Administrative Services Agreement
between
Blue Cross and Blue Shield of Alabama
and

City Of Orange Beach
Group 00526
Effective Date: January 1, 2023

Original Effective Date: May 1, 1994

ADMINISTRATIVE SERVICES AGREEMENT

between

BLUE CROSS AND BLUE SHIELD OF ALABAMA
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858
(herein called the Claims Administrator)

and

CITY OF ORANGE BEACH
4099 Orange Beach Blvd
Orange Beach, AL 36561
(herein called the Employer)

ARTICLE I – INTRODUCTION

The effective date of this Agreement is 12:01 a.m. on the date stated on the cover page of this Agreement, and from year to year thereafter unless and until terminated pursuant to Article VI. If there is any inconsistency between this Agreement and the Implementation or Enrollment Agreement between the parties, the terms of this Agreement shall control. This Agreement is issued and delivered in the State of Alabama, and is governed (subject to any applicable federal laws) by the laws of the state of Alabama. Article VII contains defined terms that are used in this Agreement. Unless the context clearly requires otherwise, any defined terms contained in the Plan, when used in this Agreement, shall have the same meaning as in the Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

The Claims Administrator has executed this Agreement and sent it to the Employer at the address appearing in the records of the Claims Administrator. The Claims Administrator intends to rely upon the terms of this document in its administration of the Plan. The Employer understands and acknowledges that, if it fails to respond to reasonable requests by the Claims Administrator for the Employer to return a signed copy of the Agreement or propose written changes, the Agreement shall be deemed binding and in full effect as of the effective date stated on the cover page.

ARTICLE II - ALLOCATION OF ADMINISTRATIVE DUTIES

The Employer and the Claims Administrator each agree to perform the administrative duties identified in this Article II. Each party shall perform these duties consistent with applicable laws.

A. Eligibility and Enrollment

1. Claims Administrator's Duties. The Claims Administrator will furnish appropriate application forms and related material and will provide such assistance as may be reasonably necessary for the Employer to enroll its employees, former employees, and their eligible dependents in the Plan. The Claims Administrator will maintain up-to-date eligibility status records on all enrolled Members as submitted by the Employer. The Claims Administrator will issue identification cards to each Member who is enrolled in the Plan and who is certified as eligible by the Employer.

2. Employer's Duties. The Employer will determine whether and when employees, former employees, or dependents are eligible to enroll in the Plan. The Employer will provide timely and accurate data to the Claims Administrator that appropriately identifies all employees, former employees, and dependents who are enrolled or disenrolled in the Plan and the effective dates of such enrollment or disenrollment.

3. Other.

   a. The Claims Administrator will rely on eligibility information submitted by the Employer as satisfying the terms of the Plan and the requirements of the Medicare Secondary Payer (MSP) statutes and regulations (42 U.S.C. Section 1395(y), and 42 CFR Part 411, Subparts B-H). If the Centers for Medicare and Medicaid Services (CMS) makes demand upon the Employer for repayment or other remedy in cases which CMS determines that the Plan should have paid primary, the Claims Administrator is authorized to repay CMS and add that amount to the next invoice for the Cost of Claims in Article III. Upon request, the Employer will promptly provide written authorization to the Claims Administrator to repay CMS. The Employer agrees that, if it fails to provide prompt written authorization, it will be responsible for interest and penalties, as applicable, that may be due to CMS.

   b. If the Employer retroactively cancels coverage for one or more Members, the Claims Administrator will not request refunds of payments made more than 60 days before the date on which the Employer satisfactorily notifies the Claims Administrator of the retroactive cancellation. The Claims Administrator will credit any payments recovered for the 60-day retroactive cancellation period to the Cost of Claims pursuant to Article III. Prior to obtaining refunds, the Claims Administrator may request satisfactory assurance from the Employer that the Member has been properly retroactively terminated pursuant to the Affordable Care Act (including the completion of any appeals) and has been properly offered and declined to elect COBRA coverage. Any refund to the Employer of the Administrative Charge paid with respect to retroactively cancelled Members will not exceed the Administrative Charge paid or payable with respect to such Members for the 60-day retroactive cancellation period.

   c. Without in any way limiting the generality of any other provision of the Agreement, Employer understands and acknowledges that Employer is solely and completely responsible for the Plan's compliance with COBRA, HIPAA, the Affordable Care Act and other applicable laws as such laws may affect any Member's retroactive loss of coverage under the Plan. Furthermore, and without in any way limiting the generality of Article V, Employer agrees to hold the Claims Administrator harmless, to the extent permitted by law, from and against any and all loss or liability that the Claims Administrator may incur as a result of any Member's retroactive loss of coverage under the Plan.

B. Customer Service

The Claims Administrator will provide Members with access to a toll-free Customer Service phone number during the hours of 7:00 a.m. to 6:00 p.m., central time, on days during which the Claims Administrator is open for business. Customer Service will respond to requests from Members concerning claims processing and adjudication and will coordinate - when necessary - requests for information that involve other departments of the Claims Administrator.

C. Benefit Booklet (Summary Plan Description)

1. Claims Administrator's Duties. The Employer requests the Claims Administrator to prepare a benefit booklet that will serve as a summary plan description (SPD) or summary of material modifications (SMM). Pending finalization of the benefit booklet, the Employer directs the Claims Administrator to process benefits and terms under the plan in accordance with the provisions of the Group Enrollment or Implementation Agreement, this Agreement, the standard benefit language maintained by the Claims Administrator for the type of plan established by the Employer herein, and any draft benefit booklets treated as "operative" by the Claims Administrator. A draft benefit booklet shall be considered operative by the Claims Administrator when the booklet serves as the primary, but not the sole, instrument upon which the Claims Administrator bases its administration of the Plan, without regard to whether the booklet is finalized or distributed to the Plan's participants. If there is any conflict between any of the foregoing documents, the Claims Administrator is directed to resolve such conflict in a manner that best effectuates the intent of the Employer and the Claims Administrator as of the date on which claims were incurred.

2. Employer's Duties. The Employer acknowledges and understands that it is the plan administrator and plan sponsor of the Plan under applicable law and/or the terms of the Plan. Among other things, this imposes upon the Employer the sole legal responsibility to (i) prepare the benefit booklet, (ii) determine whether the benefit booklet distributed to Plan participants satisfies applicable legal requirements, (iii) ascertain that the booklet accurately and fully describes the benefits that the Employer intends the Claims Administrator to provide or administer, and (iv), distribute the booklet in a timely fashion and appropriate manner to Plan participants. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan or applicable law to the Claims Administrator.

D. Summary of Benefits and Coverage (SBC) and Uniform Glossary

The Employer may prepare their own SBC and Uniform Glossary or may request the Claims Administrator to prepare both documents. At the request of the Employer, the Claims Administrator will prepare a draft SBC for the benefits that the Claims Administrator administers under the Plan that the Employer may use either as the SBC or in connection with the preparation of its own SBC. In either case, the Employer acknowledges and understands that the Affordable Care Act imposes upon the Employer the sole legal responsibility to (i) prepare the SBC and Uniform Glossary (ii) determine whether the SBC and Uniform Glossary distributed to Plan participants satisfies the requirements of the Affordable Care Act, and (iii), distribute the SBC and the Uniform Glossary in a timely fashion and appropriate manner to Plan participants. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan or applicable law to the Claims Administrator.

E. Required Reports

1. Claims Administrator's Duties. The Claims Administrator will send to the Employer such information that the Claims Administrator has within its possession as will permit the Employer to prepare, file, and/or distribute reports for the Plan required by law or regulation.

2. Employer's Duties. The Employer will prepare, file, and/or distribute reports for the Plan required by law or regulation.

F. Claims Processing and Adjudication

1. Claims Administrator's Duties. The Claims Administrator will exercise the discretionary authority to process and adjudicate claims under the Plan. This authority encompasses all determinations and findings necessary to process and adjudicate claims, such as the discretionary authority to construe and apply the Plan, make findings of fact, and determine whether services or supplies are medically necessary (within the meaning of the Plan) or otherwise satisfy the medical standards or guidelines required for payment of benefits under the Plan (such as, for example, the requirement that medical services or supplies not be experimental or investigational). The Claims Administrator will include a description of its claims procedures in the draft benefit booklet prepared by the Claims Administrator in accordance with Section C above. The Employer will be responsible for making all eligibility determinations under the Plan. It is the Employer's intent that the Claims Administrator's determination be given the highest level of deference and finality permitted under applicable law.

2. Employer's Duties. The Employer may, in writing, instruct the Claims Administrator to prospectively pay or deny specified claims or a class of claims that the Employer has determined in its discretion are, or are not, payable under the Plan. The Claims Administrator will comply with such instructions to the extent permissible under the Claims Administrator's provider contracts and to the extent the Claims Administrator has not relied to its detriment on prior practice or Plan interpretation.

G. Appeals

1. Administrative Appeals

   a. Claims Administrator's Duties. The Claims Administrator will exercise the discretionary authority to review denied claims and if applicable, follow the requirements under the Affordable Care Act. The Claims Administrator will be responsible for providing the Member with a full and fair review of his or her denied claim. The Claims Administrator will include a description of its appeal procedures in the draft benefit booklet prepared by the Claims Administrator in accordance with Section C above. It is the Employer's intent that the Claims Administrator's determination be given the highest level of deference and finality permitted under applicable law. It shall be the responsibility and duty of the Employer to comply with any applicable notice provisions, appeal provisions and other provisions of the Affordable Care Act related to Employer's initial Member eligibility determinations and retroactive cancellations.

   b. Employer's Duties. The Employer may, in writing, instruct the Claims Administrator to prospectively grant or deny specified appeals or a class of appeals that the Employer has determined in its discretion are, or are not, consistent with the terms of the Plan. The Claims Administrator will comply with such instructions to the extent permissible under the Claims Administrator's provider contracts and to the extent that the Claims Administrator has not relied to its detriment on prior practice or Plan interpretation.

2. Affordable Care Act External Reviews

   If the Plan is subject to the external review requirements under the Affordable Care Act, it is the desire and understanding of the Employer that, in order to comply with the applicable external review provisions under the Affordable Care Act (including applicable regulations, Technical Guidance and other guidance issued from time to time thereunder), the Claims Administrator has entered into, and will endeavor to enter into and to maintain agreements with at least three (3) independent review organizations to furnish external review services to Members in accordance with the provisions of the Affordable Care Act applicable to self-funded group health plans. If the Plan is subject to the external review requirements under the Affordable Care Act, Employer hereby authorizes and directs Claims Administrator to accept external review requests from Members and assign such requests to its independent review organizations to administer such external reviews in accordance with the provisions of the Affordable Care Act applicable to self-funded group health plans.

H. Managed Care Services

When applicable under the Plan, the Claims Administrator will exercise the discretionary authority to make determinations that are necessary or appropriate for Case Management, Disease Management, Care Coordination, and other similar Managed Care Programs.

I. Actuarial Services

Upon reasonable request, the Claims Administrator will provide the Employer with Claims cost projections and analyses and such other actuarial and statistical data as may be reasonably requested by the Employer to perform its administrative and Plan design responsibilities.

J. COBRA

The Employer will determine whether a Member is entitled to continue coverage under COBRA and will provide the required notices and COBRA application form to a Member who is so entitled. The Employer will determine the amount of the monthly COBRA premium and be responsible for all other COBRA requirements including billing and collection of premiums.

K. HIPAA Privacy and Security

1. Claims Administrator's Duties. The Claims Administrator will function as a business associate of the Plan in accordance with the privacy and security regulations issued by the Secretary of Health and Human Services under HIPAA. The Claims Administrator will sign a separate business associate agreement with the Plan. In the event of any conflict between this Agreement and the Business Associate Agreement, the Business Associate Agreement shall control.

2. Employer's Duties. The Employer is responsible for the Plan's compliance with the HIPAA privacy and security regulations and for its own compliance, as Plan sponsor, with those regulations.

L. National Medical Support Notices

1. Claims Administrator's Duties. The Claims Administrator will enroll a child as directed by the Employer pursuant to the terms of a National Medical Support Notice (NMSN).

2. Employer's Duties. The Employer will determine whether a medical support notice is a NMSN and notify the Claims Administrator of its determination.

M. Subrogation

The Claims Administrator shall pursue subrogation and reimbursement recoveries where appropriate. Subrogation and reimbursement recoveries shall be credited to the Cost of Claims as provided for in Article III.

N. Litigation Involving the Plan

1. The Claims Administrator is authorized but not required to provide a defense against claims for benefits and other litigation involving the Plan. The Claims Administrator is further authorized to act on behalf of the Plan and the Employer with regard to settlement of any claims for which it provides a defense. The Claims Administrator is further authorized in its discretion to determine whether and when in its judgment the Plan should be added as a necessary party to litigation.

2. The Employer shall in all cases remain responsible for the cost of benefit payments under the Plan, regardless of whether such payments are made pursuant to settlement of litigation or court order and regardless of whether benefit payments are denominated as such or as some form of damages or other liability. The Employer's obligation to fund any such benefit payments shall survive the termination of this Agreement.

3. The Claims Administrator is authorized to act on behalf of the Plan and the Employer in litigating and settling cases or controversies that involve multiple plans and plan participants, whether arising in contract, tort or any other legal theory. Examples include, but are not limited to, cases arising out of defective medical devices or medicines, overpayments, and provider fraud or provider suits where the provider has sued multiple Blue Cross entities. Any amounts recovered, less all direct costs such as outside attorneys' fees, will be credited against the monthly charges in Article III. In some cases the applicable amount recovered may have to be estimated when, for example, a court will not release information that would allow identification of the plans and/or participants involved and the settlement is based upon the number of lives in all plans covered by the Claims Administrator compared to the total number of lives covered by the industry.

O. Stop-Loss Insurance

1. <u>Claims Administrator's Duties</u>. Upon written request, the Claims Administrator will provide stop-loss reports to the Employer on adjudicated claims.

2. <u>Employer's Duties</u>. The Employer is responsible for selecting and maintaining in force, if desired, suitable stop-loss insurance coverage and for giving all required notifications to the stop-loss insurer.

P. Employer as Plan Sponsor

1. The Employer is the Plan sponsor. As such, the Employer is responsible for notifying Members of any lapse or loss of coverage or changes to or termination of this Agreement to the extent required by law.

2. As Plan sponsor, the Employer also exercises non-fiduciary discretion concerning the design of the Plan. The Employer acknowledges that changes in Plan design may be limited by the capabilities of the Claims Administrator's claims processing systems or prior medical necessity certifications that the Claims Administrator may have provided in reliance on the existing Plan design. The Employer therefore agrees that it will not implement a change in Plan design or communicate a change to Members unless the Employer gives the Claims Administrator a reasonable period of time - prior to implementation of the proposed change - to review and comment on the proposed change and its effective date. If, after consultation with the Employer, the Claims Administrator determines that it will be unable to administer the proposed change as of the desired or any later effective date, it shall so advise the Employer and the Employer shall assume full responsibility for administration of the change.

Q. WELLNESS PROGRAMS [Applies only if Claims Administrator administers Employer's Wellness Program]

The Employer may, in writing, request Claims Administrator to provide the Plan Sponsor's Wellness Program.

a. <u>Claims Administrator Duties.</u> The Employer requests Claims Administrator to offer the Plan's Sponsors employee and other eligible participant's enrollment in the Plan's Wellness Program. At Employer's election, Employer requests Claims Administrator to provide services selected and delegated to the Claims Administrator. Claims Administrator will rely on participant information submitted by Employer to provide wellness program services elected by Employer. Claims Administrator warrants that all protected health information gathered will be stored and used in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

b. <u>Employer's Duties.</u> The Employer acknowledges and understands that it is the wellness program administrator and sponsor of the program under applicable law and/or the term of the Wellness Program.

Among other things, this imposes upon the Employer the sole legal responsibility to determine whether the Wellness Program satisfies applicable legal requirements. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan, wellness program or applicable law to the Claims Administrator. Employer understands and acknowledges that Employer is solely and completely responsible for the Plan's wellness program's compliance with ERISA, ADA, GINA and other applicable laws. Plan Sponsor agrees to offer to its employees and other eligible participants the Wellness Program as outlined by the Plan Sponsor. Plan Sponsor agrees to pay Claims Administrator for wellness services as defined in Article III-Financial Arrangement. Plan Sponsor agrees that any and all protected health information must be used and protected in accordance with HIPAA.

ARTICLE III - FINANCIAL ARRANGEMENT

A. Payment Procedures

1. The Claims Administrator will call and/or fax the Employer by 2:00 p.m. central time each Thursday of the week to advise of the pending Cost of Claims level specified below in this Article III.

2. The Employer will transfer funds for the Cost of Claims and Administrative Charges into an account designated by the Claims Administrator by the close of business each Friday. In recognition of the Claims Administrator's risk of reimbursement for the Cost of Claims (as defined below), it is agreed that if the Employer fails to transfer sufficient funds to pay the pending Cost of Claims, the Claims Administrator may at its discretion (i) suspend all pending Claims automatically without notice to the Employer or any Member until it has sufficient reassurance that there has been transferred an amount into the account sufficient to pay the Claims Administrator for the Cost of Claims and (ii) recall payments for Claims already made but for which there is an insufficient amount in the account to pay the Cost of Claims.

3. The Claims Administrator will provide the Employer with a statement reconciling the level of Cost of Claims paid plus Administrative Charges versus deposits at the end of each month. Following the reconciliation, any amount due to or from the Employer will be adjusted on a subsequent wire transfer.

B. Cost of Claims

The Claims Administrator's charge to the Employer for Claims will be the amount which the Claims Administrator is ultimately obligated to pay for such Claims including, but not limited to, retroactive adjustments or supplemental payments required by various provider agreements. For example, the Employer must pay the Claims Administrator for Claims incurred before the termination of the Agreement but paid after it terminates, as provided under "Run-out" below. Such Claims will be reflected in a monthly detail listing sent to the Employer.

The Cost of Claims will be adjusted upwards or downwards, as applicable, by the following:

1. <u>Net Subrogation Recoveries.</u> The net amount recovered through Subrogation will be credited against the Cost of Claims.

2. <u>Access Fees</u>. Access fees, if applicable under Article V, will be added to the Cost of Claims.

3. <u>Credit for Multi-Plan Litigation</u>. The Claims Administrator will reduce the Cost of Claims by the amount of any applicable recovery allocated to the Employer as a result of awards, settlements, or judgments involving multi-plan litigation as described in Article II.

C. Administrative Charges

The Employer will pay the Claims Administrator a weekly Administrative Charge of 10.85% of the Cost of Claims for health and a weekly Administrative Charge of 14.10% of the Cost of Claims for dental (excluding any charges for access fees).

D. Run-out

In the event of termination of this Agreement, the Employer will pay the Claims Administrator for the Cost of Claims on all claims that were incurred, but not paid by the Claims Administrator before the effective date of the termination of this Agreement. This provision will apply to all claims originally filed within the timely filing period set forth in the Plan as in effect prior to termination of this Agreement. In addition, the Employer will pay the Claims Administrator an Administrative Charge of 10.85% of the Cost of Claims for health and 14.10% of the Cost of Claims for dental during the run-out period. The Cost of Claims and Administrative Charge will be paid on the same basis as set forth in Article III.A.

E. Mental Health Disorders and Substance Abuse Interface Service

The Employer carves out their mental health disorders and substance abuse benefits to a third party vendor. The Employer will pay the Claims Administrator an interface service fee of $1.50 per covered contract holder (including COBRA contracts) per month in order for the Claims Administrator to collect and report mental health disorders and substance abuse related expenses to the third party vendor.

This charge is in addition to the Administrative Charge listed in Article III.C above.

F. Prescription Drug Interface Service

The Employer carves out their Prescription Drug benefits to a third party vendor. The Employer will pay the Claims Administrator an interface service fee of $1.50 per covered contract holder (including COBRA contracts) per month in order for the Claims Administrator to collect and report Prescription Drug related expenses to the third party vendor. **This charge is in addition to the Administrative Charge listed in Article III.C above.**

G. Air Medical Transportation Services

The Claims Administrator contracts with a third party to provide air medical transportation services. The Employer will pay the Claims Administrator a separate monthly charge of $1.23 per covered contract holder (including COBRA contracts) for this service.
This charge is in addition to the Administrative Charge listed in the Article III.C above.

ARTICLE IV - CLAIMS AUDITS

A. Purpose

The following rules are designed to:

1. Establish a procedure by which the Employer or its authorized representatives may conduct comprehensive audits and reviews of the accuracy of the Claims Administrator's processing of Claims under the Plan in order to identify any improperly processed Claims;

2. Establish the procedure that the Claims Administrator will follow to correct any identified Claims errors;

3. Protect the legitimate business interest of the Claims Administrator; and,

4. Facilitate the protection of individually identifiable health information.

B. Employer's Audit Rights

1. The Employer may engage the services of any person or entity (hereinafter referred to as "Auditor") to audit the accuracy of the Claims Administrator's payment of Claims under the Plan. Except as provided for in the next paragraph, all costs of an audit or review shall be borne by the Employer. For purposes of this Agreement, the term "audit" means the examination of a sample of Claims consistent with generally accepted auditing standards. Sample size will be determined in a fashion consistent with generally accepted auditing standards, not to exceed a size that would be selected using statistically valid sampling techniques. If any questions should arise concerning the audit sample size, the parties will negotiate in good faith to reach a mutually agreed upon resolution. The agreed upon sample size shall not preclude the subsequent review and correction of all Claims affected by any systematic error identified during the audit.

2. The Claims Administrator will provide appropriate staff to support Plan audits (as defined above), the costs of which are included in the Employer's administrative fees. If the Employer or Auditor wishes to conduct a review of paid Claims on any basis other than generally accepted auditing standards, the Employer and Claims Administrator will negotiate a mutually agreed upon fee, to be paid by the Employer, necessary to cover the additional costs incurred by the Claims Administrator for such a review. Prior to undertaking the audit, the Employer shall require the Auditors to execute a confidentiality agreement in a form satisfactory to the Claims Administrator.

3. Audits of Claims must be (i) commenced within 24 months of the date the Claims were paid, and (ii) completed and submitted to the Claims Administrator within 36 months of the date the Claims were paid. The Employer will be deemed to have accepted as correct the processing of all Claims with respect to which an audit is not commenced, completed, and submitted to the Claims Administrator within the foregoing time frames.

4. The Employer understands and acknowledges that information, data, documentation, or software disclosed by the Claims Administrator in the course of or related to the audit contains individually identifiable health information about Plan Members ("Member Health Data") as well as information that is proprietary to the Claims Administrator's business operations ("Proprietary Data"). The Employer further understands and acknowledges that all Proprietary Data is confidential and a valuable trade secret of the Claims Administrator, and that any disclosure or use of such data for any purpose other than to evaluate the accuracy of the Claims Administrator's processing of Claims under this Agreement will cause irreparable harm and loss to the Claims Administrator. Proprietary Data includes, but is not limited to, UCR limits, negotiated provider payments, hospital per-diems, retroactive reimbursement mechanisms, and other negotiated terms between the Claims Administrator and hospital and medical providers. In view of the foregoing, the Employer agrees that neither it nor the Auditors shall release or disclose to any third party any data or information obtained from the Claims Administrator during the course of the audit without first affording the Claims Administrator the opportunity to determine whether such data or information includes any Proprietary Data. If it does, the Claims Administrator may require the removal of Proprietary Data from the material to be released or disclosed. Notwithstanding the foregoing, Section B.4 shall not be construed to prevent the parties from disclosing price and quality information in accordance with applicable Federal law.

5. The Employer warrants that the Plan will enter into a suitable business associate agreement with the Auditors prior to the commencement of the audit. This agreement will authorize the Claims Administrator to release Member Health Data to the Auditors.

C. Procedures for Audits of Claims

1. The Employer shall provide prior written notice to the Claims Administrator regarding its intention to perform an audit or review of the Claims Administrator's accuracy of Claims payments.

2. The Auditors may contact the hospital or medical providers with whom Blue Cross and Blue Shield of Alabama or another Blue Cross/Blue Shield Plan has a contract without written consent of the Claims Administrator only in order to confirm payment of the audited Claims. All other contact with providers regarding Blue Cross or Blue Shield payments must first receive written consent of Blue Cross and Blue Shield of Alabama.

3. The Employer will furnish the Claims Administrator a copy of the completed audit report. Upon receipt of the audit report, the Claims Administrator will provide a written statement to the Employer of any disputed findings or conclusions.

4. Should the Auditors identify disputed Claim payments under the Plan, the Employer and the Claims Administrator shall in good faith determine if the claims payments are in error and allocate responsibility for such errors among themselves, based on the relative degree of fault of each party. With respect to Claims errors that the parties determine are the responsibility of the Claims Administrator, the Claims Administrator will make a refund to the Employer of such erroneous payments and may thereafter, for its own account, recover the amount of the refund from the provider or the Member. In all other cases, the Claims Administrator will request a refund of the Claim (to the extent permitted by law) from the provider, Member, or in the case of claims paid through the BlueCard Program, the Host Plan, except to the extent that the retroactive eligibility adjustment provisions of Article II provide otherwise. Upon receipt of the refund, the Claims Administrator will credit the Employer with the amount of the refund.

Notwithstanding anything in this Article IV to the contrary, no adjustments or refunds shall be made on the basis of statistical projections of sample dollar errors.

ARTICLE V - GENERAL PROVISIONS

A. Delegation of Discretionary Authority

The Employer hereby delegates to the Claims Administrator the discretionary responsibility and authority to process and adjudicate Claims under the Plan, to construe, interpret, and administer the Plan, and to perform every other act necessary or appropriate in connection with the Claims Administrator's provision of administrative services hereunder. To the extent not delegated to the Claims Administrator in this agreement or pursuant to the terms of the Plan, the Employer retains the discretionary authority to manage and administer the Plan.

Whenever the Claims Administrator makes reasonable determinations that are neither arbitrary nor capricious in its administration of the Plan, those determinations will be final and binding on the Plan's participants or beneficiaries, subject only to applicable rights of review under the Plan and thereafter to judicial review to determine whether the Claims Administrator's determination was arbitrary or capricious.

B. Indemnification and Reliance on Employer Directions

Each party agrees to indemnify, defend, and hold the other harmless from and against any liability that the other party may incur as a result of the indemnifying party's breach of this Agreement or failure to comply with applicable law; provided that the Employer will in all cases remain responsible for payment of benefits under the Plan.

The Claims Administrator is entitled to rely on instructions, communications, or directions from the Employer concerning Plan design, eligibility determinations, benefit changes, and other areas of Plan administration for which the Employer is responsible. The Claims Administrator has no obligation or responsibility to question or refuse to follow such instructions, communications, or directions. The Employer will indemnify, defend, and hold the Claims Administrator harmless from any liability arising from the Claims Administrator's reliance on such instructions, communications, or directions.

C. Late Payment

If the Administrative Charges specified in Article III are not paid by the last day of the month in which such Charges are due, the Employer shall pay the Claims Administrator a penalty for each day such Charges are deemed late. The amount of the penalty will be calculated daily and will be based on the overnight repurchase rate that was in effect on the last day of the month in which the charges were due. This rate is published in the Money Rates section of the Wall Street Journal.

Charges are "late" each day a wire transfer in the proper amount is not received by the Claims Administrator.

D. Premium Taxes

The Claims Administrator will not invoice for any state premium taxes; provided that if a portion of Plan benefits are provided through separate, underwritten, arrangements (such as Expanded Psychiatric Services), the Employer understands and acknowledges that premium taxes attributable to such underwritten arrangements will be billed to the Employer as a part of the premium or as a part of the Administrative Charge.

E. Affordable Care Act Fees and Taxes

Employer is responsible for calculating, remitting and paying to the appropriate federal agencies all Affordable Care Act fees and taxes that apply to the Plan.

F. Changes in Agreement

1. The Employer and the Claims Administrator may amend this Agreement at any time without notice to any employee or dependent through the mutual written agreement of the Claims Administrator (duly executed by its officer authorized to do so) and of the Employer (duly executed by its officer authorized to do so). Amendments to the Enrollment or Implementation Agreement that are duly adopted after the effective date of this Agreement that affect the financial arrangement between the parties shall be deemed to amend the financial provisions of this Agreement.

2. Notwithstanding the foregoing, payment by the Employer of Administrative Charges following the effective date of an amendment to or restatement of this Agreement proposed in writing and duly executed by the Claims Administrator and sent to the Employer at its most recent address as reflected in the Claims Administrator's records shall constitute the Employer's binding acceptance of the terms of the amendment or restatement.

3. No representative or employee of the Claims Administrator is authorized to amend or vary the terms and conditions of this Agreement or to make any agreement or promise not specifically contained herein or to waive any provision hereof other than by the means prescribed above in this Article V.

G. Notices

1. Any notice given by the Claims Administrator under this Agreement shall be sufficient and effective for all purposes if and when mailed to the Employer at its address or emailed to the Decision Maker for the Employer as appearing in the records of the Claims Administrator.

2. Any notice given to the Claims Administrator by the Employer shall be sufficient if mailed to the Claims Administrator at 450 Riverchase Parkway East, Birmingham, Alabama 35244-2858.

3. All notices by or to the Claims Administrator shall be in writing.

H. Blue Cross and Blue Shield Association

Employer on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Employer and Blue Cross and Blue Shield of Alabama, 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, (the "Association") permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Employer on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Employer for any of Blue Cross and Blue Shield of Alabama's obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.

I. Out of Area Services

Overview

Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever members access healthcare services outside the geographic area Claims Administrator serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements.

1. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when members' access covered healthcare services outside the geographic area Claims Administrator serves, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

a. Liability Calculation Method Per Claim – In General

Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to Claims Administrator by the Host Blue.

Employer Liability Calculation

The calculation of Employer liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to Claims Administrator by the Host Blue under the contract between the Host Blue and the provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer 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.

b. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's provider contracts. The negotiated price made available to Claims Administrator by the Host Blue may be represented by one of the following:

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

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 Employer 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 Employer 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 Employer 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 Employer. If Employer terminates, 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 liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

c. BlueCard Program Fees and Compensation

Employer understands and agrees to reimburse Claims Administrator for certain fees and compensation which Claims Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services.

The specific BlueCard Program fees and compensation that are charged to Employer are set forth in Exhibit X. BlueCard Program Fees and compensation may be revised from time to time as described in Section H.H below.

2. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Claims Administrator may process your member claims for covered healthcare services through Negotiated Arrangements.

In addition, if Claims Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this agreement, then the terms and conditions set forth in Claims Administrator's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when members access such network(s). In negotiating such arrangement(s), Claims Administrator is not acting on behalf of or as an agent for Employer, Employer's group health plan or Employer's members.

Member Liability Calculation

Member liability calculation will be based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Claims Administrator and that allows Employer's members access to negotiated participation agreement networks of specified participating providers outside of Claims Administrator's service area.

Fees and Compensation

Employer understands and agrees to reimburse Claims Administrator 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section H.H below. In addition, the participation agreement with the Host Blue may provide that Claims Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claims Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in Exhibit X.

3. Special Cases: Value-Based Programs

Value-Based Programs Overview

Employer's members may access covered healthcare 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 Shared Savings arrangements.

a. 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 Claims Administrator, which Claims Administrator will pass directly on to Employer 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:

i. Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to Employer via an enhanced provider fee schedule.
ii. Supplemental Factor: The charge to accounts for Value-Based Programs incentives/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/Shared Savings settlements to accounts are outside of the claim system. Claims Administrator will pass these Host Blue charges directly through to Employer 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:

i. Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
ii. 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 Employer terminates, Employer 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 liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, 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 Claims Administrator for Care Coordinator Fees for provider services which we will pass on to Employer as follows:

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

As part of this agreement, Claims Administrator and Employer will not impose member cost sharing for Care Coordinator Fees.

b. Value-Based Programs under Negotiated Arrangements

If Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's members, Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

Exception: 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, Claims Administrator and Employer may agree to waive member cost sharing for care coordinator fees.

4. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, 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 Claims Administrator they will be credited to Employer's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer as a percentage of the recovery.

5. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, Claims Administrator will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability.

6. Nonparticipating Providers outside Claims Administrator's Service Area

Member Liability Calculation

In General

When covered healthcare services are provided outside of Claims Administrator's service area by nonparticipating providers, the amount(s) a member pays for such services will be based on either the Host Blue's nonparticipating 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 nonparticipating provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

Exceptions

In some exception cases, Claims Administrator may pay claims from nonparticipating healthcare providers outside of Claims Administrator's service area based on the provider's billed charge. This may occur in situations where member did not have reasonable access to a participating provider, as determined by Claims Administrator or by applicable law. In other exception cases, Claims Administrator may pay such claims based on the payment Claims Administrator would make if Claims Administrator were paying a nonparticipating provider inside of Claims Administrator's service area. This may occur where the Host Blue's corresponding payment would be more than Claims Administrator's in-service area nonparticipating provider payment. Claims Administrator may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

Fees and Compensation

Employer understands and agrees to reimburse Claims Administrator for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer are set forth in Exhibit X. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section H.H below.

7. Blue Cross Blue Shield Global Core® Program

a. General Information

If members are outside the United States (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core® when accessing covered healthcare services. The Blue Cross Blue Shield Global Core® is not served by a Host Blue.

Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core® Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their deductibles, coinsurance, etc. In such cases, the hospital will submit member claims to the Blue Cross Blue Shield Global Core® Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered healthcare services.

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

b. Blue Cross Blue Shield Global Core® Program-Related Fees

Employer understands and agrees to reimburse Claims Administrator for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under the Blue Cross Blue Shield Global Core® Program are set forth in Exhibit X. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section H.H below.

8. 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, Claims Administrator shall provide Employer 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 Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If Employer fails to respond to the notice and does not terminate this agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claims Administrator will then allow such modifications to become part of this agreement.

J. Blue Distinction Centers and Blue Distinction Centers+

Blue Distinction Centers and Blue Distinction Centers+ (BDC and BDC+) are national programs administered by the Blue Cross and Blue Shield Association for the provision of certain specialty care services by participating BDC and BDC+ providers to Plan members. The Employer will pay the Claims Administrator an access fee when Plan members use the BDC or BDC+ global contracted arrangements outside of the Claims Administrator's exclusive service area (state of Alabama). The access fee is billed regularly throughout the year.

These charges are in addition to the Administrative Charge listed in Article III C.

ARTICLE VI - TERMINATION OF AGREEMENT

This Agreement and all rights hereunder may be terminated at any time by either the Employer or the Claims Administrator upon 30 days written notice to the other given in the manner prescribed by Article V; provided however, that termination of this Agreement shall not terminate either party's indemnification rights under Article V, nor shall it terminate the Employer's obligation to pay the Claims Administrator for the Cost of Claims and Administrative Charges related to Claims incurred before the effective date of termination of this Agreement. Other provisions of this Agreement that survive termination are specified elsewhere herein.

ARTICLE VII – DEFINITIONS

The defined terms in this Agreement are as follows:

"Administrative Charges" means the monthly charges specified in Article III.

"Affordable Care Act" means The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 and regulations thereunder.

"Agreement" means this Administrative Services Agreement between the Claims Administrator and the Employer, any amendment to or any revisions of this Administrative Services Agreement made in accordance with Article V.

"Claim" means benefits provided under the Plan after the effective date of this Agreement or its termination, and for which the date of service or treatment (incurred date) is prior to the date of termination of this Agreement.

"Cost of Claims" means the amount described in Article III.

"Employer" means City Of Orange Beach (including subsidiaries) and any corporate successor thereto.

"Member" means a subscriber or eligible dependent who has coverage under the Plan.

"Net Amount Recovered through Subrogation" means the net amount, if any, which the Claims Administrator recovers from any other party less all direct costs and expenses of the recovery such as attorneys' fees and court costs. "Direct costs" and "expenses" do not include the salaries, benefits or administrative expenses of employees of the Claims Administrator.

"Plan" means the City Of Orange Beach Group Medical Plan and Group Dental Plan established by City Of Orange Beach having an effective date of May 1, 1994, as said Plan may be amended from time to time. The written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator consist of this Agreement, the Group Enrollment or Implementation Agreement, and the benefit booklet prepared by the Claims Administrator that will serve as the Summary Plan Description in accordance with Article II, Section C. Pending finalization of the benefit booklet, the written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator will also consist of the standard benefit language maintained by the Claims Administrator for the type of plan established by the Employer, and any draft benefit booklets treated as operative by the Claims Administrator in accordance with Article II, Section C.

ARTICLE VIII – EXECUTION

IN WITNESS WHEREOF, the following parties have caused their respective duly authorized representative to execute this Administrative Services Agreement as of the effective date of this Agreement.

BLUE CROSS AND BLUE SHIELD OF ALABAMA

By

Rebekah Elgin Council Date ______________________________

Rebekah Elgin Council, Senior Vice President and Chief Marketing Officer

CITY OF ORANGE BEACH

By______________________________________ Date ______________________________

Title_____________________________________

Exhibit X
Administrative Services Agreement
Inter-Plan Arrangement Fees and Compensation

Only the BlueCard Program Access Fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in the General Administrative Fee.

The Access Fee is charged by the Host Blue to Claims Administrator for making its applicable provider network available to Employer’s employees. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential Claims Administrator receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged, Claims Administrator passes the Access Fee directly on to Employer.

BlueCard Program Access Fees: A BlueCard Program Access Fee may be charged only if the Host Blue’s arrangement with its healthcare provider prohibits billing members for amounts in excess of the negotiated payment. However, a healthcare provider may bill members for non-covered healthcare services and for cost sharing (for example, deductibles, copayments and/or coinsurance) related to a particular claim.

How the Blue Card Program Access Fee Affects Employer: Sometimes the Access Fee is a negative amount, which is known as an Access Fee Credit. Any Access Fee Credits will be credited to Claims Administrator and Claims Administrator will pass the entire Access Fee Credit on to Employer.

Instances may occur in which the claim payment is zero or Claims Administrator pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Claims Administrator will pay the Host Blue’s Access Fee and pass it along directly to Employer as stated above even though Employer paid little or had no claim liability.

A General Administrative Fee encompasses fees Claims Administrator charges to Employer for administering Employer’s benefit plan. They may include both local and Inter-Plan fees. For purposes of this agreement, they include the following BlueCard Program-related fees other than the BlueCard Program Access Fee: namely, Administrative Expense Allowance (AEA) Fee, Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee, PPO Provider Directory Fee and Blue Cross Blue Shield Global Core Program Fees, if applicable.

Purchaser Name: **City Of Orange Beach**

Purchaser Base Group Number(s): **005260001**

Effective Date: (Contract Year) of this Exhibit X: **January 01, 2023 through December 31, 2023**

Inter-Plan Arrangements Fees

BlueCard Program Fees

Access Fees:	3.62% of network savings, capped at $2,000.00 per claim. Note: Employer may incur higher Inter-Plan Access Fees for enrollment in group contracts with account prefixes used for less than 1,000 members.

General Administrative Fee

Any Nonparticipating Provider Claims Processing Fees:	$0 per claim for out-of-network claims. (Access Fees, Toll-free Number Fees and PPO Provider Directory Fees do not apply when members access nonparticipating providers).