CITY COUNCIL AGENDA ITEM COVER MEMO

Agenda Item Number: _____

Meeting Type: Regular

Meeting Date: Sep 24, 2015

Action Requested By: Human Resources

Agenda Type: Resolution

Subject Matter:

Agreement between the City of Huntsville and Blue Cross and Blue Shield of Alabama for Administrative Services

Exact Wording for the Agenda:

Resolution authorizing the Mayor to execute the renewal agreement with Blue Cross and Blue Shield of Alabama for group health insurance administrative services.

Note: If amendment, Please state title and number of the original

Item to be considered for: Action

Unanimous Consent Required: No

Briefly state why the action is required; why it is recommended; what council action will provide, allow and accomplish and; any other information that might be helpful.

This contract is needed to provide for the yearly renewal of health claims administration for employees, retirees and dependents.

Associated Cost: _____

Budgeted Item: _____

MAYOR RECOMMENDS OR CONCURS: _____

Department Head: [signature]

Date: 9/14/15

ROUTING SLIP
CONTRACTS AND AGREEMENTS

Originating Department: Human Resouces

Council Meeting Date: 9/24/2015

Department Contact: Cindy Lehman

Phone # 256-427-5244

Contract or Agreement: Blue Cross and Blue Shield of Alabama Administrative Services Agreement

Document Name: Administrative Services Agreement between Blue Cross and Blue Shield of Alabama a...

City Obligation Amount:

Total Project Budget:

Uncommitted Account Balance:

Account Number:

Procurement Agreements

Select...	Select...

Grant-Funded Agreements

Select...	Grant Name:

Department	Signature	Date
1) Originating		9/14/15
2) Legal		9/16/15
3) Finance		9/16/15
4) Originating		
5) Copy Distribution		
a. Mayor's office (1 copies)		
b. Clerk-Treasurer (Original & 2 copies)		

Revised 04/15/2011

RESOLUTION NO. 15-____

WHEREAS Blue Cross and Blue Shield of Alabama currently administers the Bluecard PPO (PMD) option and the Alabama Personal Choice health insurance plans offered by the City of Huntsville; and

WHEREAS, the City of Huntsville desires to implement additional services and benefit changes, with the attached rates, effective January 1, 2016; and

WHEREAS, the City of Huntsville desires to continue its tobacco use policy requiring twelve (12) months of tobacco free certification to receive the non-tobacco rate; and

WHEREAS, the City of Huntsville desires to continue its Healthy Lifestyles Program for enrollment and participation in a Health Risk Assessment/Biometric Screening to receive the Wellness rate; and

WHEREAS, the City of Huntsville desires to renew and extend the Administrative Services Agreement with Blue Cross and Blue Shield of Alabama for the aforementioned health insurance plans for the period of October 1, 2016 through September 30, 2017; and

NOW, THEREFORE, BE IT RESOLVED by the City Council of the City of Huntsville, Alabama, that the Mayor be, and he is hereby authorized to enter into an Administrative Services Agreement between Blue Cross and Blue Shield of Alabama and City of Huntsville, on behalf of the City of Huntsville, a municipal corporation in the State of Alabama, which said agreement is substantially in words and figures similar to that certain document attached hereto and identified as an "Administrative Services Agreement between Blue Cross and Blue Shield of Alabama and City of Huntsville", consisting of twenty-seven (27) pages plus thirteen (13) pages consisting of related documents and the date of September 24, 2015, appearing on the margin of the first page, together with the signature of the President or President Pro Tem of the City Council, an executed copy of said document being permanently kept on file in the Office of the City Clerk-Treasurer of the City of Huntsville, Alabama.

ADOPTED this the 24th day of September, 2015.

_____
President of the City Council of
the City of Huntsville, Alabama

APPROVED this the 24th day of September, 2015.

_____
Mayor of the City of
Huntsville, Alabama

2016 Benefit Rates

Div.	Active Employees - Bi-Weekly	Employee	Employee + Spouse	Employee + Child(ren)	Family
005	PPO Plan - Wellness	$ 33.38	$ 73.67	$ 54.67	$ 86.12
000	PPO Plan Regular	$ 44.92	$ 85.21	$ 66.21	$ 97.66
T05	*PPO Plan Wellness Tobacco*	*$ 51.84*	*$ 92.13*	*$ 73.13*	*$ 104.58*
T00	*PPO Plan Regular Tobacco*	*$ 63.38*	*$ 103.67*	*$ 84.67*	*$ 116.12*
005	PCN Plan - Wellness	*$ 35.04*	*$ 77.14*	*$ 57.31*	*$ 90.26*
000	PCN Plan Regular	$ 46.58	$ 88.68	$ 68.85	$ 101.80
T05	*PCN Plan Wellness Tobacco*	*$ 53.50*	*$ 95.60*	*$ 75.77*	*$ 108.72*
T00	*PCN Plan Regular Tobacco*	*$ 65.04*	*$ 107.14*	*$ 87.31*	*$ 120.26*

Div.	Retirees - Monthly	Employee	Employee + Spouse	Employee + Child(ren)	Family
05M	PPO Plan- Wellness	*$ 284.78*	*$ 574.79*	*$ 425.61*	*$ 672.75*
07M	*PPO Plan - Wellness Retiree Official*	*$ 72.32*	*$ 159.62*	*$ 118.45*	*$ 186.59*
00M	PPO Plan Regular	$ 309.78	$ 599.79	$ 450.61	$ 697.75
04M	PPO Plan - Regular Retiree Official	$ 97.33	$ 184.62	$ 143.46	$ 211.60
T5M	*PPO Plan Wellness Tobacco*	*$ 324.78*	*$ 614.79*	*$ 465.61*	*$ 712.75*
T0M	*PPO Plan Regular Tobacco*	*$ 349.78*	*$ 639.79*	*$ 490.61*	*$ 737.75*
05M	PCN Plan - Wellness	*$ 290.54*	*$ 586.58*	*$ 434.68*	*$ 686.53*
00M	PCN Plan Regular	$ 315.54	$ 611.58	$ 459.68	$ 711.53
T5M	*PCN Plan Wellness Tobacco*	*$ 330.54*	*$ 626.58*	*$ 474.68*	*$ 726.53*
T0M	*PCN Plan Regular Tobacco*	*$ 355.54*	*$ 651.58*	*$ 499.68*	*$ 751.53*

Div.	COBRA - Monthly	Employee	Employee + Spouse	Employee + Child(ren)	Family
05S	PPO Plan - Wellness	*$ 491.77*	*$ 1,085.44*	*$ 805.42*	*$ 1,268.79*
00S	PPO Plan Regular	$ 516.77	$ 1,110.44	$ 830.42	$ 1,293.79
T5S	*PPO Plan Wellness Tobacco*	*$ 531.77*	*$ 1,125.44*	*$ 845.42*	*$ 1,308.79*
T0S	*PPO Plan Regular Tobacco*	*$ 556.77*	*$ 1,150.44*	*$ 870.42*	*$ 1,333.79*
05S	PCN Plan - Wellness	*$ 516.22*	*$ 1,136.55*	*$ 844.31*	*$ 1,329.90*
00S	PCN Plan Regular	$ 541.22	$ 1,161.55	$ 869.31	$ 1,354.90
T5S	*PCN Plan Wellness Tobacco*	*$ 556.22*	*$ 1,176.55*	*$ 884.31*	*$ 1,369.90*
T0S	*PCN Plan Regular Tobacco*	*$ 581.22*	*$ 1,201.55*	*$ 909.31*	*$ 1,394.90*

President of the City Council of the
City of Huntsville, Alabama
Date: _____

City of Huntsville
2016 Tobacco Use Certification Policy

Effective January 1, 2016, City of Huntsville group health plan subscribers who use tobacco products will be charged an additional $40 per month in health insurance premiums.

If you and/or your spouse and/or dependent, if covered under the City's health insurance plan, smokes or uses tobacco products, you will pay a surcharge of $40 per month for employee-only coverage, employee plus spouse, employee plus children or family coverage.

What is a Tobacco Product? Tobacco products are defined as: The product made or derived from tobacco that is intended for human consumption, including any component, part or accessory of a Tobacco Product. Tobacco Product includes but is not limited to cigarettes, cigars, pipes, water pipes (hookah), bidis, kreteks, electronic nicotine delivery systems (ENDS), electronic cigarettes, certain dissolvables, gels, smokeless tobacco, snuff, and chewing tobacco.

You will be charged the tobacco user surcharge, unless you certify no one covered under your City of Huntsville group health insurance uses tobacco products and no one has used tobacco products within the past twelve (12) months. However, you can qualify for the non-tobacco premium rate if you and/or your spouse and/or dependent satisfactorily completes the tobacco cessation program offered by the City's group health plan, the tobacco cessation program offered by the City's Health & Wellness Center administered by CareHere, or another tobacco cessation program as approved by the City's Insurance & Benefits office. Please note that if it is unreasonably difficult due to a medical condition for you and/or your spouse and/or dependent to qualify for the regular premium rate or if it is medically inadvisable for you and/or your spouse and/or dependent to attempt to achieve the standards to qualify for the regular premium rate under the group health plan, please contact the City's Insurance & Benefits office who will work with you to develop a reasonable alternative standard to qualify for the regular premium rate.

You are required to certify your tobacco use status and/or your covered spouse and/or dependent's tobacco use status every year. You are also required to resubmit a Tobacco Use Certification form if you and/or your covered spouse and/or dependent's tobacco use status changes during the year. All subscribers who enroll in the City's group health plan must certify their tobacco use status and/or their covered spouse and/or dependent's tobacco use status by completing the Tobacco Use Certification form.

Please Note: All subscribers must submit certification concerning their tobacco use to the City's Insurance & Benefits Office annually during the Open Enrollment period. Be sure to keep a copy of the completed Tobacco User Certification form for your records.

If you, your covered spouse and/or dependent desire to participate in an approved tobacco cessation program, you can contact the following:
City of Huntsville Health & Wellness Center (Tobacco Cessation Coach) at 1-877-866-6430
Blue Cross and Blue Shield of Alabama (Quit for Life Program) at 1-888-768-7848

It is your responsibility to contact an approved tobacco cessation program and sign up for tobacco cessation classes. For tobacco cessation programs, other than the tobacco cessation programs offered by Blue Cross and Blue Shield of Alabama or by the City's Health & Wellness Center administered by CareHere, you may incur a fee which is not covered by the City of Huntsville's group health plan.

2016 TOBACCO USE CERTIFICATION FORM

Subscriber Name: _____ ID # (or last 4 digits of SSN): _____
(Please Print)

NON-TOBACCO USE CERTIFICATION

☐ **By checking this box, I certify that I am eligible for the regular premium rate.**

I certify that myself and/or my spouse and/or eligible dependent(s), covered on my health insurance plan, are not currently using any tobacco products as defined in the Tobacco Use Certification Policy and have not used any tobacco products within the last twelve (12) months; or have completed a tobacco cessation program within the last twelve (12) months and no longer use tobacco products; or otherwise qualify based upon a reasonable alternative standard.

I certify that this information is true and correct to the best of my knowledge and that misrepresentation or falsification of information is grounds for disciplinary actions in accordance with Section 13 of the City of Huntsville's personnel policies and procedures.

I understand that if it is determined that I or my covered spouse or dependent(s) have used tobacco products within the last twelve (12) months, I will immediately be required to pay the tobacco user premium rate for the remainder of the current year and I will be charged the tobacco user premium rate retroactively to January 1st, or to the date my coverage became effective if after January 1st, or from the date I did not pay the surcharge.

I certify that if this information changes at any time during the upcoming year, while I have group health coverage through the City of Huntsville, I will notify the City's Insurance & Benefits office of such change within 30 days through completion and re-submission of this form.

I understand that if it is determined that I and/or my covered spouse and/or eligible dependent(s) start using tobacco products subsequent to the date of this certification and I do not notify the City's Insurance & Benefits office, I will immediately be required to pay the tobacco user premium rate for the remainder of the current year.

Subscriber's Signature: _____ Date: _____

TOBACCO USE CERTIFICATION

☐ **By checking this box, I certify that I am NOT eligible for the regular premium rate.**
I certify that one or more persons covered under my group health insurance plan with the City of Huntsville uses tobacco products in some form or that I choose not to disclose my status as it relates to tobacco use.

I understand that if myself and/or my covered spouse and/or dependent(s) who are tobacco users complete a tobacco cessation program offered by the group health plan, by the City's Health & Wellness Center administered by CareHere, another tobacco cessation program as approved by the City's Insurance & Benefits office, or complete an approved reasonable alternative standard, then I will be eligible for the regular premium rate for the remainder of the plan year.

Subscriber's Signature: _____ Date: _____

City of Huntsville Healthy Lifestyles Program
Enrollment Form: Plan Year 2016

Member Name (Please Print)	☐ Male	☐ Employee
Employee ID # (or Last 4 digits of Social Security #)	☐ Female	☐ Retiree
Phone Number	Date of Birth	☐ COBRA Participant

A. Participation Election

☐ **I want to participate** in the City of Huntsville Healthy Lifestyles Program.

Health Screenings are performed by health professionals. Screenings include a personal risk assessment questionnaire; measurement of blood pressure, heart rate, body fat, height and weight; blood profile including lipids plus glucose; and one-on-one consultation with a health professional.

I understand that my election to participate in the health screening is completely voluntary and that my personal blood profile will be kept completely confidential. I also understand that my participation in the health screening will adjust my premium contributions.

I further understand that until I complete the standard required for the Wellness rate, my premium contribution for 2016 will reflect the non-wellness/Regular rate. Once I complete the standard, my premium contribution will be changed to reflect the Wellness participation rate effective the first of the month following confirmation of completion.

Signature: _____ Date: _____

B. Participation Waiver

☐ **I do not want to participate** in the City of Huntsville Healthy Lifestyles Program.

Signature: _____ Date: _____

Please Return Completed Form to:

City of Huntsville, Benefits Office
PO Box 308
Huntsville, AL 35804
Fax: (256) 427-5078

City of Huntsville Healthy Lifestyles Program

The City of Huntsville recognizes that individuals who practice healthy behaviors are the key to holding down rising health care costs. While we realize it is not our role to manage every aspect of your health, we do know that we can make a difference for many individuals. Therefore, those taking steps to achieve a healthier lifestyle are rewarded. If you do not elect to participate you are not penalized. Instead, the City will reward those who work hard at their health with the Healthy Lifestyles Program. The 2016 Healthy Lifestyles Program provides an opportunity to receive a discount of up to $300 for the 2016 plan year.

- For the 2016 plan year, the City of Huntsville is offering a Wellness discount of $25 per month off the group health plan regular rate. Members can receive the Wellness discount by enrolling in the Healthy Lifestyles Program and participating in the Health Risk Assessment and Biometric Screening (HRA/BioS).
- The HRA/BioS can be completed at a City of Huntsville HRA event offered during November and December of 2015, by appointment at the City's Health & Wellness Center, or with a City of Huntsville designated healthcare professional. The results of the HRA/BioS screening are strictly confidential.
- If it is unreasonably difficult, due to a medical condition, for you to achieve the standard for reward under this program, or if it is medically inadvisable for you to attempt to achieve the standard for the reward under this program, you may contact the City's Insurance & Benefits office at (256) 427-5240 and we will work with you to develop another way to qualify for this reward.
- **New for the 2016 plan year** - The reduced Wellness rate will be applied upon completion of the HRA/BioS, or an alternate standard. *To receive the Wellness discount beginning January 1, 2016, you must complete the HRA/BioS, or an alternate standard, no later than December 18, 2015.* Enrollees who complete the HRA/BioS, or an alternate standard, after December 18, 2015 will receive the Wellness discount effective the 1st of the month following confirmation of completion.
- If you do not enroll in the Healthy Lifestyles Program by completing and returning this form, you will not be eligible for the Wellness discount for the 2016 plan year and the group health plan regular rate will apply for the 2016 plan year.

How do I sign up to participate in the Healthy Lifestyles Program?

Enroll: Sign the Enrollment Form on the reverse side indicating that you wish to participate in the City of Huntsville Healthy Lifestyles Program. If enrolling as a new employee or newly eligible to participate, you must return the Healthy Lifestyles Program enrollment form within 30 days of benefit eligibility. If enrolling during the Open Enrollment Period, this form must be returned to Human Resources by **November 2, 2015** to participate for the 2016 plan year.

Schedule an appointment: The HRA/BioS can be completed at a City-sponsored HRA Event, at the City's Health & Wellness Center administered by CareHere, or with a City of Huntsville designated healthcare professional.

Questions: Direct questions about the Healthy Lifestyles Program benefit to the Insurance & Benefits Office at (256) 427-5240, or email your questions to HR-Benefits@huntsvilleal.gov.

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Amendment to Enrollment Agreement

This is to amend the Enrollment Agreement of an existing Group Plan(s) administered by
Blue Cross and Blue Shield of Alabama
(the "Claims Administrator")
for
The City Of Huntsville
(the "Employer"),
a Self Funded group, effective January 01, 2016
Group Number(s): **02576**

Group Name:	City Of Huntsville	Financial:	Self Funded
Group Number:	02576	Divisions:	All
Corporate Code:	290920001	Renewal:	Renewal
Effective Date:	1/1/2016		

PHYSICAL ADDRESS

Address 1:	308 Fountain Cir SW	City:	Huntsville
Address 2:		State:	AL
County:	Madison	Zip:	35801-4240
County Code:			

BILLING ADDRESS

Address 1:	308 Fountain Cir SW	City:	Huntsville
Address 2:	Po Box 308	State:	AL
County:		Zip:	35801-4240

GROUP CONTACTS

	Sal.	Name	Title	Telephone
Billing:	Ms	Cynthia Lehman	Insurance & Benefits Mgr	(256) 427-5244
Benefits:	Ms	Cynthia Lehman	Insurance & Benefits Mgr	(256) 427-5244
Decision:	Mr	Byron Thomas	Director of HR	(256) 427-5240

BCBSAL REPRESENTATIVES

	Name	Telephone	Email
District Sales Rep:	James Watkins	256-726-9101	mwatkins@bcbsal.org
District Account Manager:			
District Service Rep:	Becky McCartha	205-220-7954	RMcCartha@bcbsal.org

County:
Group IRS ID Number: 636001296

Benefit Changes

Inpatient Hospital Precertification Penalties
The inpatient hospital precertification section of the plan(s) is hereby amended to delete the provisions related to inpatient hospital precertification penalties and to replace them with the following inpatient hospital precertification provisions:

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

Precertification of Physician-Administered Drugs
The plan(s) is hereby amended by adding the following precertification requirements to physician-administered drugs:

Precertification (also sometimes referred to as prior authorization) is required for certain physician-administered drugs. You can find a list of the physician-administered drugs that require precertification at AlabamaBlue.com/web/pharmacy/drugguide.html. This list will be updated monthly.

Physician-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility or physician's office. Physician-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the physician-administered drug.

The plan(s) is hereby amended by adding the following additional precertification provisions:

Outpatient Hospital Benefits, Physician Benefits and Other Covered Services
Precertification is required for certain outpatient hospital benefits, physician benefits and other covered services. The benefit booklet lists these services that require precertification at the time of the printing of this booklet. You can find a list of the additional outpatient hospital benefits, physician benefits and other covered services that require precertification at AlabamaBlue.com/precert. This list will be updated

quarterly. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

If precertification is not obtained, no benefits will be payable under the plan.

Update of Compound Drug Definition
The Prescription Drug Benefits section of the plan(s) is hereby amended to delete the paragraph related to compound drugs and replace it with the following new compound drug paragraph to read as follows:

Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as the highest cost-sharing non-specialty drug Tier.

Administrative Information

Health Coverage Reporting
Employer will prepare and file Forms 1094-B and 1095-B (Minimum Essential Coverage Reporting) with respect to coverage for Employer's members as required under the ACA. Employer will prepare and file Forms 1094-C and Forms 1095-C (Employer Shared Responsibility Reporting for all employers with 50 or more full-time equivalent employees in the previous calendar year).

Special Instructions

Effective January 1, 2016:

1. Change the In network physician office visit and outpatient consultations copay from $25.00 to $30.00.
2. Change the Individual out of pocket (OOP) max from $2,500.00 to $3,000.00, no change to the family OOP max.
3. Pharmacy copays for Diabetic Insulin/medications will have a $25.00 copay per prescription regardless of Tier.
4. Administrative fees for 10/1/15 through 9/30/17 are $39.00 per contract per month (PCPM).
5. Interface fee of $0.75 PCPM for MH/SA carve out will be waived 10/01/2015 – 09/30/2016.

6. Drug Exclusion Strategy

The group elects to participate in the drug exclusion strategy that includes the following drug categories:

- Androgen/Anabolic Steroids
- Doxycycline/Minocycline
- Growth Hormones
- Insomnia
- Nasal Steroids
- Test Strips

- Topical Antibiotics
- Topical Retinoids

There is not an opportunity to customize.

All other arrangements remain the same.

Customer Signature Decision Maker or Other Authorized Representative	Mike Watkins / R McCarthe Blue Cross and Blue Shield of Alabama Representative
Mayor, City of Huntsville Title	Account Executive Title
9-24-2015 Date	9-17-15 Date

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Amendment to Enrollment Agreement

This is to amend the Enrollment Agreement of an existing Group Plan(s) administered by
Blue Cross and Blue Shield of Alabama
(the "Claims Administrator")
for
The City Of Huntsville
(the "Employer"),
a **Self Funded group, effective January 01, 2016**.
Group Number(s): **29092**

Group Name:	**The City Of Huntsville**	**Financial:**	**Self Funded**
Group Number:	**29092**	**Divisions:**	**All**
Corporate Code:	**290920001**	**Renewal:**	**Renewal**
Effective Date:	**1/1/2016**		

PHYSICAL ADDRESS

Address 1:	**308 Fountain Cir SW**	**City:**	**Huntsville**
Address 2:		**State:**	**AL**
County:	**Madison**	**Zip:**	**35801-4240**
County Code:			

BILLING ADDRESS

Address 1:	**308 Fountain Cir SW**	**City:**	**Huntsville**
Address 2:	**Po Box 308**	**State:**	**AL**
County:		**Zip:**	**35801-4240**

GROUP CONTACTS

	Sal.	Name	Title	Telephone
Billing:	**Ms**	**Cynthia Lehman**	**Insurance & Benefits Mgr**	**(256) 427-5244**
Benefits:	**Ms**	**Cynthia Lehman**	**Insurance & Benefits Mgr**	**(256) 427-5244**
Decision:	**Mr**	**Byron Thomas**	**Director of HR**	**(256) 427-5240**

BCBSAL REPRESENTATIVES

	Name	Telephone	Email
District Sales Rep:	**James Watkins**	**256-726-9101**	**mwatkins@bcbsal.org**
District Account Manager:			
District Service Rep:	**Becky McCartha**	**205-220-7954**	**RMcCartha@bcbsal.org**

County:
Group IRS ID Number: 636001296

Benefit Changes

Inpatient Hospital Precertification Penalties
The inpatient hospital precertification section of the plan(s) is hereby amended to delete the provisions related to inpatient hospital precertification penalties and to replace them with the following inpatient hospital precertification provisions:

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

For precertification call 1-800-248-2342 (toll-free).

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

Precertification of Physician-Administered Drugs
The plan(s) is hereby amended by adding the following precertification requirements to physician-administered drugs:

Precertification (also sometimes referred to as prior authorization) is required for certain physician-administered drugs. You can find a list of the physician-administered drugs that require precertification at AlabamaBlue.com/web/pharmacy/drugguide.html. This list will be updated monthly.

Physician-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility or physician's office. Physician-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.

If precertification is not obtained, no benefits will be payable under the plan for the physician-administered drug.

The plan(s) is hereby amended by adding the following additional precertification provisions:

Outpatient Hospital Benefits, Physician Benefits and Other Covered Services
Precertification is required for certain outpatient hospital benefits, physician benefits and other covered services. The benefit booklet lists these services that require precertification at the time of the printing of this booklet. You can find a list of the additional outpatient hospital benefits, physician benefits and other covered services that require precertification at AlabamaBlue.com/precert. This list will be updated quarterly. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

If precertification is not obtained, no benefits will be payable under the plan.

Update of Compound Drug Definition
The Prescription Drug Benefits section of the plan(s) is hereby amended to delete the paragraph related to compound drugs and replace it with the following new compound drug paragraph to read as follows:

Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as the highest cost-sharing non-specialty drug Tier.

Administrative Information

Health Coverage Reporting
Employer will prepare and file Forms 1094-B and 1095-B (Minimum Essential Coverage Reporting) with respect to coverage for Employer's members as required under the ACA. Employer will prepare and file Forms 1094-C and Forms 1095-C (Employer Shared Responsibility Reporting for all employers with 50 or more full-time equivalent employees in the previous calendar year).

Special Instructions

Effective January 1, 2016:

1. Change the physician office visit and outpatient consultations copay from $25.00 to $30.00.
2. Change the individual out of pocket (OOP) max from $3,000.00 to $3,500.00, no change to the family OOP max.
3. Change Point of Sale pharmacy arrangement, member will now pay their coinsurance and/or deductible at the time of purchase.
For example, Tier 2 drugs, member will pay 20% of the allowance subject to the Calendar Year Deductible. Tier 3 drugs, member will pay 35% of the allowance subject to the Calendar Year Decutible at the pharmacy.
Member will no longer need to file paper pharmacy claim for reimbursement for Tier 2 and 3 drugs.
Tier 1 drugs will remain covered at 100% of the allowance after a $10.00 copay.
4. Pharmacy copays for Diabetic Insulin/Medications will have a flat $25.00 copay per prescription regardless of Tier.
5. Administrative fees for 10/1/15 through 9/30/17 are $39.00 per contract per month.
6. Interface fee of $0.75 PCPM for MH/SA carve out will be waived 10/01/2015 – 09/30/2016.

7. Drug Exclusion Strategy

The group elects to participate in the drug exclusion strategy that includes the following drug categories:

- Androgen/Anabolic Steroids
- Doxycycline/Minocycline
- Growth Hormones
- Insomnia
- Nasal Steroids
- Test Strips
- Topical Antibiotics
- Topical Retinoids

There is not an opportunity to customize.

All other arrangements remain the same.

	Mike Watkins / R McCatha
Customer Signature Decision Maker or Other Authorized Representative	Blue Cross and Blue Shield of Alabama Representative
Mayor, City of Huntsville	Account Executive
Title	Title
9-24-2015	9-17-15
Date	Date

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

City of Huntsville
Group 29092 and 02576
Effective: October 1, 2015

Original Effective Date: April 1, 1990

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

and

City of Huntsville
308 Fountain Circle
Huntsville, Alabama 35801
(herein called the Employer)

ARTICLE I - INTRODUCTION

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

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

ARTICLE II - ALLOCATION OF ADMINISTRATIVE DUTIES

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

A. Eligibility and Enrollment

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

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

3. Other.

   a. The Claims Administrator will rely on eligibility information submitted by the Employer as satisfying the terms of the Plan and the requirements of the Medicare Secondary Payer

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

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

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

B. Customer Service

The Claims Administrator will provide Members with access to a toll-free Customer Service phone number during the hours of 8:00 a.m. to 5:00 p.m., central time, on days during which the Claims Administrator is open for business. Customer Service will respond to requests from Members concerning claims processing and adjudication and will coordinate - when necessary - requests for information that involve other departments of the Claims Administrator.

C. Benefit Booklet (Summary Plan Description)

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

2. Employer's Duties. The Employer acknowledges and understands that it is the plan administrator and plan sponsor of the Plan under applicable law and/or the terms of the Plan. Among other things, this imposes upon the Employer the sole legal responsibility to (i) prepare the benefit booklet, (ii) determine whether the benefit booklet distributed to Plan participants satisfies applicable legal requirements, (iii) ascertain that the booklet accurately and fully describes the benefits that the Employer intends the Claims Administrator to provide or administer, and (iv),

distribute the booklet in a timely fashion and appropriate manner to Plan participants. Nothing in this Agreement and no actions taken by the Claims Administrator are intended to delegate any of the Employer's responsibilities under the Plan or applicable law to the Claims Administrator.

D. Required Reports

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

   Claims Administrator's Pharmacy Benefit Manager ("PBM") may require payment for any non-standard prescription drug reports requested by Employer. Employer agrees to pay to Claims Administrator any additional PBM fees related to such non-standard reports.

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

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

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

E. Claims Processing and Adjudication

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

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

F. Appeals

1. Administrative Appeals

   a. Claims Administrator's Duties The Claims Administrator will exercise the discretionary authority to review denied claims and if applicable, follow the requirements under the

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

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

2. Affordable Care Act External Reviews

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

G. Managed Care Services

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

H. Actuarial Services

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

I. COBRA

1. Claims Administrator's Duties. The Claims Administrator will receive monthly COBRA premium payments directly from Members to whom the Employer has offered COBRA coverage and who have elected to purchase such coverage. Upon receipt of timely premium payments in the applicable amount certified by the Employer, the Claims Administrator will provide COBRA benefits to qualified beneficiaries for the shorter of (i) the period of time such benefits are required to be provided under COBRA, or (ii), the period of time this Agreement remains in effect.

2. Employer's Duties. The Employer will determine whether a Member is entitled to continue coverage under COBRA and will provide the required notices and COBRA application form to a Member who is so entitled. The Employer will determine the amount of the monthly COBRA premium and notify the Claims Administrator of that amount pursuant to a procedure to be agreed upon by the Employer and the Claims Administrator.

J. HIPAA Privacy and Security

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

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

K. National Medical Support Notices

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

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

L. Subrogation

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

M. Litigation Involving the Plan

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

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

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

N. Stop-Loss Insurance

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

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

O. Employer as Plan Sponsor

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

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

ARTICLE III - FINANCIAL ARRANGEMENT

A. Payment Procedures

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

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

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

B. Cost of Claims

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

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

1. Net Subrogation Recoveries: The net amount recovered through Subrogation will be credited against the Cost of Claims.

2. Access Fees: Access fees, if applicable under Article V, will be added to the Cost of Claims.

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

4. Prescription Drug Rebates: The Claims Administrator contracts with a Pharmacy Benefit Manager (PBM) to provide PBM services. Some manufacturers of prescription drugs currently provide volume rebates on their drugs to the PBM, a portion of which will be credited by the Claims Administrator towards the Cost of Claims. In no case will the rebates alter the paid amount of any individual Claim.

C. Administrative Charges

Effective October 1, 2015 through September 30, 2017, the employer will pay the claims administrator a monthly Administrative charge of $39.00 per covered contract holder or former contract holder for health (excluding any credits for prescription drug rebates and any charges for access fees). In addition, the Claims Administrator retains the Administrative Charge permitted to be charged under the COBRA regulations and paid by the COBRA contract holder.

Claims Administrator's Pharmacy Benefit Manager ("PBM") may require payment for any non-standard prescription drug reports requested by Employer. Employer agrees to pay to Claims Administrator any additional PBM fees related to such non-standard reports.

D. Run-out

Effective October 1, 2015 through September 30, 2017, in the event of termination of this Agreement, the Employer will pay the Claims Administrator for the Cost of Claims on all claims that were incurred, but not paid by the Claims Administrator before the effective date of the termination of this Agreement. This provision will apply to all claims originally filed within the timely filing period set forth in the Plan as in effect prior to termination of this Agreement. In addition, the Employer will pay the Claims Administrator an Administrative Charge of 5.9% of the Cost of Claims for health during the run-out period. The Cost of Claims and Administrative Charge will be paid on the same basis as set forth in Article III.A.

E. Quit for Life Tobacco Cessation Program

The Claims Administrator contracts with a third party to provide telephonic tobacco cessation counseling with nicotine replacement therapy (NRT). The Employer will pay the Claims Administrator a separate charge per participant in the program of $157 for five counseling sessions, self-help materials, and 12 months of unlimited inbound calls for members who currently use tobacco or who have recently quit and need additional support. In addition, the Employer will pay the Claims Administrator a separate charge per participant for nicotine replacement therapy of: $130 for an eight week supply of 21 mg nicotine patches, $140 for an eight week supply of 14 or 7 mg nicotine patches, $150 for an eight week supply of 4 or 2 mg nicotine gum, and $150 for an eight week supply of 4 or 2 mg nicotine lozenges. Pricing for the NRT program is under a contractual agreement with the Quit for Life program and is subject to change at the discretion of Free and Clear. Free and Clear/Alere Wellbeing is the company that administers the American Cancer Society Quit For Life program.

All NRT products (patch, gum or lozenge) are subject to NRT sales/use tax when purchased in the states of Washington, Indiana and Oklahoma. The sales/use tax rate is based upon the city, county and state where the member actually resides. Currently, the tax rate for the above mentioned states varies from 4-11%. Our group billing process will not itemize the sales/use tax charges. Rather, the sales/use tax will be incorporated into the total NRT charges for that member. A slight variation in charges may be noticed for members who reside in the affected states.

ARTICLE IV - CLAIMS AUDITS

A. Purpose

The following rules are designed to:

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

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

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

4. Facilitate the protection of individually identifiable health information.

B. Employer's Audit Rights

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

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

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

4. The Employer understands and acknowledges that information, data, documentation, or software disclosed by the Claims Administrator in the course of or related to the audit contains individually identifiable health information about Plan Members ("Member Health Data") as well as information that is proprietary to the Claims Administrator's business operations ("Proprietary Data"). The Employer further understands and acknowledges that all Proprietary Data is confidential and a valuable trade secret of the Claims Administrator, and that any disclosure or use of such data for any purpose other than to evaluate the accuracy of the Claims Administrator's processing of Claims under this Agreement will cause irreparable harm and loss to the Claims Administrator. Proprietary Data includes, but is not limited to, UCR limits, negotiated provider payments, hospital per-diems, retroactive reimbursement mechanisms, and other negotiated terms between the Claims Administrator and hospital and medical providers. In view of the foregoing, the Employer agrees that neither it nor the Auditors shall release or disclose to any third party any data or information obtained from the Claims Administrator during the course of the audit without first affording the Claims Administrator the opportunity to determine whether such data or information includes any Proprietary Data. This information does not apply to information that 1) was previously known to recipient; 2) is or becomes publicly

available through no fault of recipient; 3) is disclosed to recipient by a third party having no obligation of confidentiality to discloser relating to such Confidential Information; 4) is independently configured by recipient; or 5) is required to be disclosed as a matter of law. If it does, the Claims Administrator may require the removal of Proprietary Data from the material to be released or disclosed.

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

C. Procedures for Audits of Claims

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

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

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

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

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

ARTICLE V - GENERAL PROVISIONS

A. Delegation of Discretionary Authority

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

Except as provided in sections II(E) and II(F) herein, whenever the Claims Administrator makes reasonable determinations that are neither arbitrary nor capricious in its administration of the Plan, those determinations will be final and binding on the Plan's participants or beneficiaries, subject only to applicable rights of review under the Plan and thereafter to judicial review to determine whether the Claims Administrator's determination was arbitrary or capricious.

B. Indemnification and Reliance on Employer Directions

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

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

C. Late Payment

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

Charges are "late" each day a check in the proper amount, which is not returned for any reason, is not received by the Claims Administrator.

D. Premium Taxes

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

E. Affordable Care Act Fees and Taxes

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

F. Changes in Agreement

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

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

G. Notices

1. Any notice given by the Claims Administrator under this Agreement shall be sufficient and effective for all purposes if and when mailed to the Employer at the following address: City of Huntsville, 308 Fountain Circle, Huntsville, AL 35801, ATTN: Byron Thomas, Director of Human Resources.

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

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

H. Out-of-Area Services

Blue Cross and Blue Shield of Alabama has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area Blue Cross and Blue Shield of Alabama serves, the claims for those services may be processed through one of these Inter-Plan Programs and presented to Blue Cross and Blue Shield of Alabama for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this agreement are described generally below.

Typically, Members, when accessing care outside the geographic area we serve, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

I. BlueCard® Program

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible to Employer for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard® Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

1. Liability Calculation Method Per Claim

The calculation of Member liability on Claims for covered healthcare services processed through the BlueCard® Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to us by the Host Blue.

The calculation of your liability on Claims for covered healthcare services processed through the BlueCard® Program will be based on the negotiated price made available to us by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services.

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

(a) the actual price. An actual price is a negotiated payment without any other increases or decreases, or

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

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

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

If a Host Blue uses either an estimated price or an average price on a claim, it may also hold some portion of the amount that you pay in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from you. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. Some Host Blues may retain interest earned, if any, on funds held in variance accounts.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge.

Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, we would then calculate Member liability and your liability in accordance with applicable law.

2. Returns of Overpayments

Under the BlueCard® Program, recoveries from a Host Blue or from participating healthcare providers can arise in several ways including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a Claim-by-Claim or prospective basis.

3. BlueCard® Program Fees and Compensation

Employer understands and agrees to reimburse Blue Cross and Blue Shield of Alabama for certain fees and compensation which we are obligated under the BlueCard® Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard® Program vendors, as described below. Fees and compensation under the BlueCard® Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any groups. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with your benefit period under this agreement.

Blue Cross and Blue Shield of Alabama will charge these fees as follows:

Only the BlueCard® Program access fee may be charged separately each time a claim is processed through the BlueCard® Program. If one is charged, it will be a percentage of the discount/differential Blue Cross and Blue Shield of Alabama receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed $2,000 for any claim. All other BlueCard® Program-related fees are included in our general administrative fee.

In addition to the access fee described above, the applicable general administrative fee is noted in Article III C.

4. Negotiated National Account Arrangements

As an alternative to the BlueCard® Program, your Member claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

If Blue Cross and Blue Shield of Alabama and you have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this agreement, then the terms and conditions set forth in Blue Cross and Blue Shield of Alabama negotiated National Account arrangement(s) with such Host Blue(s) shall apply. Employer agrees that the relevant participation agreement describes Blue Cross and Blue Shield of Alabama's responsibility in connection with the processing and payment of claims when Blue Cross and Blue Shield of Alabama Members access such networks.

Member Liability Calculation

Member liability calculation will be based on the negotiated price/lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section I.1.) made available to Blue Cross and Blue Shield of Alabama by the Host Blue that allows your Members access to negotiated participation agreement networks of specified participating healthcare providers outside of Blue Cross and Blue Shield of Alabama service area.

Fees and Compensation

Employer understands and agrees to reimburse Blue Cross and Blue Shield of Alabama for certain fees and compensation which we are obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by any groups. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with your benefit period under this agreement.

In addition, the participation agreement with the Host Blue may provide that Blue Cross and Blue Shield of Alabama must pay an administrative and/or a network access fee to the Host Blue, and you further agree to reimburse Blue Cross and Blue Shield of Alabama for any such applicable administrative and/or network access fees. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard® Program.

5. Non-Participating Healthcare Providers Outside Claims Administrator's Service Area

Member Liability Calculation

a. In general, when covered healthcare services are provided outside of the Blue Cross and Blue Shield of Alabama service area by non-participating healthcare providers, the amounts a Member pays for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by

applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

b. Exceptions. In some exception cases, we may pay such claims based on the payment we would make if we were paying a non-participating provider inside of our service area, as described elsewhere in this agreement, where the Host Blue's corresponding payment would be more than our in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In other exception cases, Blue Cross and Blue Shield of Alabama may pay claims from non-participating healthcare providers outside of our service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by us in our sole and absolute discretion or by applicable state law. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this paragraph.

Fees and Compensation

No additional fees would apply for utilization of a non-participating provider. All non-par associated fees are included in the general administrative fee.

J. Blue Distinction Centers and Blue Distinction Centers+

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

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

ARTICLE VI - TERMINATION OF AGREEMENT

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

ARTICLE VII - DEFINITIONS

The defined terms in this Agreement are as follows:

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

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

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

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

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

"Employer" means City of Huntsville (including subsidiaries) and any corporate successor thereto.

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

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

"Plan" means the City of Huntsville Group Medical Plan established by City of Huntsville having an effective date of April 1, 1990, as said Plan may be amended from time to time. The written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator consist of this Agreement, the Group Enrollment or Implementation Agreement, and the benefit booklet prepared by the Claims Administrator that will serve as the Summary Plan Description in accordance with Article II, Section C. Pending finalization of the benefit booklet, the written instruments evidencing the benefits and terms of the Plan to be administered by the Claims Administrator will also consist of the standard benefit language maintained by the Claims Administrator for the type of plan established by the Employer, and any draft benefit booklets treated as operative by the Claims Administrator in accordance with Article II, Section C.

ARTICLE VIII - EXECUTION

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

BLUE CROSS AND BLUE SHIELD OF ALABAMA

By Rebekah Elgin-Council

Date 9.21.15

Rebekah Elgin-Council

Vice President, Marketing

City of Huntsville

By_____ Date _____

Title_____

Company Name	City of Huntsville
Group Number(s)	29092 + 02576

BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of the Effective Date by and among Plan, Business Associate and Plan Sponsor. For purposes of this Agreement, all capitalized terms contained in this Agreement, not otherwise defined herein, shall have the meanings ascribed to them in Schedule A, attached hereto and made a part hereof.

RECITALS:

A. Business Associate provides Administrative Services to Plan.

B. Plan Sponsor sponsors Plan and provides Plan Administrative Services to Plan. In the performance of the Plan Administrative Services, Plan Sponsor requires access to PHI.

C. HIPAA Rules and Plan require that Business Associate comply and Business Associate is willing to comply with the HIPAA Rules in connection with the performance of the Administrative Services, all upon the terms and conditions set forth herein.

D. Plan also desires that Business Associate disclose and Business Associate is willing to disclose Summary Health Information, enrollment/disenrollment information and PHI to Plan Sponsor and Designated Plan Sponsor Employees upon the terms and conditions set forth herein.

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

1. **Term**. The term of this Agreement shall commence on the Effective Date and shall continue for so long as Business Associate is providing the Administrative Services, unless earlier terminated pursuant to this Agreement.

2. **Permitted Uses and Disclosures of PHI on Behalf of Plan**. Plan and Business Associate hereby agree that Business Associate may, in the performance of the Administrative Services, use and disclose PHI to health care providers, other business associates of Plan, agents or subcontractors of Business Associate, and others, in any manner Plan would be permitted or required to use and disclose PHI under the HIPAA Rules if Plan were performing the Administrative Services including without limitation, for Treatment, Payment and Health Care Operations. Business Associate may de-identify PHI in accordance with § 164.514 of the HIPAA Rules, and such de-identified information is not subject to the terms of this Agreement.

Business Associate recognizes and agrees that when acting as a business associate hereunder, Business Associate is obligated by law to comply with the applicable provisions of the HIPAA Rules. To the extent that Business Associate is to carry out a responsibility of Plan or Plan Sponsor under part 164, subpart E of the HIPAA rules, Business Associate shall comply with the requirements of subpart E that apply to Plan or Plan Sponsor in the performance of such obligation.

3. **Permitted Uses and Disclosures of PHI for Business Associate Operations.** Plan and Business Associate hereby agree that Business Associate may use PHI, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may disclose PHI for its proper management and administration or to carry out its legal responsibilities if the disclosure is required by law or if Business Associate obtains reasonable written assurances from the Person to who PHI will be disclosed that: (a) PHI will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to such Person or only as required by law; and (b) such Person will notify Business Associate of any instances of which it becomes aware in which the confidentiality of PHI was breached. Business Associate may also use and disclose PHI to provide Data Aggregation services relating to the Health Care Operations of Plan.

4. **Disclosure of Summary Health Information and Enrollment Information to Plan Sponsor.** Plan hereby authorizes and directs Business Associate to disclose Summary Health Information and information about an individual's enrollment in or disenrollment from Plan and Plan Sponsor as requested from time to time by Plan Sponsor. In disclosing Summary Health Information to Plan Sponsor hereunder, Plan hereby authorizes and directs Business Associate to, and Plan Sponsor hereby agrees, Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor:

A. Plan Sponsor shall only request Summary Health Information for the purpose of (i) obtaining premium bids from health insurers for providing health insurance coverage under Plan; or (ii) modifying, amending, or terminating Plan.

B. Plan has included all necessary statements in its notice of privacy practices required by the HIPAA Rules to permit Plan and Business Associate to disclose Summary Health Information to Plan Sponsor.

5. **Disclosure of PHI to Designated Plan Sponsor Employees.** Plan hereby authorizes and directs Business Associate to disclose PHI to Designated Plan Sponsor Employees as requested from time to time by Designated Plan Sponsor Employees. If requested by Plan Sponsor, Plan also authorizes and directs Business Associate to give Plan Sponsor electronic access to PHI for use by Designated Plan Sponsor Employees. In disclosing PHI to Designated Plan Sponsor Employees hereunder, Plan hereby authorizes and directs Business Associate, to, and Plan Sponsor hereby agrees Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor:

A. The Privacy Plan Amendment has been duly adopted by all necessary or appropriate action of Plan and Plan Sponsor and is, or will be, in full force and effect on the Effective Date. Plan has included all necessary statements in its notice of privacy practices required by the HIPAA Rules to permit Plan and Business Associate to disclose PHI to

Designated Plan Sponsor Employees. Plan Sponsor and Plan shall promptly notify Business Associate of any modification or amendment to the Privacy Plan Amendment. Plan Sponsor and Plan shall also promptly notify Business Associate of any additions to or deletions from the Designated Plan Sponsor Employees.

B. Plan Sponsor shall ensure that only Designated Plan Sponsor Employees shall use or have the opportunity to use, any electronic access to PHI provided to Plan Sponsor by Business Associate hereunder.

C. On and after the Effective Date, Plan and Designated Plan Sponsor Employees will comply in all respects with the HIPAA Rules and the Privacy Plan Amendment that are applicable to this Agreement.

D. Designated Plan Sponsor Employees shall request only PHI from Business Associate that is the minimum necessary as required by the HIPAA Rules to perform the Plan Administrative Services.

6. **Disclosures of PHI to Privacy Officer**. Plan hereby authorizes and directs Business Associate to disclose PHI to the Plan's Privacy Officer for purposes of implementing the HIPAA Rules and as may be requested by the Privacy Officer from time to time. In disclosing PHI to the Plan's Privacy Officer, Plan hereby authorizes and directs Business Associate to, and Plan Sponsor hereby agrees Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor: All necessary actions under the HIPAA Rules have been performed to permit the Plan's Privacy Officer to have access to the PHI as described herein.

7. **Minimum Necessary**. Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request. Business Associate and Plan acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HIPAA Rules. Plan shall notify Business Associate of:

(i) any limitation(s) in the notice of privacy practices of Plan under the HIPAA Rules, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

(ii) any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI; and

(iii) any restriction on the use or disclosure of PHI that Plan has agreed to or is required to abide by under §164.522 of the HIPAA Rules, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Furthermore, Plan agrees to notify Business Associate prior to Plan's agreement to any of the forgoing changes, limitations, revocations, or restrictions.

8. **Unauthorized Use or Disclosure**. Business Associate shall not use or further disclose PHI other than as permitted by this Agreement or as required by law.

9. **Privacy and Security Safeguards**. Business Associate will develop, implement, maintain and use appropriate safeguards to comply with the HIPAA Rules and prevent use or disclosure of PHI (including electronic PHI) other than as provided in this Agreement or as required by law.

10. **Sub-Contractors and Agents**. Business Associate will ensure that any of its subcontractors and agents (to whom Business Associate provides PHI in connection with the Administrative Services) agrees to the same restrictions and conditions that apply to Business Associate hereunder, through a written agreement in accordance with §164.502(e)(1)(ii) and §164.308(b)(2), if applicable, of the HIPAA Rules.

11. **Compliance with Standard Transactions**. If Business Associate conducts, in whole or in part, Standard Transactions for or on behalf of Plan, Business Associate will comply and will require any of its subcontractors or agents involved with the conduct of such Standard Transactions to comply with each applicable requirement of 45 CFR Part 162. Business Associate will not enter into or permit its subcontractors or agents to enter into any trading partner agreement in connection with the conduct of Standard Transactions for, or on behalf of, Plan that: (a) changes the definition, data condition, or use of a data element or segment in a Standard Transaction; (b) adds any data elements or segments to the maximum defined data set; (c) uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or (d) changes the meaning or intent of the Standard Transaction's implementation specification.

12. **Plan Access to PHI**. Upon receipt of a request from Plan, and in accordance with the written policies of Business Associate then in effect, Business Associate will promptly make available to Plan or, at Plan's direction, to the individual requesting PHI (or the individual's personal representative) for inspection and obtaining copies of any PHI (including electronic copies of PHI in a designated record set as necessary) about said individual that is in Business Associate's custody or control, so that Plan may meet its access obligations under §164.524 of the HIPAA Rules.

13. **Amendment of PHI**. Business Associate will, upon receipt of notice from Plan, and in accordance with the written policies of Business Associate then in effect, promptly amend or permit Plan access to amend any portion of PHI, so that Plan may meet its amendment obligations under §164.526 of the HIPAA Rules. If authorized by Plan, Business Associate will, upon receipt of a request from the individual requesting amendment to his PHI, promptly amend such PHI so that Plan may meet its amendment obligations under §164.526 of the HIPAA Rules.

14. **Disclosure Accounting**. Except for Excepted Disclosures, Business Associate will record the Disclosure Information for each disclosure of PHI that Business Associate makes to any Person. Business Associate need not record Disclosure Information or otherwise account for Excepted Disclosures. Upon receipt of a request from Plan and in accordance with the written policies of Business Associate then in effect, Business Associate will make available to Plan, or at Plan's direction, to the individual requesting the disclosure accounting, the Disclosure Information for the six (6) years preceding Plan's request for the Disclosure Information (except for disclosures occurring before the Effective Date), so that Plan may meet its disclosure accounting obligations under §164.528 of the HIPAA Rules.

15. **Inspection of Books and Records**. Business Associate will make its internal practices, books, and records relating to its use and disclosure of PHI under this Agreement available to the U.S. Department of Health and Human Services for the purposes of determining Plan's compliance with the HIPAA Rules.

16. **Reports to Plan**. Business Associate will report to Plan promptly any use or disclosure of PHI that violates this Agreement of which Business Associate becomes aware, including breaches of unsecured PHI as required by §164.410 of the HIPAA Rules, and any Security Incident of which it becomes aware. Business Associate will further provide to Plan, in writing, such details concerning the incident in question as Plan may reasonably request.

In addition, Business Associate will report, without unreasonable delay but in no case later than 60 days following discovery of the breach, to the Plan's Privacy Official, any breach of unsecured protected health information. Such report shall include the identification (if known) of each person whose unsecured protected health information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such breach, along with any other information required to be reported by Business Associate to Plan under the HIPAA Rules. Unless notified otherwise by Plan, Business Associate will, on behalf of Plan, provide all notifications of breaches of unsecured protected health information as required in accordance with Subpart D of 45 C.F.R. Part 164, to the extent that the breached unsecured protected health information was in the possession of Business Associate or a subcontractor or agent of Business Associate. The terms "breach" and "unsecured protected health information" shall have the meanings ascribed to them in the HIPAA Rules.

17. **Termination of Agreement for Cause**. In the event of a breach of a material term of this Agreement by Business Associate, Plan shall have the right to terminate this Agreement by providing to Business Associate written notice of termination setting forth the details of the incident that is the basis for such termination. Business Associate shall have the right to cure any such breach within thirty (30) days from its receipt of said notice of termination (the "Cure Period"). A failure by Business Associate to cure such breach within the Cure Period shall constitute a breach of this Agreement entitling Plan to terminate this Agreement at any time after the Cure Period by providing to Business Associate written notice thereof specifying the effective date of termination. Plan, Business Associate and Plan Sponsor hereby agree that, upon termination of this Agreement, the ASA shall terminate and Business Associate shall have no further obligation to perform the Administrative Services.

18. **Obligations upon Termination.**

A. **Return or Destruction.** Upon termination or expiration of this Agreement, Business Associate will, if feasible, return to Plan or destroy all PHI, in whatever form or medium (including any electronic medium under Business Associate's custody or control), including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of PHI. Business Associate will, in accordance with the written policies of Business Associate then in effect, complete such return or destruction as promptly as possible after the effective date of the termination or expiration of this Agreement. Business Associate will limit its further use or disclosure of PHI to those purposes that make return or destruction infeasible. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to the Plan notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

B. **Continuing Privacy and Other Obligations.** Business Associate's obligation to protect the privacy of PHI hereunder will be continuous and survive termination or expiration of this Agreement. The obligations of the parties hereto under Sections 12, 13, 14, 18 and 19 of this Agreement shall survive the termination or expiration of this Agreement.

19. **Indemnification.**

A. **Indemnification by Plan.** Business Associate hereby agrees to the extent provided by Alabama law to indemnify, defend and hold harmless Business Associate (including, without limitation, its officers, directors, employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to (i) the reliance of Business Associate upon Plan's representations, warranties, agreements or directions to Business Associate pursuant to this Agreement, or (ii) a breach of any of the terms and provisions of this Agreement by Plan or any party acting by or through Plan (including, without limitation, Plan's agents, employees, representatives, contractors or subcontractors).

B. **Indemnification by Plan Sponsor.** Plan Sponsor hereby agrees to the extent provided by Alabama law to indemnify, defend and hold harmless Business Associate (including, without limitation, its officers, directors, employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to (i) the reliance of Business Associate upon Plan Sponsor's representations, warranties, agreements or directions to Business Associate pursuant to this Agreement, or (ii) a breach of any of the terms and provisions of this Agreement by Plan Sponsor or any party acting by or through Plan Sponsor (including, without limitation, Designated Plan Sponsor employees, Plan Sponsor's agents, other employees, representatives, contractors or subcontractors).

C. **Indemnification by Business Associate.** Business Associate hereby agrees to indemnify, defend and hold harmless Plan (including, without limitation, their elected

and appointed officials, employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to a breach of any of the terms and provisions of this Agreement by Business Associate or any party acting by or through Business Associate (including, without limitation, Business Associate's agents, employees, representatives, contractors or subcontractors).

20. **Modification and Amendment**. Except as expressly modified or amended herein, all other terms and conditions of the ASA shall remain in full force and effect. This Agreement shall not be modified or amended in any respect except by a written instrument executed by the parties; provided, that in the event the provisions of this Agreement shall conflict with the requirements of applicable law concerning the use, handling, disclosure and/or treatment of PHI (including, without limitation, the HIPAA Rules), as such laws may be modified, amended, or superceded from time to time, this Agreement shall be deemed amended as necessary to conform to such legal requirements at all times.

21. **No Third Party Beneficiaries**. This Agreement is entered into by and among Plan, Plan Sponsor and Business Associate for the exclusive benefit of each of the parties hereto. This Agreement shall not be construed to confer any rights or remedies upon any Person, except the parties hereto and their respective officers, directors, shareholders, employees, agents, successors and assigns.

22. **Conflicts**. The terms and conditions of this Agreement will override and control any conflicting terms and conditions in the ASA related to the privacy and security of PHI.

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute this Agreement, effective as of the Effective Date, in multiple originals on the date written below.

Plan:

City of Huntsville Group Health Plan(s)
(Insert Company Name)

By: [signature]
Signature

Tommy Battle
Please print name

Title: Mayor, City of Huntsville
Please print

Date: 9/12/2013

Plan Sponsor:

City of Huntsville
(Insert Company Name)

By: [signature]
Signature

Tommy Battle
Please print name

Title: Mayor, City of Huntsville
Please print

Date: 9/12/2013

Business Associate:

Blue Cross and Blue Shield of Alabama

By: [signature]
Signature

Tim Sexton

Title: Chief Marketing Officer

Date: 9/11/13

SCHEDULE A
TO
BUSINESS ASSOCIATE AGREEMENT

For purposes of this Agreement, all capitalized terms contained in this Agreement shall have the following meanings:

"Administrative Services" shall mean the administrative services that Business Associate provides to or on behalf of Plan in connection with administering the benefits provided by Plan as claims administrator of Plan under the ASA.

"ASA" shall mean one or more administrative services agreements (including any implementation or Enrollment Agreement between Business Associate and Plan Sponsor) which may be entered into by and between Business Associate and Plan Sponsor, from time to time, pursuant to which Business Associate provides the Administrative Services, as the same may be modified, amended, renewed or superceded.

"Business Associate" shall mean Blue Cross and Blue Shield of Alabama.

"Data Aggregation" shall have the meaning set forth in §164.501 of the HIPAA Rules.

"Designated Plan Sponsor Employees" shall mean those persons designated in writing by Plan to Business Associate, on or before the Effective Date, as being included within the class of employees or other workforce members under the control of Plan Sponsor designated in the Privacy Plan Amendment that are authorized to use and disclose PHI in accordance with the Privacy Plan Amendment.

"Disclosure Information" shall mean the information described in §§164.528(b)(2)-(3) of the HIPAA Rules.

"Effective Date" shall mean the effective date of the ASA.

"Excepted Disclosures" shall mean disclosures of PHI by Business Associate set forth in §164.528(a)(1) of the HIPAA Rules.

"Health Care Operations" shall have the meaning set forth in §164.501 of the HIPAA Rules.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Payment" shall have the meaning set forth in §164.501 of the HIPAA Rules.

"Person" shall include individuals, trusts, estates, corporations (both non-profit and other corporations), partnerships (both limited and general), joint ventures, limited liability companies,

unincorporated associations, and governmental agencies and organizations. Person shall not include Plan, Plan Sponsor or Business Associate.

"PHI" shall mean Protected Health Information that Business Associate receives from, or creates or receives for, or on behalf of Plan in connection with the performance of the Administrative Services.

"Plan" shall mean one or more group health plans sponsored by Plan Sponsor to which Business Associate provides the Administrative Services.

"Plan Administrative Services" shall mean the plan administrative services performed by Plan Sponsor pursuant to the plan documents of Plan, including the Privacy Plan Amendment.

"Plan Sponsor" shall mean the entity who sponsors the Plan and who has executed this Agreement (by its duly authorized representative) on the signature line designated for the Plan Sponsor on the execution page of this Agreement.

"Privacy Plan Amendment" shall mean that amendment to the plan documents of Plan that complies in all respects with the requirements set forth in §164.504(f)(2) of the HIPAA Rules and for which Plan has received a written certification as required by the HIPAA Rules, on or before the Effective Date.

"Protected Health Information" shall have the meaning set forth in §164.501 of the HIPAA Rules.

"Security Incident" shall have the meaning set forth in §164.304 of the HIPAA Rules. However, unless otherwise requested by Plan, Security Incident does not include "trivial incidents" that occur on a daily basis and do not represent a material threat to the confidentiality, integrity, or availability of PHI covered by this Agreement (such as scans or pings of Business Associate's computers or computer networks).

"Summary Health Information" shall have the meaning set forth in §164.504(a) of the HIPAA Rules.

"Treatment" shall have the meaning set forth in §164.501 of the HIPAA Rules.