AMENDMENT 2 TO THE ADMINISTRATIVE SERVICES AGREEMENT WITH LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT "EMPLOYER"

This Amendment is made part of the Administrative Services Agreement and is effective January 1, 2020. This Amendment supplements and amends the Agreement between Employer and Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield. If there are any inconsistencies between the terms of the Agreement or its Schedules and this Amendment, the terms of this Amendment shall control.

1. The following definition replaces "ARTICLE 1 - DEFINITIONS - PAID CLAIMS (2) Prescription Drug Claims" in its entirety:

   PRESCRIPTION DRUG CLAIMS. This provision is intentionally omitted.

2. The following definition replaces "ARTICLE 1 - DEFINITIONS - Prescription drug" in its entirety:

   PRESCRIPTION DRUG. This provision is intentionally omitted.

3. The following provision is added to Article 4 - Claims Payment Method as provision (c):

   c) Employer acknowledges and directs Anthem to utilize offsetting and cross-plan offsetting to recover overpaid Claims from Network Providers. Offsetting and cross-plan offsetting will be conducted only in cooperation with non-Network Providers who have expressly agreed to such procedures and have agreed that members will be held harmless. Offsetting is the practice of Anthem recovering overpayments made to a Network Provider by withholding overpaid amounts from subsequent payments to be made to the same Network Provider. Cross-plan offsetting is the practice of Anthem recovering overpayments made to a Network Provider for one member by withholding the overpaid amount from subsequent payments to be made to the same Network Provider for another member, who receives benefits under a different group health plan for which Anthem pays the Claims on behalf of a different employer.

4. The following provision replaces Article 13 - Recovery and Prepayment Analysis Services (b) in its entirety:

   b) Anthem may become aware of additional recovery opportunities by means other than those described in Article 13(a). Employer grants Anthem the authority and discretion in those instances to do the following: (1) determine and take steps reasonably necessary and cost-effective to pursue the recovery such as filing a proof of claim in a class action settlement, adjusting Claims by offsetting or cross-plan offsetting as described in Article 4, commencing litigation, opting out of or objecting to a proposed settlement, and/or engaging in settlement negotiations; (2) select and retain outside counsel when needed; (3) reduce any recovery obtained on behalf of the Plan by its proportionate share of the outside counsel fees and costs incurred during litigation or settlement activities to obtain such recovery; and (4) implement or effect any settlement of the Employer's and Plan's rights by, among other things, executing a release waiving the Employer's and Plan's rights to take any action inconsistent with the settlement.

5. The following Article replaces Article 14 - Pharmacy Benefits and Services in its entirety:

   This Article is intentionally omitted.

6. Inter-Plan Schedule is replaced by the attached Inter-Plan Schedule.

7. Schedule A is replaced by the attached Schedule A.

8. Schedule B is replaced by the attached Schedule B.

9. Pharmacy Benefits Administrative Services Schedule is added as attached.

10. Exhibit A - Fees & Expenses of The Pharmacy Benefits Administrative Services Schedule is added as attached.

11. Exhibit B - Pharmacy Services of The Pharmacy Benefits Administrative Services Schedule is added as attached.

12. Exhibit C - Performance Guarantees of The Pharmacy Benefits Administrative Services Schedule is added as attached.

13. Group Health Business Associate Agreement Schedule is added as attached.

IN WITNESS WHEREOF, Anthem has caused this Amendment to be executed by affixing the signature of its duly authorized officer.

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: [signature]

Title: President

Date: 6-9-23

INTER-PLAN ARRANGEMENTS SCHEDULE
TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT

This Inter-Plan Arrangement Schedule supplements and amends the Administrative Services Agreement and is effective as of January 1, 2020. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Inter-Plan Arrangements. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Out-of-Area Services

Overview

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

Typically, when accessing care outside the Anthem Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. Anthem remains responsible for fulfilling its contractual obligations to Employer. Anthem's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the Plan covers only limited healthcare services received outside of Anthem's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Plan will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Anthem Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to Anthem by the Host Blue.

b. Employer Liability Calculation

The calculation of Employer liability on Claims for Covered Services will be based on the negotiated price made available to Anthem by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, Employer may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

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

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

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

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

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Anthem may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Anthem and one or more Host Blues for any Employer that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Anthem and Employer agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Anthem's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Anthem is not acting on behalf of or as an agent for Employer, the Plan or Members.

Member Liability Calculation

If Anthem has entered into a Negotiated Arrangement with a Host Blue, the calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Anthem and that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Anthem's service area.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.
5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Programs Overview

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to Anthem, which Anthem will pass directly on to Employer as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Employer via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Anthem will pass these Host Blue charges directly through to Employer as a separately identified amount on the Employer billings.

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

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

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

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

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

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

Care Coordinator Fees

Host Blues may also bill Anthem for Care Coordinator Fees for Provider services which Anthem will pass on to Employer as follows:

1. PMPM billings; or

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

Anthem and Employer will not impose Member cost-sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside Anthem's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Benefits Booklet, when Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, Anthem may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

2. Exceptions

In certain situations, which may occur at Employer's direction, Anthem may use other pricing methods, such as Billed Charges, the pricing Anthem would use if the healthcare services had been obtained within Anthem's Service Area, or a special negotiated price to determine the amount Anthem will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Anthem makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of Blue Cross Blue Shield Global Core® when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services. Members must contact Anthem to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

F. Return of Overpayments

Recoveries of overpayments can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Anthem they will be credited to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to Employer as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Anthem will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Anthem will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

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

H. Fees and Compensation

Employer understands and agrees to reimburse Anthem for certain fees and compensation which Anthem is obligated under the applicable Inter-Plan Arrangements described in this Schedule to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement related services. The specific Inter-Plan Arrangement fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and Blue Cross Blue Shield Global Core are charged to Employer are set forth in Section 7 of Schedule A to the Agreement. The various Inter-Plan Program Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees that may be listed on Schedule A is as follows:

Access Fee: The Access Fee is charged by the Host Blue to Anthem for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Anthem receives from the applicable Host Blue subject to a maximum of $2,000 per Claim. When charged, Anthem passes the Access Fee directly on to Employer.

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

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, Anthem passes the AEA Fee directly on to Employer.

Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The PSPM dollar amount is charged on a per Subscriber per month basis by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. The dollar amount can also be based on the size of group enrollment. When charged, Anthem passes the PSPM Fee directly on to Employer.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Anthem and replaces all other fees, including the Access Fee and AEA Fee. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Anthem for administrative services the Host Blue provides in processing Claims for Employer's Members. When charged, Anthem passes the Non-Standard AEA Fee directly on to Employer.

Central Financial Agency (CFA) Fee: The CFA Fee is a fixed dollar amount per payment notice and is paid by Anthem to the BCBSA. This fee applies each time Anthem receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Anthem's behalf and requesting that Anthem either approve or deny payment. When charged, Anthem passes the CFA Fee directly on to Employer. The CFA Fee supports ongoing operations of BCBSA programs and services, including but not limited to Blue Cross Blue Shield AXIS® Data Services, network solutions, and BlueCard Program-related applications.

Inter-Plan Teleprocessing System (ITS) Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Anthem and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Anthem electronically. Anthem then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA Fee and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Anthem via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to the BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim. When charged, Anthem passes the ITS Transaction Fee directly on to Employer.

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: Kenyan Wattington

Title: President

Date: 6-9-22

SCHEDULE A
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT

This Schedule A shall govern the Agreement Period from January 1, 2020 through December 31, 2020. For purposes of this Agreement Period, this Schedule shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules, and this Schedule A, the terms of this Schedule A shall control.

Section 1. **Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. January 1, 2020 to the end of the day of December 31, 2020.

Paid Claims shall be processed pursuant to the terms of this Agreement when incurred and paid as follows:

Incurred from January 1, 2015 through December 31, 2020 and
Paid from January 1, 2020 through December 31, 2020.

Anthem shall provide any offer to renew this Agreement at least 30 days prior to the end of an Agreement Period.

Section 2. **Broker or Consultant Base Compensation**

Medical

Not Applicable

Section 3. **Administrative Services Fees**

Change to Administrative Services Fees. In addition to the provisions in Article 18(c), Anthem reserves the right to change the Administrative Services Fees provided in this Section 3 of Schedule A during the Agreement Period based upon the occurrence of any of the following events:

A change in law or regulation that materially impacts underwriting assumptions made at the time of the offer or renewal.

If Employer terminates the Pharmacy Services Schedule with PBM at any time, then Anthem shall have the right to amend the Administrative Services Fees indicated in Section 3 of Schedule A of this Agreement.

A. **Base Administrative Services Fee**

PPO
Composite $ 31.70 per Subscriber per month

HSA
Composite $ 31.70 per Subscriber per month

Article 3(a) Retroactive Adjustments to Enrollment.

Anthem will not credit Employer Administrative Services Fees that relate to retroactive deletions and conversely, Anthem will not charge, and Employer shall not pay, Administrative Services Fees that relate to retroactive additions to enrollment.

B. **Health and Wellness Program Fees**

Not applicable

C. **Other Fees or Credits**

Fee for Subrogation Services. The charge to Employer is 25% of gross subrogation recovery.

Fee for Overpayment Identification and Claims Prepayment Analysis Activities. The charge to Employer is 25% of (i) the amount recovered from review of Claims and membership data and audits of Provider and Vendor activity to identify overpayments and (ii) the difference between the amount Employer would have been charged absent prepayment analysis activities and the amount that was charged to Employer following performance of the prepayment analysis activities. This includes, but is not limited to COB, contract compliance, and eligibility. The fee for Overpayment Identification and Claims Prepayment Analysis Activities will not exceed $25,000 per Claim.

Fee for Independent Claims Review: $550.00 per independent review

Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member per month amount charged to Employer for the Provider performance bonus portion of the Enhanced Personal Health Care program. These charges are included in Paid Claims on the invoice and may accumulate towards any stop loss policy amounts.

Non-Network Savings Fee. If Anthem or its Vendor negotiates with a non-Network Provider for Covered Services from the non-Network Provider, Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability for the Covered Service (the "Plan Liability Amount"). In the case of facility-based Provider Claims, Plan Liability Amount will be based on the negotiated rate; if negotiations are not successful, the Plan Liability Amount shall be determined using a pricing tool. In the case of professional Provider Claims, Plan Liability Amount will be based upon the negotiated rate obtained by Anthem or its Vendor, if applicable (in the absence of successfully negotiated Claims, there will be no fee charged as the amount will be determined by the local Blue plan). These Claims will not be included in any Performance Guarantee calculations.

Section 4. Paid Claims, Billing Cycle and Payment Method

A. **Paid Claims**

Paid Claims are described in Article 1-Paid Claims Definition of the Agreement.

B. **Billing Cycle**

Weekly

Anthem shall notify Employer of the amount due to Anthem as a result of Claims processed and paid by Anthem according to the billing cycle described above. The actual date of notification of Paid Claims and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

C. **Payment Method**

ACH Demand Debit Reimbursement for Paid Claims. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than the next business day following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

Section 5. **Administrative Services Fee Billing Cycle and Payment Method**

A. **Billing Cycle**

Monthly List Bill (pay as billed)

Anthem shall notify Employer of the amount due to Anthem pursuant to Section 3 of Schedule A according to the billing cycle described above. The actual date of notification of amounts due and the Invoice Due Date will be determined according to Anthem's regular business practices and systems capabilities.

B. **Payment Method**

ACH Demand Debit Reimbursement. Anthem will initiate an ACH demand debit transaction that will withdraw the amount due from a designated Employer bank account no later than the next business day following the Invoice Due Date, however, if the Invoice Due Date falls on either a banking holiday, a Saturday or a Sunday, the withdrawal shall be made on the following banking day.

Section 6. **Claims Runout Services**

A. **Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Agreement.

B. **Claims Runout Administrative Services Fees**

Medical:

The fee for Claims Runout Services will be waived. Fees in Sections 3(B) and 3(C) of this Schedule A that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to the Agreement Period but were not billed during the Agreement Period, will be billed and payable during the Claims Runout Period. Payment is due to Anthem by the Invoice Due Date.

Section 7. **Inter-Plan Arrangements:**

The following Inter-Plan Arrangement-related fees are included in the Base Administrative Services Fee: Access Fees paid to Host Blues, the Administrative Expense Allowance ("AEA") Fee, Central Financial Agency Fees, ITS Transaction Fees, Blue Cross Blue Shield Global Core® Program services Fees and any Negotiated Arrangement Fees.

Section 8. **Other Amendments. The Administrative Services Agreement is otherwise amended as follows:**

Blue Cross Blue Shield Global Core

All references to BlueCard Worldwide are replaced by Blue Cross Blue Shield Global Core.

Notice of Loss of Grandfathering Status

In the event Employer maintains a grandfathered health plan(s), as that term is used in the Patient Protection and Affordable Care Act ("PPACA"), Employer shall not make any changes to such plan(s), including, but not limited to, changes with respect to Employer contribution levels, without providing Anthem with advance written notice of the intent to change such plan(s). Making changes to grandfathered plans without notice to Anthem may result in the plan(s) losing grandfathered status and significant penalties and/or fines to Employer and Anthem. In the event Employer implements changes to its plan(s) and does not provide advance notice to Anthem, Employer agrees to indemnify Anthem according to the indemnification provisions set forth elsewhere in this Agreement for any penalties, fines or other costs assessed against Anthem.

Additionally, at each renewal after September 23, 2010, Employer shall affirm in writing, upon reasonable request of Anthem, that it has not made changes to its plan(s) that would cause the plan(s) to lose its/their grandfathered status

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If Employer loses grandfathered Plan status under PPACA and notifies Anthem of such loss no fewer than 90 days before the effective date of the change, Anthem will implement the additional group market (insurance) reforms that apply to non-grandfathered health Plans subject to the provisions of Article 18 of this Agreement.

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: Herman W. Lattimore

Title: President

Date: 6-9-22

SCHEDULE B
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT

This Schedule B shall govern the Agreement Period from January 1, 2020 through December 31, 2020. For purposes of this Agreement Period, this Schedule B shall supplement and amend the Agreement between the Parties. If there are any inconsistencies between the terms of the Agreement including any prior Schedules and this Schedule B, the terms of this Schedule B shall control.

The following is a list of services that Anthem will provide under this Agreement for the Base Administrative Services Fee listed in Section 3(A) of Schedule A. These services will be furnished to Employer in a manner consistent with Anthem's standard policies and procedures for self-funded plans

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Anthem may also offer additional, optional services to Employer, and such services, whether or not purchased by Employer, are not included in the services set forth below in this Schedule B. By way of example and not limitation, Anthem may offer certain optional programs that include utilization management activities. In such event, the services associated with those programs are not included in the services described below. Services under Article 13 will only be pursued or performed for Claims associated with these programs or that would have been impacted by these programs if the programs are purchased by Employer. If Employer has purchased such services, those services and any additional fees are also listed in Schedule A.

SERVICES INCLUDED IN THE BASE ADMINISTRATIVE SERVICES FEE IN SECTION 3A OF SCHEDULE A

Management Services

Anthem's benefits and administration as described in this paragraph:

- Anthem definitions, and exclusions
- Anthem complaint and appeals process (One mandatory level of appeal, one voluntary level of appeal)
- Claims incurred and paid as provided in Schedule A, excluding activities related to Claim recovery
- Accumulation toward plan maximums beginning at zero on effective date
- Anthem Claim forms
- ID card
- Explanation of Benefits (Non-customized)

• Acceptance of electronic submission of eligibility information in HIPAA-compliant format

• Preparation of Benefits Booklet (accessible via internet)

• Account reporting - standard data reports

• Standard billing and banking services

• Plan Design consultation

• Employer eServices

- Add and delete Members
- Download administrative forms
- View Member Benefits and request ID cards
- View eligibility
- View Claim status and detail

• Responsible Reporting Entity for the Plan

• Information for preparation of SBC

Claims and Customer Services

- Claims processing services
- Medicare crossover processing
- Employer customer service, standard business hours
- Member customer service, standard business hours
- 1099s prepared and delivered to Providers
- Residency-based assessments and/or surcharges and other legislative reporting requirements
- Member eServices
- Member identity theft and credit monitoring and identity repair
- Women's Health and Cancer Rights Act notices

Care Management

- Health Care Management
  - Referrals
  - Utilization management
  - Case management
  - Anthem Medical Policy
- SpecialOffers
- Transplant services - Blues Distinction
- Healthy Solutions Newsletter (available online)
- MyHealth (Member Portal)
  - Electronic Health Risk Assessment
  - Personal Health Record
  - Online Communities
  - Member Alerts
- Health and Wellness Services (All Plans)
  - ConditionCare
    - Asthma
    - Pulmonary disease
    - Congestive heart failure
    - Coronary artery disease
    - Diabetes
  - Future Moms
  - ComplexCare
  - 24/7 NurseLine

- My Health Advantage-Gold Level

- Cancer Care Quality Program

Networks

- Access to networks

  - Provider Network
  - Mental Health/Substance Abuse Network
  - Coronary Services Network
  - Human Organ and Tissue Transplant Network
  - Complex and Rare Cancer Network
  - Bariatric Surgery Network

- Network Management

- Online Provider directory

- Inter-Plan Arrangements

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: Norman Wetherington

Title: President

Date: 6-9-22

PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Lexington-Fayette Urban County Government

This Pharmacy Benefits Administrative Services Schedule ("Pharmacy Services Schedule") is by and between Employer and IngenioRx, Inc., an Anthem Affiliate that will be referenced as the pharmacy benefits manager ("PBM") for the purposes of this Pharmacy Services Schedule. The Pharmacy Services Schedule supplements and amends the Agreement between the Parties and is effective as of January 1, 2020 ("Effective Date"). Description of the Pharmacy Services and applicable fees for such services are set forth in the Exhibits (the "Exhibits") to this Pharmacy Services Schedule and made a part of this Pharmacy Services Schedule. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to the Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect. If there are any inconsistencies between the terms contained in this Schedule, and the terms contained in any of the Exhibits to this Pharmacy Benefits Schedule, the terms of the Exhibits shall control.

A. **Definitions**. The following definitions apply to this Pharmacy Services Schedule. Terms not otherwise defined in this Pharmacy Services Schedule shall have the same meaning as such term is otherwise defined in the Agreement.

Authorized Generics are Prescription Drugs produced by brand pharmaceutical companies and marketed under a private label, at Generic Drug prices. Authorized Generics are identical to their Brand Drug counterpart in both active and inactive ingredients.

Average Wholesale Price (AWP) shall mean the benchmark price of a prescription drug based on the actual 11-digit National Drug Code ("NDC") for the product and package size on the date dispensed to a member as established and reported by Medi-Span or by another nationally recognized pricing source selected by PBM in its sole discretion.

Brand MAC is a multi-source Brand Drug that is included on the Maximum Allowable Cost ("MAC") list and paid at the MAC cost basis.

Branded Generic Claims are multi-source Brand Drugs that were billed to the Employer at the Generic Drug cost.

Brand Name Prescription Drug or **Brand Drug** is a Prescription Drug product that is not a Generic Drug.

Compound Drug is a mixture of two or more ingredients when at least one of the ingredients in the preparation is an FDA-approved Prescription Drug, excluding the addition of only water or flavoring to any preparation.

Covered Prescription Services means a Covered Service that is Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member's Benefits Booklet.

Dispense As Written Claims With Code 1 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because substitution was not prescribed by the Provider.

Dispense As Written Claims With Code 2 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Member requested the Brand Drug.

Dispense As Written Claims With Code 3 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacist selected the Brand Drug.

Dispense As Written Claims With Code 4 are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug was not in stock.

Dispense As Written Claims With Code 5 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the pharmacy dispensed the Brand Drug at the Generic Drug cost (also known as "House Generic Claims").

Dispense As Written Claims With Code 6 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of an override.

Dispense As Written Claims With Code 7 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because the Brand Drug is mandated by state and federal laws and regulations.

Dispense As Written Claims With Code 8 are Claims where a Brand Drug was dispensed when a Generic Drug exists, because the Generic Drug is not available in the marketplace.

Dispense As Written Claims With Code 9 are Claims where a Brand Drug was dispensed when a Generic Drug is available, because of other non-specified reason.

Dispense As Written Claims are Claims where a Brand Drug was dispensed when a Generic Drug exists and is available.

Drug Rebates as referenced herein shall include Medical Drug Rebates and/or Prescription Drug Rebates.

Generic Prescription Drug or **Generic Drug** is a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

Government Reimbursement Claims are Claims submitted by any state, person or entity acting on behalf of a state under Medicaid or similar federal or state government health care programs for which Employer is deemed to be the primary payer as defined by applicable federal or state laws.

Medical Drug Rebates are rebates Anthem and/or PBM receives directly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by Anthem and covered under the medical benefit portion of the Plan(s).

Most Favored Nations Limitations are government restrictions that preclude pharmacies from making pricing agreements with PBMs or others that are more favorable than those afforded to state-run programs, such as Medicaid.

Network Pharmacy or **Network Pharmacies** are a network of pharmacies that have entered into contractual arrangements with PBM under which such pharmacies agree to provide Covered Prescription Services to Members and accept negotiated fees for such services.

Pharmacy Benefit Plan means that portion of the Benefits Booklet that describes Covered Prescription Services that is administered by PBM. Pharmacy Benefit Plan coverage includes any deductible or co-insurance provided for under the Covered Prescription Services.

Powder Claims are Claims for drugs where the dosage form, as identified by Medispan database or other nationally recognized pricing source selected by PBM in its sole discretion from time to time, is powder.

Prescription Drug. Insulin and those drugs and drug compounds that are included in the U.S. Pharmacopoeia and that are required to be dispensed pursuant to a prescription or that are otherwise included on PBM' s formulary (e.g., certain over-the-counter drugs).

Prescription Drug Claims. Notwithstanding the definition of Paid Claim as set forth in Article 1 of the Agreement, Prescription Drug Claims shall mean an amount that PBM invoices Employer for Prescription Drugs dispensed to Members by pharmacies. PBM's invoice shall be included as part of the invoice Anthem bills for other Paid Claims, as further set forth in the Agreement.

Prescription Drug Rebates are rebates collected by PBM directly or indirectly from pharmaceutical manufacturers for Claims for Prescription Drugs administered by PBM and attributable to the pharmacy benefit portion of the Plan(s).

Secondary Claims are Claims where PBM is the secondary payer due to coordination of benefits (COB) with one or more other payers.

Single Source Generics are those Generic Drugs that are provided by two or fewer Pharmaceutical Manufacturers as defined at the GPI14 level or such Generic Drugs that are in the market with supply limitations or competitive restrictions.

Specialty Drugs are drugs dispensed from a Specialty Service Pharmacy and/or high-cost, injected, infused, oral, or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty Drugs may have special handling, storage, and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance.

Specialty Service Pharmacy is the PBM-owned or contracted specialty pharmacy that primarily dispenses Specialty Drugs, outside of the retail pharmacy Network and home delivery pharmacy.

Usual and Customary (U&C) Charge is the amount a cash paying customer pays a pharmacy for a Prescription Drug. PBM shall require Network Pharmacies to submit the Usual and Customary Charges with all Claim submissions.

B. **Obligations of PBM.**

In addition to the services provided by Anthem under Article 2 of this Agreement, and if applicable to the Pharmacy Benefit Plan and as indicated in Exhibit B, PBM will provide the following pharmacy benefit management administrative and support services (the "Pharmacy Services"):

1. **Network Pharmacy Services.**

a. PBM shall offer Employer access to a network of pharmacies that have entered into contractual arrangements with PBM or its Vendors under which such pharmacies agree to provide pharmacy services to Members and accept negotiated fees for such services ("Network Pharmacies"). PBM shall determine, in its sole discretion, which pharmacies shall be Network Pharmacies, and the composition of Network Pharmacies may change from time to time.

b. PBM shall arrange for the dispensing of covered Prescription Drugs to Members through one or more networks of Network Pharmacies. If a Member obtains a covered Prescription Drug from a pharmacy that is not in the network, the Member shall be responsible for the total cost of the covered Prescription Drug. PBM's network will provide Members adequate access to the covered Prescription Drugs at the Network Pharmacies. Employer acknowledges that the availability of Prescription Drugs is subject to market conditions and that PBM cannot, and does not, assure the availability of any Prescription Drug from a Network Pharmacy.

c. PBM and/or its Vendors shall perform periodic desktop and onsite audits of Network Pharmacies to ensure compliance with billing requirements as well as other terms and conditions of the Network Pharmacy agreements. PBM will pay Employer, or apply as a credit to invoices, the amounts PBM recovers from these audits. Employer will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Employer that are not required by applicable law.

d. Pursuant to the terms of the contract between PBM and Network Pharmacy, no Network Pharmacy shall charge, collect a deposit from, or have any recourse against a Member for the covered Prescription Drugs other than applicable cost shares, including in the event of breach of the Agreement and/or this Pharmacy Services Schedule by Employer or insolvency of Employer. This provision shall survive the termination of the Agreement and/or this Pharmacy Services Schedule for any covered Prescription Drug provided to a Member prior to such termination.

e. PBM shall offer Employer a home delivery pharmacy program through which Members may receive home delivery covered Prescription Services. The home delivery pharmacy shall dispense Covered Prescription Drugs upon receipt from a Member of (i) a valid new or refill prescription order and (ii) applicable cost share. The covered Prescription Drug shall be mailed to the Member's address set forth in the eligibility file, or as appearing on the face of the prescription, so long as such address is within the United States. Additional fees for express mail, shipping or handling may be charged to Members. PBM may suspend such services to a Member if Member fails to remit any applicable cost share due.

f. PBM shall offer Employer a specialty pharmacy program through which Members may receive specialty pharmacy drug services. PBM shall provide all necessary information and forms to Members to obtain these specialty Prescription Drug services.

g. PBM shall operate a toll-free call center to respond to inquiries from Network Pharmacies regarding Pharmacy Services provided by PBM provided pursuant to this Pharmacy Services Schedule, including but not limited to technical and claims processing issues and Member eligibility verification ("Pharmacy Help Desk"). The Pharmacy Help Desk shall be available 24 hours a day, 7 days a week.

2. **Drug Formularies.**

a. PBM will furnish and maintain a drug formulary for use with the Pharmacy Benefit Plan, and PBM shall periodically review and update its formulary. Employer shall adopt such formulary as part of the design of the Pharmacy Benefit Plan. The drug formulary will be made available to Members on PBM's web site and upon request may be provided to Employer in a mutually acceptable format for Employer's distribution to Members.

b. PBM has placed certain Prescription Drugs on formularies that are developed through a process involving two committees, the Pharmacy and Therapeutics Committee ("P&T") and the Value Assessment Committee ("VAC"). The P&T examines the safety and efficacy of a Prescription Drug in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The VAC examines member impact, provider impact, economics, law and regulations, and market dynamics as it determines tiering and utilization management edit placement of Prescription Drugs on the formularies in a manner consistent with the clinical determinations of the P&T.

c. PBM will notify Members of any removal of a covered Prescription Drug from formularies in accordance with applicable laws.

d. In the event a Member or Provider believes that a Prescription Drug or supply not included on a formulary is medically necessary to treat the Member's individual condition, the Member or Provider may request a coverage exception. In the coverage exception process, PBM will consider a variety of factors that include, but are not limited to, Prescription Drugs previously tried and failed by the Member to treat a particular diagnosis or condition, whether the Member is clinically stable on the Prescription Drug, and/or whether switching to a covered Prescription Drug would result in a clinically significant adverse reaction or other harm to the Member.

3. **Claims Processing Services.**

a. PBM shall perform administrative services for Employer, including but not limited to, processing Claims with a Claims Incurred Date indicated in Section 1 of Exhibit A for Covered Prescription Services in accordance with the Pharmacy Benefit Plan. PBM will pay, on Employer's behalf, only Claims that are: (1) timely submitted by Network Pharmacies through PBM's point-of-sale service system; and (2) properly submitted by Members as requests for reimbursement for Covered Prescription Services. Employer may request PBM, on an exception basis, to process and pay Claims that were denied by PBM or take other actions with respect to the Pharmacy Benefit Plan that are not specifically set forth in this Agreement or the Benefits Booklet. PBM may honor such requests subject to system override capability and Employer paying a processing fee that has been mutually agreed to by the Parties.

b. PBM will implement certain administrative overrides to authorize the dispensing of Prescription Drugs in response to certain requests that include but are not limited to requests for lost/stolen drugs and vacation supplies.

c. PBM shall disburse to Member or Network Pharmacies payments that it determines to be due according to the provisions of the Pharmacy Benefit Plan.

d. PBM shall provide notice in writing when a Member submitted Claim has been denied or a prior authorization request has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Pharmacy Benefit Plan and shall otherwise satisfy applicable law governing the notice of a denied Claim.

4. **Utilization and Clinical Management Programs.**

a. PBM will provide a concurrent drug utilization program that assists pharmacies in identifying potential drug interactions, incorrect drug dosage, and inappropriate drug use and misuse. The program utilizes real-time Member health and safety protocols designed to monitor and screen each claim against the Member's Prescription Drug profile and is designed to help promote appropriate Prescription Drug use and help prevent adverse Member reactions. PBM shall make available to prescribing Providers, subject to such prescribing Providers' system capabilities, electronic access to Member eligibility; Prescription Drug Formulary status; Member medication history; a listing of Formulary alternative Prescription Drugs; and applicable cost share.

b. PBM shall offer additional programs to help ensure clinically appropriate use of Prescription Drugs, and effectively manage the cost of care that may include but not be limited to drug edits (i.e. prior authorization, step therapy, quantity limits, and dose optimization), enhanced fraud waste and abuse program, and medication review. Employer shall pay fees for the programs selected by Employer as set forth on Exhibit A. Employer shall abide by all applicable policies and procedures of the programs selected that may require Employer to provide requested information prior to PBM initiating the service.

5. **General Provisions.**

a. PBM shall assist Employer in determining whether its Prescription Drug benefit constitutes "creditable prescription drug coverage" as that term is used under the Medicare Part D laws (specifically, 42 C.F.R. 423.56). Unless otherwise agreed to by the Parties, Employer shall be solely responsible for communicating with Members regarding creditable prescription drug coverage matters.

b. PBM shall make available a toll-free number staffed by adequately trained personnel to address Member questions.

c. PBM will provide Employer with PBM's standard management and utilization reporting package in connection with the Pharmacy Services provided pursuant to this Pharmacy Services Schedule. At Employer's expense, PBM may prepare and provide custom and ad hoc reports within an agreed-upon time and format, at the rate set forth in Schedule A of the Agreement and/or Exhibit A of this Pharmacy Services Schedule, as applicable.

d. PBM will provide Pharmacy Services in accordance with the Pharmacy Benefit Plan and the Plan document(s) adopted by Employer. The Pharmacy Services shall be procedural only and shall be performed by PBM within the framework of policies, interpretations, rules, practices, and procedures made, established, and provided in writing to PBM by Employer.

e. PBM will maintain all licenses, permits, certifications, registrations, and other regulatory approvals required by law necessary for the performance of PBM's obligations pursuant to this Pharmacy Services Schedule.

f. PBM will maintain at least one of the following accreditations during the term of the Agreement and this Pharmacy Services Schedule: (a) National Committee for Quality Assurance ("NCQA") certification; (b) Utilization Review Accreditation Commission ("URAC") Drug Utilization Management accreditation; and/or (c) such other NCQA certifications and URAC accreditations applicable to the Pharmacy Services provided hereunder.

g PBM shall not be responsible for any adverse consequences from Employer's request to change from one pharmacy benefit administrator to another pharmacy benefit administrator.

C. **Obligations of Employer.** To the extent not already provided under Article 3 of this Agreement, Employer shall:

1. Provide PBM with timely, accurate and complete information necessary for PBM to provide the Pharmacy Services. PBM shall be under no obligation to verify the accuracy and completeness of information provided to it by Employer.

2. Provide accurate, timely, complete, and ongoing Member eligibility information to PBM using PBM's prescribed format and methods. Such information shall include, but shall not be limited to, the number and names of Members eligible for and covered under the Pharmacy Benefit Plan and any other information determined by PBM to be necessary to provide Pharmacy Services. PBM will load Member eligibility data no later than three business days after receipt from Employer. PBM will be entitled to rely on the accuracy and completeness of the Member eligibility data from Employer. Employer shall be solely responsible for any errors in Member eligibility data that Employer provides to PBM.

D. **Drug Rebate Management.**

1. During any Agreement Period, Employer shall not contract, directly or indirectly through a third party, with a manufacturer or any other third party for rebates, discounts, or other financial incentives on claims that are eligible for Prescription Drug Rebates under this Agreement. In the event that PBM determines such violation of this paragraph, Employer shall be deemed ineligible to earn Prescription Drug Rebates, the Drug Rebate Program will be suspended, and Employer shall be required to reimburse PBM for any Prescription Drug Rebates that were previously earned. If Employer fails to reimburse PBM for such Prescription Drug Rebates within 10 business days of PBM's request, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM. Additionally, PBM may renegotiate the guarantees and/or any pricing terms of the Agreement.

2. Employer acknowledges and agrees that Prescription Drug Rebate amounts are subject to change for reasons including but not limited to:

   a. Prescription Drug Rebate eligibility is modified under an agreement between PBM and/or its Vendor and a manufacturer;

   b. laws and regulations affecting the distribution or the amount of Prescription Drug Rebates available or payable under such laws and regulations; or

   c. any action(s) or inaction(s) by manufacturer that impacts the availability or amount of Prescription Drug Rebate earned, that includes, but is not limited to, manufacturer's discontinuation of the covered Prescription Drugs.

   If any change set forth in (a) - (c) above occurs, PBM may provide written notice to Employer of such change as soon as reasonably practicable. In such event, PBM shall notify Employer and revise or eliminate such payment as of the effective date of the reduction or elimination of the Drug Rebate payment. Such reduction or elimination of the Drug Rebate payment shall result in either a change in the Base Administrative Services Fee as described in Article 18(c) of the Agreement or a change in the percentage of Prescription Drug Rebates retained by PBM.

3. PBM will use reasonable efforts to negotiate and collect Prescription Drug Rebates from manufacturers. PBM shall not be required to institute litigation to negotiate and collect Prescription Drug Rebates from manufacturers. If PBM or its designee does elect to bring suit to recover Prescription Drug Rebates from manufacturers, PBM shall be entitled to deduct all reasonable attorney's fees and other expenses incurred in such litigation prior to payment of the Prescription Drug Rebates to Employer. Neither Party shall be responsible to the other Party, its affiliates, directors, employees, agents, successors, or permitted assigns for any claim arising from: (i) any failure by a manufacturer to pay any Prescription Drug Rebates; (ii) any breach of an agreement relating to the transactions contemplated by or otherwise relating to this Agreement by any manufacturer; or (iii) any negligence or misconduct of any manufacturer.

4. In the event that PBM, its Vendor, and/or manufacturer identifies through audit or other means that Employer has received an overpayment or an erroneous Drug Rebate payment, Employer shall immediately refund such amounts. If Employer fails to do so, PBM shall have the right to recover said amounts by offsetting such amounts against any amounts PBM owes Employer under this Agreement or any other agreement between Employer and PBM.

5. Prescription Drug Rebates paid pursuant to the Agreement and Exhibit A of the Pharmacy Services Schedule are intended to be treated as "discounts" pursuant to the Federal Anti-Kickback Statute set forth at 42 C.F.R. § 1320a-7b and implementing regulations.

6. PBM shall continue to provide Employer its share of the Prescription Drug Rebates under this provision until the termination of this Agreement and any applicable Claims Runout Period. PBM shall provide a final report of the Prescription Drug Rebates received attributable to Employer's Plan after the end of the Claims Runout Period. Any Prescription Drug Rebates received by PBM after the end of the Claims Runout Period shall be retained by PBM.

7. Employer acknowledges and agrees that no Prescription Drug Rebates shall be paid pursuant to Exhibit A unless and until this Pharmacy Benefit Services Schedule is fully executed.

E. **Pharmacy Base Administrative Services Fees and Expenses**

1. Employer agrees to pay PBM fees for the Pharmacy Services as set forth on Exhibit A.

2. PBM's fees for the Pharmacy Services may be renegotiated in the event of substantial changes that would increase or decrease the obligations or costs of providing the Pharmacy Services, including but not limited to changes in the Pharmacy Benefit Plan, legislative changes, or postal rate changes. In addition to other rights set forth in Article 18(c) of the Agreement, PBM shall have the right to change the Pharmacy Base Administrative Services Fees or other fees provided in Exhibit A if: (a) PBM is no longer the sole provider of the Covered Prescription Services contemplated in this Pharmacy Services Schedule; (b) Employer implements an on-site pharmacy; or (c) a change in applicable law occurs resulting in an increase in the cost or amount of Covered Prescription Services under this Agreement. PBM shall provide notice to Employer of the change in the Pharmacy Base Administrative Services Fees at least 30 days prior to the implementation date of such change. Any change in the Pharmacy Base Administrative Services Fees will be effective as of the date the change occurs, even if that date is retroactive. If such change is unacceptable to Employer, either Party shall have the right to terminate this Pharmacy Services Schedule by giving written notice of termination to the other Party before the effective date of the change. If Employer accepts the proposed Pharmacy Base Administrative Services Fees, PBM shall provide a revised Exhibit A, and, if applicable, Schedule A, that will then become part of this Agreement without the necessity of securing Employer's signature on the Exhibit and, if applicable, Schedule.

3. If changes in the Pharmacy Benefit Plan are incompatible with existing systems and procedures and require PBM or its subcontractor to perform additional programming, reports, or services, such additional activities will be performed at the expense of Employer, if agreed to by PBM.

4. Employer shall be responsible for out-of-pocket production costs, travel expenses, and banking expenses incurred by PBM in carrying out implementation activities at the request of Employer.

5. PBM shall not provide or be responsible for the expenses or costs of services furnished by attorneys, actuaries, certified public accountants, investment counselors, or investment analysts, or for similar services performed for Employer. PBM shall not be authorized to engage such services or incur any expense or cost therefore without the written consent of Employer. In the event that such services are engaged by PBM at the written request of Employer, Employer shall be responsible for all costs and expense thereof, that shall be separately billed by the provider of the services or by PBM as incurred.

6. Employer agrees to pay PBM fees for Claims Runout Services described in Section 5 of Exhibit A of the Pharmacy Services Schedule.

F. **Audits.**

1. Unless otherwise provided for in this Section F of the Pharmacy Services Schedule, the parties acknowledge and agree that the Claims audit provisions set forth in Article 12 of the Agreement shall apply. However, in the event of any conflict between the Claims audit provisions in Article 12 of the Agreement and this Pharmacy Services Schedule, the terms and conditions of this Pharmacy Services Schedule shall govern with respect to the provision of Pharmacy Services.

2. Employer, must provide at least 60 days prior written notice to PBM of its intent to conduct an audit of PBM's performance under this Pharmacy Services Schedule to ensure compliance with the Agreement and applicable laws. The scope of an audit including time, place, type and duration of all audits must be reasonable, agreed to by PBM, and in accordance with PBM's audit procedures and guidelines. Onsite audits and access to claims processing systems will not be permitted.

3. Any Employer requests for a third party auditor to audit will constitute Employer's direction and authorization to PBM to disclose Employer-specific information, including Member information and PHI, to Employer's auditor. PBM will provide Employer's auditor with access to all applicable Employer-specific information reasonably necessary to determine the accuracy of Claims payments and verify PBM's performance under this Pharmacy Services Schedule, subject to PBM's third party confidentiality obligations; provided, however, any other documentation requested during the course of an audit not in the audit scope or necessary for the audit, will be provided at PBM's discretion.

4. Employer shall not be permitted to audit any contract between PBM, its Vendors, subcontractors, or manufacturers.

G. **Termination.** In addition to the provisions in Article 19 of this Agreement,

1. Either Party may terminate this Pharmacy Services Schedule by giving 90 days notice prior to the date of the termination.

2. This Pharmacy Services Schedule shall terminate on the date the Agreement is terminated unless otherwise agreed to by the Parties. If the Parties agree to continue the Pharmacy Services Schedule after termination, applicable provisions of the Agreement shall remain in effect until a new agreement is reached by the Parties.

3. This Pharmacy Services Schedule shall terminate on the effective date of any governmental body's action that prohibits all activities contemplated under this Pharmacy Services Schedule.

4. Following termination of only this Pharmacy Services Schedule, the remainder of the Agreement shall continue in full force and effect during the Agreement Period. Termination of this Pharmacy Services Schedule will not terminate the rights or obligations of either Party arising out of the period during which this Agreement was in effect.

5. In the event of termination of this Pharmacy Services Schedule, PBM shall not be responsible for notifying Members of such termination or of the procedure to be followed to retain or obtain Plan coverage.

6. Upon notice of termination of this Pharmacy Services Schedule for any reason other than for non-payment of amounts due under this Schedule, the Parties will mutually develop a transition plan that includes but is not limited to: (1) a schedule of transition activities and timelines for completion; (2) a detailed description of the respective roles of PBM and Employer; and (3) such other information and planning as necessary to ensure that the transition takes place according to an agreed upon schedule and with minimum disruption to Members. The transition plan shall be subject to written approval by both Parties.

7. Unless mutually agreed to in writing by the Parties, upon termination of this Pharmacy Services Schedule, Employer shall cease adoption and use of PBM's formulary as part of its Plan and agrees that it shall not copy, distribute, or sell PBM's formulary.

IN WITNESS WHEREOF, the Parties have executed this Schedule to be effective as of the pharmacy Agreement Period.

Lexington-Fayette Urban County Government

By: Linda Gorton

Title: Mayor

Date: 7/6/2022

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: Kenneth Wethington

Title: President

Date: 10-9-22

IngenioRx, Inc.

By: Paul Mochetto

Title: President

Date: 6/6/2022

EXHIBIT A
PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Lexington-Fayette Urban County Government

This Exhibit A shall govern the Agreement Period from January 1, 2020 through December 31, 2020 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

Section 1. **Effective Date and Renewal Notice**

This Agreement Period shall be from 12:01 a.m. January 1, 2020 to the end of the day of December 31, 2020.

Paid Claims shall be processed pursuant to the terms of this Pharmacy Services Schedule when incurred and paid as follows:

- Incurred from January 1, 2015 through December 31, 2020 and
- Paid from January 1, 2020 through December 31, 2020.

PBM shall provide any offer to renew this Pharmacy Services Schedule at least 30 days prior to the end of an Agreement Period.

Section 2. **Broker or Consultant Base Compensation**

Not Applicable

Section 3. **Pharmacy Administrative Services Fees**

Change to Administrative Services Fees. The Administrative Services Fees in Section 3 of Schedule A of the Agreement and the Pharmacy Administrative Services Fees in Section 3 of Exhibit A may be changed during the Agreement Period based upon an event in Article 18(c) of the Agreement or Section E(2) of the Pharmacy Services Schedule.

A. **Pharmacy Base Administrative Services Fee**

Pharmacy Base Administrative Services Fee. The Pharmacy Administrative Services Fees shall also include a fee that will be charged monthly for services related to pharmacy benefits management including, but not limited to, pharmacy mail services, clinical services, and customer services. Such fee shall be $0.00.

B. **Drug Rebate Allocation**

1 PBM and/or its Vendor has negotiated programs with pharmaceutical manufacturers for drug rebates on certain Prescription Drugs dispensed to Members and has arranged for payments of such rebates to be made directly to PBM ("Drug Rebate Programs"). PBM has entered into such Drug Rebate Programs on its behalf and not on behalf of Employer, and therefore retains all rights, title, and interest to any and all actual Prescription Drug Rebates it receives from manufacturers and/or its Vendor. Such Drug Rebate Programs are not based solely on the Prescription Drug utilization of one Employer Plan, but rather are based on the Prescription Drug utilization of all individuals enrolled in PBM managed programs. The Prescription Drug Rebates are conditioned on certain Prescription Drugs being included on the formulary that PBM requires Employer to adopt as part of its Plan. Employer shall be paid or credited a portion or the amount attributable to its actual or estimated value of Prescription Drug Rebates as described in Section 3(B) of Exhibit A.

2. PBM may receive and retain administrative fees directly from pharmaceutical manufacturers. In addition, PBM may receive and retain service fees from pharmaceutical manufacturers for providing services (e.g., Provider and Member education programs that promote clinically appropriate and safe dispensing and use of Prescription Drugs). For purposes of this Pharmacy Services Schedule, administrative fees and service fees received by PBM shall not be considered Prescription Drug Rebates.

3. Prescription Drug Rebates: PBM will pay to Employer 100% of the Prescription Drug Rebates attributable to Employer's Plan subject to PBM's timely and actual receipt of payment and accompanying data from pharmaceutical manufacturers. On a quarterly basis, PBM shall credit Employer the Prescription Drug Rebates it has guaranteed in the Prescription Drug Rebates Performance Guarantee as defined in Exhibit C. PBM shall have the right to collect from Employer any rebate amount that PBM is required to pay a pharmaceutical manufacturer as a result of a pharmaceutical manufacturer audit or for any other reason. Provided, however, if the total Prescription Drug Rebates Performance Guarantee, as defined in Exhibit C, exceeds the amount described herein, the PBM will pay the Employer the difference.

4. Medical Drug Rebates. PBM shall retain 100% of the Medical Drug Rebates.

C. **Other Fees or Credits**

Fee for Pharmacy Prior Authorization. $55.00 per authorization.

Fee for Pharmacy Physician Review. $800.00 per review

Fee for Vaccine Administration. PBM shall charge a fee for the administration of vaccines at a retail pharmacy location of $2.50 per vaccine.

Fee for Medication Review Note. PBM shall charge a fee of $0.30 per pharmacy Claim for clinical, quality and cost-of-care messages in personalized Member communications.

Fee for Custom Communications. PBM shall charge a fee of $1.00 per custom communication requested by the Employer.

Fee for Member-Submitted Claims. PBM shall charge a fee of $1.00 per Claim for each Member-submitted Claim.

PBM Services Early Termination Fee. In consideration of the special pricing arrangements under this Agreement, Employer shall pay PBM an Early Termination Fee, as described below, if Employer terminates the pharmacy portion of the Plan before the end of the Performance Period (as defined in Exhibit C) for any reason other than PBM's failure to comply with a material duty or obligation related to the administration of pharmacy benefits under this Agreement. The Early Termination Fee shall be calculated by multiplying $2.95 PSPM by (i) the average monthly Subscriber count for the 6 months immediately prior to termination; multiplied by (ii) the number of months remaining in the Performance Period. Upon termination of the Agreement, 0.00% of unpaid Rebates for services prior to termination will be retained by PBM. If Employer intends to terminate the pharmacy portion of the Plan before the end of the Performance Period, Employer must provide PBM with the required termination notice under Section G of the Pharmacy Services Schedule. In the event Employer terminates the pharmacy portion of the Plan before the end of the Performance Period, the applicable Early Termination Fee will be billed to Employer with the amount due within 30 days of the termination date.

Invoices for Prescription Drug Claims: When PBM invoices Employer for Prescription Drug Claims, the amount billed will reflect pricing that may be greater than the amount that is paid to pharmacies for those Claims (Margin Pricing). The use of Margin Pricing provides some control over price swings that members may otherwise experience when filling prescriptions.

Fee for Ad Hoc Reports. PBM shall provide, on an annual basis, up to 20 hours of time needed to generate custom or ad hoc reports at no additional charge. The charge to Employer beyond 20 hours per year is $150.00 per hour for time needed to generate custom or ad hoc reports.

Section 4. **Pharmacy Administrative Services Fees and Paid Claims Billing Cycle and Payment Method**

Billing cycles and payment methods are contained in Schedule A.

Section 5. **Claims Runout Services**

A. **Claims Runout Period**

Claims Runout Period shall be for the 12 months following the date of termination of this Pharmacy Services Schedule.

B. **Claims Runout Administrative Services Fee**

Pharmacy:

The fee for Claims Runout Services will be waived. Fees that (i) are associated with Claims processed or reviewed during the Claims Runout Period including without limitation subrogation fees, Claims prepayment analysis fees, recovery fees, network access fees; or (ii) apply to the Pharmacy Services Schedule Period but were not billed during the Pharmacy Services Schedule Period, will be billed and payable during the Claims Runout Period. Payment is due to PBM by the Invoice Due Date.

Section 6. **Other Amendments. The Pharmacy Benefits Administrative Services Schedule is otherwise amended as follows:**

Not applicable

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield

By: Norman Wettstein

Title: President

Date: 6-9-22

IngenioRx, Inc.

By: Paul M Mycielski

Title: President

Date: 6/6/2022

EXHIBIT B
PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Lexington-Fayette Urban County Government

This Exhibit B shall govern the Agreement Period from January 1, 2020 through December 31, 2020 and is made part of this Pharmacy Benefits Administrative Services Schedule. This Exhibit is intended to supplement the Agreement between the Parties as it relates to Pharmacy Services only. In the event of an inconsistency between the applicable provisions of this Pharmacy Services Schedule and the Agreement, the terms of this Pharmacy Services Schedule shall govern, but only as they relate to Pharmacy Services. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

The following is a list of services that PBM will provide under this Pharmacy Services Schedule for the Base Administrative Services Fee set forth on Exhibit A. These services will be furnished to Employer in a manner consistent with PBM's standard policies and procedures for self-funded plans. PBM may also offer services to Employer that have an additional fee. If Employer has purchased such services, those services and any additional fees are also set forth on Exhibit A.

Prescription Benefit Services

- Home delivery pharmacy
- Specialty Pharmacy Services
  - Prescription eServices
  - Pharmacy locator
  - Online formulary
- Point of sale claims processing
- Home delivery claims processing
- Home delivery call center with toll free number
- Home delivery regular shipping and handling
- Standard management reports
- Ad hoc reports (subject to additional programming charge)
- Concurrent Drug Utilization Review (DUR) programs
- Retrospective DURs
- Administrative override (i.e., vacation, lost, stolen or spilled medications)
- Pharmacy help desk with toll free number
- Audits of pharmacies
- Assistance in determining "creditable prescription drug coverage" under Medicare Part D

EXHIBIT C
PHARMACY BENEFITS ADMINISTRATIVE SERVICES SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
Lexington-Fayette Urban County Government

This Exhibit C provides certain guarantees pertaining to PBM's performance under the Agreement between the Parties ("Performance Guarantees") and shall be effective for each year in the period from January 1, 2020 through December 31, 2020 (the "Performance Period"). Descriptions of the terms of each Performance Guarantee applicable to the Parties are set forth in the Attachments (the "Attachments") to this Exhibit C and made a part of this Exhibit C. This Exhibit shall supplement and amend the Pharmacy Benefits Administrative Services Schedule between the Parties. If there are any inconsistencies between the terms of the Agreement and this Exhibit C, the terms of this Exhibit C shall control. If there are any inconsistencies between the terms contained in this Exhibit, and the terms contained in any of the Attachments to this Exhibit C, the terms of the Attachments to this Exhibit C shall control.

Section 1. **General Conditions**

A. The Performance Guarantees described in the Attachments to this Exhibit C shall be in effect only for the Performance Period indicated above, unless specifically indicated otherwise in the Attachments. Each Performance Guarantee shall specify a/an:

1. Allocation. The term Allocation is the percent of total Amount at Risk to each Performance Guarantee.

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

3. Measurement Period. The term Measurement Period is the period of time under that PBM's performance is measured, that may be the same as or differ from the period of time equal to the Performance Period.

4. Performance Category. The term Performance Category describes the general type of Performance Guarantee.

5. Reporting Period. The term Reporting Period refers to how often PBM will report on its performance under a Performance Guarantee.

6. Service Feature. The term Service Feature is a service standard stipulated and defined to be guaranteed.

B. PBM shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the Attachments to this Exhibit C. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by PBM shall be based on PBM's then current measurement and calculation methodology, that shall be available to Employer upon request.

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

D. If the Agreement is not executed, PBM shall have no obligation to make payment under these Performance Guarantees.

E. Unless otherwise specified in the Attachments to this Exhibit C, the measurement of the Performance Guarantee shall be based on data that is maintained and stored by PBM or its Vendors.

F. If Employer terminates the Agreement or the Pharmacy Services Schedule between the Parties prior to the end of the Performance Period, or if the Agreement or the Pharmacy Services Schedule is terminated for non-payment, then Employer 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.

G. PBM reserves the right to make changes to any of the Performance Guarantees provided in the Attachments to this Exhibit C upon the occurrence, in PBM's determination, of either:

1. a change to the Plan benefits or the administration of the Plan initiated by Employer that results in a substantial change in the services to be performed by PBM or the measurement of a Performance Guarantee;

2 an increase or decrease of 10% or more of the number of Members that were enrolled for coverage on the latter of the effective date or renewal date of this Pharmacy Services Schedule.

3. a failure by Employer to implement its responsibilities under the clinical management programs that are part of the Plan;

4. a failure by Employer to adopt the Formulary;

5. a change in the proportionate mix of Employer's retail and home delivery Prescription Drug Claims of more than 10% (including, but not limited to, a change in the overall Members' percentage of usage of retail and mail order pharmacies);

6. a change in pharmacy utilization patterns of more than 10% (including, but not limited to, a change in the overall Members' percentage of usage of Brand Drugs, Generic Drugs, and Specialty Drugs);

7. a change that results in PBM no longer being the exclusive source of Prescription Drug Rebates for Employer's Plan;

8. the determination that Employer has an on-site pharmacy with 340b designation or any such designation where the pharmacy receives upfront pricing discounts from pharmaceutical manufacturers, that was not disclosed or known by PBM as of the effective date of this Attachment to Exhibit C;

9. PBM is no longer the sole administrator for Employer's Prescription Drug Plan;

10. a government action or major change in pharmaceutical industry practices that eliminates or materially reduces the manufacturer Drug Rebate program; or

11. a failure by Employer to maintain the selected Formulary and applicable clinical edits or Employer has excepted Members from application of the selected Formulary and clinical edits that prevent full savings from accruing.

Should there be a change in occurrence as indicated above and these changes negatively impact PBM's ability to meet the Performance Guarantees, PBM shall have the right to modify the Performance Guarantees contained in the Attachments.

H. For the purposes of calculating compliance with the Performance Guarantees contained in the Attachments to this Exhibit C, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances that are beyond the control of PBM, or its Vendors, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, acts of war or power outage, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

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

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

K. Employer acknowledges and agrees that each Performance Guarantee will be measured based on the Measurement Period as described in the Attachments to this Exhibit C and prorated to account for Employer specific Effective or renewal dates when measured using aggregated data. The Performance Guarantee will begin on the Employer Effective Date. However, if the Employer terminates the Pharmacy Benefits Schedule before the end of a Measurement Period, the Performance Guarantee measured will be based on the entire Measurement Period during which the termination occurred.

Section 2. Payment

A. If PBM fails to meet any of the obligations specifically described in a Performance Guarantee described in the Attachments to this Exhibit C, PBM shall pay Employer the amount set forth in the Section describing the Performance Guarantee. Payment shall be in the form of a credit on Employer's invoice for Administrative Services Fees that will occur annually unless otherwise stated in the Performance Guarantee.

B. Notwithstanding the above, PBM has the right to offset any amounts owed to Employer under any of the Performance Guarantees contained in the Attachments to this Exhibit C against any amounts owed by Employer to PBM under: (1) any Performance Guarantees contained in the Attachments to this Exhibit C; or (2) the Agreement.

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

D. Where the Amount at Risk for a Performance Guarantee is on a percentage of a Per Subscriber Per Month (PSPM) fee basis, the Guarantee will be calculated by multiplying the PSPM amount by the actual annual enrollment during the Measurement Period.

E PBM shall reconcile the pricing Performance Guarantees described in Attachment 1 to Exhibit C on an annual basis, calculated in accordance with Section 4 of this Exhibit C. The reconciliation for each year of the Performance Period will be submitted to Employer within 90 days after the end of the Measurement Period and any resulting value shortfall shall by paid by PBM to Employer within 30 days following submission of the reconciliation report.

F PBM shall pass through rebate amounts collected by PBM as described in Attachment 1 to Exhibit C on a quarterly basis in accordance with Section 3 of this Exhibit C to Employer within 180 days after the end of the calendar quarter. PBM will pass through additional collections from prior quarters in subsequent quarterly disbursements. PBM shall reconcile the Performance Guarantees for each rebate Performance Guarantee described in Attachment 1 to Exhibit C on an annual basis, calculated in accordance with Section 3 of this Exhibit C. The reconciliation for each Measurement Period will be submitted to Employer within 10 months following the end of the Measurement Period and any resulting value shortfall shall be paid by PBM to Employer within 30 days following the reconciliation.

Section 3. Prescription Drug Rebate Performance Guarantees

A Any payment due to Employer under a rebate Performance Guarantee will be offset by favorable results achieved in any other rebate Performance Guarantee. Any payment due to Employer under this Performance Guarantee will be offset by favorable results achieved in the Prescription Drug pricing Performance Guarantee.

B This Performance Guarantee will be determined by comparing the total Prescription Drug Rebates Performance Guarantee to the Prescription Drug Rebates credited to the Employer pursuant to the Pharmacy Services Schedule and Section 3(B) of Exhibit A. If the total Prescription Drug Rebates Performance Guarantee exceeds the Prescription Drug Rebates credited to the Employer, PBM will credit Employer the difference.

C For purposes of these Performance Guarantees, the following Claims will not be included in the calculation:

- Medicare Part D;
- 340b pharmacy;
- Prescriptions filled in Massachusetts, Alaska, Hawaii, or Puerto Rico, or filled in any state that imposes some form of Most Favored Nations limitations on pharmacy reimbursement;
- Vaccines;
- Zero Balance Claims;
- Claims paid on the basis of U&C charges;
- Compound Drugs;
- Over-the-counter drugs;
- Member-submitted Claims;
- Government Reimbursement Claims.
- Out-of-Network Claims;
- Mail Claims less than 60 days supply;

Section 4. **Prescription Drug Pricing Performance Guarantees**

A To determine any payment due to Employer under these Prescription Drug pricing Performance Guarantees, each Performance Guarantee is calculated based on the Prescription Drugs that were paid during the Measurement Period for:

- retail pharmacy,
- Home delivery,
- Specialty Drugs,

(each such subset of Paid Claims is referred to as a "Pricing Guarantee Category").

Each guarantee within a Pricing Guarantee Category is then compared to the sum of appropriate portion of the Paid Claims for Prescription Drugs plus any Member cost shares associated with each Performance Guarantee within that Pricing Guarantee Category (other than those associated with Zero Balance Claims). Paid Claims for Prescription Drugs include Ingredient Costs plus Dispensing Fees. Therefore, Paid Claims for Prescription Drugs dispensed by a retail pharmacy are separated into Brand and Generic Ingredient Costs and Brand and Generic Dispensing Fees. These Ingredient Costs and Dispensing Fees are compared against each identified Performance Guarantee provided in this Pharmacy Services Schedule to determine if the Performance Guarantee is met.

B Any payment due to Employer under any Performance Guarantee within a pricing guarantee Performance Category will not be offset by: (i) favorable results achieved in any other Performance Guarantee within that same pricing guarantee Performance Category, (ii) overall favorable results for a pricing guarantee Performance Category; or (iii) any rebate guarantee.

C The following conditions apply to this Performance Guarantee:

1 This Performance Guarantee applies to Claims submitted by Network Providers applicable to Employer's Plan.

2 The following Claims will be excluded from this Performance Guarantee:

- Medicare Part D;
- 340b pharmacy;
- Prescriptions filled in Massachusetts, Alaska, Hawaii, or Puerto Rico, or filled in any state that imposes some form of Most Favored Nations limitations on pharmacy reimbursement;
- Vaccines;
- Prescriptions filled through the Employer's on-site pharmacy;
- Claims paid on the basis of U&C charges;
- Compound Drugs;
- Over-the-counter drugs;
- Member-submitted Claims;
- Government Reimbursement Claims.
- Out-of-Network Claims;
- Mail Claims less than 60 days supply;

D In the event that there are court or government imposed or industry wide or pricing source initiated changes in the AWP reporting source or source changes in the methodology used for calculating AWP, including, without limitation, changes in the mark-up factor used in calculating AWP (collectively, the "AWP Changes"), the terms of any financial relationship between the Parties that relate to AWP will be modified by PBM such that the value of AWP for the purpose of such relationship(s) will have the same economic equivalence in the aggregate to the value used by the Parties prior to the AWP Change. The intent of this provision is to preserve the relative economics of both Parties for such financial relationships based upon AWP to that which existed immediately prior to the AWP Change.

In the event that the AWP pricing benchmark used by PBM's PBM hereunder is replaced with another benchmark calculation, PBM may switch to such new pricing benchmark. If a change to pricing guarantees is deemed necessary PBM will provide written notice of new pricing terms at least 30 days before the effective date of the change.

ATTACHMENT 1 TO EXHIBIT C
Performance Guarantees

TO ADMINISTRATIVE SERVICES AGREEMENT
WITH
Employer Legal Name

Pharmacy Performance Guarantees

This Attachment is made part of Exhibit C and will be effective for the Performance Period from 1/1/2018 through 12/31/2020. This Attachment is intended to supplement and amend the Agreement between the Parties. The Measurement Period for these Performance Guarantees will be annual, unless otherwise specified herein. These Performance Guarantees are guaranteed upon offer and acceptance of renewal of the medical portion of the Agreement.

Pharmacy Performance Guarantee	**Measurement and Reporting Period**
Prescription Drug Rebate Guarantees	**Measurement Period** Annual
Minimum Drug Rebates: (a) The Prescription Drug Rebates Employer receives from PBM will not be less than the following amounts ("Total Drug Rebates Guarantee"):	**Reporting Period** Annual
NATIONAL FORMULARY	
NON-SPECIALTY DRUGS	
BRAND NAME PRESCRIPTION DRUGS	
(1) An amount equal to the sum of N/A (YR1) $147.37 (YR2) $193.88 (YR3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at **retail** pharmacy Network Providers ; plus	
(2) An amount equal to the sum of N/A (YR1) $308.67 (YR2) $421.10 (YR3) per Paid Claim for Non-Specialty Brand Name Prescription Drugs dispensed at **home delivery** Network Providers for a supply for 60 days or greater.	
SPECIALTY DRUGS	
BRAND NAME PRESCRIPTION DRUGS	
(1) An amount equal to the sum of N/A (YR1) $1,282.52 (YR2) $2,025.37 (YR3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at **retail pharmacy** Network Providers; plus	
(2) An amount equal to the sum of N/A (YR1) $1,031.47 (YR2) $1,319.27 (YR3) per Paid Claim for Specialty Brand Name Prescription Drugs dispensed at **home delivery** Network Providers.	
Prescription Drug Pricing Guarantees	**Measurement Period** Annual
Prescription Drug Pricing: (a) The Prescription Drug Pricing Guarantees for Ingredient Cost Discount and Dispensing Fees will be the amounts listed under the following Pricing Guarantee Categories:	**Reporting Period** Annual

NATIONAL RETAIL PHARMACY NETWORK

RETAIL PHARMACY NETWORK PROVIDERS
The guarantees for retail pharmacy Network Providers will be the following amounts:

1. Brand Discount: AWP minus 18.50% (YR1) 18.50% (YR2) 19.50% (YR3)

Pharmacy Performance Guarantee	Measurement and Reporting Period

2. Brand Dispensing Fee: $0.60 (YR1) $0.60 (YR2) $0.50 (YR3)
3. Generic Discount: AWP minus 79.00% (YR1) 79.25% (YR2) 80.50% (YR3)
4. Generic Dispensing Fee: $0.60 (YR1) $0.60 (YR2) $0.50 (YR3)

MAIL/HOME DELIVERY OPTIONS

HOME DELIVERY PHARMACY

The guarantees for home delivery for a supply of 60 days or greater will be the following amounts:

1. Brand Discount: AWP minus 26.00% (YR1) 26.00% (YR2) 26.00% (YR3)
2. Brand Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3)
3. Generic Discount: AWP minus 82.50% (YR1) 82.75% (YR2) 84.00% (YR3)
4. Generic Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3)

SPECIALTY SERVICE OPTIONS

SPECIALTY DRUGS

The guarantees for Specialty DRUGS will be the following amounts:

1. Brand Discount: AWP minus 14.25% (YR1) 14.25% (YR2) 15.00% (YR3)
{VA350} Brand Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3)
3. Generic Discount: AWP minus 58.00% (YR1) 58.00% (YR2) 58.00% (YR3)
4. Generic Dispensing Fee: $0.00 (YR1) $0.00 (YR2) $0.00 (YR3)

GROUP HEALTH BUSINESS ASSOCIATE AGREEMENT SCHEDULE
TO
ADMINISTRATIVE SERVICES AGREEMENT
WITH
LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT

This Group Health Plan Business Associate Agreement Schedule supplements and amends the Administrative Services Agreement and is effective as of January 1, 2020. In the event of an inconsistency between the applicable provisions of this Schedule, any other Schedule and/or the Agreement, the terms of this Schedule shall govern, but only as they relate to the Group Health Plan Business Associate Agreement. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.

This Business Associate Agreement ("Agreement") is made among Anthem ("Business Associate"), and the Group Health Plan as defined in the Administrative Services Agreement ("Plan"), and the Employer ("Employer").

WITNESSETH AS FOLLOWS:

WHEREAS, Employer has established and maintains a plan of health care benefits which is administered by the Employer or its designee as an employee welfare benefit plan under applicable law;

WHEREAS, Employer has retained Business Associate to provide certain claims administrative services with respect to the Plan which are described and set forth in a separate Administrative Services Agreement among those parties ("ASO Agreement"), as amended from time to time;

WHEREAS, Employer is authorized to enter into this agreement on behalf of Plan;

WHEREAS, the parties to this Agreement desire to establish the terms under which Business Associate may use or disclose Protected Health Information (or "PHI") such that the Plan may comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and the Privacy, Security, Breach Notification and Standard Transactions regulations found at 45 C.F.R. Parts 160-164 (collectively, the "HIPAA Regulations") along with any guidance and/or regulations issued by the U.S. Department of Health and Human Services.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the Plan, Employer and Business Associate hereby agree as follows:

I.. DEFINITIONS

Unless otherwise defined in this Agreement, capitalized terms shall have the same meaning as used in the HIPAA Regulations. Such terms shall only have such meaning with respect to the information created or maintained in support of this Agreement and the parties ASO Agreement. A reference in this Agreement to any section of the HIPAA Regulations shall mean the section as in effect or as amended.

II.. BUSINESS ASSOCIATE'S RESPONSIBILITIES

A. Privacy of Protected Health Information

1. **Confidentiality of Protected Health Information**. Except as permitted or required by this Agreement, Business Associate will not use or disclose Protected Health Information without the authorization of the Individual who is the subject of such information or as Required by Law.

2. **Prohibition on Non-Permitted Use or Disclosure**. Business Associate will neither use nor disclose PHI except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by the Plan or its Plan administrator, (3) as authorized by Individuals, or (4) as Required by Law.

3. **Permitted Uses and Disclosures**. Business Associate is permitted to use or disclose PHI as follows:

    a. **Functions and Activities on Plan's Behalf**. Business Associate will be permitted to use and disclose PHI(a) for the management, operation and administration of the Plan, (b) for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment,

Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 C.F.R. § 164.501, and (c) as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties provided that such use or disclosure would not violate the HIPAA Regulations.

i. **42 C.F.R. Part 2 Acknowledgement**. The parties acknowledge that information subject to 42 C.F.R. Part 2 ("Part 2") may be used and disclosed for Plan's payment and health care operations under the terms of this Agreement and the ASO Agreement to the extent that Business Associate is a Contractor and Plan is a Third Party Payer as defined under Part 2. Business Associate shall: (i) comply with Part 2, (ii) implement appropriate safeguards to protect such information, (iii) report non-permitted uses or disclosures of such information in a manner consistent with this BAA, and (iv) refrain from re-disclosing such information unless permitted by law.

b. **Business Associate's Own Management and Administration**

i. **Protected Health Information Use**. Business Associate may use PHI as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities.

ii. **Protected Health Information Disclosure**. Business Associate may disclose PHI as necessary for Business Associate's proper management and administration or to carry out Business Associate's legal responsibilities only (i) if the disclosure is Required by Law, or (ii) if before the disclosure, Business Associate obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will: (x) hold PHI in confidence, (y) use or further disclose PHI only for the purposes for which Business Associate disclosed it to the entity or as Required by Law; and (z) notify Business Associate of any instance of which the entity becomes aware in which the confidentiality of any PHI was breached.

c. **Miscellaneous Functions and Activities**

i. **Protected Health Information Use**. Business Associate may use PHI as necessary for Business Associate to perform Data Aggregation services, and to create De-identified PHI, Summary Health Information and/or Limited Data Sets.

ii. **Protected Health Information Disclosure**. Business Associate may disclose, in conformance with the HIPAA Regulations, PHI to make Incidental disclosures and to make disclosures of De-identified PHI, Limited Data Sets, and Summary Health Information. Business Associate may also disclose, in conformance with the HIPAA Regulations, PHI to Health Care Providers for permitted purposes including health care operations.

d. **Minimum Necessary and Limited Data Set**. Business Associate's use, disclosure or request of PHI shall utilize a Limited Data Set if practicable. Otherwise, Business Associate will make reasonable efforts to use, disclose, or request only the minimum necessary amount of PHI to accomplish the intended purpose.

B. **Disclosure to Plan and Employer (and their Subcontractors)**. Other than disclosures permitted by Section II.A.3 above, Business Associate will not disclose PHI to the Plan, its Plan administrator or Employer, or any business associate or subcontractor of such parties except as set forth in Section IX.

C. **Business Associate's Subcontractors and Agents**. Business Associate will require its subcontractors and agents to provide reasonable assurance, evidenced by a written contract that includes obligations consistent with this Agreement with respect to PHI.

D. **Reporting Non-Permitted Use or Disclosure, Breaches and Security Incidents**

1. **Non-permitted Use or Disclosure**. Business Associate will maintain a report of any use or disclosure of PHI not permitted by this Agreement of which Business Associate becomes aware and provide such report, periodically or upon request, to the Plan or its Plan administrator. Such report shall not include instances where Business Associate inadvertently misroutes PHI to a provider to

the extent the disclosure is not a Breach as defined under 45 CFR §164.402.

2. **Security Incidents**. Business Associate will report any Breach or security incidents of which Business Associate becomes aware. A security incident is an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, and involves only Electronic PHI that is created, received maintained or transmitted by or on behalf of Business Associate. The parties acknowledge and agree that this Section constitutes notice by Business Associate to Plan of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Plan shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

3. **Breach**. Business Associate will promptly, and without unreasonable delay, report to Plan any Breach of Unsecured PHI. Business Associate will cooperate with Plan in investigating the Breach and in meeting the Plan's obligations under applicable breach notification laws. In addition to providing notice to Plan of a Breach, Business Associate will provide any required notice to individuals and applicable regulators on behalf of Plan.

E. **Termination for Breach of Privacy Obligations**. Without limiting the rights of the parties set forth in the ASO agreement, each party will have the right to terminate this Agreement and the ASO Agreement if the other has engaged in a pattern of activity or practice that constitutes a material breach or violation of their obligations regarding PHI under this Agreement.

Prior to terminating this Agreement as set forth above, the terminating party shall provide the other with an opportunity to cure the material breach. If these efforts to cure the material breach are unsuccessful, as determined by the terminating party in its reasonable discretion, the parties shall terminate the ASO Agreement and this Agreement, as soon as administratively feasible. If for any reason a party has determined the other has breached the terms of this Agreement and such breach has not been cured, but the non-breaching party determines that termination of the Agreement is not feasible, the party may report such breach to the U.S. Department of Health and Human Services.

F. **Disposition of PHI**

1. **Return or Destruction Upon ASO Agreement End**. The parties agree that upon cancellation, termination, expiration or other conclusion of the ASO Agreement, destruction or return of all PHI, in whatever form or medium (including in any electronic medium under Business Associate's custody or control) is not feasible given the regulatory requirements to maintain and produce such information for extended periods of time after such termination. In addition, Business Associate is required to maintain such records to support its contractual obligations with its vendors and network providers and, as applicable, maintain Individual treatment records. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those consistent with applicable business and legal obligations for so long as Business Associate, or its subcontractors or agents, maintains such PHI. Business Associate may destroy such PHI in accordance with applicable law and its record retention policy that it applies to similar records.

2. **Exception When Business Associate Becomes Plan's Health Insurance Issuer**. If upon cancellation, termination, expiration or other conclusion of the ASO Agreement, Business Associate (or an affiliate of Business Associate) becomes the Plan's health insurance underwriter, then Business Associate shall transfer any PHI that Business Associate created or received for or from Plan to that part of Business Associate (or affiliate of Business Associate) responsible for health insurance functions.

3. **Survival of Termination**. The provisions of this Section II.F. shall survive cancellation, termination, expiration, or other conclusion of this Agreement and the ASO Agreement.

III.. ACCESS, AMENDMENT AND DISCLOSURE ACCOUNTING

A. Access

1. Business Associate will respond to an Individual's request for access to his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with 45 C.F.R. § 164.524.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of access under the HIPAA Regulations. Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Individual (or the Individual's personal representative), any PHI about the Individual created or received for or from the Plan in Business Associate's custody or control, so that the Plan may meet its access obligations under 45 C.F.R. § 164.524.

B. Amendment

1. Business Associate will respond to an Individual's request to amend his or her PHI as part of Business Associate's normal customer service functions, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in 45 C.F.R. § 164.526.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to amend under the HIPAA Regulations. Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will amend any portion of the PHI created or received for or from the Plan in Business Associate's custody or control, so that the Plan may meet its amendment obligations under 45 C.F.R. § 164.526.

C. Disclosure Accounting

1. Business Associate will respond to an Individual's request for an accounting of disclosures of his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to the Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in 45 C.F.R. § 164.528.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right to an accounting of disclosures under the HIPAA Regulations by performing the following functions so that the Plan may meet its disclosure accounting obligation under 45 C.F.R. § 164.528:

    a. **Disclosure Tracking**. Business Associate will record each disclosure that Business Associate makes of PHI, which is not excepted from disclosure accounting under Section III.C.2.b.

        i. The information about each disclosure that Business Associate must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 C.F.R. § 164.502(a)(2)(ii) or §164.512.

        ii. For repetitive disclosures of PHI that Business Associate makes for a single purpose to the same person or entity (including to the Plan or Employer), Business Associate may record (a) the Disclosure information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

    b. **Exceptions from Disclosure Tracking**. Business Associate will not be required to record Disclosure information or otherwise account for disclosures of PHI (a) for Treatment, Payment

or Health Care Operations, (b) to the Individual who is the subject of the PHI, to that Individual's personal representative, or to another person or entity authorized by the Individual (c) to persons involved in that Individual's health care or payment for health care as provided by 45 C.F.R. § 164.510, (d) for notification for disaster relief purposes as provided by 45 C.F.R. § 164.510, (e) for national security or intelligence purposes, (f) to law enforcement officials or correctional institutions regarding inmates, (g) that are incident to a use or disclosure that is permitted by this Agreement or the ASO Agreement, or (h) as part of a limited data set in accordance with 45 C.F.R. § 164.514(e).

c. **Disclosure Tracking Time Periods**. Business Associate will have available for the Plan the Disclosure information required by this Section III.C.2 for the six (6) years immediately preceding the date of the Plan's request for the Disclosure information.

d. **Provision of Disclosure Accounting**. Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will make available to the Plan, or at the Plan's direction to the Individual, the Disclosure information regarding the Individual, so the Plan may meet its disclosure accounting obligations under 45 C.F.R. § 164.528.

D. Confidential Communications

1. Business Associate will respond to an Individual's request for a confidential communication as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Regulations. If an Individual's request, made to Business Associate, extends beyond information held by Business Associate or Business Associate's subcontractors, Business Associate will inform the Individual to direct the request to the Plan, so that Plan may coordinate the request. Business Associate assumes no obligation to coordinate any request for a confidential communication of PHI maintained by other business associates of Plan.

2. In addition, Business Associate will assist the Plan in responding to requests by Individuals that are made to the Plan to invoke a right of confidential communication under the HIPAA Regulations. Upon receipt of written notice (includes faxed and emailed notice) from the Plan, Business Associate will begin to send all communications of PHI directed to the Individual to the identified alternate address so that the Plan may meet its access obligations under 45 C.F.R. § 164.522(b).

E. Restrictions

1. Business Associate will respond to an Individual's request for a restriction as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the Individual. Despite the fact that the request is not made to the Plan, Business Associate will respond to the request with respect to the PHI Business Associate and its subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Regulations.

2. In addition, Business Associate will promptly, upon receipt of notice from Plan, restrict the use or disclosure of PHI, provided the Business Associate has agreed to such a restriction. Plan and Employer understand that Business Associate administers a variety of different complex health benefit arrangements, both insured and self-insured, and that Business Associate has limited capacity to agree to special privacy restrictions requested by Individuals. Accordingly, Plan and Employer agree that it will not commit Business Associate to any restriction on the use or disclosure of PHI for Treatment, Payment or Health Care Operations without Business Associate's prior written approval.

IV.. SAFEGUARD OF PHI

A. Business Associate will develop and maintain reasonable and appropriate administrative, technical and physical safeguards, as required by Social Security Act § 1173(d) and 45 C.F.R. § 164.530(a) and (c) and as required by the HIPAA Regulations, to ensure and to protect against reasonably anticipated threats or hazards to the security or integrity of health information, to protect against reasonably anticipated unauthorized use or disclosure of health information, and to reasonably safeguard PHI from

any intentional or unintentional use or disclosure in violation of this Agreement.

B. Business Associate will also develop and use appropriate administrative, physical and technical safeguards to preserve the Availability of electronic PHI, in addition to preserving the integrity and confidentiality of such PHI. The "appropriate safeguards" Business Associate uses in furtherance of 45 C.F.R. § 164.530(c), will also meet the requirements contemplated by 45 C.F.R. Parts 160, 162 and 164, as amended from time to time.

V.. COMPLIANCE WITH STANDARD TRANSACTIONS

Business Associate will comply with each applicable requirement for Standard Transactions established in 45 C.F.R. Part 162 when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with the Plan.

VI.. INSPECTION OF BOOKS AND RECORDS

Business Associate will make its internal practices, books, and records relating to its use and disclosure of PHI created or received for or from the Plan available to the U.S. Department of Health and Human Services to determine Plan's compliance with the HIPAA Regulations or this Agreement.

VII.. MITIGATION FOR NON-PERMITTED USE OR DISCLOSURE

Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

VIII.. PLAN'S RESPONSIBILITIES

A. **Preparation of Plan's Notice of Privacy Practices**. Plan shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, upon Plan's or Employer's request, Business Associate will provide Plan with its NPP that Plan may use as the basis for its own NPP. Plan will be solely responsible for the review and approval of the content of its NPP, including whether its content accurately reflects Plan's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from Business Associate, the Plan shall not create any NPP that imposes obligations on Business Associate that are in addition to or that are inconsistent with the NPP prepared by Business Associate or with the obligations assumed by Business Associate hereunder.

B. **Distribution of Notice of Privacy Practice**. Plan shall bear full responsibility for distributing its own NPP as required by the HIPAA Regulations.

C. **Changes to PHI**. Plan shall notify Business Associate of any change(s) in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such change(s) may affect Business Associate's use or disclosure of such PHI.

D. **Minimum Necessary and Part 2**. Plan agrees to make commercially reasonable efforts to disclose only the minimum amount of PHI necessary, including such PHI that may be regulated under Part 2. Plan, to the extent that it operates as a Third Party Payer under Part 2, shall notify Business Associate of any information it transmits directly or indirectly to Business Associate that is subject to Part 2.

IX.. DISCLOSURE OF PHI TO THE PLAN, EMPLOYER AND OTHER BUSINESS ASSOCIATES

A. The following provisions apply to disclosures of PHI to the Plan, Employer and other business associates of the Plan.

1. **Disclosure to Plan**. Unless otherwise provided by this Section IX, all communications of PHI by Business Associate shall be directed to the Plan.

2. **Disclosure to Employer**. Business Associate may provide Summary Health Information regarding the Individuals in the Plan to Employer upon Employer's written request for the purpose either: (a) to obtain premium bids for providing health insurance coverage for the Plan, or (b) to modify, amend or terminate the Plan. Business Associate may provide information to Employer on whether an Individual is participating in the Plan or is enrolled in or has disenrolled from any insurance coverage offered by the Plan.

3. **Disclosure to Other Business Associates and Subcontractors**. Business Associate may disclose PHI to other entities or business associates of the Plan if the Plan authorizes Business Associate in writing to disclose PHI to such entity or business associate. The Plan shall be solely responsible for ensuring that any contractual relationships with these entities or business associates and subcontractors comply with the requirements of 45 C.F.R. § 164.504(e) and § 164.504(f).

X.. MISCELLANEOUS

A. **Agreement Term**. This Agreement will continue in full force and effect for as long as the ASO Agreement remains in full force and effect. This Agreement will terminate upon the cancellation, termination, expiration or other conclusion of the ASO Agreement.

B. **Automatic Amendment to Conform to Applicable Law**. Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement or to the ASO Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan, Employer, and Business Associate remain in compliance with such regulations, unless Business Associate elects to terminate the ASO Agreement by providing Employer notice of termination in accordance with the ASO Agreement at least thirty (30) days before the effective date of such final regulation or amendment to final regulations.

C. **Conflicts**. The provisions of this Agreement will override and control any conflicting provision of the ASO Agreement. All other provisions of the ASO Agreement remain unchanged by this Agreement and in full force and effect. This Agreement shall replace and supersede any prior business associate agreements executed between the parties relating to the ASO Agreement.

D. **No Third Party Beneficiaries**. The parties agree that there are no intended third party beneficiaries under this Agreement. This provision shall survive cancellation, termination, expiration, or other conclusion of this Agreement and the ASO Agreement.

E. **Interpretation**. Any ambiguity in this Agreement or the ASO Agreement or in operation of the Plan shall be resolved to maintain compliance with the HIPAA Regulations.

F. **References**. References herein to statutes and regulations shall be deemed to be references to those statutes and regulations as amended or recodified.

G. **Acknowledgement**. The parties acknowledge and agree that since the inception of ASO Agreement, which may precede this Agreement, Business Associate has acted and operated in accordance with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164, including Subpart E of 45 CFR Part 164), any applicable state privacy laws, any applicable state security laws and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the HITECH Act).

Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue

By: Kenneth Wetherington

Title: President

Date: 6-9-22