Standard Professional Services Agreement ("PSA")

AGREEMENT FOR FULLY-INSURED MEDICAL COVERAGE

This agreement ("Agreement"), dated as of June 1, 2024 ("Effective Date") is by and between the County of Sonoma, a political subdivision of the State of California (hereinafter "County"), and Anthem Insurance Companies, Inc doing business as Anthem BC Health Insurance (hereinafter "Consultant").

R E C I T A L S

WHEREAS, Consultant represents that it is a duly qualified, licensed, and experienced in the administration of **Fully-Insured Medical Coverage** and related services; and

WHEREAS, in the judgment of the Director of Human Resources, it is necessary and desirable to employ the services of Consultant for **Fully-Insured Medical Coverage and related services.**

NOW, THEREFORE, in consideration of the foregoing recitals and the mutual covenants contained herein, the parties hereto agree as follows:

A G R E E M E N T

l. Scope of Services.

1.1 Consultant's Specified Services

Consultant shall perform the services described in **Exhibit A** attached hereto and incorporated herein by this reference (hereinafter "Scope of Services"), and within the times or by the dates provided for in **Exhibit A** and pursuant to Article 7, Prosecution of Work. In the event of a conflict between the body of this Agreement and **Exhibit A**, the provisions in the body of this Agreement shall control.

1.2 Cooperation With County. Consultant shall reasonably cooperate with County and County staff in the performance of all work hereunder.

1.3 Performance Standard. Consultant shall perform all work hereunder in a manner consistent with the level of competency and standard of care normally observed by a person practicing in Consultant's profession. County has relied upon the professional ability and training of Consultant as a material inducement to enter into this Agreement. Consultant hereby agrees to provide all services under this Agreement in accordance with generally accepted professional practices and standards of care, as well as the requirements of applicable federal, state and local laws, it being understood that acceptance of Consultant's work by County shall not operate as a waiver or release. If County determines that any of Consultant's work is not in accordance with such level of competency and standard of care, County, in its sole discretion, shall have the right to do any or all of the following: (a) require Consultant to meet with County to review the quality of the work and resolve matters of concern; (b) require Consultant to repeat the

work at no additional charge until it is satisfactory; (c) terminate this Agreement pursuant to the provisions of Article 4; or (d) pursue any and all other remedies at law or in equity.

1.4 Assigned Personnel.

a. Consultant shall assign only competent personnel to perform work hereunder. In the event that at any time County, in its reasonable discretion, desires the removal of any person or persons assigned by Consultant to perform work hereunder, Consultant shall remove such person or persons immediately upon receiving written notice from County.

b. Any and all persons identified in this Agreement or any exhibit hereto as the project manager, project team, or other professional performing work hereunder are deemed by County to be key personnel whose services were a material inducement to County to enter into this Agreement, and without whose services County would not have entered into this Agreement. Consultant shall not remove, replace, substitute, or otherwise change any key personnel without the prior written consent of County, which consent shall not be unreasonably withheld or delayed.

c. In the event that any of Consultant's personnel assigned to perform services under this Agreement become unavailable due to resignation, sickness or other factors outside of Consultant's control, Consultant shall be responsible for timely provision of adequately qualified replacements.

2. Payment.

For all services and incidental costs required hereunder, Consultant shall be paid in accordance with **Exhibit B**. Expenses not expressly authorized by the Agreement shall not be reimbursed.

Unless otherwise noted in this Agreement, payments shall be made within the normal course of County business after presentation of an invoice in a form approved by the County for services performed.

Pursuant to California Revenue and Taxation code (R&TC) Section 18662, the County shall withhold seven percent of the income paid to Consultant for services performed within the State of California under this agreement, for payment and reporting to the California Franchise Tax Board, if Consultant does not qualify as: (1) a corporation with its principal place of business in California, (2) an LLC or Partnership with a permanent place of business in California, (3) a corporation/LLC or Partnership qualified to do business in California by the Secretary of State, or (4) an individual with a permanent residence in the State of California.

If Consultant does not qualify, County requires that a completed and signed Form 587 be provided by the Consultant in order for payments to be made. If Consultant is qualified, then the County requires a completed Form 590. Forms 587 and 590 remain valid for the duration of the Agreement provided there is no material change in facts. By signing either form, the Consultant agrees to promptly notify the County of any changes in the facts. Forms should be sent to the County pursuant to Article 12. To reduce the amount

withheld, Consultant has the option to provide County with either a full or partial waiver from the State of California.

3. Term of Agreement. The term of this Agreement shall be from **June 1, 2024** to **May 31, 2026** unless terminated earlier in accordance with the provisions of Article 4 below.

4. Termination.

4.1 Termination Without Cause. Notwithstanding any other provision of this Agreement, at any time and without cause, County shall have the right, in its sole discretion, to terminate this Agreement by giving 60 days written notice to Consultant.

4.2 Termination for Cause. Notwithstanding any other provision of this Agreement, should Consultant fail to perform any of its obligations hereunder, within the time and in the manner herein provided, or otherwise violate any of the terms of this Agreement, County may terminate this Agreement by giving Consultant 60 days advance written notice of such termination, stating the reason for termination.

4.3 Delivery of Work Product and Final Payment Upon Termination.
In the event of termination, Consultant, within 14 days following the date of termination, shall deliver to County, subject to the requirements and limitations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), all reports, original drawings, graphics, plans, studies, and other data or documents, in whatever form or format, assembled or prepared by Consultant or Consultant's subcontractors, consultants, and other agents in connection with this Agreement and shall submit to County an invoice showing the services performed, and copies of receipts for reimbursable expenses (if any) up to the date of termination.

4.4 Payment Upon Termination. Upon termination of this Agreement by County, Consultant shall be entitled to receive as full payment for all services satisfactorily rendered and reimbursable expenses properly incurred hereunder, an amount which bears the same ratio to the total payment specified in the Agreement as the services satisfactorily rendered hereunder by Consultant bear to the total services otherwise required to be performed for such total payment provided, however, that if County terminates the Agreement for cause pursuant to Section 4.2, County shall deduct from such amount the amount of damage, if any, sustained by County by virtue of the breach of the Agreement by Consultant.

4.5 Authority to Terminate. The Board of Supervisors has the authority to terminate this Agreement on behalf of the County. In addition, the Purchasing Agent or Human Resources Department Head, in consultation with County Counsel, shall have the authority to terminate this Agreement on behalf of the County.

5. Indemnification. Consultant agrees to accept all responsibility for loss or damage to any person or entity, including County, and to indemnify, hold harmless, and release County, its officers, agents, and employees, from and against any actions, claims, damages, liabilities, disabilities, or expenses, that may be asserted by any person or entity, including Consultant, that

arise out of, pertain to, or relate to Consultant's or its agents', employees', contractors', subcontractors', or invitees' performance or obligations under this Agreement. Consultant agrees to provide a complete defense for any claim or action brought against County based upon a claim relating to such Consultant's or its agents', employees', contractors', subcontractors', or invitees' performance or obligations under this Agreement. Consultant's obligations under this Section apply whether or not there is concurrent or contributory negligence on County's part, but to the extent required by law, excluding liability due to County's conduct. County shall have the right to select its legal counsel at Consultant's expense, subject to Consultant's approval, which shall not be unreasonably withheld. This indemnification obligation is not limited in any way by any limitation on the amount or type of damages or compensation payable to or for Consultant or its agents under workers' compensation acts, disability benefits acts, or other employee benefit acts.

6. Insurance. With respect to performance of work under this Agreement, Consultant shall maintain insurance as described in **Exhibit C**, which is attached hereto and incorporated herein by this reference, and shall require all of its subcontractors, consultants, and other agents to maintain insurance commensurate with the services they provide.

7. Prosecution of Work. The execution of this Agreement shall constitute Consultant's authority to proceed immediately with the performance of this Agreement and provide the services during the time period contemplated by this Agreement. Performance of the services hereunder shall be completed within the time required herein, provided, however, that if the performance is delayed by earthquake, flood, high water, or other Act of God or by strike, lockout, or similar labor disturbances, the time for Consultant's performance of this Agreement shall be extended by a number of days equal to the number of days Consultant has been delayed.

8. Extra or Changed Work. Extra or changed work or other changes to the Agreement may be authorized only by written amendment to this Agreement, signed by both parties. Changes which do not exceed the delegated signature authority of the Department may be executed by the Department Head in a form approved by County Counsel. The Board of Supervisors or Purchasing Agent must authorize all other extra or changed work which exceeds the delegated signature authority of the Department Head. The parties expressly recognize that, pursuant to Sonoma County Code Section 1-11, County personnel are without authorization to order extra or changed work or waive Agreement requirements. Failure of Consultant to secure such written authorization for extra or changed work shall constitute a waiver of any and all right to adjustment in the Agreement price or Agreement time due to such unauthorized work and thereafter Consultant shall be entitled to no compensation whatsoever for the performance of such work. Consultant further expressly waives any and all right or remedy by way of restitution and quantum meruit for any and all extra work performed without such express and prior written authorization of the County.

9. Representations of Consultant.

9.1 Standard of Care. County has relied upon the professional ability and training of Consultant as a material inducement to enter into this Agreement. Consultant hereby agrees that all its work will be performed and that its operations shall be conducted in accordance with generally accepted and applicable professional practices and standards as well as the requirements of applicable federal, state and local laws, it being understood that acceptance of Consultant's work by County shall not operate as a waiver or release.

9.2 Status of Consultant. The parties intend that Consultant, in performing the services specified herein, shall act as an independent contractor and shall control the work and the manner in which it is performed. Consultant is not to be considered an agent or employee of County and is not entitled to participate in any pension plan, worker's compensation plan, insurance, bonus, or similar benefits County provides its employees. In the event County exercises its right to terminate this Agreement pursuant to Article 4, above, Consultant expressly agrees that it shall have no recourse or right of appeal under rules, regulations, ordinances, or laws applicable to employees.

9.3 No Suspension or Debarment. Consultant warrants that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in covered transactions by any federal department or agency. Consultant also warrants that it is not suspended or debarred from receiving federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the General Services Administration. If the Consultant becomes debarred, consultant has the obligation to inform the County.

9.4 Representation, Warranty and Responsibility as to Data Security

Consultant confirms that it has adopted, and will maintain through the term of this Agreement, information security standards, practices and policies regarding cybersecurity that meet or exceed industry standards and as required by law, including the "Cybersecurity Program Best Practices" issued by the DOL in April 2021.

9.5 Taxes. Consultant agrees to file federal and state tax returns and pay all applicable taxes on amounts paid pursuant to this Agreement and shall be solely liable and responsible to pay such taxes and other obligations, including, but not limited to, state and federal income and FICA taxes. Consultant agrees to indemnify and hold County harmless from any liability which it may incur to the United States or to the State of California as a consequence of Consultant's failure to pay, when due, all such taxes and obligations. In case County is audited for compliance regarding any withholding or other applicable taxes, Consultant agrees to furnish County with proof of payment of taxes on these earnings.

9.6 Records Maintenance. Consultant shall keep and maintain full and complete documentation and accounting records concerning all services performed that are compensable under this Agreement and shall make such documents and records available to County for inspection at any reasonable time. Consultant shall maintain such records for a period of four (4) years following completion of work hereunder or such longer period as may be required by applicable law or CMS requirements.

9.7 Conflict of Interest. Consultant covenants that it presently has no interest and that it will not acquire any interest, direct or indirect, that represents a financial conflict of interest under state law or that would otherwise conflict in any manner or degree with the performance of its services hereunder. Consultant further covenants that in the performance of this Agreement no person having any such interests shall be employed. In addition, if requested to do so by County, Consultant shall complete and file and shall require any other person doing work under this Agreement to complete and file a "Statement of Economic Interest" with County disclosing Consultant's or such other person's financial interests.

9.8 Statutory Compliance/Living Wage Ordinance. Consultant agrees to comply with all

applicable federal, state and local laws, regulations, statutes and policies, including but not limited to the County of Sonoma Living Wage Ordinance, applicable to the services provided under this Agreement as they exist now and as they are changed, amended or modified during the term of this Agreement. Without limiting the generality of the foregoing, Consultant expressly acknowledges and agrees that this Agreement may be subject to the provisions of Article XXVI of Chapter 2 of the Sonoma County Code, requiring payment of a living wage to covered employees. Noncompliance during the term of the Agreement will be considered a material breach and may result in termination of the Agreement or pursuit of other legal or administrative remedies.

9.9 Nondiscrimination. Without limiting any other provision hereunder, Consultant shall comply with all applicable federal, state, and local laws, rules, and regulations in regard to nondiscrimination in employment because of race, color, ancestry, national origin, religion, sex, marital status, age, medical condition, pregnancy, disability, sexual orientation or other prohibited basis, including without limitation, the County's Non-Discrimination Policy. All nondiscrimination rules or regulations required by law to be included in this Agreement are incorporated herein by this reference.

9.10 AIDS Discrimination. Consultant agrees to comply with the provisions of Chapter 19, Article II, of the Sonoma County Code prohibiting discrimination in housing, employment, and services because of AIDS or HIV infection during the term of this Agreement and any extensions of the term.

9.11 Assignment of Rights. Consultant assigns to County all rights throughout the world in perpetuity in the nature of copyright, trademark, patent, right to ideas, in and to all versions of the plans and specifications, if any, now or later prepared by Consultant specifically and solely on County's behalf in connection with this Agreement. Consultant agrees to take such actions as are necessary to protect the rights assigned to County in this Agreement, and to refrain from taking any action which would impair those rights. Consultant's responsibilities under this provision include, but are not limited to, placing proper notice of copyright on all versions of the plans and specifications as County may direct, and refraining from disclosing any versions of the plans and specifications to any third party without first obtaining written permission of County. Consultant shall not use or permit another to use the plans and specifications in connection with this or any other project without first obtaining written permission of County.

9.12 Ownership and Disclosure of Work Product. All reports, original drawings, graphics, plans, studies, and other data or documents ("documents"), in whatever form or format, assembled or prepared by Consultant or Consultant's subcontractors, consultants, and other agents, specifically and solely on County's behalf, in connection with this Agreement, and designated in writing by the County as a "work for hire" prior to creation by Consultant, shall be the property of County. County shall be entitled to immediate possession of such documents upon completion of the work pursuant to this Agreement. Upon expiration or termination of this Agreement, Consultant shall promptly deliver to County all such documents, which have not already been provided to County in such form or format, as County deems appropriate. Such documents shall be and will remain the property of County without restriction or limitation. Consultant may retain copies of the above- described documents but agrees not to disclose or discuss any information gathered, discovered, or generated in any way through this Agreement without the express written permission of County.

9.13 Authority. The undersigned hereby represents and warrants that he or she has authority to execute and deliver this Agreement on behalf of Consultant.

10. Demand for Assurance. Each party to this Agreement undertakes the obligation that the other's expectation of receiving due performance will not be impaired. When reasonable grounds for insecurity arise with respect to the performance of either party, the other may in writing demand adequate assurance of due performance and until such assurance is received may, if commercially reasonable, suspend any performance for which the agreed return has not been received. "Commercially reasonable" includes not only the conduct of a party with respect to performance under this Agreement, but also conduct with respect to other agreements with parties to this Agreement or others. After receipt of a justified demand, failure to provide within a reasonable time, but not exceeding thirty (30) days, such assurance of due performance as is adequate under the circumstances of the particular case is a repudiation of this Agreement. Acceptance of any improper delivery, service, or payment does not prejudice the aggrieved party's right to demand adequate assurance of future performance. Nothing in this Article limits County's right to terminate this Agreement pursuant to Article 4.

11. Assignment and Delegation. Neither party hereto shall assign, delegate, sublet, or transfer any interest in or duty under this Agreement without the prior written consent of the other, and no such transfer shall be of any force or effect whatsoever unless and until the other party shall have so consented.

12. Method and Place of Giving Notice, Submitting Bills and Making Payments. All notices, bills, and payments shall be made in writing and shall be given by personal delivery or by U.S. Mail or courier service. Notices, bills, and payments shall be addressed as follows:

TO: COUNTY:

Cheryl Thibault, Benefits Manager
Human Resources Benefit Unit
County of Sonoma
575 Administration Drive, Suite 117C
Santa Rosa, CA 95403

TO: CONSULTANT:

_____
_____
_____

[Consultant name, address and email Facsimile Number may be included]

When a notice, bill or payment is given by a generally recognized overnight courier service, the notice, bill or payment shall be deemed received on the next business day. When a copy of a notice, bill or payment is sent by facsimile or email, the notice, bill or payment shall be deemed received upon transmission as long as (1) the original copy of the notice, bill or payment is promptly deposited in the U.S. mail and postmarked on the date of the facsimile or email (for a payment, on or before the due date), or (2) the sender has a written confirmation of the facsimile transmission or email, and (3) the facsimile or email is transmitted before 5 p.m. (recipient's time). In all other instances, notices, bills and payments shall be effective upon receipt by the recipient. Changes may be made in the names and addresses of the person to whom notices are to be given by giving notice pursuant to this paragraph.

13. Miscellaneous Provisions.

13.1 No Waiver of Breach. The waiver by County of any breach of any term or promise contained in this Agreement shall not be deemed to be a waiver of such term or provision or any subsequent breach of the same or any other term or promise contained in this Agreement.

13.2 Construction. To the fullest extent allowed by law, the provisions of this Agreement shall be construed and given effect in a manner that avoids any violation of statute, ordinance, regulation, or law. The parties covenant and agree that in the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby. Consultant and County acknowledge that they have each contributed to the making of this Agreement and that, in the event of a dispute over the interpretation of this Agreement, the language of the Agreement will not be construed against one party in favor of the other. Consultant and County acknowledge that they have each had an adequate opportunity to consult with counsel in the negotiation and preparation of this Agreement.

13.3 Consent. Wherever in this Agreement the consent or approval of one party is required to an act of the other party, such consent or approval shall not be unreasonably withheld or delayed.

13.4 No Third-Party Beneficiaries. Nothing contained in this Agreement shall be construed to create and the parties do not intend to create any rights in third parties.

13.5 Applicable Law and Forum. This Agreement shall be construed and interpreted according to the substantive law of California, regardless of the law of conflicts to the contrary in any jurisdiction. Any action to enforce the terms of this Agreement or for the breach thereof shall be brought and tried in Santa Rosa or the forum nearest to the city of Santa Rosa, in the County of Sonoma.

13.6 Captions. The captions in this Agreement are solely for convenience of reference. They are not a part of this Agreement and shall have no effect on its construction or interpretation.

13.7 Merger. This writing is intended both as the final expression of the Agreement between the parties hereto with respect to the included terms and as a complete and exclusive statement of the terms of the Agreement, pursuant to Code of Civil Procedure Section 1856. No modification of this Agreement shall be effective unless and until such modification is evidenced by a writing signed by both parties.

13.8. Survival of Terms. All express representations, waivers, indemnifications, and limitations of liability included in this Agreement will survive its completion or termination for any reason.

13.9 Time of Essence. Time is and shall be of the essence of this Agreement and every provision hereof.

13.10. Counterpart; Electronic Signatures. The parties agree that this Agreement may be executed in two or more counterparts, each of which shall be deemed an original, and together

which when executed by the requisite parties shall be deemed to be a complete original agreement. Counterparts may be delivered via facsimile, electronic mail (including PDF) or other transmission method, and any counterpart so delivered shall be deemed to have been duly and validly delivered, be valid and effective for all purposes, and shall have the same legal force and effect as an original document. This Agreement, and any counterpart, may be electronically signed by each or any of the parties through the use of any commercially available digital and/or electronic signature software or other electronic signature method in compliance with the U.S. federal ESIGN Act of 2000, California's Uniform Electronic Transactions Act (Cal. Civil Code § 1633.1 et seq.), or other applicable law. By its use of any electronic signature below, the signing party agrees to have conducted this transaction and to execution of this Agreement by electronic means.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

CONSULTANT: Anthem Insurance Companies, Inc.

By: _____

Title: _____

Date: _____

COUNTY: COUNTY OF SONOMA

EXECUTED BY:

By: _____
Janell Crane, Director of Human Resources

Date: _____

APPROVED AS TO FORM FOR COUNTY:

By: _____

Title: _____

Date: _____

CERTIFICATES OF INSURANCE REVIEWED, ON FILE, AND APPROVED AS TO SUBSTANCE FOR COUNTY:

By: _____
Janell Crane, Director of Human Resources

Date: _____

EXHIBIT A
SCOPE OF SERVICES

Consultant agrees, upon request from County, to provide services as set forth in this **Exhibit A**. Consultant will perform these services as requested by the County as the County in its sole discretion deems appropriate, subject to applicable law, regulations and requirements of governmental entities. All work will be issued incrementally with documented scope and prior written approval of County. County does not guarantee any minimum or maximum amount of work under this agreement.

The costs of said services based on the cost schedule set forth in **Exhibit B**.

EXHIBIT A

Medicare Advantage Group Agreement

This Anthem Medicare Preferred (PPO) Medicare Advantage Group Agreement (hereinafter "Agreement") is entered into as of June 1, 2024 (hereinafter "Effective Date") by and between the County of Sonoma (hereinafter "Group") and Anthem Insurance Companies, Inc. doing business as Anthem BC Health Insurance Company (hereinafter "Anthem BC Health") sponsor of the Anthem Medicare Preferred (PPO) Medicare Advantage with Prescription Drug Plan (hereinafter "MAPD Plan"), upon the following terms and conditions. Anthem BC Health and Group each are sometimes referred to herein as a "Party" and collectively as the "Parties."

ARTICLE 1 - PURPOSE

Group has requested Anthem BC Health to provide health insurance coverage to its eligible retirees and other eligible individuals as described in this Agreement. Upon Anthem BC Health's receipt and acceptance of Group's signed application for coverage and payment of the first premium, this Agreement will be deemed executed by Group and shall be effective in accordance with its terms. This Agreement supersedes any prior agreements between the Parties regarding the subject matter of this Agreement. Anthem BC Health's standard policies, as they may be amended from time to time, will be used in the performance of services specified in this Agreement and the provision of benefits described in the Evidence of Coverage.

ARTICLE 2 - DEFINITIONS

In this Agreement, the following terms will have the meanings set forth below. Capitalized terms used in this Agreement that are not defined below are defined in the Evidence of Coverage.

Agreement. The following documents will constitute the entire Agreement between the Parties: this Agreement, and any addenda, endorsements, and schedules which are hereby incorporated by reference; the Evidence of Coverage and any riders thereto; the Group application; and the individual Applications and any reclassifications thereof submitted by Members of the Group.

Agreement Period. The 12-month period beginning on the Effective Date, and consecutive 12-month periods thereafter until the Agreement is terminated pursuant to the termination provisions herein.

Anniversary Date. The Anniversary Date of this Agreement means the date that falls at the end of each 12-month period following the Effective Date of this Agreement. All periods of time under this Agreement will begin and end at 12:01 A.M. local time at the Group's address.

Application. Any mutually agreed upon enrollment mechanism, including, without limitation, paper applications provided by Members or Group and spreadsheets or electronic enrollment files.

CMS. Centers for Medicare & Medicaid Services, a federal agency within the United States Department of Health and Human Services.

Covered Service. Any hospital, medical, prescription or other health care service rendered to Members for which benefits are provided pursuant to the Evidence of Coverage.

Creditable Coverage. Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial

guidelines.

Effective Date. This Agreement shall be effective at 12:01 A.M. on June 1, 2024 and shall continue in full force and effect thereafter until terminated as provided herein.

Eligible Individual(s). Individuals who meet the requirements specified by the Group's eligibility rules, CMS requirements, this Agreement, and the Evidence of Coverage.

Eligibility Notice. A notice provided by Group to Anthem BC Health setting forth information regarding individuals eligible to participate in the MAPD Plan. An Eligibility Notice may be an "initial" notice, including an Application, provided prior to the Effective Date or a "subsequent" notice provided from time to time thereafter. See Section 3.E below.

Evidence of Coverage. The Evidence of Coverage document provided to Members and any endorsements or riders thereto which defines those Covered Services and benefits available to Members under this Agreement. The Evidence of Coverage also defines the rights and responsibilities of the Member and the MAPD Plan.

Grace Period. The period specified in Section 6.C hereof for payment by Group of premiums and other charges.

Late Enrollment Penalty. A penalty amount imposed by CMS and added to a Member's monthly premium if the Member has gone without Medicare Part D Prescription Drug Coverage or other Creditable Coverage for a continuous period of 63 days or more before enrolling in the Part D Plan.

Low-Income Subsidy. A Medicare subsidy program to assist Eligible Individuals with limited income and resources to pay Medicare prescription drug program costs.

Member. A person with Medicare (i) who is eligible to get Covered Services, (ii) who has enrolled in the MAPD Plan, and (iii) whose enrollment has been confirmed by CMS.

Prescription Drug Coverage. Prescription drug benefits offered through the MAPD Plan that provide Medicare Part D Prescription Drug Coverage, which helps pay for certain outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B, combined with non-Medicare prescription drug coverage that supplements the Part D coverage.

Provider. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Evidence of Coverage.

ARTICLE 3 - ELIGIBILITY AND ENROLLMENT

3.A Only Eligible Individuals may be enrolled in the MAPD Plan.

3.B Those individuals initially enrolled shall be Eligible Individuals for whom an Application shall have been timely filed for enrollment for themselves. Dependents who are Eligible Individuals shall be enrolled upon the timely filing of an Application on such dependent's behalf.

3.C The Group or its designee shall have the opportunity to submit Applications to add new, transferred and newly eligible individuals to the group of Members initially enrolled under this Agreement. However, before qualifying for enrollment, the new, transferred or newly eligible individual must meet all of the applicable eligibility requirements as set forth in this Agreement.

3.D The effective date of coverage for any such additional Member whose Application is accepted by Anthem BC Health shall be in accordance with the Evidence of Coverage and CMS requirements in effect at the time the Member's Application is approved.

3.E With such frequency as the Parties shall agree, Group shall furnish Anthem BC Health with Eligibility Notices setting forth deletions and changes to information provided in a Member's initial Application or subsequent Eligibility Notices.

3.F Anthem BC Health reserves the right to limit retroactive changes to enrollment in accordance with CMS guidance. Acceptance of payments from the Group or the payment of benefits to persons no longer eligible will not obligate Anthem BC Health to provide or continue to provide benefits for such persons.

3.G A Member who is determined by the Group or its designee to be ineligible for enrollment in the MAPD Plan shall be reported by Group on an Eligibility Notice as a deletion from the listing of Members reasonably in advance of such Member's termination. Anthem BC Health shall provide notice of termination to such Member in accordance with Anthem BC Health policies, the Evidence of Coverage and CMS requirements, and the Member's coverage shall terminate in accordance with such notice.

3.H Any retroactive disenrollments must be submitted by Anthem BC Health to CMS for approval. The Group or its designee shall be responsible for providing Anthem BC Health with applicable data or information required to substantiate Anthem BC Health's request to CMS for such retroactive disenrollment.

3.I If Anthem BC Health verifies a Member's eligibility based on information provided by Group and such information gives rise to an erroneous verification of eligibility by Anthem BC Health, the Group will indemnify and hold Anthem BC Health harmless for any losses or damages arising from the Group's or its designee's failure to provide timely, accurate and complete eligibility information in a manner and format acceptable to Anthem BC Health.

ARTICLE 4 - OBLIGATIONS OF ANTHEM BC HEALTH

4.A Anthem BC Health shall provide health care benefits to Members who receive Covered Services under the terms of this Agreement and the Evidence of Coverage. However, in no event will Anthem BC Health provide benefits for services rendered prior to the Effective Date or after the termination of this Agreement, or for any period for which full premium payment has not been paid to Anthem BC Health, except as otherwise provided in the Evidence of Coverage and/or applicable CMS requirements.

4.B Anthem BC Health shall furnish or make available an identification card, Evidence of Coverage and all other CMS-required documents for each Member enrolled in the plan(s) covered by this Agreement.

4.C Anthem BC Health shall furnish appropriate Application forms and related material necessary and appropriate for the enrollment of Members, and shall provide such assistance to the Group or its designee as may be reasonably necessary for enrollment purposes. Anthem BC Health shall

maintain current eligibility status records in accordance with the Eligibility Notice(s) submitted by the Group or its designee for the purpose of administering this Agreement.

4.D Anthem BC Health shall send a Creditable Coverage attestation form to applicable Members in accordance with CMS guidelines regarding the administration of any Late Enrollment Penalty that may be imposed by CMS.

4.E Any Late Enrollment Penalty assessed as a result of a lapse or other gap in Creditable Coverage, may be paid by Group on behalf of its membership. If the Group chooses not to pay such Late Enrollment Penalties for its Members, Anthem BC Health will bill the applicable Member directly for any Late Enrollment Penalty assessed by CMS.

4.F Per CMS requirements, the Evidence of Coverage provided by Anthem BC Health includes information on programs to help Members with limited resources pay for their prescription drugs.

4.G Anthem BC Health is responsible for pursuing recoveries of claim payments as appropriate and as required or allowed by law. Anthem BC Health shall determine which recoveries it will pursue in its discretion. However, Anthem BC Health may not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or by an agreement with a Provider or other vendor.

4.H Anthem BC Health will review, investigate, process and pay claims according to the terms and conditions of this Agreement, the Evidence of Coverage, and Anthem BC Health's contracts with Providers or other vendors. Anthem BC Health may make benefit payments to either Providers or Members as described in the Evidence of Coverage, and will coordinate benefits with other payors as required by law. Anthem BC Health will give notice in writing to the Member when a claim for benefits has been denied. The notice will provide the reasons for the denial and the right to an appeal of the denial in accordance with the procedures set forth in the Evidence of Coverage.

4.I Either Party may subcontract any of its duties under this Agreement without the prior written consent of the other Party; provided, however, that the Party subcontracting such duties shall remain responsible for fulfilling its obligations under this Agreement.

ARTICLE 5 - OBLIGATIONS OF GROUP

5.A The Group or its designee shall keep such records and furnish to Anthem BC Health such notification and other information as may be reasonably required by Anthem BC Health for the purpose of determining eligibility for coverage, enrolling and disenrolling Members, processing terminations, effecting changes in this Agreement, effecting changes due to an individual becoming eligible for Medicare, effecting changes due to a Member becoming disabled, determining the amount payable by the Group under this Agreement, or for any other purpose reasonably related to the administration of this Agreement. The Group or its designee will give notification of eligibility to each Member who is or will become eligible for enrollment, and will collect and submit to Anthem BC Health an Application for each Member desiring to enroll.

5.B The Group or its designee shall promptly forward to Anthem BC Health all Applications, notices or other writings delivered to the Group or its designee from Members or individuals applying for coverage under this Agreement. If Group receives a question or complaint regarding benefits under this Agreement, Group shall advise the Member to contact Anthem BC Health.

5.C The Group or its designee will timely distribute to Members notices of premium changes and termination of this Agreement. Notice by Anthem BC Health to the Group shall be deemed to constitute notice to all Members in order to effectuate any such change or termination; provided, however, that Anthem BC Health reserves the right to provide any such notice(s) to Members if Anthem BC Health deems it appropriate. Group or its designee shall comply with all applicable laws and regulations relating to the distribution of notices and information to Members.

5.D Group hereby acknowledges, agrees and certifies its compliance during the term of this Agreement with the following requirements as they relate to Group's MAPD Plan(s).

5.D.1 Premium – Group hereby agrees and certifies, as to Member premium, if any, that:

(i) Different amounts can be subsidized by Group for different classes of Members in an MAPD Plan, provided such classes are reasonable and based upon objective business criteria (i.e., years of service, business location, job category, nature of compensation). Different classes cannot be based on eligibility for the Part D Low Income Subsidy. Accordingly, Group hereby certifies that such classes (if any) are reasonable and based upon objective business criteria.

(ii) The premium within a given class does not vary by Member, and

(iii) With regard to the Part D premium, Members cannot be charged for prescription drug coverage provided under the MAPD Plan more than the sum of his or her monthly premium attributable to basic prescription drug coverage and 100% of the monthly premium attributable to his or her non-Medicare Part D benefits (if any).

(iv) Group must pass through any direct subsidy payments received from CMS to reduce the amount that the Member pays (or in those instances where the Member in the Group plan pays premiums on behalf of a Medicare-eligible spouse or dependent, the amount the Member pays).5.D.2 Low Income Subsidy – Group hereby agrees and certifies, as to Members who are subsidy eligible individuals pursuant to, but not limited to, 42 C.F.R. 423.773, that:

(i) The monthly premium subsidy amount for a Member eligible for the low-income subsidy will be first used to reduce the Member's portion of the monthly premium, and any remaining amount will be used to reduce Group's premium contribution. If the Group pays 100% of the premium, the Group may retain the full subsidy.

(ii) It is the Group's responsibility to reimburse or refund Members who are subsidy eligible individuals any premium credit resulting from the Low Income Subsidy, if applicable, in accordance with paragraph (i) above. Group agrees and certifies that any such credit owed to eligible Members shall be returned to the applicable Member(s) by Group within forty-five (45) days of discovering the Member premium credit or notice from Anthem BC Health (whichever occurs first).

5.E In connection with any disclosure by Anthem to Group pursuant to Section 20.C and/or

Section 21.C, upon request by Anthem, Group shall execute an agreement provided by Anthem with respect to the confidentiality of the information referenced in such Sections.

ARTICLE 6 – PREMIUM AND GRACE PERIOD

6.A The premium rates for coverage under this Agreement are set forth in Addendum A. Premium rates are based on the data provided by Group, consistent with applicable laws.

6.B Anthem BC Health does not have an obligation to accept a partial premium payment. Group must make payments regardless of any contributions to those payments by Members.

6.C The full amount due as set forth in Addendum A, including premium, taxes, fees or assessments, is due and payable on the 1st of each month during the term of this Agreement. Group is entitled to a 30-day period following the due date (the "Grace Period"), for the payment of any premium and/or other amounts due. The payment amount must equal the "TOTAL DUE" amount shown on the billing statement, less any payment previously remitted but not reflected on the current billing statement. Once the Group exceeds its Grace Period and enters into Anthem BC Health's delinquency process, Group must pay 100% of the "TOTAL DUE" to avoid termination.

ARTICLE 7 - NOTICES

Any required notice under this Agreement will be deemed sufficient when made in writing and delivered by first class mail; personal delivery; electronic mail, as permitted by law, or overnight delivery with confirmation capability. Such notice will be deemed to have been given as of the date of the mailing, delivery to the delivery service, or sending by electronic mail, as the case may be. Anthem BC Health will provide notice to Group's principal place of business as shown on Anthem BC Health's records. Group will provide notice to its designated Anthem BC Health MAPD Representative.

ARTICLE 8 - CHANGES IN THE AGREEMENT

8.A During the Agreement Period, Anthem BC Health may change the benefit provisions and the terms and conditions thereof and/or the premium rates as a result of changes in benefit provisions or other requirements mandated by CMS or federal law, or changes in benefit provisions agreed to by the Parties in writing. Anthem BC Health will provide written notice to the Group not less than 60 days before the effective date of any such change (other than mutually agreed changes) or such shorter notice as may be required to comply with CMS or federal laws changes. If Group does not meet underwriting or other requirements set forth in Addendum A, Anthem BC Health may change the premium rates by giving notice to Group as soon as reasonably possible after learning that Group does not meet such underwriting or other requirements.

8.B Except as otherwise provided in this section 8.B below, an amendment to this Agreement will not be effective unless in writing and signed by an authorized representative of Anthem BC Health and Group. If any change to the Agreement, benefits, and/or premium rates is unacceptable to Group, Group may terminate coverage under this Agreement by giving written notice of termination to Anthem BC Health in accordance with section 9.A below. Payment of the new amount in the event of a premium rate change, or continued payment of the current amounts in the event of an Agreement or benefit change only, will constitute acceptance of the change by Group, without the

necessity of securing Group's signature on the schedule or amendment. The schedule or amendment will then become a part of this Agreement.

8.C Notwithstanding the provisions of Section 8.B above, unless Group provides sixty (60) days' advance written notice of termination, this Agreement will automatically renew on each Anniversary Date, with the benefits and at the rates set forth in each year's Renewal Addendum and Amendment to Group's Agreement.

ARTICLE 9 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

9.A Group may terminate this Agreement at any time by giving Anthem BC Health at least sixty (60) days' advance written notice of termination. Group must pay all amounts due for each Member covered through the effective date of termination of this Agreement. Unless Group provides sixty (60) days' advance written notice of termination, this Agreement will automatically renew on each Anniversary Date, with the benefits and at the rates set forth in each year's Renewal Addendum and Amendment to Group's Agreement.

9.B Notwithstanding any other provision of this Article, if the Group fails to make in full any payment due under this Agreement within the Grace Period, Anthem BC Health may, in its sole discretion, terminate this Agreement, with written notice. Notwithstanding such termination or suspension, Anthem BC Health may, in its sole discretion, accept late payment of delinquent amounts submitted with a written request by Group to reinstate and, upon acceptance by Anthem BC Health, this Agreement may be reinstated retroactively to the last date for which full premium payment was made. Any such acceptance of a delinquent payment by Anthem BC Health shall not be deemed a waiver of Anthem BC Health's right to terminate this Agreement for any future failure of the Group to make full and timely payment of amounts due under this Agreement. Delivery of payment to Anthem BC Health or Anthem BC Health's receipt and negotiation of a tendered payment through its automatic deposit procedures shall not be deemed acceptance of such reinstatement or a retraction of such termination unless Anthem BC Health provides written notice to Group of reinstatement. Upon termination of the Agreement as provided in this paragraph, Anthem BC Health shall only have liability to make payment for Covered Services provided through the last date for which full premium payment was made by the Group.

9.C Notwithstanding any other provision of this Agreement, if the Group, or its designee (if any) (1) engages in fraudulent conduct or misrepresentation, Anthem BC Health may, in its discretion, rescind, cancel or terminate this Agreement immediately, subject to CMS guidelines, and (2) if the Group is non-compliant with the contribution or participation requirements of this Agreement, Anthem BC Health may terminate this Agreement upon sixty (60) days' advance written notice. The Group shall be liable to Anthem BC Health for any and all payments made and losses or damages sustained by Anthem BC Health arising as a result of such Group or designee's conduct.

9.D In the event Anthem BC Health decides, in its sole discretion, to discontinue offering a particular Medicare Advantage and/or prescription drug product, Anthem BC Health has the right to terminate such product as permitted by applicable law, by giving written notice of termination of this Agreement to Group at least ninety (90) days before the effective date of termination.

9.E Upon termination of this Agreement, Anthem BC Health shall cease to have any liability for benefits or claims incurred after the effective date of termination (except as may be otherwise

provided in the Evidence of Coverage), and shall have no liability to offer continuation or conversion coverage to Members.

ARTICLE 10 - CLAIMS PAID AFTER EFFECTIVE DATE OF TERMINATION

In the event that (1) the Group terminates this Agreement without giving notice to Anthem BC Health as required by this Agreement, (2) the Agreement is terminated pursuant to Article 9.B or 9.C hereof, or (3) a Member is no longer eligible for coverage and has been terminated from the coverage without timely notice to Anthem BC Health, and, in each case, and, after the effective date of termination, Anthem BC Health (or its subcontracted vendors) makes payment of any claims which would otherwise have been payable under the terms of this Agreement but for the fact that the claims were incurred after the effective date of Agreement termination or Member ineligibility, as the case may be, the Group shall be liable to reimburse Anthem BC Health for all claim amounts paid.

ARTICLE 11 - TERMINATION OF COVERED PERSONS

In addition to Anthem BC Health's termination and cancellation rights described in the Evidence of Coverage, Anthem BC Health reserves the right to cancel or rescind any health care benefits provided hereunder to any Member who, in Anthem BC Health's determination, engages in misrepresentation and/or fraudulent conduct in relation to any Application for coverage or any claims made for coverage or under this Agreement.

ARTICLE 12 - DATA REPORTS

In the event the Group requests from Anthem BC Health information records or data reports which, in Anthem BC Health's opinion, differ substantially in substance or form from information records or data reports prepared by Anthem BC Health in the ordinary course of business (and if Anthem BC Health, in its discretion, agrees to provide such reports), Anthem BC Health shall be entitled to fix a reasonable charge for provision of such reports, and such charge shall be payable by Group at a mutually agreeable time.

ARTICLE 13 - LIMITATION ON ACTIONS

No action at law or in equity shall be brought to recover for any claims for any services covered under this Agreement unless such action is commenced not later than three (3) years after the date of the giving of the required notice or furnishing the required proof.

ARTICLE 14 - NO WAIVER

No failure or delay by either Party to exercise any right or to enforce any obligation under this Agreement, in whole or in part, shall operate as a waiver to enforce compliance with such right or obligation in the future. No course of dealing between Group and Anthem BC Health will operate as a waiver of any right or obligation under this Agreement.

ARTICLE 15 - ASSIGNMENT

Neither Party may assign all or part of this Agreement without first obtaining the written consent of the other Party; provided, however that, subject to applicable laws, Anthem BC Health may assign all or part of its duties and obligations to: (1) another qualified insurance carrier under an assumption reinsurance arrangement; (2) any affiliate or successor in interest of Anthem BC Health; or, (3) another qualified

insurance carrier surviving a merger, reorganization, sale, or similar event involving Anthem BC Health or Anthem BC Health's assets. Any assignee under this Agreement must continue to fulfill all Agreement obligations of the Party assigning this Agreement.

ARTICLE 16 - SERVICE MARKS

This Agreement constitutes a contract solely between Group and Anthem BC Health. Anthem BC Health is an independent corporation operating under a license with the Blue Cross and Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield Plans, permitting Anthem BC Health to use the Blue Cross and/or Blue Shield Service Marks in the State of California. Anthem BC Health is not contracting as the agent of the Association. Group has not entered into this Agreement based upon representations by any person other than Anthem BC Health. No person, entity, or organization other than Anthem BC Health will be held accountable or liable to Group for any of Anthem BC Health's obligations provided under this Agreement. This paragraph will not create any additional obligations on the part of Anthem BC Health, other than those obligations contained in this Agreement.

ARTICLE 17 – INTERPLAN/MEDICARE ADVANTAGE PROGRAM FOR PPO

17.A Out-of-Area Services – Medicare Advantage. Anthem BC Health has relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Inter-Plan Medicare Advantage Program." This Program operates under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). When Members access healthcare services outside the geographic area MAPD Plan serves, the claim for those services will be processed through the Inter-Plan Medicare Advantage Program. The Inter-Plan Medicare Advantage Program available to Members under this Agreement is described generally below.

17.B Member Liability Calculation. When a Member receives Covered Services outside of the MAPD Plan service area from a Medicare Advantage PPO network provider, the cost of the service, on which Member liability (copayment/coinsurance) is based will be either:

- The Medicare allowable amount for Covered Services; or
- The amount the Host Blue negotiates with its provider on behalf of MAPD Plan Members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

17.C Nonparticipating Healthcare Providers Outside of MAPD Plan Service Area. When Covered Services are provided outside of the MAPD Plan service area by nonparticipating healthcare providers, the amount(s) a Member pays for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

ARTICLE 18 - AGREEMENT ADMINISTRATION

18.A Anthem BC Health has the authority to determine eligibility for benefits under the Agreement. Anthem BC Health also has the authority to resolve all questions arising under the Evidence of Coverage and to establish and amend the policies and procedures with regard to the administration of benefits under the Evidence of Coverage. Anthem BC Health's authority to determine eligibility for benefits shall be exercised consistently with the provisions of the Agreement, the Evidence of Coverage, applicable Provider agreements, and applicable law.

18.B Anthem BC Health may waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Evidence of Coverage if such waiver is in the best interest of a Member or will facilitate effective and efficient administration of claims.

18.C Anthem BC Health may, from time to time, institute pilot or test programs regarding disease management, utilization management, case management and/or wellness initiatives. Such initiatives may impact some, but not all Members. Anthem BC Health reserves the right to discontinue a pilot or test program at any time without notice.

18.D Anthem BC Health will have sole responsibility for resolving appeals from claim decisions, consistent with applicable law.

ARTICLE 19 - RELATIONSHIP OF THE PARTIES

Group and Anthem BC Health are separate legal entities. Nothing in this Agreement will cause either Party to be deemed a partner, agent or representative of the other Party. Neither Party will have the express or implied right or authority to assume or create any obligation on behalf of the other Party.

ARTICLE 20 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

20.A All capitalized terms used but not defined in this Article have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

20.B Anthem BC Health may disclose Summary Health Information to Group for purposes of obtaining premium bids from other carriers or third-party payers, or for amending or terminating the Plan.

20.C Anthem BC Health may disclose Protected Health Information ("PHI") to Group for it to carry out Plan administration functions, but such disclosure may occur only after receipt of written certification from Group that: (1) Group's Plan documents and operations comply with the privacy requirements of HIPAA; (2) Group has provided notice to affected individuals as required by HIPAA; and (3) PHI will not be used for the purpose of employment-related actions or other actions not related to administration of benefits under the Plan or permitted by law.

20.D Anthem BC Health will comply with any additional disclosure restrictions required by applicable state and federal law.

ARTICLE 21 - MISCELLANEOUS

21.A Anthem BC Health hereby notifies Group that Anthem BC Health or its vendors may have reimbursement contracts with certain providers for the provision of and payment for health care services and supplies provided to, among others, Members under this Agreement. Under some of these contracts, there may be settlements which require Anthem BC Health to pay the providers or vendors additional money (which may or may not be solely funded by Anthem BC Health) or which require the providers or vendors to return a portion of volume discounts, rebates, or excess money paid. Such providers or vendors may include entities affiliated with Anthem BC Health. Under many provider or vendor contracts, the negotiated reimbursement

does not contemplate any type of settlement between Anthem BC Health and the provider or vendor. Group has no responsibility for additional payment to vendors nor any right to discounts, rebates, or excess money received from vendors.

21.B All Members enrolled under this Agreement shall have only the rights and benefits, and shall be subject to the terms and conditions, set forth in this Agreement and in the Evidence of Coverage.

21.C Anthem BC Health agrees to treat all proprietary information about Group's operations and its Plan in a confidential manner. Group agrees to treat all information about Anthem BC Health's business operations, rate and discount information, and other proprietary data or information in a confidential manner. Neither Party will disclose any such information to any other person without the prior written consent of the Party to whom the information pertains. However, Anthem BC Health may disclose such information to its regulators, legal advisors, lenders, business advisors, and other third parties for purposes related to the subject matter of this Agreement, or for research purposes. Anthem BC Health may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party detailing the circumstances and extent of the disclosure.

21.D The Parties acknowledge that Anthem BC Health is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Providers participating in MAPD Plan's networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of Anthem BC Health's coverage determinations.

21.E Neither Party shall be deemed to be in violation of this Agreement if such Party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, acts of terrorists, acts of war, floods, pandemic, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

21.F Group agrees and understands that the Agreement is the controlling document for all legal purposes. The terms of the Agreement may not be altered or changed without the advance written agreement of Anthem BC Health.

21.G Reference is made to the provisions of 42 C.F.R. §422.402, as supplemented by Chapter 10 of the Medicare Managed Care Manual, regarding federal preemption of state laws with respect to Medicare Advantage plans, including Employer Group Waiver Plans, offered by Medicare Advantage organizations. Such plans are required to abide by all applicable federal laws, regulations and CMS or other federal agency rules, guidance or other requirements promulgated with respect to such plans (collectively, "Medicare Laws"). Any obligations of Anthem BC Health in any agreement to which this Medicare Advantage Group Agreement is attached or made a part of to comply with or based upon the requirements of state or local law, regulations or guidance, including, without limitation, regulations or guidance issued by state or local governmental agencies, shall not be binding on the MAPD Plan, which shall comply with applicable Medicare Laws in all aspects of MAPD Plan governance and operations.

21.H This Agreement supersedes any and all prior agreements between the Parties, whether written or oral, and other documents, if any, addressing the subject matter of this Agreement.

21.I If any provision of this Agreement is found to be invalid, illegal or unenforceable under applicable law, order, judgment or settlement, such provision will be excluded from the Agreement and the remainder of this Agreement will be enforceable and interpreted as if such provision is excluded.

21.J By the payment of appropriate premiums, Group accepts the terms and conditions of this Agreement, retroactive to the Effective Date, without necessity of Group's signature.

21.K Any applicable addenda attached to this Agreement hereby are incorporated into this Agreement by reference.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed in duplicate by affixing the signatures of duly authorized officers.

County of Sonoma	Anthem Insurance Companies, Inc. doing business as Anthem BC Health Insurance Company, sponsor of the Anthem Medicare Preferred (PPO) Medicare Advantage with Prescription Drug Plan
By_____	By_____
Title_____	Title_____
Date_____	Date_____

Exhibit B

County of Sonoma

Featured Plans and Rates - MAPD

Effective: June 01, 2024 through May 31, 2027

SOLD

Below Rates are valid for 6/1/2024 - 5/31/2025

Medical Plan	**Custom PPO Plan 0PH No Ded**
Pharmacy Plan	**Custom Enhanced 5/10/10 ND FG CMAXF ECDHLP SG (30 day supply)**
Members	**728**
Medical	**Monthly billed PMPM rates**
Medical PMPM Premium	$160.82
Pharmacy	**Monthly billed PMPM rates**
Part D Rate	$70.91
Senior Rx Plus Rate	$53.97
Pharmacy PMPM Premium	$124.88
Total	**Monthly billed PMPM rates**
Total Rate	**$285.70**

** The MAPD premium increase for year two will not exceed the year one total quoted rate by more than 7.5% plus any additional government imposed taxes or fees, if applicable.

** The Medical premium increase for year three will not exceed the year two quoted total rate by more than 5% plus any additional government imposed taxes or fees, if applicable. Part D premium for year three has not been determined.

MA 0PH 210216421446 F20240222 PD 150813063735 F20240222

C.B. 2/27/2024

County of Sonoma Assumptions & Conditions Effective 06/01/2024 through 05/31/2027

Rates, rate guarantees, and benefits may need to be revised based on legislative, regulatory or other changes including, but not limited to, CMS guidance which becomes effective during the quoted product years. This includes pending CMS guidance in the Part D plan as part of the Inflation Reduction Act (IRA). Additionally, a future change to require pharmaceutical manufacturers' rebates at the point-of-sale could have a material impact on the EGWP pricing.

Plan parameters and formularies are approved by CMS on an annual basis and can change in January each year. All Part D plan changes, such as deductibles, copays, Part D and non-Part D drug coverage, may only be implemented on the group's original effective date and in January of each year thereafter.

Quote assumes Group will pay, on behalf of its members, any Late Enrollment Penalties (LEP) for applicable members. Should Group request Anthem to provide LEP billing directly to members, a premium adjustment may apply.

Participants have Medicare Parts A and B.

Eligibility for coverage for subscribers or their dependents is based on the subscriber meeting their group's requirements for coverage of retiree medical benefits.

Contracted rates are on a Per-Member-Per-Month (PMPM) basis. Each individual will receive the same equal rate; a two member contract would receive twice the rate; a three member contract would receive triple the rate.

The group will contribute $500 towards the premium. If the contribution strategy does change, Anthem must be notified and reserves the right to re-evaluate its underwriting position. If more than one plan is offered to members, then County of Sonoma shall offer Anthem plan coverage to all eligible Members at terms and contribution levels that are no less favorable than those applicable to any other health coverage available through County of Sonoma .

This plan may be limited in some states to groups that qualify as a large group within that state. The large group definition varies by state.

The pricing census included a total of 728 retired members, including 35 Medicare eligible, pre-65 retired members. If the enrolled membership differs from the pricing census by more than 10% we reserve the right to review and change the pricing if necessary.

Broker Commissions are excluded.

This quote assumes Anthem will co-exist with Kaiser & UHC. No additional carriers or benefit plans will be added to the retiree offering. Furthermore, the quote assumes Anthem will offer a single plan design. Any additional plan selections will be subject to underwriting consideration.

The group's eligibility policy will apply allowing for re-enrollment on the group's anniversary. "In-and-out" enrollments, with the exception of life status changes, are not allowed off the policyholder's anniversary.

A minimum of 90-day implementation is required.

Anthem may retroactively modify the premium rates if the data provided is inaccurate or new data is submitted that varies from the data previously provided to Anthem by group or its representative.

This quote is contingent upon the majority of the enrolled membership residing in an adequate network service area. The service area and plan design are subject to CMS approval.

Additional communications beyond those mandated by CMS or operationally required, such as printed home mailers, may be subject to additional marketing communication expenses for development, fulfillment, and/or mailing.

This quote assumes co-branding (plan sponsor name and/ or logo is allowed on member materials including Medicare Advantage plan quality and health programs).

Pharmacy benefits are based on a two plan benefit structure: an EGWP plan that covers the standard Part D benefit plan as defined by CMS and the Senior

Medical and prescription drug plans must be sold as a package.

Pharmacy benefits are based on a two plan benefit structure: an EGWP plan that covers the standard Part D benefit plan as defined by CMS and the Senior Rx Plus plan that provides the additional drug coverage.

Multi-Year Stipulation; Multi-Year pricing may be adjusted if any of the following stipulations are not met:

The MAPD premium increase for year two will not exceed the year one total quoted rate by more than 7.5% plus any additional government imposed taxes or fees, if applicable. The medical premium increase for year three will not exceed the year two quoted rate by more than 5% plus any additional government imposed taxes or fees, if applicable. The pharmacy premium for year three has not yet been determined.

Annual CMS Part D parameter changes do not impact claim projection by more than 2%.

Rates subject to CMS guidance, legislative changes, regulation changes, etc. that could alter projected costs or revenue impacting quoted years starting in 2024. This includes CMS annual notice of Capitation Rates and Payment Policies which may contribute to benchmark changes, risk score actions, or changes in payment methodologies.

Rates are subject to change based on impacts from adjustments to the 2025 and 2026 CMS Call Letter.

Group must implement Part D plan parameters and formularies approved by CMS each year.

Group contracts for a minimum of three years.

Assumes group/fund membership will not vary more than 10% from the quoted membership and county mix does not change by more than 10%.

Renewal caps do not include additional products, plan changes, or services being added to the retiree group offering by Anthem or another carrier.

Renewal caps also exclude additional government imposed taxes or fees, and do not apply if regulatory or legislative changes materially modify the product offering.

Member contribution to plan relative to other plan offerings (if any) does not increase and in general member contribution to plan for the member does not increase by more than 5% as a percentage of the premium rates.

The rate cap is invalid if there is a pandemic (an outbreak of a disease over a wide geographic area that affects an exceptionally high proportion of members) declared by the Centers for Disease Control to have occurred during the policy period.

If a Force Majeure event occurs during the policy period, this rate cap may be revoked. "Force Majeure" means any cause beyond the reasonable control of a Party, including but not limited to acts of God, civil or military disruption, terrorism, fire, strike, flood, riot or war.

Allowance Stipulations

Implementation Allowance of $25,000 is for a bona fide expense that benefits the member (better service or better member outcomes) and/or the Medicare

The expense is limited to the amount of the actual cost of the services incurred within 4 months before or 2 months after the initial effective date, not to exceed amounts ($25,000) listed in the proposal.

The implementation expenses must be documented in detail from the consultant or 3rd party vendor and must be approved by Anthem as conforming to the requirements of the first Allowance stipulation above. The invoice cannot state "for services rendered".

For communications services, Anthem would need to review all communication materials developed by the consultant or 3rd party vendor and provide modifications within a specified timeframe before production.

EXHIBIT C

County of Sonoma Contract Insurance Requirements Template #5

With respect to performance of work under this Agreement, Consultant shall maintain and shall require all of its subcontractors, consultants, and other agents to maintain insurance as described below unless such insurance has been expressly waived by the attachment of a *Waiver of Insurance Requirements*. Any requirement for insurance to be maintained after completion of the work shall survive this Agreement.

County reserves the right to review any and all of the required insurance policies and/or endorsements, but has no obligation to do so. Failure to demand evidence of full compliance with the insurance requirements set forth in this Agreement or failure to identify any insurance deficiency shall not relieve Consultant from, nor be construed or deemed a waiver of, its obligation to maintain the required insurance at all times during the performance of this Agreement.

1. **Workers Compensation and Employers Liability Insurance**
   - **a.** Required if Consultant has employees as defined by the Labor Code of the State of California.
   - **b.** Workers Compensation insurance with statutory limits as required by the Labor Code of the State of California.
   - **c.** Employers Liability with minimum limits of $1,000,000 per Accident; $1,000,000 Disease per employee; $1,000,000 Disease per policy.
   - **d.** *Required Evidence of Insurance*: Certificate of Insurance.

   If Consultant currently has no employees as defined by the Labor Code of the State of California, Consultant agrees to obtain the above-specified Workers Compensation and Employers Liability insurance should employees be engaged during the term of this Agreement or any extensions of the term.

2. **General Liability Insurance**
   - **a.** Commercial General Liability Insurance on a standard occurrence form, no less broad than Insurance Services Office (ISO) form CG 00 01.
   - **b.** Minimum Limits: $10,000,000 per Occurrence; $10,000,000 General Aggregate; $10,000,000 Products/Completed Operations Aggregate. The required limits may be provided by a combination of General Liability Insurance and Commercial Excess or Commercial Umbrella Liability Insurance. If Consultant maintains higher limits than the specified minimum limits, County requires and shall be entitled to coverage for the higher limits maintained by Consultant.
   - **c.** Any deductible or self-insured retention shall be shown on the Certificate of Insurance. If the deductible or self-insured retention exceeds $100,000 it must be approved in advance by County. Consultant is responsible for any deductible or self-insured retention and shall fund it upon County's written request, regardless of whether Consultant has a claim against the insurance or is named as a party in any action involving the County.
   - **d.** **County of Sonoma, its officers, agents, and employees** shall be endorsed as additional insureds for liability arising out of operations by or on behalf of the Consultant in the performance of this Agreement.
   - **e.** The insurance provided to the additional insureds shall be primary to, and non-contributory with, any insurance or self-insurance program maintained by them.
   - **f.** The policy definition of "insured contract" shall include assumptions of liability arising out of both

ongoing operations and the products-completed operations hazard (broad form contractual liability coverage including the "f" definition of insured contract in ISO form CG 00 01, or equivalent).

g. The policy shall cover inter-insured suits between the additional insureds and Consultant and include a "separation of insureds" or "severability" clause which treats each insured separately.

h. *Required Evidence of Insurance:*

i. Certificate of Insurance.

3. Automobile Liability Insurance

a. Minimum Limit: $1,000,000 combined single limit per accident. The required limits may be provided by a combination of Automobile Liability Insurance and Commercial Excess or Commercial Umbrella Liability Insurance.

b. Insurance shall cover all owned autos. If Consultant currently owns no autos, Consultant agrees to obtain such insurance should any autos be acquired during the term of this Agreement or any extensions of the term.

c. Insurance shall cover hired and non-owned autos.

d. *Required Evidence of Insurance*: Certificate of Insurance.

4. Professional Liability/Errors and Omissions Insurance

a. Minimum Limit: $10,000,000 per claim or per occurrence.

b. Any deductible or self-insured retention shall be shown on the Certificate of Insurance. If the deductible or self-insured retention exceeds $100,000 it must be approved in advance by County.

c. If the insurance is on a Claims-Made basis, the retroactive date shall be no later than the commencement of the work.

d. Coverage applicable to the work performed under this Agreement shall be continued for two (2) years after completion of the work. Such continuation coverage may be provided by one of the following: (1) renewal of the existing policy; (2) an extended reporting period endorsement; or (3) replacement insurance with a retroactive date no later than the commencement of the work under this Agreement.

e. *Required Evidence of Insurance*: Certificate of Insurance specifying the limits and the claims-made retroactive date.

5. Cyber Liability Insurance

Network Security & Privacy Liability Insurance:

a. Minimum Limit: $10,000,000 per claim or per occurrence, $10,000,000.00 aggregate.

b. Coverage shall be sufficiently broad to respond to the duties and obligations as is undertaken by the Consultant in this agreement and shall include, but not be limited to, claims involving security breach, system failure, data recovery, business interruption, cyber extortion, social engineering, infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, and alteration of electronic information. The policy shall provide coverage for breach response costs (including notification costs), regulatory fines and penalties as well as credit monitoring expenses.

c. If the insurance is on a Claims-Made basis, the retroactive date shall be no later than the commencement of the work.

d. Coverage applicable to the work performed under this Agreement shall be continued for two (2) years after completion of the work. Such continuation coverage may be provided by one of the following: (1) renewal of the existing policy; (2) an extended reporting period endorsement; or (3) replacement insurance with a retroactive date no later than the commencement of the work under this Agreement.

e. *Required Evidence of Insurance*: Certificate of Insurance specifying the limits and the claims-made retroactive date.

6. Standards for Insurance Companies

Insurers, other than the California State Compensation Insurance Fund, shall have an A.M. Best's rating of at least A:VII.

7. Documentation

a. The Certificate of Insurance must include the following reference: **County of Sonoma Agreement 6-1-2024 to 5-31-2025.**

b. All required Evidence of Insurance shall be submitted prior to the execution of this Agreement. Consultant agrees to maintain current Evidence of Insurance on file with County for the entire term of this Agreement and any additional periods if specified in Sections 1 – 4 above.

c. The name and address for Additional Insured endorsements and Certificates of Insurance is: **County of Sonoma, Department of Human Resources, 575 Administration Drive, Suite 117C, Santa Rosa, CA 95403.**

d. Required Evidence of Insurance shall be submitted for any renewal or replacement of a policy that already exists, at least ten (10) days before expiration or other termination of the existing policy.

e. Consultant shall provide immediate written notice if: (1) any of the required insurance policies is terminated; (2) the limits of any of the required policies are reduced; or (3) the deductible or self-insured retention is increased.

f. Upon written request, certified copies of required insurance policies must be provided within thirty (30) days.

8. Policy Obligations

Consultant's indemnity and other obligations shall not be limited by the foregoing insurance requirements.

9. Material Breach

If Consultant fails to maintain insurance which is required pursuant to this Agreement, it shall be deemed a material breach of this Agreement. County, at its sole option, may terminate this Agreement and obtain damages from Consultant resulting from said breach. Alternatively, County may purchase the required insurance, and without further notice to Consultant, County may deduct from sums due to Consultant any premium costs advanced by County for such insurance. These remedies shall be in addition to any other remedies available to County.

EXHIBIT D
PERFORMANCE GUARANTEES

This Addendum to the Medicare Advantage Group Agreement between Consultant Insurance Company (hereinafter "Consultant") and the County of Sonoma dated as of June 1, 2024 provides certain guarantees pertaining to Consultant's performance under the Agreement ("Performance Guarantees") and shall be effective for the period from June 1, 2024 through May 31, 2026. Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachment to this Addendum and incorporated by reference into this Addendum. This Addendum shall supplement the Agreement. If there are any inconsistencies between the terms of the Agreement, including any prior Addendums or Exhibits, and this Addendum, the terms of this Addendum shall control. Capitalized terms used but not defined herein shall have the meaning(s) set forth in the Agreement.

Section 1. General Conditions

A. The Performance Guarantees described in the Attachment to this Addendum shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachment.

B. Each Performance Guarantee shall specify:

(1) Performance Category. The term Performance Category describes the general type of Performance Guarantee.

(2) Reporting Period. The term Reporting Period refers to how often Consultant will report on its performance under a Performance Guarantee.

(3) Measurement Period. The term Measurement Period is the period of time over which Consultant's performance is measured, which may be the same as or different from the period of time equal to the Performance Period.

(4) Performance Period. Each year (or partial year) of the contract over which the Performance Guarantee is measured.

(5) Penalty Calculation. The term Penalty Calculation generally refers to how Consultant's payment will be calculated, in the event Consultant does not meet the target(s) specified under the Performance Guarantee.

(6) Amount at Risk. The term Amount at Risk means the amount Consultant may pay if it fails to meet the target(s) specified under the Performance Guarantee.

C. Anthem BC Health shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachment to this Addendum. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Anthem BC Health shall be based on Anthem BC Health's then current measurement and calculation methodology, which shall be available to Group upon request.

D. Any audits performed by Consultant to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

E. If the Parties do not have a fully executed Agreement in effect at the end of the Measurement Period, Consultant shall have no obligation to make payment under these Performance Guarantees.

F. Unless otherwise specified in the Attachment to this Addendum, the measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by Consultant to the activity to which the specific Performance Guarantee being measured relates; and (2) data that is maintained and stored by Consultant or its Vendors.

G. If Group terminates the Agreement prior to the end of the Performance Period, or if the Agreement is terminated by Consultant for non-payment of amounts owed by Group to Consultant, then Group shall forfeit any right to collect any further payments under any outstanding Performance Guarantees, whether such Performance Guarantees are for a prior or current Measurement Period or Performance Period.

H. Anthem BC Health reserves the right to make changes to or eliminate any of the Performance Guarantees provided in the Attachment to this Addendum upon the occurrence, in Consultant's determination, of any of the following:

(1) A change to the plan benefits or the administration of the plan initiated by Group that results in a substantial change in the services to be performed by Anthem BC Health or the measurement of a Performance Guarantee; or

(2) Anthem BC Health does not receive information or other support from Group that would allow Anthem BC Health to meet the Guarantee; or

(3) Changes in law

(4) The number of Medicare Advantage enrolled members goes up or down by 10% or more after the plan or renewal starts.

I. As determined by Anthem BC Health, Performance Guarantees may be measured using either aggregated data or Group-specific Data. The term Group-specific Data means the data associated with Group's Plan that has not been aggregated with other data from other groups. Performance Guarantees will specify if Group-specific Data shall be used for purposes of measuring performance under the Performance Guarantee.

J. The guarantees are measured and settled annually, with exceptions specified.

K. Performance will be based on the results of a designated service team/business unit assigned to Group, unless the guarantee is noted differently.

L. If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the Group participates in the program and such components for the entirety of the Measurement Period associated with the Performance Guarantee.

M. All Performance Guarantees may be revisited and may potentially be impacted due to a cause beyond the reasonable control of a Party such as a pandemic (an outbreak of disease that affects an exceptionally high proportion of members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement Period that impacts a meaningful portion of the Group's population.

N. The credit for any penalties will be calculated on a Per Member Per Month (PMPM) basis. Penalties will be calculated by multiplying the guarantee's PMPM amount by the applicable penalty percentage and the average actual enrollment during the Measurement Period. Penalties with respect to Implementation Guarantees, if any, will be calculated by multiplying the guarantee's PMPM amount by the applicable penalty percentage and the average actual annual enrollment.

O. The Standard Management Report performance guarantee applies when there are 1,000 or more Medicare Advantage enrolled members on the Effective Date and throughout the Performance Period.

P. Performance Guarantees apply when there are 500 or more enrolled members on the Effective Date and throughout the Performance Period.

Section 2. <u>Payment</u>:

A. If Anthem BC Health fails to meet any of the obligations specifically described in a Performance Guarantee, Anthem BC Health shall pay Group the applicable amount set forth in the Attachment describing the Performance Guarantee. Payment shall be in the form of a check to the Group which will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, Consultant has the right to offset any amounts owed to Group under any of the Performance Guarantees contained in the Attachment to this Addendum against any amounts owed by Group to Consultant, including, without limitation, under the Agreement.

C. Notwithstanding the foregoing, Anthem BC Health's obligation to make payment under the Performance Guarantees is conditioned upon Group's timely performance of its obligations provided in the Agreement, in this Addendum and the Attachment, including providing Anthem BC Health with the information or data required by Anthem BC Health in the Attachment. Anthem BC Health shall not be obligated to make payment under a Performance Guarantee if Group's or Group's vendor's action or inaction adversely impacts Anthem BC Health's ability to meet any of its obligations provided in the Attachment related to such Performance Guarantee, which expressly includes, but is not limited to, Group's or its vendor's failure to timely provide Anthem BC Health with accurate and complete data or information in the form and format expressly required by Anthem BC Health.

D. The Parties acknowledge and agree that Anthem BC Health not meeting a Performance Guarantee in and of itself shall not constitute a breach by Anthem BC Health of this Agreement and that the remedy for not meeting Performance Guarantees will be payment of amounts set forth in the Performance Guarantee Exhibit.

Attachment D – Performance Guarantee Agreement

Performance Guarantees

Amounts at Risk

The total amount at risk for the below performance guarantees between Anthem BC Health and the County shall not exceed $3.00 Per Member per Month (PMPM) in Year One and $2.40 PMPM in Year Two.

Performance Category	Year One 6/1/2024 - 5/31/2025	Year Two 6/1/2025 - 5/31/2026
Implementation Timeliness	$0.30 PMPM	N/A
Open Enrollment ID Card Issuance	$0.30 PMPM	N/A
Medicare Advantage Member Services - Call Abandonment Rate	$0.30 PMPM	$0.30 PMPM
Medicare Advantage Member Services - Service Level	$0.30 PMPM	$0.30 PMPM
Medicare Advantage Member Services – Service Skills	$0.30 PMPM	$0.30 PMPM
Medical Claims Payment Accuracy	$0.30 PMPM	$0.30 PMPM
Medical Claims Financial Accuracy	$0.30 PMPM	$0.30 PMPM
Medical Claims Processing Timeliness	$0.30 PMPM	$0.30 PMPM
Standard Online Management Report Package	$0.30 PMPM	$0.30 PMPM
Website Availability	$0.30 PMPM	$0.30 PMPM

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement & Reporting Period
Implementation Timeliness	Year 1 $0.30 PMPM	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Consultant and will contain tasks to be completed by the County and/or Consultant and a timeframe for completion of each task. The implementation plan will also contain measurement periods specific to each task. Consultant's payment under this Guarantee is conditioned upon the County's completion of all designated tasks by the dates specified in the implementation plan.	**Results** 95% or Greater 90.0% to 94.9% 85.0% to 89.9% Less than 85.0%	**Penalty** None 25% 50% 100%	Measurement Period Implementation Period Reporting Period 60 calendar days following end of implementation period
Open Enrollment ID Card Issuance	Year 1 $0.30 PMPM	100% of ID cards will be mailed to Open Enrollment participants no later than the County's effective date provided that Consultant receives an accurate electronic eligibility file and timely receipt of CMS confirmation of enrollment. An Accurate Eligibility File is defined as (1) an electronic eligibility file formatted in a mutually agreed upon manner; (2) received by Consultant no later than 30 calendar days prior to the County's effective date; and (3) contains an error rate of less than 1%. This Guarantee will apply to clean enrollment records in the electronic eligibility file. This will be measured using client-specific results.	**Results** 100% 98.5% to 99.9% 97.0% to 98.4% Less than 97.0%	**Penalty** None 25% 50% 100%	Measurement Period Effective Date Reporting Period 60 calendar days following end of implementation period
Medicare Advantage Member Services – Abandonment Rate	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	A maximum of 5% of member calls will be abandoned. Abandoned Calls are defined as member calls that are waiting for a Customer Service Representative (CSR) but are abandoned before connecting with a CSR. This Guarantee will be calculated based on the number of calls abandoned divided by the total number of calls received in the customer service telephone system. Calls abandoned in less than five	**Results** 5.0% or Less 5.01% to 5.50% 5.51% to 6.00% Greater than 6%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual

seconds will not be included in this calculation.

This will be measured on the Medicare Advantage population enrolled through Group contracts.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement & Reporting Period
Medicare Advantage Member Services – Service Level	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	80% of calls will be answered by a CSR within 30 seconds or less. Service Level is defined as the percentage of calls answered by a CSR within 30 seconds or less; out of total calls received. This Guarantee will be calculated based on the total number of calls received in the customer service telephone system. This will be measured on the Medicare Advantage population enrolled through Group contracts.	**Results** 80.0% or Greater 79.0% to 79.9% 78.0% to 78.9% Less than 78.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual
Medicare Advantage Member Services – Service Skills	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	A minimum average score of 85% will be attained on the Service Skills component of the member satisfaction survey. The e-mail survey is conducted after a member calls a CSR. Each member caller is asked to rate the CSR. The response is scored based on the total number of attributes that a member caller rates as positive, defined as top-2-box scores, divided by the number of attributes for which the member caller provides an answer (Member Score). This Guarantee will be calculated by determining the average of all Member Scores. This will be measured on the Medicare Advantage population enrolled through Group contracts.	**Results** 85.0% or Greater 83.5% to 84.9% 82.0% to 83.4% Less than 82.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual
Medical Claims Payment Accuracy	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	A minimum of 97% of medical claims will be paid or denied correctly. This Guarantee will be calculated based on the number of audited medical claims paid and denied correctly divided by the total number of audited medical claims paid and denied. The calculation of this Guarantee excludes claims in any quarter that Groups request changes to Plan benefits, until all such changes have been implemented. This will be measured on Medicare book of business.	**Results** 97.0% or Greater 95.5% to 96.9% 94.0% to 95.4% Less than 94.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual
Medical Claims Financial Accuracy	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	A minimum of 98% of medical claim dollars will be processed accurately. This Guarantee will be calculated based on the total dollar amount of audited medical claims paid correctly divided by the total dollar amount of audited medical paid claims. The calculation of this Guarantee does not include claim adjustments. The calculation of this Guarantee also excludes in any quarter claims for Groups when the Group requests changes to Plan benefits, until all such changes have been implemented. This will be measured on Medicare book of business.	**Results** 98.0% or Greater 96.5% to 97.9% 95.0% to 96.4% Less than 95.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual
Medical Claims Processing Timeliness	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	A minimum of 95% of clean medical claims will be adjudicated within 30 calendar days of receipt provided that Consultant receives accurate and timely eligibility information to allow timely claims processing. Clean medical claims are defined as claims that process through the system without the need to obtain additional information from the provider, member, or other external sources. This Guarantee will be calculated based on the number of clean medical claims processed within 30 calendar days of receipt divided by the total number of clean claims. The calculation of this Guarantee does not include claim adjustments and does not include claims for Members enrolled under COBRA. The calculation also excludes in any quarter, claims when Groups request changes to Plan benefits, until all such changes have been	**Results** 95.0% or Greater 93.5% to 94.9% 92.0% to 93.4% Less than 92.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual

	implemented. This will be measured on Medicare book of business.

Performance Category	Amount at Risk	Guarantee	Penalty Calculation		Measurement & Reporting Period
Website Availability	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	Anthem BC Health guarantees 98% availability of all participant accessed Consultant.com web-based services; excluding regularly scheduled and emergency maintenance periods, Force Majeure events (e.g. power failure), network attacks, outages from Internet Service Providers (ISP) and system dependencies. Maintenance includes server backups, file backups, full database backups and database re-orgs, among other health checks. Dependencies include external systems for which Consultant (and its affiliates) has no control.	**Results** 98% or Greater 96.5% to 97.9% 95.0% to 96.4% Less than 95.0%	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual
Standard Online Management Report Package	Year 1 $0.30 PMPM Year 2 $0.30 PMPM	Standard management reports will be made available online to the County on average no later than 30 calendar days following the end of the month. The reports will include financial, utilization and clinical information.	**Results** 30 Days or Less 31 to 45 Days 46 to 60 Days Greater than 60 Days	**Penalty** None 25% 50% 100%	Measurement Period Annual Reporting Period Annual