceeds the Specific Stop Loss Level on a member basis for the Contract Period to date.

Credit will be applied on the next monthly billing statement.

2. ELIGIBILITY

Prior to the initial Contract Period and each renewal Contract Period thereafter, Plan Sponsor shall provide Blue Cross NC with the Group Health Plan document(s) (e.g., summary plan description (SPD)) and applicable corporate policies (e.g., leave of absence policies), herein incorporated by reference, that clearly defines all categories of Members on the Group Health Plan for the Contract Period. Categories of individuals not specifically and clearly referenced in the document(s) provided may be ineligible for reimbursement under this Stop Loss Contract.

3. PREMIUM PAYMENT

The method of payment of administrative fees described in the Administrative Services Agreement between the Plan Sponsor, the Group Health Plan and Blue Cross NC shall apply to payment of Stop Loss premiums.

4. NON-ACCUMULATION

Specific Stop Loss coverage is not accumulative from Contract Period to Contract Period.

5. SPECIFIC STOP LOSS LEVEL

The Specific Stop Loss Level for an individual Member's Paid Claims for this Contract Period is indicated in the Notice for Stop Loss Insurance Coverage.

6. AGGREGATING SPECIFIC STOP LOSS DEDUCTIBLE

The Aggregating Specific Stop Loss Deductible for each Contract Period is that Aggregating Stop Loss Level indicated in the Notice for Stop Loss Insurance Coverage.

7. NOTICE FOR STOP LOSS INSURANCE COVERAGE

Prior to the initial Contract Period and each renewal Contract Period thereafter, Blue Cross NC

shall provide the Plan Sponsor with a written Notice for Stop Loss Insurance Coverage, incorporated herein by reference including the following information:

a. The beginning and ending dates of the Contract Period

b. The Specific Stop Loss Level for an individual Member's Paid Claims for the Contract Period

c. The rates to be charged for the Specific Stop Loss coverage for the Contract Period

d. Names of Members to whom the Specific Stop Loss Level set forth in [Section 5] does not apply and the applicable Specific Stop Loss Level for such Members.

e. The Aggregating Specific Stop Loss Deductible.

In the event of a conflict between this contract and the Notice for Stop Loss Insurance Coverage, the latter shall control.

8. CONTINUATION AND TERMINATION

This contract will continue in force during the initial Contract Period as set forth and during each subsequent Contract Period subject to the Plan Sponsor's timely payment of premiums for Specific Stop Loss Coverage at such rates as set forth in the Notice for Stop Loss Insurance Coverage and subject to the following termination provision:

This contract shall terminate immediately upon the occurrence of the first of the following: (i) when any payment of premiums is past due and the Plan Sponsor fails to pay any sum required hereunder within 30 days after a payment due date; provided Plan Sponsor has received prior written notice at least 15 days prior to termination; (ii) upon thirty (30) days' prior mutual written consent of the Plan Sponsor and Blue Cross NC; (iii) upon expiration of the Contract Period as specified herein (iv) upon termination of the Administrative Services Agreement. In the event the Plan Sponsor initiates termination of the Specific Stop Loss Insurance Contract prior to the end of a Contract Period, Blue Cross NC will retain all Specific Stop Loss premium and fees paid and terminate the Contract as of the date to which premiums are paid. Claims paid after the termination date of the Contract will not be subject to Specific Stop Loss coverage, except as stated in the Notice for Stop Loss Insurance Coverage.

9. RENEWAL

Renewal of this contract shall occur upon Blue Cross NC's issuance to the Plan Sponsor of the Notice for Stop Loss Insurance Coverage described in paragraph 7 of this Specific Stop Loss Insurance Contract and payment of premium or fee therefore.

10. MODIFICATION

This contract shall not be modified or changed except as set forth herein or upon mutual written consent of the authorized parties hereto. This contract shall function in addition to those terms

and conditions of the Administrative Services Agreement, which shall remain in full force and effect.

If, from the date of the stop loss quotation to the end of the Contract Period, any of the following events occur, Blue Cross NC may make an adjustment to Specific Stop Loss rates: (1) a change in benefits that materially affects Blue Cross NC's liability under the Contract; (2) a 10% or more increase or decrease in: the number of covered persons compared to the number of covered persons quoted; or the demographic factor, including but not limited to the age/sex make-up of the group or geographic location of enrollees;
(3) a 10% or more change or shift in contract types.

Blue Cross NC will give the Plan Sponsor written notice of any adjustment to Specific Stop Loss rates permitted under this section not less than 30 days before the adjustment becomes effective. Such adjustment shall not become effective without the written consent of the Plan Sponsor.

11. LIMITATION OF LIABILITY

This contract shall not bring about liability of Blue Cross NC to any party or individual other than the Plan Sponsor.

12. BLUE CROSS BLUE SHIELD ASSOCIATION

The Plan Sponsor, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this contract constitutes a contract solely between the Plan Sponsor and Blue Cross NC, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Blue Cross NC to use the Blue Cross and Blue Shield Service Mark in the State of North Carolina and that Blue Cross NC is not contracting as an agent of the Blue Cross and Blue Shield Association. The Plan Sponsor, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Blue Cross NC and that no person, entity or organization other than Blue Cross NC shall be held accountable or liable to the Plan Sponsor for any of Blue Cross NC's obligations to the Plan Sponsor created under this contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross NC other than those obligations created under other provisions of this contract.

13. OVERPAYMENTS AND THIRD PARTY LIABILITY

The defense of any legal action instituted on a claim for benefits under the Group Health Plan to which this Specific Stop Loss Insurance Contract applies shall be the obligation of the Plan Sponsor. Blue Cross NC, at its own election and expense, shall have the right to participate with the Plan Sponsor in the defense or appeal of any action, suit or proceeding in which Blue Cross NC, in its sole discretion, determines that it may become involved.

The Plan Sponsor agrees to inform Blue Cross NC of any legal action instituted on a claim for

benefits under the Group Health Plan which does or which may involve liability of Blue Cross NC under this Specific Stop Loss Insurance Contract provision. Such notification shall be in the form of a written memorandum and shall be accompanied by copies of any summons, subpoenas, pleadings, motions, and/or orders concerning the legal action.

The Plan Sponsor undertakes to prosecute any and all valid claims that the Plan Sponsor may have against third parties including without limitation, amounts identified through claims audit, coordination of benefits, non-duplication of benefits, workers' compensation, and subrogation arising out of any occurrence resulting in a loss payment by the Plan Sponsor and to account for any amounts recovered.

Any coordination of benefits refunds or third party liability amounts received or recovered by the Plan Sponsor with respect to the Group Health Plan shall be used to pay court costs and attorney fees (if any) and, if such amounts are attributable to claim payments included in the Group Health Plan's experience for any Contract Year during which the Specific Stop Loss Level was exceeded, to reimburse Blue Cross NC for any amount that it may have paid or become liable to pay the Plan Sponsor under this Specific Stop Loss Insurance Contract during the current contract year. The Plan Sponsor may deduct attorney's fees and court costs that it incurs in prosecuting any subrogation claim or other recovery action from the gross amount of any recovery, prior to reimbursing Blue Cross NC for any claim payment made pursuant to the Contract. Thereafter, all remaining amounts shall be applied in the manner determined by the Plan Sponsor or Plan Administrator.

IN WITNESS WHEREOF, the Parties have caused their duly authorized representatives to execute this contract to be effective as of the date first above written.

Signed for: Plan Sponsor

By:_____
Signature of Authorized Official

Name:_____

Title:_____

Date:_____

Signed for Blue Cross and Blue Shield of North Carolina

By: Tunde Sotunde, M.D.
Tunde Sotunde, M.D. (Jul 8, 2022 13:56 EDT)
Signature of Authorized Official

Name: Tunde Sotunde, M.D.

Title: President and Chief Executive Officer

Date: Jul 8, 2022

Signed for: Plan Administrator and Group Health Plan

By:_____
Signature of Authorized Official

Name:_____

Title:_____

Date:_____

NOTICE

FOR

STOP LOSS INSURANCE COVERAGE

Rowan County
Group Number: 14161963

Contract Period: 7/1/2022 to 6/30/2023
Coverage: Medical and Prescription Drug

Specific Stop Loss

Contract Type: Paid in 12
Level: $100,000
Cumulative Specific Stop Loss Deductible: $150,000
Specific Lifetime Maximum: Unlimited
Rate Per Month Per Contract Type: $152.37

- The Employer is responsible for providing Blue Cross NC with current eligibility language.
- The Employer is responsible for administering their member eligibility correctly.
- Claims paid on ineligible members based upon the Employer's written eligibility language will NOT be eligible for Stop Loss coverage.
- Stop Loss reimbursement for claims in excess of the specific deductible are subject to member eligibility verification. Blue Cross NC requires that the employer provide the Summary Plan Description (SPD) and Leave of Absence language no later than 90 days after the policy's effective date. Specific Stop Loss claims will not be reimbursed until these documents have been received.
- Paid Claims shall mean claims released for payment by Blue Cross NC on any day during the given Contract Period, regardless of the date incurred.

IN WITNESS WHEREOF, the Parties have caused their duly authorized representatives to execute this Notice as of the date first above written.

Signed For: Rowan County

By _____
Print Name and Title of Authorized Official

_____
Signature of Authorized Official

Date: _____

Signed For: BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

By Tunde Sotunde, M.D.
Tunde Sotunde, M.D. (Jul 8, 2022 13:56 EDT)

Date: Jul 8, 2022