March 17, 2015

To: **Mayor Bemrich and City Council**

From: **David Fierke, City Manager**
Jamie N. Anderson, HR Director

Subject: **Health Insurance 2015 Plan Renewal**

ACTION: **For vote Monday, March 23, 2015**

Brief History

The City has provided health insurance as part of its benefit package to employees for many years. Health insurance is part of the union benefit package for employees covered by a collective bargaining agreement and is part of the policies for non-unionized employees. Our current health insurance benefit allows eligible employees the choice of two plans. The city council has approved this health insurance benefit in the past.

In January 2014 the City changed the plan year from a fiscal year to a calendar year to bring our plans into alignment with the IRS benefit year and implement the High Deductible Health Plan with a Health Savings Account.

Analysis of Issue

In order to maintain the health insurance policy as specified in the union contracts it is necessary for the City to provide health insurance at the prescribed levels within the collective bargaining agreements and for non-unionized employees. A summary of each plan offered to employees is attached.

Renewal documents for the 2015 plan year were signed by the previous human resource director and submitted to Wellmark on October 29, 2014. However, due to an oversight, a resolution for plan renewal for was not provided to Council until now.

Budget Impact

The cost for health insurance has been budgeted for the FY15 & FY16 budget for 2015 insurance plan year.

Strategic Plan Impact

NA

Comprehensive Plan Impact

NA

Subcommittee or Commission Review / Recommendation
NA

Staff Conclusions / Recommendations
The Human Resource Director and City Manager recommend approval.

Alternatives
If health insurance policies are not renewed the City will be in violation of union contracts and city benefit policies.

Implementation and Accountability
The Human Resource Director will continue to implement the renewal of this insurance policy, upon approval by the City Council.

Signed

Jamie N. Anderson
Human Resource Director

Approved

David R. Fierke
City Manager

2015 HEALTH INSURANCE

Eligible City employees may choose one of the two health insurance plan options available. A summary of each plan is below.

1. **Plan A - HDHP**
   Alliance Select – HDHP (High Deductible Health Plan)

   Deductible = Max out-of-pocket: $2500/$5000 single/family.
   (The deductible and max-of-pocket are the same.)

   All costs, including prescription costs, are first applied to the deductible/max out of pocket until that deductible/max out of pocket limit is reached at which time the plan covers all additional costs in full.

   Total monthly premium costs effective January 1, 2015:
   Single = $333.27
   Family = $833.23

   For Plan A the employee pays $0 towards the monthly premium.

   In conjunction with the HDHP is a **Health Savings Account (HSA)**. This is an account that the plan holder can use to pay for medical expenses. The HSA works much like a personal checking account specifically set up for medical expenditures. The City is placing 50% of the deductible or $1250/$2500 for single/family plan holders into the HSA. For the first year of the plan (calendar year 2015) one-fourth of the employer contribution will be put into the HSA at the start of each quarter. Employees are also able to place money into the HSA on a pre-tax basis. Deductions for employee contributions will be done similar to how we have done FSA deductions with the employees deduction being divided into 24 equal amounts taken out each paycheck except for the middle paycheck of the month in those months in which a third paycheck occurs. This money is then placed into the HSA and used for medical expenses on a tax free basis. There are significant penalties if the money is used for non-medical expenditures. Typical examples of medical expenditures include prescriptions, office visits, emergency room visits and x-rays. Any money not used during the plan year is retained in the HSA and accumulates from year to year. These funds remain with the employee even when the employee leaves employment.

2. **Plan B – AS500**
   Alliance Select - 500 Deductible Plan
   Deductible: $500/$1000 single/family
   Max out-of-pocket: $1000/$2000 single/family
   Co-insurance: 80/20
   Prescription co-pay: $5/$20 for generic/non-generic will continue. There is also a specialty drug co-pay of $85.

   Total monthly premium:
   Single = $543.33
   Family = $1391.98

   For Plan B the employee contribution is 8% of the total monthly premium, which is:
   Single = $43.47
   Family = $111.36

   This employee contribution will be deducted on a pre-tax basis with one half of the contribution amount being deducted each paycheck except for the middle paycheck in those months with three pay checks.

   You may elect to participate in a **Flexible Spending Account (FSA)**, as in previous years. An FSA allows you to set aside a portion of your salary before taxes to pay primarily for medical expenses and dependent care costs not covered by insurance. Once you pay for the expense, you are reimbursed by your plan. This deduction comes out of your paycheck twice per month.

   The total amount you elect for your FSA will be available any time of the year, even if the funds have not yet been withheld from your pay. For dependent care reimbursement accounts, qualified expenses are reimbursed up to the amounts you have contributed throughout the plan year. It's important to remember that if you don't use all the money in your flex account, you will lose it at the end of the plan year.

If you have any questions regarding benefits please contact Jamie at (515) 586-6869.

RESOLUTION NO. _____

A RESOLUTION EXTENDING GROUP HEALTH INSURANCE FOR THE CALENDAR YEAR 1/1/2015 TO 12/31/2015

WHEREAS, the City wishes to provide the most effective benefits to their employees; and

WHEREAS, the City wishes to provide programs that meet the needs of its employees.

NOW, THEREFORE, BE IT RESOLVED, Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health plan of Iowa, Inc, be extended as the health insurance carrier, with all the features of existing contract, for the period January 1st, 2015, to December 31st, 2015.

BE IT FURTHER RESOLVED that the Human Resource Director is hereby authorized and designated to enter into the appropriate contract documents to secure said coverages.

PASSED AND ADOPTED by the City Council of the City of Fort Dodge, Iowa, this _____ day of _____ 2015.

Ayes: _____

Nays: _____

Other: _____

City of Fort Dodge, Iowa

_____
Matt Bemrich, Mayor

Attest:

_____
Jeff Nemmers, City Clerk

Wellmark

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

☐ Amendment to Binder dated ____/____/____

RENEWAL GROUP BINDER AGREEMENT - IOWA

Account Legal Name	Account Rep & #	Effective Date
City of Fort Dodge	Penny Schmitt	01 / 01 / 2015

Physical Address: Address Line 1: 819 1st Ave. S.
Address Line 2: _____
City: Fort Dodge State: IA ZIP+4: 50501

Group/Section #'s (Include all Sections or attach a matrix)
08051-various (see matrix)

Physical Address of Billing contact: Address Line 1: same as above
Address Line 2: _____
City: _____ State: _____ ZIP+4: _____

If billing contact address is different than Accounts Physical Address shown above, this is:
☐ Alternate location of above Account; or ☐ 3rd Party Billing Service. **(If 3rd party billing service, Account acknowledges that Wellmark Group Statement of premium invoice delivered periodically to any third party service provider can be viewed by Account by registering for electronic billing at www.wellmark.com.)**

Account Key:	Plan Year Month:	Unique Alpha Prefix:
17190	January	

NO YES **ADDITIONAL PRODUCTS**

☑ ☐ Dental *Attached Rate Exhibit(s)* ☐ Blue Dental ☐ Blue Dental PPO

ADDITIONAL SERVICES

☑ ☐ COBRA Administration (Attached Addendum)
☐ Standard ☐ Full Service (SF only)

☑ ☐ Health and Care Management Services *Include Rate Exhibit*
☐ Self Funded ☐ Self Funded over 5000 contracts
☐ Fully Insured and Minimum Premium Buy Up

☑ ☐ Third-Party EOBs *$10/EE/Yr*

OTHER

☑ ☐ ACA Addendum See Attached (FI and SF Grandfathered Plans Only)
☑ ☐ Is group part of an association? If yes, name and association code? _____
☑ ☐ Savings Guarantee (500+ Contracts) *See Attached Exhibit(s)*
☑ ☐ Performance Guarantee (500+ Contracts) *See Attached Exhibit(s)*
☑ ☐ Terminal Rider (Must be signed) *See Attached Rate Exhibit(s)*
☑ ☐ Admin Guarantee *See Attached*

ENROLLMENT

☑ MSP Status *MSP Addendum regardless of group size*
☐ Paper Applications ☐ EDI ☑ Blues Enroll ☐ NA ☐ Excel Spreadsheet
When will Enrollment Information be Received? ____/____/____
☑ ☐ Does the open enrollment date differ from the renewal date?
If so OE date is: ____/____/____

CARRIER INFORMATION

Is Wellmark the Exclusive Carrier/Administrator?
☑ Yes ☐ No
If No, identify carrier(s) & # of Enrolled by carrier.

Is Wellmark the Stop Loss Carrier?
☑ Yes ☐ No ☐ N/A
If No, identify Stop Loss Carrier

Stop-Loss Terms: _____
Stop-Loss LOB: _____

DENTAL COVERAGE

If group is adding dental coverage, please answer the questions below

When health and dental are both offered, are Employees required to take both products?
☐ Yes ☐ No

When health and dental are both offered and the Employee selects both products, are Spouse/Dependents also required to take both products? ☐ Yes ☐ No

WHPI Only

☐ Yes ☐ No* Employer is accountable for communicating
- covered benefits
- noncovered benefits
- practitioner and provider availability
- a summary of UM procedures (prior approval, referral, etc.)
- potential network, service or benefit restrictions
- pharmaceutical management procedures
- a summary of Wellmark's policy on collection use and disclosure of PHI

*If no, JITKits/Enrollment Guides must be distributed

RENEWAL GROUP BINDER AGREEMENT - IOWA

Benefit Product Selected					
Benefit Name	Health OBS Number	Rx OBS Number	Benefit Name	Health OBS Number	Rx OBS Number
Alliance Select	4110-173	4102-51			
Alliance Select	4110-174	4102-50			

For Internal Use Only

Set Up/Description (attach additional sheet of paper if needed; include group membership, billing, funding changes, if applicable)
Group will no longer be offering the $100 deductible plan.

Completed by _____

☑ Change ☐ No Change ☐ Retro ☐ Off Renewal	**CONTRACTED AGENCY NAME**	**SELLING AGENT NAME**	**SELLING AGENT NUMBER**	**CONTRACTED AGENCY TAX ID**

This Binder Agreement serves solely as evidence of Wellmark's agreement to provide the health coverage and administrative services and to provide services for any applicable stop loss insurance coverage indicated above. The Account agrees to the terms and payment obligations stated herein and agrees to pay Wellmark the applicable rates, administrative fees, and stop loss premium stated in the proposal(s). Execution of this Binder Agreement by the Account authorizes Wellmark to implement the administration of this coverage including the processing and settlement of claims for members of the Account's group plan incurred within the Rating Period. On or about the effective date of the coverage, Wellmark shall issue and execute a definitive agreement setting forth the rights and responsibilities of Wellmark and Account. Account's payment to Wellmark of the applicable fees as of the effective date is evidence of Account's agreement to the terms specified in the definitive agreement

Account understands and agrees that Wellmark defines a National Account as any company headquartered in Iowa but which also has employees in other states whose claims are processed through the Blue Card program. Signatures on this Binder Agreement confirm that it is issued for delivery in Iowa. Only persons associated with a National Account or with Account locations in Iowa are eligible for coverage. If the entity is not headquartered in Iowa, coverage will be void for any persons associated with Account locations outside of Iowa.

Account acknowledges and agrees that Wellmark will rely on the information contained in the Affordable Care Act ("ACA") Addendum. Account represents to Wellmark that the information contained in the ACA Addendum is correct. Account agrees that it will provide Wellmark at least 60 days prior written notice of any change that may affect grandfather status.

This Binder Agreement shall expire upon Wellmark's issuance and execution of the definitive agreement, except the COBRA Addendum, Affordable Care Act Addendum, and/or Health and Care Management Programs/Services Rating Exhibit, if any, which will remain in effect and become a part of the definitive agreement. It is hereby agreed and understood that the terms and conditions of the definitive agreement and benefits document(s) issued by Wellmark to the Account, and the terms and conditions of the definitive stop loss policy issued by stop loss carrier, if any, shall govern and control the terms stated in this Binder. Any inconsistency between this Binder Agreement, including any attachments, and any subsequently issued executed definitive agreement(s) shall be construed in favor of the subsequently issued document.

This Binder Agreement shall be governed in accordance with Iowa Law.

Group/Account

By James Vollmer Title Human Resource Director

Printed Name James Vollmer Date 10 / 29 / 2014

Wellmark

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MEDICARE COMPLIANCE

The purpose of this communication is to notify employers of the mandatory reporting requirements of the Medicare, Medicaid, and SCHIP Extension Act of 2007 which were passed into law in July 2008. Your cooperation in providing the necessary employer data and data for each employee and dependent is needed in order to comply with the requirements.

The Section 111 mandates of the law help payers identify when the Centers for Medicare and Medicaid Services (CMS) should pay secondary to employer group health coverage. The goal includes reducing the amount CMS may pay as primary when they should have paid as secondary.

Under the requirements, all health plan, liability, no fault and workers compensation coverages must register with CMS as a Responsible Reporting Entity (RRE) and must report to CMS employer and member information. In order to fulfill the mandated requirements and report accurately to CMS, Wellmark, as a RRE, must gather and groups must provide the following information:

- Employer Tax Identification Number (ETIN)
- Evidence of status as a Commonly Owned/Controlled Group of Organizations, Multi/Multiple Employer Group health plan (such as an Association or Trust), Hour Bank or Union health plan
- Total number of group employees/group size
- Social Security Numbers (SSNs) or Health Insurance Claim Numbers (HICNs) of active employees, spouses, domestic partners
- SSNs or HICNs for those dependents with end stage renal disease (ESRD) or disabled
- Status of all employees and effective date of that status (i.e. active, COBRA, retired)
- Disability information begin or end dates, if known

Please take a moment to complete the Confirmation of Medicare Secondary Payer (MSP) Addendum form. This will allow us to capture your employer data for reporting to CMS. Member data is gathered through the use of the group's existing enrollment and eligibility data collection channels, which may include paper applications or electronic data exchanges and should be provided through those processes.

Failure to provide the group information requested on the attached Confirmation of MSP Addendum can result in penalties being assessed to the group including, but not limited to, $1,000 per day per member for not accurately reporting to CMS and/or an excise tax equivalent to 25 percent of the employer's group health plan expenses for the relevant year.

Clear Form

Wellmark

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FOR ADMINISTRATIVE USE ONLY
New Group: Group # _____
Coverage Effective Date: ____/____/____

CONFIRMATION OF MSP ADDENDUM

ALL NEW AND RENEWAL GROUPS ARE REQUIRED TO SUBMIT A COMPLETED FORM. FAILURE TO SUBMIT A COMPLETED FORM WILL DELAY THE INITIAL ENROLLMENT OR RENEWAL PROCESS UNTIL THIS FORM IS SUBMITTED.

Part A - Employer Information

Please complete a separate confirmation form for each Employer Tax Identification Number you use to report employee earnings to the Internal Revenue Service (IRS). See the Medicare Secondary Payer Definitions page (M-1756) for more information on terms shown in italics.

Employer Tax Identification Number: 4 2 6 0 0 4 6 7 5

Group Number (Renewing Groups Only): 08051

Employer Name: City of Fort Dodge

Employer Address: 819 1st Ave S

City: Fort Dodge State: IA Zip: 50501

Contact Person: Jamie Anderson

Telephone Number: 515-576-6869 E-mail Address (optional): janderson@fortdodgeiowa.org

1. Did your organization make contributions on behalf of any employee who was covered under a *collectively bargained Health and Welfare Fund* (i.e., union plan) during the previous calendar year? ☐ Yes ☑ No
2. Did you have 20 or more *employees* for 20 or more calendar weeks (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous or current calendar year? If no, in the event you experience a change, you must notify Wellmark when this change occurs. ☑ Yes ☐ No
3. Did you have 100 or more *employees* during 50 percent of your business days (this includes all full-time, *part-time,* intermittent, *leased* and/or seasonal employees, not just those eligible or enrolled employees) during the previous calendar year? ☑ Yes ☐ No
4. Did your organization participate in a *multi* or *multiple employer group health plan* (more than one employer in group, i.e., Multiple Employer Welfare Association) during the previous calendar year? ☐ Yes ☑ No
   If yes, what is the name and address of the *multi* or *multiple employer plan?*
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
5. Was your organization part of a commonly owned or commonly controlled group of organizations during the previous calendar year? ☐ Yes ☑ No
   If yes, what is the name and address of the *commonly owned/controlled entity?*

Name: _____ Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Part B - Employer Certification

I certify that the information provided is accurate and truthful. All information will be used to identify the *Medicare Secondary Payer* status of *Medicare*-enrolled *employees.*

James Vollmer
Signature

10 / 29 / 2014
Date

Send completed MSP form based on following:			
IA & SD Large Groups (new or renewal)	IA & SD Small Groups (new or renewing with benefit changes)	IA Small Groups renewing with no benefit change - send this form to:	SD Small Groups renewing with no benefit change
Submit this completed MSP form with group's health plan new or renewal paperwork	Submit this completed MSP form with group's health plan new or renewal paperwork	Fax: (515) 376-9044 or Wellmark, Inc. PO Box 9232 – Mail Station 3W396 Des Moines, IA 50306-9232	Send this completed MSP form to: Wellmark, Inc. PO Box 5023 – Station 338 Sioux Falls, SD 57117-5023

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Self Funded Alternate Rates

Group Name *City of Fort Dodge*
Account Key *00017190*
Rating Period: *01/01/2015 to 12/31/2015*

Alternate Benefit Offering	Enrollment	Stop Loss Terms
OBS #4110-173 / #4102-51	54 Single	12/18 Contract
Alliance Select	146 Family	
Deductible: $500 / $1,000		No Monthly Aggregate
Coinsurance: 20% / 30%		Monthly Settlement
OPM: $1,000 / $2,000	200 Total	
Office Visit Copay: $0		
BlueRx Complete		
Deductible: $0 / $0		
Copay: $5/$20		

FINAL RATES

	Level	Fee/Contract	Estimated Annual Premium Based on Current Enrollment
Individual Stop Loss	$50,000	$175.70	$421,680
Aggregate Stop Loss	120%	$5.62	$13,488
Administrative Fees - Health	w/monthly settlement	$37.35	$89,640
Administrative Fees - PBM		$1.87	$4,488
	Consultant Fee	$0.00	$0
	Total Administrative Fees	$220.54	$529,296
Network Access Fee		$8.26	$19,824

	Single	Family	Annual Projection
Expected Claims	$468.52	$1,246.26	$2,487,048
Administrative, NAF & Stop Loss Fees	$103.44	$275.15	$549,092
Estimated Suggested Rates*	$571.96	$1,521.41	$3,036,140
Attachment Points	$562.22	$1,495.51	$2,984,452
Administrative, NAF & Stop Loss Fees	$103.44	$275.15	$549,092
Estimated Maximum Liability to Fund*	$665.66	$1,770.66	$3,533,544

*Actual results may vary. Also, rates provided include administrative costs based on the entire group population.
Individual Stop Loss includes coverage for Health and Drug and is based on a lifetime maximum of unlimited.
Aggregate Stop Loss includes coverage for Health and Drug. The maximum Aggregate reimbursement is unlimited.

Employer Signature: James Vollmer Date: 10-29-14

Comments:

Pharmacy Fee/Contract is an estimate based on account specific member counts at the time the renewal was completed. The account will not be billed the estimated Pharmacy administration Fee/Contract amount. Rather, the account will be billed $0.68 PMPM on its monthly invoice.

Consultant fee, if applicable, is an amount determined by the consultant and employer, and included here for the convenience of the employer to understand the total cost of services from Wellmark and the consultant. The consultant fee will be invoiced by Wellmark pursuant to agreement between Wellmark, Employer and Consultant.

Wellmark is not providing any legal or professional advice with regard to compliance of any federal or state law, regulations, or guidance. Law, regulations and guidance on specific provisions has been and will continue to be provided by the appropriate federal and state agencies and regulators. The information provided reflects Wellmark's understanding of the most current information and is subject to change without further notice. Please note that plan benefits, rates, renewal rate adjustments, and rating impact calculations are subject to change and may be revised during a plan's rating period based on guidance and regulations issued by the appropriate federal and state agencies and regulators. Wellmark makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of law or regulation.

Wellmark will not determine whether coverage is discriminatory or otherwise in violation of Internal Revenue Code Section 105(h). Wellmark also will not provide any testing for compliance with Internal Revenue Code Section 105(h). Wellmark will not be held liable for any penalties or other losses resulting from any employer offering coverage in violation of section 105(h). Wellmark will not determine whether any change in an Employer Administered Funding Arrangement affects a health plan's grandfathered health plan status under ACA or otherwise complies with ACA. Wellmark will not be held liable for any penalties or other losses resulting from any Employer Administered Funding Arrangement. For purposes of this paragraph, an "Employer Administered Funding Arrangement" is an arrangement administered by an employer in which the employer contributes toward the member's share of benefit costs (such as the member's deductible, coinsurance, or copayments) in the absence of which the member would be financially responsible. An Employer Administrative Funding Arrangement does not include the employer's contribution to health insurance premiums or rates.

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Self Funded Renewal Rates

Group Name: *City of Fort Dodge*

Account Key: *00017190*

Renewal Period: *01/01/2015 to 12/31/2015*

Current Benefit Offerings	Current Enrollment	Stop Loss Terms
OBS #4110-174 / 4102-50	15 Single	12/18 Contract
Alliance Select	37 Family	
Deductible: $2500 / $5,000		
Coinsurance: 0%/0%		Monthly Settlement
OPM: $2,500 / $5,000	52 Total	
Office Visit Copay: $0		
BlueRx Complete		
Deductible: $2500/$5000		

FINAL RATES

	Level	Fee/Contract	Estimated Annual Premium Based on Current Enrollment
Individual Stop Loss	$50,000	$175.70	$109,637
Aggregate Stop Loss	120%	$5.62	$3,507
Administrative Fees - Health	w/monthly settlement	$37.35	$23,306
Administrative Fees - PBM		$1.87	$1,167
Consultant Fee		$0.00	$0
Total Administrative Fees		$220.54	$137,617
Network Access Fee		$8.26	$5,154

	Single	Family	Annual Projection
Expected Claims	$322.54	$857.96	$438,991
Admin, NAF & Stop Loss Fees	$103.44	$275.15	$140,786
Estimated Suggested Rates*	$425.98	$1,133.11	$579,777
Attachment Points	$387.05	$1,029.55	$526,789
Admin, NAF & Stop Loss Fees	$103.44	$275.15	$140,786
Estimated Max Liability to Fund*	$490.49	$1,304.70	$667,575

*Actual results may vary. Also, rates provided include administrative costs based on the entire group population.
Individual Stop Loss includes coverage for Health and Drug and is based on a lifetime maximum of unlimited.
Aggregate Stop Loss includes coverage for Health and Drug. The maximum Aggregate reimbursement is unlimited.

Employer Signature: James Vollan Date: 10-29-14

Comments:

Wellmark.
Your Health. Well Protected.

Self Funded Renewal Rates

Group Name: *City of Fort Dodge*

Account Key: *00017190*

Renewal Period: *01/01/2015 to 12/31/2015*

Pharmacy Fee/Contract is an estimate based on account specific member counts at the time the renewal was completed. The account will not be billed the estimated Pharmacy administration Fee/Contract amount. Rather, the account will be billed $0.68 PMPM on its monthly invoice.

These rates are Compatible Health Savings Account (HSA) Benefits and do not include the employer/employee funded HSA account funding or the cost of the administration of these accounts.

Consultant fee, if applicable, is an amount determined by the consultant and employer, and included here for the convenience of the employer to understand the total cost of services from Wellmark and the consultant. The consultant fee will be invoiced by Wellmark pursuant to agreement between Wellmark, Employer and Consultant.

Wellmark is not providing any legal or professional advice with regard to compliance of any federal or state law, regulations, or guidance. Law, regulations and guidance on specific provisions has been and will continue to be provided by the appropriate federal and state agencies and regulators. The information provided reflects Wellmark's understanding of the most current information and is subject to change without further notice. Please note that plan benefits, rates, renewal rate adjustments, and rating impact calculations are subject to change and may be revised during a plan's rating period based on guidance and regulations issued by the appropriate federal and state agencies and regulators. Wellmark makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of law or regulation.

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Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

ADMINISTRATIVE SERVICES AGREEMENT

WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA

and

City of Fort Dodge

Agreement Effective Date: January 1, 2015

Form Number: IA WBCBSI LG SF Version: 11/14

ADMINISTRATIVE SERVICES AGREEMENT

THIS ADMINISTRATIVE SERVICES AGREEMENT ("**Agreement**") is made and entered into effective the first day of January 2015, ("**Effective Date**") by and between Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, an Iowa mutual insurance company, (herein "**Wellmark**"), and City of Fort Dodge (herein "**Account**").

RECITALS

1. Account is the plan sponsor of a group health plan within the meaning of and in accordance with applicable federal or state law for its common law employees and other eligible individuals and this Agreement is issued to Account as the "group policyholder".

2. The group health plan is sponsored and funded by Account. Account wishes to enter into a financial arrangement with Wellmark under which Account is solely responsible for the Claims Paid for Covered Services provided to its Members. Wellmark does not assume any financial risk or obligation with respect to the Claims Paid for Covered Services provided to Members of the Plan.

3. Account desires that Wellmark provide services for its group health plan and Wellmark is willing to provide such services subject to the terms and conditions set forth herein.

NOW, THEREFORE, it is hereby agreed as follows:

ARTICLE 1
AGREEMENT DEFINITIONS

1.1 "**Administrative Fee**" means an amount or amounts that Wellmark charges the Account for Administrative Services and which includes allocations for Wellmark's cost of administering the Plan and general operating costs. The monthly Administrative Fee is shown on **Exhibit "A"**, Administrative Fees, Network Access Fees, Other Fees, attached to this Agreement and incorporated by this reference.

1.2 "**Administrative Services**" means those services to be performed by Wellmark for Account and the Plan under this Agreement, as described in Article 3 of this Agreement.

Administrative Services expressly exclude any services for the administration of continued health coverage pursuant to COBRA or any state or federal law relating to continuation coverage of the Plan, except as may be specified in a COBRA Administrative Services Agreement or Addendum between the parties.

1.3 "**Affordable Care Act**" or "**ACA**" means the Patient Protection and Affordable Care Act, enacted March 23, 2010, and the Health Care and Education Reconciliation Act (collectively, "**ACA**"), including implementing regulations.

1.4 "**Agreement**" means this Administrative Services Agreement, including all Exhibits, Benefits Document(s), amendments, Plan Member enrollment form(s), any applicable Health and Care Management Services Exhibit, and any COBRA Administrative Services Agreement or Addendum between the parties. This Agreement also

incorporates by this reference the terms of the HIPAA Business Associate Agreement entered into between Wellmark and the Plan.

1.5 "**Amounts Not Covered**" means the amounts that are the liability of the Member under the Plan. These include services that are not covered by the Plan, charges for services that are determined to be not medically necessary, reductions in benefits for failure to follow notification requirements, and charges for services that have reached a Plan maximum. Amounts Not Covered does not include amounts that are the responsibility of a health care provider under a provider's contract with Wellmark.

1.6 "**Benefits Document**" means the written document(s) that describe and define the terms and benefits of the Plan and may be titled Benefits Certificate, Coverage Manual, or something similar. If the Plan is subject to the terms of ERISA, Account may at its option incorporate the Benefits Document into its ERISA Summary Plan Description (SPD).

1.7 "**Claims Paid**" means the dollar amount of Wellmark's payment on behalf of the Account for Incurred Claims.

1.8 "**COBRA**" means the group health coverage continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, including implementing regulations.

1.9 "**Confidential Information**" means all non-public confidential or proprietary information, in any form, delivered or made available (whether pursuant to this Agreement or otherwise) by one party or its affiliates, directors, officers, employees and agents (the "**Disclosing Party**") to the other party, its affiliates, directors, officers, employees and agents (the "**Receiving Party**"). Confidential Information shall include, but not be limited to, employee, Plan Member, and Member information (including names, addresses and social security numbers), Protected Health Information, personally identifiable information, medical records, Plan claims data, payment data, and all other Confidential Information of every kind and character. Any information with respect to Wellmark's systems, procedures, methodologies and practices used by it in connection with the claims process, claims payment and utilization monitoring functions of the Plan, together with the negotiated fees, terms, payment arrangements, discounts with providers, and related information shall be deemed to be Confidential Information. Confidential Information shall not include information which (a), at the time of disclosure, is available to the general public; (b) becomes at a later date available to the general public through no fault of Receiving Party and then only after such later date; (c) Receiving Party can demonstrate was in its possession before receipt from Disclosing Party; (d) Receiving Party can demonstrate was independently developed; or (e) is disclosed to Receiving Party without restriction on disclosure by a third party who has the lawful right to disclose such information.

1.10 "**Covered Charges**" means the amount a health care provider bills a Member or Wellmark for Covered Services in accordance with the terms of the Benefits Document.

1.11 "**Covered Services**" means the medically necessary health care services provided to a Member and described in and covered by the applicable Benefits Document.

1.12 "**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended, including implementing regulations.

1.13 "**Grandfathered Health Plan or Non-Grandfathered Health Plan**" mean the same as such terms are used in ACA.

1.14 "**Health and Care Management Services**" means health management and wellness services Wellmark may provide to Members designed to encourage good health and help them make decisions about health care. These services may include, but are not limited to, telephonic personal health assistant 24/7, condition support (disease management), pregnancy support, advanced care management, wellness services, wellness consulting services, or other programs.

1.15 "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended, including implementing regulations.

1.16 "**Host Blue**" means the local Blue Cross and/or Blue Shield plan or licensee in a geographic area outside of the Wellmark service area.

1.17 "**Incurred Claims**" means claims for payment of health services that are provided to Members pursuant to the Plan with a date of service during the Rating Period.

1.18 "**Incurred Date**" means the date health services are provided to Members. With regard to inpatient hospital or facility services, the date of the Member's admission to the facility is the Incurred Date.

1.19 "**Maximum Allowable Fee**" means a dollar amount Wellmark establishes using various methodologies for Covered Services and supplies. For medical services, this amount is developed from various sources, such as charges billed for the same service or supply by most health care providers within Iowa, economic indicators, or relative value indices developed or approved by Wellmark, and is based on the simplicity or complexity of the service provided. For medical services received outside of Iowa or South Dakota, the Maximum Allowable Fee is either determined in accordance with the section of this Agreement entitled Out-of-Area Services or is the amount as described in the preceding sentence.

For all dental procedures covered under this Agreement, the fee schedule is developed based on Wellmark's contracts with dentists, input from its dental consultants, and the charges billed for the same procedure by dentists in Iowa.

1.20 "**Member**" means a person, including a Plan Member's spouse or eligible dependents, who is eligible and enrolled to receive health benefits under the terms of the Plan as determined and identified by Account.

1.21 "**Network Access Fee**" means the amount charged to Account to gain the collective advantages of the network of providers with which Wellmark, a Host Blue, or any subcontractor of either, has contracted for the provision of Covered Services. The fee is a monthly amount as shown on Exhibit "A", and may include funding for provider incentives. If the Network Access Fee is expressed as a percentage of Network Savings, the fee applies to Incurred Claims regardless of the date the claim is paid. A portion of the Network Access Fee may include an allocation for administrative expenses above the Administrative Fee.

1.22 "**Network Savings**" means the amount saved due to payment arrangements between Wellmark or a Host Blue and health care providers. It is generally calculated as the difference between the Covered Charge and the Maximum Allowable Fee. This result is then added to any other reductions in the liability to a provider pursuant to a contract between Wellmark and the provider, including, but not limited to, reductions for failure to satisfy any notification requirements and medical necessity determinations. If the amount paid to a provider on any claim exceeds the Covered Charges, the Network Savings may be reflected as a negative dollar amount on Account's bill.

1.23 "**Plan**" means the group health plan or plans sponsored and maintained by Account, the terms of which are described in the applicable Benefits Document.

1.24 "**Plan Member**" means a common law employee or other individual identified by Account as a person eligible and enrolled to receive health benefits under the Plan subject to the terms, conditions, and limitations described in the Plan documents and who is the applicant on a completed enrollment form that has been provided to and accepted by Wellmark.

1.25 "**Plan Year**" means the year designated by the plan sponsor as the plan year in the plan document of the Plan or as set forth on Exhibit "A".

1.26 "**Protected Health Information**" or "**PHI**" means the same as the term "protected health information" in 45 CFR §160.103.

1.27 "**Rating Period**" means the period of time set forth on Exhibit "A" or the most recent revision to Exhibit "A".

ARTICLE 2
RESPONSIBILITIES OF ACCOUNT

2.1 **Group Health Plan Compliance**. Account is the plan administrator and plan sponsor of the Plan for purposes of this Agreement and ERISA, if applicable. Account will exercise its responsibilities in the time required by law and has full responsibility for all of the following:

a. Maintaining the Plan, determining Plan design, and funding payment of Incurred Claims;

b. Determining eligibility criteria for Members in accordance with Wellmark's established enrollment and underwriting guidelines, including the requirements for locations or Members located outside of Iowa; Account is responsible for enrolling and canceling individuals in the Plan in accordance with such criteria and agrees to terminate coverage for ineligible individuals;

c. Designating the Plan Year for the Plan;

d. Compliance with all applicable laws, reporting and disclosure requirements, including specifically, furnishing Members with Plan documents or notices as may be required by law, the non-discrimination provisions of ACA and HIPAA, and the notices and requirements with regard to COBRA continuation coverage. Account's responsibilities for administration of COBRA requirements may be

delegated to Wellmark, but only to the extent expressly specified and agreed upon with Wellmark in a COBRA Administrative Services Agreement or Addendum;

e. Reviewing and approving promptly templates or drafts of Benefits Document(s) provided by Wellmark, and delivering or making available Benefits Document(s), and provider directories if applicable, to Plan Members. Based on the eligibility and benefit information Account provides, Wellmark will draft written Benefits Document(s) stating the benefits, terms and conditions of the Plan. Account is responsible for reviewing the draft Benefits Document(s) promptly, typically within thirty (30) days of receiving the draft document(s), and determining to Account's satisfaction that the document(s) meet all of Account's legal and business obligations and advising Wellmark of any necessary revisions or approval. In the absence of Account's approval, Wellmark will administer the benefits in accordance with the benefit information provided by Account and Wellmark's most similar standard Benefits Document(s) language;

f. Making final determinations regarding claims, claims internal appeals, or claims exceptions, except to the extent expressly delegated to, and accepted by, Wellmark in Sections 3.1 and 3.4 of this Agreement;

g. Delivering to Plan Members the notices and documents required by ACA, HIPAA, or ERISA, if applicable, in the time and manner required by law, including the summary of benefits and coverage ("**SBC**"), the summary of material modification, employer notice of the availability of coverage options under the health insurance marketplace, and applicable HIPAA notices relating to health coverage portability such as the Special Enrollment Notice. Account will also make available to Members on request the uniform glossary of insurance-related terms;

h. Providing to Wellmark written notice of initial benefit selections, limitations, and exclusions, changes in the benefits at renewal, or material modifications at any time during the Rating Period. Account shall provide such notice(s) in the time and manner required by Wellmark to fulfill the issuance of SBCs, preparation of Benefits Document templates, or the issuance of other required notices within the time required by law;

i. If the Account terminates the coverage of any Plan Member or Member retroactively, Account represents that it either has not collected any premium contribution from the retroactively terminated Member, or has refunded any premium contribution to the retroactively terminated Member, for the period following the effective date of the termination;

j. Payment of any state premium tax, use tax, or similar tax, or any similar benefit or Plan-related charge, tax, surcharge or assessment, however denominated, that may be assessed on the Plan or related to the administration of the Plan, including any penalties and interest payable with respect thereto;

k. If the Account has a Grandfathered Health Plan, Account shall notify Wellmark at least sixty (60) days prior to the effective date written notice of any change in the

employer contribution information or any other information that may impact the Grandfathered Health Plan determination;

l. Account shall maintain a process for external review of final internal adverse benefit determinations as required by ACA, except to the extent expressly delegated to, and accepted by, Wellmark in this Agreement; and

m. Calculating, reporting, and payment of any fees and assessments, however denominated, required for all group health plans under ACA, including specifically, the per Member Patient-Centered Outcomes Research fees and the Transitional Reinsurance Program fees. Account's responsibilities for calculation and reporting of the Transitional Reinsurance Program fees only may be delegated to Wellmark, but only to the extent expressly specified and agreed upon with Wellmark as shown in Exhibit "A" attached to this Agreement.

2.2 **Furnishing Information; Electronic Information**. Account agrees to furnish Wellmark with reports, data, and information, including but not limited to, eligibility, enrollment, and demographic information for each Member (including social security numbers for each Member as required by law), benefit selection or benefit changes for the Plan, claims history, and information necessary for the administration of coordination of benefits, limitations, exclusions contained in the Plan, and any other Account services. Account shall provide all such information in a time, form, electronic format if applicable, and manner required by Wellmark and is responsible for the timeliness, integrity, retention, and accuracy of information and records provided to Wellmark. Wellmark shall be entitled to rely upon such information in determining any person's rights to benefits under the Plan, in determining the availability or renewability of health plans that may be offered to Account, and in discharging its responsibilities under this Agreement. Account recognizes the importance to the successful provision of the Administrative Services the timely, accurate, and complete reporting of the information set forth in this section and that should there be a delay in Account's delivery of such information, Wellmark shall not be responsible for the provision of the Administrative Services affected by such delay.

Eligibility or enrollment information provided to Wellmark on an electronic basis shall be provided in a standard medium and layout using Wellmark's proprietary format, the HIPAA ANSI 834 standard format, or an application such as BluesEnroll, unless the parties agree in writing to a non-standard format or application. Account acknowledges that it may be responsible for additional fees if it uses a non-standard format or if Wellmark is required to perform a comparison study of the full eligibility file.

2.3 **Account Representation; Notice of Persons Eligible for Coverage; Changes in Eligibility**. Account represents to Wellmark that the terms of any eligibility criteria, conditions, and/or waiting period imposed under the Plan are, and shall be for so long as this Agreement is in effect, in compliance with all applicable laws and regulations, including specifically, the prohibition on excessive waiting periods. Account shall enroll persons eligible for coverage in the Plan in advance of each person's effective date of coverage and shall provide Wellmark with each person's name, Plan selection, and other required identifying information. Account shall provide all initial enrollment information in advance of the Effective Date of this Agreement. As new persons become eligible, or as eligibility changes occur, including any special enrollment events that require a person to be offered coverage or changed to a different enrollment status such as COBRA or state continuation, Account shall provide Wellmark with updated required

information as the changes occur, in advance of the effective date of the change if possible, or at least once each week. Account's delay in providing eligibility changes more than three (3) months following the effective date of the change shall delay the requested effective date of coverage for the person and may cause Incurred Claims not to be paid.

2.4 **Notice of Persons Terminated or No Longer Eligible for Coverage; Account's Liability for Claims Paid for Ineligible Individuals**. Account shall notify Wellmark of each person's termination or ineligibility for coverage under the Plan in advance, but in no event no later than three (3) months following the requested date of termination. If Account does not notify Wellmark within three (3) months following the requested date of termination, the requested termination shall not be effective any earlier than three (3) months prior to the date Wellmark receives the required notice. If Incurred Claims prior to the date Wellmark is notified of the coverage termination have been paid and are not recouped, Account shall be responsible for the Claims Paid. For Claims Paid prior to the date Wellmark is notified of the coverage termination related to pharmacy services or supplies, Account shall pay the amount of the Claims Paid. For Claims Paid prior to the date Wellmark is notified of the coverage termination for all other services or supplies, Wellmark shall, at its election, (a) attempt to recoup such payments from the individual or the involved provider, unless Wellmark determines recoupment is not feasible under the circumstances, or extends beyond an eighteen (18) month recoupment period; or (b) bill Account for such Claims Paid and associated Administrative Fee and Account shall pay the amount due to Wellmark.

2.5 **Medicare Secondary Payer ("MSP")**. Federal law mandates coordination of health care benefits in certain instances where a Member is covered under both a group health plan and Medicare. Proper coordination of benefits in this context depends on obtaining and maintaining accurate and timely information regarding such dual health coverage. Pursuant to contract and applicable law, Wellmark provides information to Centers for Medicare and Medicaid Services ("CMS") regarding such dual health coverage for Members and Account enrollment on a quarterly or more frequent basis.

Account is solely responsible for compliance with MSP laws and other requirements. Wellmark shall use all information provided by Account to properly coordinate benefits. In the event Account does not timely provide to Wellmark information requested by Wellmark regarding Account's size and status and Employer Identification Number(s), or does not gather and timely provide information to Wellmark concerning the Medicare enrollment of Members, Account enrollment, and related information (including, without limitation, Member Social Security Numbers), or such other information as requested by Wellmark for inclusion on the Confirmation of MSP form submissions and other disclosures, Account shall be solely responsible for non-compliance with MSP laws and other requirements, including, without limitation, any damages, losses, taxes, interest charges, and administrative penalties (including, without limitation, any civil money penalties) that may be assessed or otherwise result in connection therewith (including, without limitation, any claims by Members, providers or other claimants), and mistaken payments to CMS on behalf of Medicare enrolled Members.

2.6 **Customized Services**. From time to time, Account may request Wellmark to provide customized services. Such services shall be performed pursuant to further written agreement between Account and Wellmark. Account shall be charged according to the prevailing fees on the Wellmark price schedule or as agreed by the parties in advance.

2.7 **Grandfathered Health Plan Representation**. In the event Account is being issued a new Agreement by Wellmark and the Plan is to be treated by Wellmark as a Grandfathered Health Plan, Account represents and warrants to Wellmark that (a) its prior health plan coverage was, immediately prior to termination of such coverage, a Grandfathered Health Plan, and (b) the Plan will include no changes that will result in loss of treatment as a Grandfathered Health Plan as of the Effective Date of this Agreement.

2.8 **Stop Loss Insurance Coverage**. Account is solely responsible for the Claims Paid for Members of the Plan. Account may at its option purchase stop loss insurance coverage from Wellmark, which shall be reflected in a separate policy issued by Wellmark. If Account purchases stop loss insurance coverage from a carrier other than Wellmark, Account shall advise Wellmark of the terms of such coverage. Account shall be solely responsible for all reports, submission of claims, payment of premiums, and any other obligation required by its stop loss policy.

ARTICLE 3
WELLMARK'S RESPONSIBILITIES

3.1 **Determination of Claims; Administrative Services**. During the term of this Agreement and subject to Account's payment to Wellmark, when due, of the charges for Claims Paid and other fees specified in this Agreement, Wellmark shall provide Administrative Services as specified in this section as follows:

a. Wellmark shall provide Account with a written draft of Benefits Document(s), for Account's review and approval as required by Section 2.1(d), setting forth the benefits, terms and conditions of the Plan for delivery to Plan Members;

b. Wellmark shall provide access to networks of health care providers and shall make information about the networks and network providers available to Members through print, Wellmark's website (Wellmark.com), or telephone or electronic service;

c. Wellmark shall prepare, print, and deliver identification cards to Plan Members;

d. Wellmark shall retain records relating to the Account, Plan and Members in accordance with all applicable state and federal laws;

e. Wellmark shall provide or make available to Account on Wellmark's website for employers or by other means in the time and manner required by law, forms of ACA or HIPAA required notices, including the summary of benefits and coverage ("**SBC**") and applicable HIPAA notices relating to health coverage portability such as the Special Enrollment Notice. Wellmark shall provide electronic access to the uniform glossary of insurance-related terms;

f. Subject to Section 6.1(c), Wellmark shall determine benefits and process Incurred Claims for health services furnished Members in accordance with the terms, limitations and conditions set forth in the Plan, the Benefits Document(s), this Agreement, applicable laws and regulations, the terms of the applicable provider agreements, and the claims administration and medical policies of

Wellmark, all of which may be revised from time to time. Processing of claims may include payment by Wellmark on behalf of Account and reporting of benefits to providers or Members, coordination of benefits, and the monitoring, detection, and investigation of potentially abusive or fraudulent claims submitted by providers or Members. Except for Paid Claims related to pharmacy services or supplies, Wellmark may make adjustments to processed claims, for a period of up to eighteen (18) months after the Incurred Claim was first processed, if Wellmark determines in its sole discretion that such adjustments are necessary and appropriate and Wellmark shall credit Account for adjustments to Claims Paid to the extent of the amount recovered. Notwithstanding the preceding sentence and except as provided in Sections 2.3 and 2.4 of this Agreement, Wellmark shall not be required to reprocess claims as a result of any changes made to information relating to a Member or the Member's benefits unless (i) in addition to submitting changes to Wellmark, Account expressly requests in writing that Wellmark reprocess specific Member claims; and (ii) such reprocessing does not extend beyond eighteen (18) months prior to the date Wellmark receives Account's request;

g. Wellmark shall process claims for benefits and shall maintain a single-level internal appeal procedure for Members to appeal adverse benefit determinations each in accordance with the applicable requirements of the Plan, ACA and ERISA, as applicable. Wellmark shall also maintain a procedure for processing external review requests of final internal adverse benefit determinations with appropriate independent review organizations, pursuant to the applicable requirements of the Plan, ACA, and ERISA, if applicable. Fees and costs for external review billed by independent review organizations ("**IROs**") will be billed to Account; and

h. To the extent that Account has delegated discretionary authority to Wellmark, Wellmark shall exercise its discretion to make determinations in connection with the administration of this Agreement and the Plan including, without limitation, determinations regarding whether services are medically necessary or whether charges are reasonable. Wellmark shall make determinations that are not arbitrary or capricious and such determinations shall be final and conclusive to the extent permitted by this Agreement and by law.

3.2 **Health and Care Management Services.** Wellmark may, at its sole discretion, offer or arrange for various Health and Care Management Services. Such services that may be offered are further described in the **Health and Care Management Services Exhibit**, attached to this Agreement and incorporated by this reference, and including those services, if any, specifically selected by Account as listed on Exhibit “A” attached to this Agreement. Health and Care Management Services may be changed, replaced, or discontinued from time to time and may be modified or removed in accordance with the Health and Care Management Services Exhibit.

3.3 **Subrogation**. Wellmark shall provide subrogation recovery service for Claims Paid while this Agreement is in force, but shall have no obligation to initiate subrogation recovery services after this Agreement is terminated and shall have no obligation to continue subrogation recovery services initiated prior to termination more than twelve (12) months following termination of the Agreement. Following the twelve (12) month run-out period, Wellmark will forward any open subrogation files information to Account. The nature and

extent of efforts to pursue subrogation recovery are within the sole discretion of Wellmark. Such subrogation recovery service may include all steps necessary to recover Claims Paid that may be found to be the liability of a third party or other insurance carrier. The Account shall be responsible for all fees or costs, including attorney's fees and the fees and costs of any third party utilized by Wellmark to perform subrogation recovery services, incurred in the recovery process, with those costs and fees first paid from any funds recovered and the net amount only credited to Account's Claims Paid amounts. Account acknowledges that its stop loss carrier has priority of any recovery in the event the Claims Paid exceed the stop loss attachment level and there is insufficient recovery to reimburse stop loss carrier and Account in full. The Account shall accept any such recoveries as negotiated by Wellmark as payment in full and the determination of the recovery amount is within the sole discretion of Wellmark.

Wellmark has sole discretion with regard to the choice of counsel to pursue subrogation recovery. Wellmark may choose to allow a Member's counsel to represent the Account's subrogation interest. However, if the fee charged for collection of the subrogation interest by legal counsel retained by the Member exceeds the prevalent fees for such services, Wellmark shall not authorize pursuit or settlement of the subrogation claim by said Member's attorney or payment of that attorney's fee without Account's written authorization. Further, if in the opinion of Wellmark, recovery of funds shall not offset the costs associated with such recovery, or recovery of the funds is not otherwise practicable, Wellmark shall inform the Account in writing of its opinion. Thereafter, unless the Account directs otherwise, Wellmark shall not further pursue the claim. In the event Account directs Wellmark to pursue Account's subrogation interest notwithstanding Wellmark's notice to Account of its opinion that the recovery shall not offset the involved costs, Account shall be responsible for all attorney's fees and costs incurred by Wellmark to pursue recovery, including the reasonable cost of Wellmark's staff time as determined by Wellmark.

Wellmark does not guarantee the recovery of funds and nothing in this section or Agreement obligates Wellmark to participate in or initiate any subrogation efforts or litigation to recover Claims Paid.

3.4 **Discretionary Authority**. Wellmark is hereby delegated the authority to determine claims for benefits and to determine internal appeals of adverse benefit determinations of Members, provided such determinations are consistent with the terms of the Plan, this Agreement, the applicable Benefits Document, ACA, and ERISA, as applicable, unless otherwise directed in writing by the Account. In making the decisions regarding claims for benefits and appeals of denied claims, Wellmark shall have discretionary authority only to the limited extent necessary to construe and interpret the terms of the Plan and to determine whether a claim is properly payable under the Plan. Notwithstanding anything herein to the contrary, Account shall have full responsibility for Plan design, for making any and all determinations whether an individual has satisfied the requirements to be a Member, and for making any determination regarding an individual's eligibility for continued coverage pursuant to COBRA.

ARTICLE 4
BILLING AND PAYMENT

4.1 **Billing; Account's Payment to Wellmark**. Account authorizes Wellmark and Wellmark agrees to process Incurred Claims as received, subject to the limitations, conditions, and exclusions stated in the Benefits Document.

Wellmark shall bill Account for Claims Paid, Network Access Fee, Administrative Fee, and other fees, based on the billing and payment method set forth on Exhibit "A", attached to this Agreement. Any adjustments due to membership or eligibility changes shall be reflected on the billing for the month in which the membership or eligibility change is made. Adjustments to Network Access Fee, Administrative Fee, and other fees, billed on a per Plan Member or per Member basis, shall be limited to a period of three (3) months prior to the date Wellmark processes the Member eligibility change. Wellmark shall provide a bill to Account that shows the amounts due and, if applicable, the amounts of any weekly payments received by Wellmark and other credits during the preceding month. Account shall promptly pay Wellmark at Wellmark's office, the total amount due, no later than the due date on the bill. Such payment may be made by wire transfer, check, automatic funds withdrawal or electronic means. If Account elects automatic funds withdrawal, it shall execute the necessary authorization. If a credit amount exceeds the amount due, Wellmark shall refund such amount to Account.

If Account elects to authorize automatic funds withdrawal from a deposit account, the automatic withdrawal will change to correspond with the applicable billing. Account's authorization for automatic funds withdrawal shall include authorization for automatic withdrawal of any changed amount unless Account calls or provides its bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If Account calls its bank to stop payment, Account may be required to provide a written request within fourteen (14) days after the call. Account will be responsible for any fee assessed by its bank for stop-payment orders made by Account.

4.2 **Late Payments**. All payments from Account to Wellmark must be paid on time and when due in accordance with Section 4.1. If the Account fails to make payments in full when due, Wellmark may in its discretion do any or all of the following: impose interest or late fees; setoff late payments from other amounts that may be due to Account under the Agreement; stop the payment of all claims for Members, regardless of the Incurred Date; require an alternative billing and payment method; or require an alternative financial arrangement. Payments not made when due shall include an interest charge on the outstanding amount from the due date until payment is made in full at the then current prime rate as published in the Midwest edition of The Wall Street Journal plus two percent (2%). The acceptance by Wellmark of any late payments or partial payments shall not constitute a waiver of any rights under this Agreement. If Account fails to make payments when due for two or more consecutive months, Wellmark may impose additional late fees of up to eighteen percent (18%) per annum.

ARTICLE 5
CONFIDENTIAL INFORMATION; REPORTING; EXAMINATION OF RECORDS

5.1 **Protected Health Information.** The rights and responsibilities of the parties and permitted uses and disclosures with respect to Protected Health Information shall be set forth in the separately executed Business Associate Agreement. If Account desires

access to mental health information, Account shall file an applicable statement with the Iowa Division of Insurance, as may be required pursuant to Iowa Code Section 228.7.

5.2 **Non-Disclosure of Confidential Information**.

a. Subject to the terms of the Business Associate Agreement and as permitted by applicable law, the Receiving Party will: (i) not disclose Confidential Information to any third party that is not an agent or consultant to Wellmark without the written authorization of the Disclosing Party; (ii) restrict disclosure of Confidential Information only to those employees, agents or consultants who have a need to know the Confidential Information for purposes related to this Agreement or the administration of the Plan and who are bound by confidentiality terms substantially similar to those in this Agreement, or its attorneys; (iii) use the same degree of care as for its own information of like importance, but at least use reasonable care, in safeguarding against disclosure of Confidential Information; and (iv) without unreasonable delay notify the Disclosing Party upon discovery of any unauthorized use or disclosure of the Confidential Information and take reasonable steps to regain possession of the Confidential Information and prevent further unauthorized actions or other breach of this Agreement.

b. If the Receiving Party is required to disclose Confidential Information pursuant to applicable law, statute, or regulation, or court order, for a purpose other than contemplated in this Agreement, the Receiving Party will give to the Disclosing Party prompt written notice of the request and a reasonable opportunity to object to such disclosure and seek a protective order or appropriate remedy. If, in the absence of a protective order, the Receiving Party determines, upon the advice of counsel, that it is required to disclose such information, it may disclose only Confidential Information specifically required and only to the extent compelled to do so.

c. All Confidential Information remains the property of the Disclosing Party and will not be copied or reproduced without the express written permission of the Disclosing Party, except for copies that are necessary to fulfill the confidentiality obligations contained in this Agreement, to render the services under this Agreement, or as otherwise allowed under the Business Associate Agreement or applicable law. A party may retain Confidential Information when obligated to do so as a matter of law, and may also retain any Protected Health Information as set forth in the Business Associate Agreement.

5.3 **Wellmark's Right to Use Confidential Information**. Wellmark shall have the right to de-identify or remove direct identifiers from the Confidential Information so that it no longer constitutes Protected Health Information, and so that such Confidential Information is no longer identifiable with respect to Account, and to aggregate such de-identified Confidential Information for any purpose whatsoever; provided that such use is in accordance with all applicable laws, including but not limited to HIPAA. Such Confidential Information, after it is de-identified or limited pursuant to HIPAA, shall no longer be subject to Section 5.2 and shall thereafter be Wellmark's property.

5.4 **Right to Examine Records; Audit**. Wellmark or its authorized representative may at its own expense examine the financial, enrollment, and claims records of Account reasonably related to the administration of this Agreement, as reasonably often as

Wellmark deems appropriate, to reconcile enrollment information and records, to determine whether Account can make the payments required by this Agreement, or to determine payment of benefits under the Plan. Such examination shall be conducted during regular business hours, upon reasonable advance written notice. The examination period may cover the most recent twenty-four (24) months only, if applicable. Upon completion of the examination, Wellmark shall share its examination findings with Account and conduct an exit conference with Account. Any third party conducting such audit on Wellmark's behalf must agree in writing to be bound by the terms and conditions of the Business Associate Agreement between Account and Wellmark.

Account's third-party authorized representative or auditor may, at Account's own expense, examine Wellmark's records reasonably and necessarily related to Wellmark's discharge of its responsibilities under this Agreement no more frequently than annually. Account shall provide Wellmark with written authorization specifying the Account or Plan information that Wellmark may disclose to the auditor. The auditor must be acceptable to Wellmark, must not compete directly or indirectly with Wellmark, and must execute a non-disclosure agreement with Wellmark prior to receiving any Protected Health Information or Wellmark Confidential Information. Such examination shall be conducted during regular business hours, upon advance written notice reasonable under the circumstances. Records subject to examination include claims records (but not including individually identifiable sensitive diagnosis information unless Account specifically authorizes such disclosure), third-party explanations of health care benefits, eligibility records, and coordination of benefits procedures. The examination period may cover the most recent twenty-four (24) months only, notwithstanding the period for claim adjustments as may be specified in Section 3.1. Upon completion of the examination, Account shall share its examination findings with Wellmark and conduct an exit conference with Wellmark.

Audits conducted by auditors compensated on a contingency fee basis are not permitted by Wellmark as such compensation arrangements are not consistent with professional auditing standards. Such standards consider these compensation arrangements to impair the auditor's or consultant's independence and objectivity. Audit practice and procedure under this Agreement will conform to generally accepted auditing and accounting principles.

5.5 **Website Access and Reporting**. Wellmark may provide Account with secured access to Wellmark's website, web-based applications, or other electronic databases with respect to the Plan and Members for the purpose of reporting, billing, or for self service. Web-based applications or databases with Member and Plan specific Confidential Information may be hosted or supported by third parties on Wellmark's behalf. If Account or a third party acting on Account's behalf accesses such websites or information, Account is subject to and agrees to all of the terms and conditions, including security restrictions and user requirements as established by Wellmark with respect to such access, as such terms are set forth in a data use agreement and in the applicable Terms and Conditions posted at Wellmark's website (Wellmark.com).

5.6 **Survival**. Any obligations of either party to the other under this Article of the Agreement survive any termination of this Agreement.

ARTICLE 6
PROVIDER PAYMENT ARRANGEMENTS; CLAIMS RECOVERIES; REBATES; ACOS; DISCLOSURE OF COMPENSATION

6.1 **Provider Payment Arrangements**. Wellmark will be responsible for negotiating and entering into separate payment arrangements with health care providers. Such provider payment arrangements and agreements shall apply to services by such providers for all Members entitled to benefits under plans insured or administered by Wellmark, including Members under this Plan.

Wellmark shall determine, in its sole discretion, the payment arrangements with health care providers including, without limitation, the Maximum Allowable Fees for Incurred Claims. Without limiting the foregoing, Wellmark may compensate providers pursuant to a variety of payment arrangements, including the following:

a. Fee for service arrangements, including, without limitation, per diem and percent of charge arrangements;

b. Fixed fee or other methodology that is based on pre-determined criteria; or

c. Episode of care arrangements under which payment is based on a pre-established rate for a health care encounter, including, without limitation, a hospital stay or outpatient visit. In the event such an arrangement is utilized, Wellmark, consistent with the methodology established by Wellmark for such arrangement, is not required to impose cost share responsibility on Members for each Covered Service Members receive.

6.2 **Network Savings Allocations**. Any Network Savings amounts allocated to the Account shall be reflected in the amount of Claims Paid. Based on Wellmark's payment arrangements with health care providers, and in accordance with Section 6.1, the amount paid on an individual claim may be more or less than the Covered Charge minus any applicable Amounts Not Covered, deductible, copayment, and coinsurance amounts. If the amount paid to a provider on any claim exceeds the Covered Charge, the Network Savings is reflected as a negative dollar amount. Any Network Savings amounts allocated to Plan Members shall be reflected in the calculation of coinsurance, where applicable. The calculation of coinsurance depends on the type and location of the services provided and the contracting status of the health care provider. The calculation of coinsurance is further described in the applicable Benefits Document.

6.3 **Non-Contracting Providers**. If the applicable Benefits Document provides benefits for Covered Services rendered by health care providers that have not contracted with Wellmark or another Blue Cross and Blue Shield Plan ("Non-Contracting Providers"), Members may be liable to Non-Contracting Providers for any difference between the Covered Charges and the Maximum Allowable Fee and Members are responsible for paying the provider in full.

6.4 **Claims Recoveries**. From time to time, Wellmark, Account, or Plan may receive notice of a pending or potential lawsuit (including, without limitation, a class action lawsuit) that seeks recovery of health care claims expenses on behalf of one or more group health plans or payors and that may include Wellmark, Account, or the Plan as a party or potential class member (a "Lawsuit"). Notwithstanding any language to the contrary in

this Agreement, Wellmark shall not participate in a Lawsuit on behalf of Account or Plan or pursue recovery on behalf of Account or Plan unless Wellmark and Account enter into a separate written agreement relating to participation, recovery, and expenses in such Lawsuit. Wellmark has no duty to notify Account or Plan of Wellmark's receipt of any notices in connection with any Lawsuit and each party is free to make its own determination whether to initiate or participate in any Lawsuit on its own behalf.

6.5 **Disclosure and Payment of Drug Rebates**. Wellmark contracts with pharmacy benefits manager(s) to provide pharmacy benefits management services. Wellmark receives from its pharmacy benefits manager(s) prescription drug rebates paid by drug manufacturers. Approximately three calendar quarters following the payment of claims for such drugs, Wellmark's pharmacy benefits manager(s) shall, in conjunction with manufacturers, calculate the proportionate share of manufacturer rebates that are attributable to the use of drugs for which rebates have been paid to the pharmacy benefits manager(s) and forward such amount to Wellmark. Wellmark shall credit or pay to Account quarterly the amount of the rebate remitted to Wellmark by the pharmacy benefits manager(s), or, in the event this Agreement has terminated, Wellmark shall either credit or pay any rebate amount directly to Account. The amount of the rebate payment may vary and additional rebate amounts may become available. Additional amounts, if any, Wellmark receives from the pharmacy benefits manager(s) in subsequent quarters will be credited to Account. Wellmark shall periodically provide Account with the total number of rebated claims and average rebate per prescription. Wellmark does not independently determine the amount of the rebate but rather relies on the pharmacy benefits manager(s) to perform that calculation and forward the results to Wellmark. Prior to the actual credit or payment of rebates, Wellmark's pharmacy benefits manager(s) or Wellmark may provide to Account the amount of rebates billed by the pharmacy benefits manager(s) to manufacturers or other estimates. Such billed amounts or other estimates may be higher or lower than the actual rebates credited or paid to Account and are not binding on Wellmark or its pharmacy benefits manager(s). The rebates shall not be allocated or distributed by Wellmark in any manner to Members nor shall the rebates be taken into account in determining any applicable deductibles, coinsurance, copayment, or out-of-pocket maximum amounts for which the Member is responsible.

6.6 **Accountable Care Organizations; Value-Based Programs.** An accountable care organization ("**ACO**") or other value-based program is a local health care organization comprised of health care providers and provider organizations that is held accountable for the quality and cost of care delivered to a defined population. Value-based programs may include ACOs, patient centered medical homes, or other programs developed by Wellmark, the Blue Cross and Blue Shield Association, or Host Blues. Wellmark has entered into collaborative arrangements with such value-based programs under which the health care providers participating in such programs are eligible for financial incentives relating to quality and cost-effective care of Wellmark members. Identifiable Data regarding Account's Members may be included in the information Wellmark provides to the value-based programs and used by the value-based program and its providers. Account authorizes Wellmark to disclose Members' Data to such value-based programs and any providers involved in such programs for use by the value-based program.

6.7 **Disclosure of Compensation**. Wellmark shall comply with Department of Labor requirements regarding the disclosure of compensation received from all sources in connection with this Agreement.

ARTICLE 7
LIABILITY OF THE PARTIES

7.1 **Responsibility for Claims**. Account is solely responsible for all Claims Paid for its Members, including, without limitation, an individual added or deleted as a result of a retroactive eligibility change. Wellmark provides Administrative Services and network access only and does not assume any financial risk or obligation with respect to claims, including, without limitation, any Claims Paid. Wellmark has no obligation to pay Incurred Claims if Account fails to pay or reimburse Wellmark in accordance with this Agreement.

7.2 **No Duty to Defend**. Wellmark shall have no duty or obligation to defend against any action or proceeding brought against Account or Plan to recover a claim for benefits. Wellmark shall, however, make available to Account and its counsel, such evidence relevant to such action or proceeding as Wellmark may have as a result of its administration of the contested benefit determination.

7.3 **Account's Liability**. Except as otherwise explicitly provided in this Agreement, Account shall accept the tender of defense and have the liability for all Plan benefit claims and all expenses incident to the Plan, and agrees to release, hold harmless, and indemnify Wellmark and its employees, officers, and directors against any and all amounts, expenses, losses, liability, claims, lawsuits, injuries, damages, taxes, interest charges, administrative penalties, and other costs or obligations, including reasonable attorneys' fees and court costs, for which Wellmark may become liable:

a. due to any state premium tax, use tax, or similar tax, or any similar benefit or plan-related charge, surcharge or assessment, federal tax, excise tax, or fee imposed on group health plans or plan sponsors under ACA, however denominated, including any penalties and interest payable with respect thereto, assessed against Wellmark on the basis of and/or measured by the amount of Plan benefits administered by Wellmark pursuant to this Agreement;

b. due to any action or proceeding brought by a third party to recover benefits under the Plan;

c. due to a release of Confidential Information to Account, the Plan, or a third party at Account's direction or arising out of any improper use of Confidential Information by Account or such third party;

d. due to Account's failure to timely provide requested information to Wellmark for inclusion on the Confirmation of MSP form submissions and other disclosures that relate to Account's size and status, Employer Identification Number(s), the Medicare enrollment of Members, Account enrollment, and related information (including, without limitation, Member Social Security Numbers), or such other information requested by Wellmark resulting in processing of claims not in compliance with MSP laws and other requirements in accordance with Section 2.5;

e. due to Account's failure to comply with applicable law relating to issuing or failing to issue the required notices in accordance with Section 2.1(g);

f. due to Account's failure or delay in providing accurate reports, data, and information regarding eligibility, enrollment, and social security number information for each Member, benefit selection, limitations, exclusions, or benefit changes for the Plan, claims history, and other information necessary for Wellmark to administer the terms, coordination of benefits, limitations, and exclusions contained in the Plan;

g. due to the Account's or its employees' or agents' negligence or material breach of their obligations under this Agreement, except to the extent that any such losses are caused by the negligence or willful misconduct of Wellmark;

h. arising from any other acts or omissions of Account that constitute a material breach of an obligation hereunder or which, in the aggregate, constitute a failure on the part of Account to perform its obligations under this Agreement in accordance with the provisions of this Agreement; or

i. due to or arising out of Wellmark's adherence with any direction from Account or decision made by Account with regard to the Plan design, provisions in the Benefits Document, or the Administrative Services provided under this Agreement.

7.4 **Selection of Counsel**. In the event litigation is instituted by a third party against the Account and/or Wellmark concerning any matter under the Plan, including a suit for Plan benefits, each party to this Agreement shall, to the extent possible, advise the other of the legal action, and shall have sole authority to select legal counsel of its choice.

7.5 **Wellmark's Liability**. In performing its obligations under this Agreement, Wellmark shall use reasonable diligence and that degree of skill and judgment possessed by one experienced in furnishing claim administration services to group health plans of similar size and characteristics as the Plan. Wellmark agrees to release, hold harmless, and indemnify Account and its employees, officers, and directors against any and all amounts, expenses, losses, liability, claims, lawsuits, injuries, damages, taxes, interest charges, administrative penalties, and other costs or obligations, including reasonable attorneys' fees and court costs, for which Account may become liable:

a. arising from any acts or omission of Wellmark which constitute a material breach of an obligation hereunder or which, in the aggregate, constitute a failure on the part of Wellmark to perform its obligations under this Agreement in accordance with the provisions of this Agreement; and

b. arising from any allegation of a breach of confidentiality arising out of release of Confidential Information to Wellmark or a third party at Wellmark's direction or arising out of any improper use of Confidential Information by Wellmark or such third party.

7.6 **Disclaimer of Warranties; Limitation of Liability**. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, WELLMARK DOES NOT MAKE AND HEREBY DISCLAIMS ANY REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR

IMPLIED, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, REGARDING ANY OF THE SERVICES WELLMARK PROVIDES OR ARRANGES TO PROVIDE UNDER THIS AGREEMENT. IN NO EVENT SHALL ANY PARTY BE LIABLE FOR INDIRECT, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR SPECIAL DAMAGES, LOSS OF DATA OR LOST PROFITS, EVEN IF THAT PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THE FOREGOING LIMITATION OF LIABILITY REPRESENTS THE ALLOCATION OF RISK BETWEEN THE PARTIES AS REFLECTED IN THE PRICING HEREUNDER AND IS AN ESSENTIAL ELEMENT OF THE BASIS OF THE BARGAIN BETWEEN THE PARTIES. ADDITIONAL DISCLAIMER OF WARRANTIES AND LIMITATION OF LIABILITIES REGARDING HEALTH AND CARE MANAGEMENT SERVICES ARE SET FORTH IN THE HEALTH AND CARE MANAGEMENT SERVICES EXHIBIT.

7.7 **Grandfathered Health Plan Disclaimer**. Account has the sole obligation to determine the status of its Plan as either a Grandfathered Health Plan or a Non-Grandfathered Health Plan.

Wellmark does not make any representation or warranty and Wellmark expressly disclaims any and all representations or warranties, oral or written, regarding the past, present, or future Grandfathered Health Plan status of the Plan.

No federal or state official has determined that this Plan qualifies as a Grandfathered Health Plan, and to the extent that this Plan is determined to be eligible as a Grandfathered Health Plan, Wellmark makes no representation or warranty that this status will be retained during the current Rating Period or any future renewal.

Wellmark is not responsible and shall not be liable for any claims, costs, liabilities, losses, penalties, damages or other expenses of any kind whatsoever that, directly or indirectly, arise from or relate to this Plan's past, present and future Grandfathered Health Plan status, lack thereof, or any changes regarding the Plan's past, present and future Grandfathered Health Plan status, including, but not limited to, any representation made by any employee, broker, agent, or independent contractor of Wellmark regarding this Plan's past, present and future Grandfathered Health Plan status.

7.8 **No Testing for Health Plans**. Wellmark will not determine whether coverage is discriminatory or otherwise in violation of Internal Revenue Code Section 105(h). Wellmark also will not provide any testing for compliance with Internal Revenue Code Section 105(h). Wellmark will not be held liable for any penalties or other losses resulting from Account offering coverage in violation of Section 105(h).

7.9 **Survival**. The indemnities set forth in this Article, including any liability of either party to the other for indemnification shall survive the termination of this Agreement.

ARTICLE 8
TERM AND TERMINATION

8.1 **Term**. This Agreement shall become effective on the Effective Date and shall continue in force for the Rating Period.

8.2 **Renewal Terms**. Unless terminated or superseded, this Agreement shall continue in force from year to year. Wellmark shall have the right to change any of the Administrative Fees or other fees for any renewal term upon thirty (30) days advance written notice. Any such changes shall be reflected on a revised or new Exhibit "A" issued by Wellmark.

8.3 **Termination Notice**. Either party may terminate this Agreement at any time by giving written notice of termination delivered to the other party at least thirty (30) days in advance of the effective date of termination.

8.4 **Termination for Nonpayment**. Wellmark may terminate this Agreement at any time, upon ten (10) days written notice delivered or mailed to Account, if Account fails to make complete payments, including late fees, when due in accordance with this Agreement or Wellmark determines that Account has inadequate funds to make payments required by this Agreement. Account is solely responsible for notifying its Plan Members of the termination of this Agreement for nonpayment or for any other reason.

8.5 **Effects of Termination**. If Wellmark terminates this Agreement for nonpayment, Wellmark shall not be required to pay on behalf of Account any Incurred Claims beyond the effective date of the termination regardless of when services were received and Wellmark may recoup Paid Claims for which Account has not paid Wellmark.

8.6 **Termination and Claims Administration**. If, following termination of this Agreement for reasons other than Account's nonpayment, Incurred Claims with Incurred Dates prior to the date of termination are submitted to Wellmark in the period specified in the Benefits Document for timely filing of claims, Wellmark shall pay these claims on behalf of Account in accordance with this Agreement and submit bills to the Account for the payment of Claims Paid for a period of twelve (12) months following termination. The bills shall also include a Network Access Fee amount when the Network Access Fee, shown on Exhibit "A", is reflected as a percentage of Network Savings or when Account makes retroactive changes to add or delete a Plan Member from coverage during the Rating Period. The Account shall pay all bills in accordance with the procedures set forth in Section 4.1. Wellmark shall not, on behalf of Account, pay Incurred Claims with dates of service following the date of termination. Wellmark shall not continue any other services for Account after the effective date of termination.

8.7 **Availability of Records**. Upon written request by the Account, Wellmark will make available to any successor benefit services administrator, designated by the Account, standard reports and materials in its possession at the time of termination that are reasonably necessary to continue the administration of the Plan. Wellmark shall provide such materials in its standard format and Account shall pay a reasonable fee for such services.

8.8 **Survival**. Any liability of either party to the other for amounts owed or owing under this Agreement, unless such amounts are de minimus, shall not be extinguished by the termination of this Agreement.

ARTICLE 9
BLUE CROSS AND BLUE SHIELD DISCLOSURES

9.1 **Blue Cross and Blue Shield Disclosure Statement**. Account on behalf of itself and its Members, hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between Account and Wellmark, which is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (BCBSA), permitting Wellmark to use the Blue Cross and Blue Shield Service Marks in the state of Iowa, and that Wellmark is not contracting as the agent of BCBSA. Account on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Wellmark and that no person, entity, or organization other than Wellmark shall be accountable or liable to Account for any of Wellmark's obligations to Account created under this Agreement. This section shall not create any additional obligations whatsoever on the part of Wellmark other than those obligations created under other provisions of this Agreement.

9.2 **Account Locations or Members Outside of Iowa**. Account understands and agrees that Wellmark defines a National Account as a company headquartered and located in Iowa that also has employees in other states whose claims are processed through Inter-Plan Programs. If Account is headquartered in Iowa, any employees or persons associated with Account are eligible for coverage under the Account's Plan, including those employed or working at Account locations outside Iowa. If Account is not headquartered in Iowa, only those employees or individuals associated with the Iowa business locations are eligible for coverage under the Account's Plan, and coverage will be void for any persons associated with Account locations outside of Iowa. Eligibility of persons located outside of Iowa, or associated with Account locations outside of Iowa, is subject to applicable law and Blue Cross and Blue Shield Association guidelines.

9.3 **Out-of-Area Services**. Wellmark has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access health care services outside the geographic area Wellmark serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Wellmark 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 Wellmark serves, obtain care from health care 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 nonparticipating health care providers. Wellmark's payment practices in both instances are described below.

a. **BlueCard® Program**. Under the BlueCard® Program, when Members access Covered Services within the geographic area served by a Host Blue, Wellmark will remain responsible to Account for fulfilling Wellmark's contract 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 health care providers, and providing some managed care services. 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, Wellmark's action will be consistent with the spirit of this description.

i. **Liability Calculation Method Per Claim**. The calculation of the Member liability on claims for Covered Services processed through the BlueCard Program, if not a flat dollar copayment amount, will be based on the lower of the participating health care provider's Covered Charges or the negotiated price made available to Wellmark by the Host Blue.

The calculation of Account's liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Wellmark by the Host Blue. Sometimes, this negotiated price may be greater than billed charges if the Host Blue has negotiated with its participating health care provider(s) an inclusive allowance (e.g., per case or per day amount) for specific health care services.

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

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

c) an average price. An average price is a percentage of Covered Charges representing the aggregate payments negotiated by the Host Blue with all of its health care 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 Blues using either an estimated price or an average price may, in accordance with Inter-Plan 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 Account 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 Wellmark 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 Account pays in a variance account, pending settlement with its participating health care providers. Because all amounts paid are final, neither variance account funds held to be paid, nor funds expected to be received, are due to or from Account. Such payable or receivable would be eventually exhausted by health care 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 a Host Blue either (i) to use a basis for determining Member liability for Covered 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 health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Wellmark would then calculate Member liability and Account's liability in accordance with applicable law.

ii. **Return of Overpayments**. Under the BlueCard Program, recoveries from a Host Blue or its participating health care providers can arise in several ways including, but not limited to, anti-fraud and abuse recoveries, health care 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 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.

iii. **BlueCard Program Fees and Compensation**. Account understands and agrees to reimburse Wellmark for certain fees and compensation which Wellmark is 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 Accounts. 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 Account benefit period under this Agreement.

All BlueCard Program-related fees, including any access fees paid to Host Blues, are included in Wellmark’s Network Access Fee and its Administrative Fee. Per claim BlueCard Program access fees will be limited to the Program’s then allowable percentage of Network Savings

received from the Host Blue and will not exceed $2,000 per claim. Account will consider any increases to the Network Access Fee and Administrative Fee amounts due to increases in BlueCard fees and compensation at the next renewal.

Wellmark's Network Access Fee, shown on Exhibit "A", may include the following fees associated with claims processing:

a) Access fees
b) Administrative Expense Allowance (AEA) fees
c) Per Contract Per Month (PCPM) fees
d) Non-Standard AEA fees.

Wellmark's Administrative Fee, shown on Exhibit "A", may include the following fees associated with claims processing:

a) Central Financial Agency (CFA) fees
b) ITS transaction fees.

b. **Nonparticipating Health Care Providers Outside Wellmark's Service Area**.

i. **Member Liability Calculation**. When Covered Services are provided outside of Wellmark's service area by nonparticipating health care providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's nonparticipating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating health care provider bills and the payment Wellmark will make for the Covered Services as set forth in this paragraph.

ii. **Exceptions.** In some exception cases, Wellmark may pay claims from nonparticipating health care providers outside of Wellmark's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by Wellmark in Wellmark's sole and absolute discretion or by applicable state law. In other exception cases, Wellmark may pay such claims based on the payment Wellmark would make if Wellmark were paying a nonparticipating provider inside of Wellmark's service area, as described elsewhere in this Agreement, where the Host Blue's corresponding payment would be more than Wellmark's in-service area nonparticipating provider payment, or in Wellmark's sole and absolute discretion, Wellmark may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating health care provider bills and the payment Wellmark will make for the Covered Services as set forth in this paragraph.

iii. **Fees and Compensation**. Account understands and agrees to reimburse Wellmark for certain fees and compensation which Wellmark is 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 specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by any Accounts. 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 Account benefit period under this Agreement.

All Inter-Plan Program-related fees are included in Wellmark's Administrative Fee. Account will consider any increases to the Administrative Fee amount due to increases in Inter-Plan Program fees and compensation at the next renewal.

Wellmark's Administrative Fee, shown on Exhibit "A", may include the following fees associated with claims processing:

a) Central Financial Agency (CFA) fees
b) ITS transaction fees.

ARTICLE 10
MISCELLANEOUS

10.1 **Change of Agreement**. If Account makes changes in the Plan or Benefits Document, Account shall give Wellmark sufficient advance notice of such changes. If Account makes any material changes in the Plan, or if material changes are required by law, including the addition or deletion of benefits, a material change in group composition or membership or eligibility requirements, such as a change in the number of eligible individuals of more than ten percent (10%), percentage of individuals enrolled, types of coverage offered, business entities covered, or offerings of other health insurers' coverage to eligible individuals, Wellmark shall have the right at its option to amend this Agreement, including an adjustment to the financial terms shown on Exhibit "A", or to terminate this Agreement in accordance with Section 8.3.

10.2 **Iowa Code Chapter 509A Compliance; No Actuarial Certification**. Nothing contained in this Agreement or on Exhibit "A" shall be construed or considered to be an actuarial opinion or certification by Wellmark in connection with Iowa Code Chapter 509A regarding the adequacy of reserves, rates, or financial condition of Account or the Plan. Account is solely responsible for compliance with all provisions of Iowa Code Chapter 509A and implementing regulations and, if applicable, is responsible for reporting any paid losses for the Account's self-funded operation of the Plan, as required by Iowa Code Section 513C.10, and for paying any assessment related to those paid losses.

10.3 **Use of Trademarks and Names**. Wellmark and Account reserve the right to control the use of their respective corporate names and any other respective symbols, assumed names, trademarks, and service marks, presently existing or subsequently established. Wellmark and Account agree not to use the corporate name, symbol, assumed names, trademarks, or service marks of the other in advertising, promotional materials, or otherwise without the prior written consent of the other. Any previously approved usage shall cease immediately upon the termination of this Agreement and any materials using

such names or marks are the property of the appropriate namesake and shall be returned to the appropriate property owner upon request or at the termination of this Agreement.

10.4 **Complete Agreement; Amendments**. The parties agree that this Agreement, including, without limitation, any Exhibits or amendments hereto, applicable Business Associate Agreement, the Health and Care Management Services Exhibit, and COBRA Administrative Services Agreement or Addendum, if any, constitute the complete and exclusive agreement and statement of the relationship between the parties with regard to the subject matter of this Agreement and supersedes all related discussions, understandings, proposals, exhibits, amendments, prior and concurrent agreements, representations and warranties, whether oral or written, and any other communications between the parties in regard to the subject matter hereof. This Agreement, including, without limitation, any Exhibits hereto, may be amended from time to time by Wellmark, and such amendments to this Agreement shall be effective only when the written amendment has been signed by an authorized representative of Wellmark and delivered in accordance with Section 10.11. Any other change, modification, or waiver of any of the terms or provisions of this Agreement shall be effective only when made in writing and signed by each party. This Agreement shall take precedence over any other documents that may be in conflict with it.

Notwithstanding the foregoing, if this Agreement supersedes a prior Agreement, health services with an Incurred Date prior to the Effective Date of this Agreement shall be processed pursuant to the terms of the applicable superseded Agreement.

10.5 **Force Majeure**. The parties to this Agreement shall be excused from any performance under this Agreement, other than payment of amounts due, for any period and to the extent they are delayed, restricted, or prevented from performing under this Agreement as a result of an act of God, war, civil disturbance, court order, labor dispute, act of terrorism, or other cause beyond their reasonable control.

10.6 **Limitation of Action**. Notwithstanding Sections 5.6, 7.9, and 8.8, no legal or equitable action or claim, may be brought against Wellmark for an action or claim arising under or relating to this Agreement more than two (2) years after the cause of action arose.

10.7 **Assignment**. The Agreement shall be binding on the parties and their respective successors and permitted assigns. Neither party may assign this Agreement to any third party, in whole or in part, without the prior written consent of the other; provided, however, Wellmark may assign this Agreement, in whole or in part, to any entity that controls, is controlled by, or is under common control with Wellmark. Further, Wellmark may, in its sole and unfettered discretion, contract with a third party to perform some Administrative Services or other of Wellmark's duties under this Agreement, including, without limitation, the subrogation recovery services for Claims Paid. To the extent Wellmark contracts with a third party to perform any such services or duties, the term "Wellmark" as used in this Agreement shall be deemed to include the contracted third party, as the context so requires.

10.8 **Waiver**. The failure of any party to enforce any terms or provisions of the Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Agreement shall not be deemed or construed to be a waiver of such default. Any waiver

of any provision of this Agreement, and any consent to any departure from the terms of any provision of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.

10.9 **Nature of Relationship; Authority of Parties**. Nothing contained in this Agreement and no action taken or omitted to be taken by Account or Wellmark pursuant hereto shall be deemed to constitute Account and Wellmark a partnership, an association, a joint venture or other entity whatsoever. Wellmark shall at all times be acting as an independent contractor under this Agreement. No party has the authority to bind the other in any respect whatsoever.

10.10 **No Third-Party Beneficiaries**. This Agreement is for the benefit of Account and Wellmark and not for any other person. It shall not create any legal relationship between Wellmark and any employee, Member, or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or of the Plan.

10.11 **Notices and Communication**. The parties shall be entitled to rely upon any communication or notice from the other in connection with this Agreement to be genuine, truthful, and accurate, and to have been authorized, signed, or issued by an officer or agent of such entity empowered to make such representation on behalf of the entity.

Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed given when delivered personally, placed in the U.S. mail (postage prepaid), delivered to a recognized courier service for delivery (delivery charges prepaid), or sent by electronic means and addressed to the last address furnished in writing. Until another address is furnished in writing, notice to Account may be addressed to the address shown on Exhibit "A" attached to this Agreement.

Notice to Wellmark may be addressed:

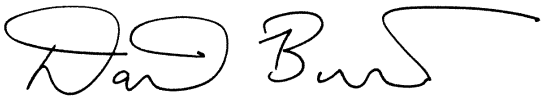
Wellmark Blue Cross and Blue Shield of Iowa
Attention: Procurement and Contracts
1331 Grand Avenue
Des Moines, Iowa 50309-2901

10.12 **State of Issue; Applicable Law; Venue**. This Agreement is issued and delivered in the state of Iowa and is performed in Des Moines, Iowa. To the extent not superseded by the laws of the United States and without regard to any conflict of law rule, this Agreement shall be construed in accordance with and governed by the laws of the state of Iowa. Any action in regard to this Agreement or arising out of the terms of this Agreement shall be instituted and litigated in the Iowa District Court or the United States District Court located in Des Moines, Polk County, Iowa, and no other.

ARTICLE 11
EFFECTIVENESS OF AGREEMENT AND WAIVER OF JURY TRIAL

THIS AGREEMENT shall be deemed to be effective and in full force as of the Effective Date indicated at the beginning of the Agreement upon the affixation of Wellmark's authorized signature below and the Account's payment to Wellmark of the Claims Paid, Network Access Fee, Administrative Fee, or other fees as billed by Wellmark. **ACCOUNT AND WELLMARK WAIVE ANY RIGHT TO A JURY TRIAL WITH RESPECT TO AND IN ANY ACTION, PROCEEDING, CLAIM, COUNTERCLAIM, DEMAND OR OTHER MATTER WHATSOEVER ARISING OUT OF THIS AGREEMENT.**

Wellmark, Inc., doing business as
Wellmark Blue Cross and Blue Shield of Iowa

By: 

David S. Brown
Executive Vice President, Chief Financial Officer and Treasurer

Wellmark Blue Cross and Blue Shield of Iowa
Administrative Services Agreement
Exhibit A
Administrative Fees, Network Access Fees, Other Fees

Account Full Legal Name and Legal Address:

City of Fort Dodge
Municipal Building
819 1st Ave S
Fort Dodge, IA 50501

Benefit Plan(s) Administered By:

Wellmark Blue Cross and Blue Shield of Iowa

Rating Period:

The Rating Period begins on 1/01/2015 and ends on 12/31/2015.

Plan Year:

The Plan Year begins on 01/01 and ends on 12/31.

Administrative Fee:

Health:	$37.35	per Plan Member per month based on active Plan Members on last day of billing month (subject to limitations listed under Billing and Payment Method below).

Pharmacy Administrative Fee:

	$0.68	per Member per month based on active Members on last day of billing month (subject to limitations listed under Billing and Payment Method below).

Network Access Fee:

	$8.26	per Plan Member per month based on active Plan Members on last day of billing month (subject to limitations listed under Billing and Payment Method below).

External Review:

External review fees for Independent Review Organizations (IROs), if applicable, will be on a per case or per external review basis and all such fees attributable to Members under the Plan shall be billed to Account in the amount billed to Wellmark by the IRO.

Subrogation:

The subrogation recovery vendor retains a service fee calculated on the recovered amount after deductions for attorneys' fees and costs. For the current calendar year the service fee is 12 ¾% of the recovered amount. This fee is subject to change. The final recovered amount received from the vendor is credited to Account.

Wellmark Blue Cross and Blue Shield of Iowa
Administrative Services Agreement
Exhibit A
Administrative Fees, Network Access Fees, Other Fees

Account Full Legal Name and Legal Address:

City of Fort Dodge
Municipal Building
819 1st Ave S
Fort Dodge, IA 50501

Billing and Payment Method:

Wellmark shall bill Account and Account shall pay monthly the Claims Paid, Administrative Fee, and all other fees.

Limitations: Any adjustments to Administrative Fee, Network Access Fee, and other fees due to membership or eligibility changes shall be reflected on the billing for the month in which the membership or eligibility change is made and shall be limited to a period of three (3) months prior to the date Wellmark processes the Member eligibility change.

Exhibit A Issue Date: 11/24/2014

HEALTH AND CARE MANAGEMENT SERVICES EXHIBIT

THIS EXHIBIT ("**Exhibit**") is attached to and constitutes a part of the Administrative Services Agreement by and between Wellmark and Account (the "**Administrative Services Agreement**"). Any capitalized term not otherwise defined herein shall have the meaning ascribed to it in the Administrative Services Agreement.

I. RECITALS

A. Pursuant to the Administrative Services Agreement, Wellmark provides certain claims administration, enrollment, and health and care management services for Account.

B. Wellmark delivers these various health and care management services described in Section II of this Exhibit ("**Health and Care Management Services**") to Wellmark's Members and other eligible individuals, either directly or through agreements with third-party vendors (the "**Vendors**") (each, a "**Vendor Agreement**").

C. Account desires to obtain, and Wellmark desires to provide, Health and Care Management Services all as further described herein.

II. SERVICES

Wellmark may, at its sole discretion, make certain Health and Care Management Services available to Account and the cost for which is included in the Administrative Fee. Wellmark may, at its sole discretion, make certain other Health and Care Management Services available for Account's purchase at a fee in addition to the Administrative Fee. Account has signified which Health and Care Management Services it wishes to purchase and such services and fees are stated in **Exhibit "A"**, Administrative Fees, Network Access Fees, Other Fees, to the Administrative Services Agreement. In consideration of the Health and Care Management Services to be received by Account from Wellmark, Account shall pay to Wellmark the fees, if any, set forth on **Exhibit "A"** to the Administrative Services Agreement. Account acknowledges that the fees may change from time to time.

TELEPHONIC PERSONAL HEALTH ASSISTANT 24/7. Telephonic Personal Health Assistant 24/7 is generally comprised of a dedicated toll-free telephone number, available twenty four hours per day, seven days per week, three hundred sixty-five days per year, that will be staffed by a registered nurse, licensed practical nurse or non-nurse personnel, who assist Members by providing information, education, decision-making assistance, advocacy and help in navigating the health care system.

ADVANCED CARE MANAGEMENT. Advanced Care Management is generally comprised of individualized coaching and support to members with severe or complex conditions.

WELLNESS SERVICES. If Account's election includes Wellness Services, which may include any of the following: Online Wellness Center and Wellness Assessment; Wellness Assessment - paper; Telephonic Health Coaching; Wellness Screenings (biometrics) - fingerstick, venipuncture, home kit or physician fax; Smoking Cessation - stand alone or with nicotine replacement; or Wellness Challenges, the following provision applies: Wellness Services are designed to help Members reduce lifestyle-related health risk factors and develop healthy behaviors. Wellness Services include assessments and behavior change tools meant to help individuals improve health, increase productivity, and decrease absenteeism.

CONDITION SUPPORT (DISEASE MANAGEMENT). If Account's election includes Condition Support (Disease Management), which may include any of the following: Asthma, Coronary Artery Disease ("CAD"), or Diabetes, the following provision applies: Condition Support (Disease Management) Services are generally comprised of the identification of Members with conditions that require significant self-care and the rendering of support through coordinated interventions and communications.

PREGNANCY SUPPORT. If Account's election includes Pregnancy Support ("**Pregnancy Support**"), the following provision applies: Pregnancy Support is generally comprised of the identification of Members who are at risk for preterm births or other complications, as well as the rendering of support through personalized health information, education, and assistance.

WELLNESS CONSULTING SERVICES. If Account elects Wellness Consulting Services ("**Consulting Services**"), which may include any of the following: Workplace Wellness Assessment; Wellness Communication Strategy; Wellness Committee Development; Vending and Cafeteria Audit; Employer Wellness Incentive Design; Employer Wellness Dashboard and Metrics; Community Based Vendor Selection; Worksite Policy and Practice Review; Wellness Certification/Accreditation; or Custom Worksite Wellness Consulting, the following provision applies: Consulting Services are generally comprised of assisting employers with creating wellness programs at their worksites.

TERMS AND CONDITIONS

1. **Term and Termination.** This Exhibit shall cover the Health and Care Management Services provided to Account as set forth in Exhibit "A" to the Administrative Services Agreement, effective as of the effective date set forth therein.

1.1 Wellmark may terminate this Exhibit or any Health and Care Management Services immediately by written notice to Account upon the termination or expiration of the Administrative Services Agreement or any Vendor Agreement or any attachment thereunder.

1.2 Wellmark may, at any time, in its discretion, terminate this Exhibit in the event of Account's failure to pay when due the fees and other amounts payable to Wellmark under this Exhibit, where such failure is not cured within ten (10) days following Wellmark's written notice to Account specifying such failure.

1.3 This Exhibit may be terminated by Wellmark or by Account at any time, with or without cause, for any reason or no reason, effective thirty (30) days following the terminating party giving written notice to the other party of its intent to terminate this Exhibit.

2. **Representations and Warranties of Account.** Account hereby represents and warrants to Wellmark as follows:

2.1 In the performance of its obligations under this Exhibit, Account shall comply with all applicable federal, state or local laws and regulations, including, without limitation, HIPAA, the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, the Americans with Disabilities Act, as amended by the Americans with Disabilities Amendments Act, the Genetic Information Non-Discrimination Act, and laws and regulations regarding maintenance and confidentiality of health, financial and other information and records, and will only access, use and disclose health, financial and other information and records in accordance with all applicable laws.

2.2 Account will not describe, discuss or promote the web portal used in connection with the Health and Care Management Services (the "**Web Portal**") in any way that is inconsistent with, or would add to, the terms and conditions of use set forth on the Web Portal.

3. **Performance Level Specifications**. Wellmark may provide or the Vendor Agreements may contain certain performance guarantees obligating Wellmark or its Vendors to meet the attributes of performance that the Health and Care Management Services shall achieve, all as set forth in detail in the respective Vendor Agreement or performance level guarantee schedule, if applicable (the "**Performance Level Specifications**" or "**PLS**"). If a Vendor does not achieve a specific PLS, pursuant to that Vendor Agreement, Wellmark shall be entitled to reimbursement of a specified percentage of the fees relating to the Health and Care Management Service at issue that are earned by that Vendor under the Vendor Agreement (the "**PLS Fees**"). To be eligible to receive its pro-rata share of PLS Fees, Account must (i) have purchased the relevant Health and Care Management Service for all 12 months of the relevant program year, and (ii) remain a customer of Wellmark through the date Wellmark receives PLS Fees for the applicable time period from its Vendors. Account will not receive any PLS Fees for any Health and Care Management Services it did not purchase and Account will not receive PLS Fees for any Consulting Services purchased hereunder.

4. **Ownership of Health and Care Management Services.** The Health and Care Management Services and their content are proprietary to Wellmark, the Vendors and their respective affiliates or suppliers, as the case may be. Except as expressly set forth in this Exhibit, the Health and Care Management Services may not be duplicated, modified, reproduced, or used for the benefit of any third party. Account acknowledges and agrees that it does not now own, nor by virtue of this Exhibit or the Health and Care Management Services rendered hereunder shall it acquire, any right, title or interest in or to the Health and Care Management Services or the intellectual property underlying such Health and Care Management Services, including, without limitation, educational materials, software, source code, hardware, technology, content, information, know how, forms, policies, procedures, manuals, specifications, service models, and designs, or any confidential information belonging to Wellmark or the Vendors or their respective affiliates or suppliers, and that all such right, title and interest is and shall remain owned by Wellmark, Vendors, or their respective affiliates or suppliers, as applicable.

5. **Changes in Law and Regulations.** Notwithstanding any other provision of this Exhibit, if any federal, state or local governmental agency or court of competent jurisdiction passes, issues, interprets or promulgates any law, rule, regulation, standard, decision or interpretation (collectively, an "**Act**") at any time while this Exhibit is in effect that prohibits the performance of, or materially enlarges, Wellmark's obligations hereunder, or otherwise impairs, restricts, limits or otherwise materially and adversely affects Wellmark's rights, benefits, or obligations hereunder, Wellmark may give Account notice of intent to amend this Exhibit to the reasonable satisfaction of Wellmark in order to comply with any such Act.

6. **Disclaimer of Warranties; Limitation of Liability.** THE HEALTH AND CARE MANAGEMENT SERVICES ARE EDUCATIONAL AND INFORMATIONAL TOOLS ONLY AND DO NOT CONSTITUTE CLINICAL SERVICES. EXCEPT AS EXPRESSLY SET FORTH IN THIS EXHIBIT, WELLMARK DOES NOT MAKE AND HEREBY DISCLAIMS ANY REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, REGARDING THE HEALTH AND CARE MANAGEMENT SERVICES, THEIR ABILITY TO REDUCE COSTS OR IMPROVE OUTCOMES. WELLMARK IS NOT RESPONSIBLE FOR DATA INACCURACIES IN THE SOURCE DATA PROVIDED BY ACCOUNT OR MEMBERS. IN NO EVENT SHALL WELLMARK BE LIABLE FOR INDIRECT, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR SPECIAL DAMAGES, LOSS OF DATA OR LOST PROFITS, EVEN IF WELLMARK HAS BEEN ADVISED OF THE

POSSIBILITY OF SUCH DAMAGES. WELLMARK'S AGGREGATE MONETARY LIABILITY TO ACCOUNT OR ITS MEMBERS OR AFFILIATES UNDER THIS EXHIBIT AND WITH RESPECT TO THE HEALTH AND CARE MANAGEMENT SERVICES FURNISHED HEREUNDER (WHETHER UNDER CONTRACT, TORT, OR ANY OTHER THEORY OF LAW OR EQUITY) SHALL NOT EXCEED, UNDER ANY CIRCUMSTANCES, THE FEES PAID BY ACCOUNT TO WELLMARK FOR THE HEALTH AND CARE MANAGEMENT SERVICES UNDER THIS EXHIBIT DURING THE ONE (1) YEAR PERIOD PRECEDING THE CLAIM, LESS THE AMOUNT OF ANY PLS FEES REIMBURSED TO ACCOUNT DURING THAT TIME. THE FOREGOING LIMITATION OF LIABILITY REPRESENTS THE ALLOCATION OF RISK BETWEEN THE PARTIES AS REFLECTED IN THE PRICING HEREUNDER AND IS AN ESSENTIAL ELEMENT OF THE BASIS OF THE BARGAIN BETWEEN THE PARTIES.

HEALTH INFORMATION PROVIDED BY WELLMARK OR THROUGH ITS VENDORS OR THEIR AFFILIATES IS BASED ON MEDICAL LITERATURE. HOWEVER, USE OF SUCH INFORMATION IS NOT INTENDED TO REPLACE PROFESSIONAL MEDICAL ADVICE AND CARE FROM A HEALTH CARE PROFESSIONAL. THE HEALTH INFORMATION IS INTENDED TO HELP PEOPLE MAKE BETTER HEALTH CARE DECISIONS AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH, BUT MAY NOT RESULT IN ACTUAL ACHIEVEMENT OF THESE GOALS. ACCOUNT EXPRESSLY ACKNOWLEDGES AND AGREES THAT WELLMARK IS NOT RESPONSIBLE FOR THE RESULTS OF ITS MEMBERS' USE OF SUCH INFORMATION, INCLUDING, BUT NOT LIMITED TO, MEMBERS CHOOSING TO SEEK OR NOT TO SEEK PROFESSIONAL MEDICAL CARE, EMERGENCY CARE, OR MEMBERS CHOOSING OR NOT CHOOSING SPECIFIC TREATMENT.

STOP LOSS POLICY

WELLMARK, INC.

and

City of Fort Dodge

Stop Loss Period: January 1, 2015 to December 31, 2015

Form Number: IA Wellmark, Inc. LG SLP Version: 11/14

STOP LOSS POLICY

THIS STOP LOSS POLICY (herein "**Policy**") is issued by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, an Iowa mutual insurance company, (herein "**Wellmark**") to City of Fort Dodge (herein "**Account**").

RECITALS

1. Account is the plan sponsor of a self-funded group health plan (herein called "the **Plan**") within the meaning of and in accordance with applicable federal or state law established for its Members. The Plan is maintained and funded by Account and Account is solely responsible for Claims.

2. Account desires that Wellmark reimburse it for Claims that satisfy the amounts and terms specified in this Policy. Account acknowledges this Policy provides it with reimbursement only for Claims meeting the terms specified in this Policy and Wellmark provides no other insurance coverage for the Plan. Wellmark assumes no financial obligation except as specified in this Policy.

NOW, THEREFORE, it is hereby agreed as follows:

ARTICLE 1
POLICY DEFINITIONS

1.1 "**Aggregate Deductible**" means the percentage of expected Claims Eligible for Reimbursement for all Members during the Stop Loss Period that is the Account's liability before any reimbursement is made under the aggregate stop loss coverage of this Policy. The Aggregate Deductible amount is shown on **Exhibit "A"**, Stop Loss Premiums and Financial Terms, which is attached to this Policy and incorporated by this reference.

1.2 "**Attachment Point**" means the amount of expected Claims Eligible for Reimbursement per Plan Member for each benefit classification. The Attachment Point is used to determine Account's Aggregate Deductible and Minimum Aggregate Deductible and is shown on **Exhibit "A"**, Stop Loss Premiums and Financial Terms, which is attached and incorporated by this reference.

1.3 "**Benefit Services Administrator**" means the company or companies providing health benefit plan administration services to Account pursuant to a separately executed administrative services agreement during the Stop Loss Period as shown on **Exhibit "A"**, Stop Loss Premiums and Financial Terms, which is attached and incorporated by this reference.

1.4 "**Claims**" means the dollar amount of the Benefit Services Administrator's payment on behalf of the Account for health care services furnished to Members that are benefits of the Plan administered by the Benefit Services Administrator. Claims may be adjusted for a period of eighteen (18) months after the Claim is first processed.

1.5 "**Claims Eligible for Reimbursement**" means Claims that have both an Incurred Date and Paid Date within the time period specified on Exhibit "A".

1.6 "**Incurred Date**" means the date health services are provided to Members. For inpatient hospital or facility services, the date of the Member's admission to the facility is the Incurred Date.

1.7 "**Individual Deductible**" means the fixed dollar amount of Claims Eligible for Reimbursement for each Member during the Stop Loss Period that is the Account's liability before any reimbursement is made under the individual stop loss coverage of this Policy. The Individual Deductible amount is shown on Exhibit "A".

1.8 "**Member**" means a person, including a Plan Member's spouse or eligible dependents, who is eligible and enrolled to receive health benefits as defined in the terms of the Plan administered by the Benefit Services Administrator.

1.9 "**Minimum Aggregate Deductible**" means an amount that is the Account's minimum liability under the aggregate stop loss coverage of this Policy. The Minimum Aggregate Deductible is the product of the number of Plan Members in effect for each Attachment Point, multiplied by each Attachment Point shown on Exhibit "A", multiplied by 90%. The results of the calculations shall be added together each month during the Stop Loss Period resulting in the year-to-date (YTD) Minimum Aggregate Deductible. The Minimum Aggregate Deductible is calculated at the beginning of the Stop Loss Period, based on the enrollment under each Attachment Point and may be recalculated during the Stop Loss Period due to a benefit change.

1.10 "**Paid Date**" means the date, on which a Claim payment is made by the Benefit Services Administrator. If a Claim is subsequently adjusted, the date of the adjustment is considered the Paid Date, provided, however, that a Claim adjusted in accordance with a decision of an Independent Review Organization making an external review determination, will use the date of the Benefit Services Administrator's adverse benefit determination as the Paid Date.

1.11 "**Plan Member**" means a common law employee, retiree, or other individual identified by Account as a person eligible and enrolled to receive health benefits subject to the terms, conditions, and limitations defined in the Plan administered by the Benefit Services Administrator.

1.12 "**Protected Health Information**" **or "PHI"** means the same as the term "protected health information" in 45 CFR §160.103.

1.13 "**Stop Loss Claims**" mean amounts that qualify for reimbursement under this Policy.

1.14 "**Stop Loss Period**" means the period of time set forth on Exhibit "A" or the most recent revision to Exhibit "A" issued to Account and attached to this Policy.

1.15 "**Stop Loss Premium**" means an amount that Wellmark charges Account for stop loss coverage. The Stop Loss Premium may include broker fees or commissions and is shown on Exhibit "A".

ARTICLE 2
RESPONSIBILITIES OF ACCOUNT

2.1 **Payment of Premiums**. Wellmark shall bill Account monthly and Account agrees to pay Wellmark the amount of the Stop Loss Premiums billed for the preceding month. Such payment may be made by wire transfer, check, automatic funds withdrawal, or electronic means. If Account elects automatic funds withdrawal, it shall execute the necessary authorization. Any adjustments due to membership or eligibility changes shall be reflected on the billing for the month in which the membership or eligibility change is made. Adjustments shall be limited to a period of three (3) months prior to the date Wellmark processes the Member eligibility change. The bill will show the amounts due and will also show any credits during the preceding month. Account shall promptly pay Wellmark at Wellmark's office, the total amount due, no later than the due date on the bill.

2.2 **Late Payments**. All payments must be paid on time and when due in accordance with Section 2.1. If the Account fails to make payments in full when due, Wellmark may discontinue the reimbursement of all Stop Loss Claims for the Account. Payments not made when due shall include an interest charge on the current amount due from the due date until payment is made in full at the then current prime rate as published periodically in the Midwest edition of The Wall Street Journal plus two percent (2%). Late fees are calculated on the entire amount due regardless of any partial payments. The acceptance by Wellmark of any late payments or partial payments shall not constitute a waiver of any rights under this Policy. If Account fails to make payments when due for two or more consecutive months, Wellmark may impose additional late fees of up to eighteen percent (18%) per annum.

2.3 **Providing Information**. Account shall provide all information reasonably necessary and as may be requested by Wellmark to establish loss for which reimbursement is claimed under this Policy. Account shall provide such information in a time, form, electronic format if applicable, and manner required by Wellmark and is responsible for the timeliness, integrity, retention, and accuracy of information and records provided to Wellmark. Wellmark shall be entitled to rely upon such information in discharging its responsibilities under this Policy. Account's failure to provide such information may cause Stop Loss Claims to be denied.

2.4 **Records Retention - Audit Privileges**. Account agrees that any records relating to the submission or reimbursement of Stop Loss Claims shall be made available to Wellmark or its authorized representatives for a period of twenty-four (24) months following the end of a Stop Loss Period.

2.5 **Notice of Persons Eligible for Coverage**. Account shall notify Wellmark of individuals eligible for the Plan and of changes in eligibility in accordance with the time and procedures set forth in the separate Administrative Services Agreement entered into between Account and the Benefit Services Administrator. Notwithstanding the effective date Account establishes for Member eligibility, no eligibility change shall be effective under the stop loss coverage more than three (3) months prior to the date the Benefit Services Administrator processes the Member eligibility change.

2.6 **Subrogation**. Account agrees that it shall pursue and prosecute any and all subrogation interests that Account may have against a third-party or any current or former Member who recovers from a third-party as a consequence of any occurrence resulting in Claims or who fails to pursue and prosecute such a right of recovery against a third-party. Account may delegate responsibility for subrogation recovery services to the Benefit Services Administrator. If Account initiates any action for recovery, Account shall notify Wellmark of such action within ten (10) days of filing such action. Account shall cooperate with Wellmark and, upon request of Wellmark, Account shall execute and deliver to Wellmark an assignment and any other instrument that may be necessary to secure Wellmark's right of recovery.

In the event Account recovers all or any portion of Claims from a third-party or from a current or former Member and Wellmark has previously paid or reimbursed Account for all or any portion of such Claims pursuant to this or a prior Stop Loss Policy, Account shall repay Wellmark the full amount of the recovery received by the Account up to the full extent of Wellmark's stop loss payment(s), regardless of whether this Policy is still in force on the date of Account's recovery. On a case by case basis, and only if Wellmark has agreed in writing and in advance, Account may reduce the amount it repays to Wellmark by reasonable and necessary expenses incurred directly by Account in obtaining recovery from the third party.

ARTICLE 3
STOP LOSS COVERAGE

3.1 **Individual Stop Loss Coverage**. Wellmark shall reimburse Account for the excess amount when the Claims Eligible for Reimbursement for a Member exceed the Individual Deductible shown on Exhibit "A", subject to any Policy limitations set forth on Exhibit "A".

3.2 **Aggregate Stop Loss Coverage**. Wellmark shall determine the aggregate stop loss coverage reimbursement as described in this Section.

a. For each month of the Stop Loss Period, the monthly Claims Eligible for Reimbursement shall be calculated by accumulating all Claims for that month, less any reimbursement made under the individual stop loss coverage during the same Stop Loss Period, less any Claims excluded from the aggregate stop loss coverage. The monthly Claims Eligible for Reimbursement shall be added together for all months during the Stop Loss Period, resulting in the year-to-date (YTD) Claims Eligible for Reimbursement;

b. For each month of the Stop Loss Period, the number of Plan Members in effect for each benefit classification shall be multiplied by the Attachment Point for each benefit classification shown on Exhibit "A". The results of the calculations shall then be added together, resulting in the monthly Aggregate Deductible. Each monthly Aggregate Deductible shall be added together for all months during the Stop Loss Period, resulting in the year-to-date (YTD) Aggregate Deductible; and

c. If the YTD Claims Eligible for Reimbursement exceed the greater of the YTD Aggregate Deductible or the YTD Minimum Aggregate Deductible, Wellmark shall reimburse Account for the excess amount within sixty (60) days after the period in which Claims are eligible for reimbursement. If the YTD Claims Eligible

for Reimbursement is less than the greater of the YTD Aggregate Deductible or the YTD Minimum Aggregate Deductible, no reimbursement by Wellmark will be made.

ARTICLE 4
CONFIDENTIAL INFORMATION; EXAMINATION OF RECORDS

4.1 **Protected Health Information**. The rights and responsibilities of the parties and permitted uses and disclosures with respect to Protected Health Information shall be set forth in the separately executed Business Associate Agreement.

4.2 **Non-Disclosure of Confidential Information**. The rights and responsibilities of the parties and permitted uses and disclosures with respect to information and data collected or developed by Wellmark related to Claims, cost, utilization, outcomes, quality, and financial performance of the Plan during the term of this Policy ("**Confidential Information**") shall be as set forth in the separately executed administrative services agreement between Account and the Benefit Services Administrator.

4.3 **Right to Examine Records**. Wellmark or its authorized representative may at its own expense examine the financial, enrollment, and Claims records of Account or its Benefit Services Administrator reasonably related to the administration of this Policy, as reasonably often as Wellmark deems appropriate, to reconcile enrollment information and records or to determine payment of Stop Loss Claims under this Policy. Such examination may be conducted either before or after reimbursement and shall be conducted during regular business hours, upon reasonable advance written notice. The examination period may cover the most recent twenty-four (24) months only, if applicable.

4.4 **Survival**. Any obligations of either party to the other under this Article of the Policy survive any termination of this Policy.

ARTICLE 5
TERM AND TERMINATION

5.1 **Term**. This Policy shall become effective as of the first date of the Stop Loss Period as set forth on Exhibit "A" and shall continue in force for the Stop Loss Period.

5.2 **Renewal Terms**. This Policy may be renewed for successive Stop Loss Periods only when a new Policy with an updated Exhibit "A" specifying a new Stop Loss Period is issued and executed by Wellmark. If Wellmark decides not to renew the Policy, it shall provide Account written notice of non-renewal delivered or mailed at least forty-five (45) days prior to the end of the term.

5.3 **Termination for Nonpayment**. Wellmark may terminate this Policy at any time, upon ten (10) days written notice delivered or mailed to Account, if Account fails to make complete payments when due in accordance with this Policy. The notice shall include the reason for the termination.

5.4 **Effects of Termination**. If Wellmark terminates this Policy for nonpayment by the Account, Wellmark shall not reimburse Claims beyond the effective date of the

termination regardless of when services were received or the Claims were paid. If this Policy terminates other than at the expiration of the Stop Loss Period, the effective date of the termination shall become the end of the Stop Loss Period.

5.5 **Survival**. Any liability of either party to the other for amounts owed or owing under this Policy, unless such amounts are de minimus, shall not be extinguished by the termination of this Policy.

ARTICLE 6
MISCELLANEOUS

6.1 **Complete Policy**. This Policy, including any exhibits or amendments, constitutes the complete and exclusive agreement and statement of relationship between the parties with regard to the subject matter of this Policy and supersedes all related discussions, proposals, prior policies, agreements, understandings, prior and concurrent agreements, representations and warranties, whether oral or written, and any other communications between the parties in regard to the subject matter of this Policy. Changes or amendments to this Policy shall be effective only when the written amendment has been signed by an authorized representative of Wellmark and delivered in accordance with Section 6.10. This Policy shall take precedence over any other documents that may be in conflict with it.

6.2 **Change of Policy**. If Account makes changes in the Plan, Account shall give Wellmark sufficient advance notice of such changes. If Account makes any material changes in the Plan administered by the Benefit Services Administrator, or if material changes are required by law, including the addition or deletion of benefits, a material change in group composition or membership or eligibility requirements, such as an increase in the ratio of family to single contracts of more than twenty percent (20%), a change in the number of eligible individuals of more than ten percent (10%), percentage of individuals enrolled, type of coverage offered, business entities covered, change in Benefit Services Administrator, or offerings of other health insurers' coverage to eligible individuals, Wellmark shall have the right at its option to amend this Policy, including an adjustment of stop loss premiums or Individual Deductible shown on Exhibit "A", or terminate this Policy. Account shall provide Wellmark written notice of any changes described in this section within thirty (30) days of such change.

6.3 **Provider Payment Arrangements; Claims Submission**. The Benefit Services Administrator has entered into payment arrangements or contracts with health care providers that affect the submission, timing, frequency, and the amount of payment of Claims. Not all health care providers participate in such payment arrangements and the Benefit Services Administrator does not determine or control the timing of any Claims submissions. Claims do not become Claims Eligible for Reimbursement unless both the Incurred Dates and Paid Dates are within the required periods.

6.4 **State of Issue; Applicable Law and Venue**. The Policy is issued and delivered in the state of Iowa and is performed in Des Moines, Iowa. To the extent not superseded by the laws of the United States and without regard to any conflict of law rule, this Policy shall be construed in accordance with and governed by the laws of the state of Iowa. Any action in regard to this Policy or arising out of the terms of this Policy shall be instituted and litigated in the Iowa District Court or the United States District Court located in Des Moines, Polk County, Iowa, and no other.

6.5 **Force Majeure**. The parties to this Policy shall be excused from performance under this Policy for any period and to the extent they are delayed, restricted, or prevented from performing under this Policy (other than payment) as a result of an act of God, war, civil disturbance, court order, labor dispute, acts of terrorism, or other cause beyond their reasonable control and such nonperformance shall not be grounds for termination or default.

6.6 **Limitation of Action**. Notwithstanding Sections 4.4 and 5.5, no legal or equitable action or claim may be brought against Wellmark for an action or claim arising under or relating to this Policy more than two (2) years after the cause of action arose.

6.7 **Assignment**. The Policy shall be binding on the parties and their respective successors and permitted assigns. Neither party may assign this Policy, in whole or in part, without the prior written consent of the other; provided, however, Wellmark may assign this Policy, in whole or in part, to any entity that controls, is controlled by, or is under common control with Wellmark.

6.8 **Waiver**. The failure of any party to enforce any terms or provisions of the Policy shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Policy shall not be deemed or construed to be a waiver of such default. Any waiver of any provision of this Policy, and any consent to any departure from the terms of any provision of this Policy, shall be effective only in the specific instance and for the specific purpose for which made or given.

6.9 **No Third-Party Beneficiaries.** This Policy is for the benefit of Account and Wellmark and not for any other person. It shall not create any legal relationship between Wellmark and any employee, Member, or any other party claiming any right, whether legal or equitable, under the terms of this Policy or of the Plan.

6.10 **Notices and Communication**. The parties shall be entitled to rely upon any communication or notice from the other in connection with this Policy to be genuine, truthful, and accurate, and to have been authorized, signed, or issued by an officer or agent of such entity empowered to make such representation on behalf of the entity.

Any notice required or permitted to be given under this Policy shall be in writing and be deemed given when delivered personally, placed in the U.S. mail (postage prepaid), delivered to a recognized courier service for delivery (delivery charges prepaid) or sent by electronic means and addressed to the last address furnished by the respective party. Until another address is furnished in writing, notice to Account may be addressed to the address shown on Exhibit “A” attached to this Policy.

Notice to Wellmark may be addressed:

Wellmark, Inc.
Attention: Procurement and Contracts
1331 Grand Avenue
Des Moines, Iowa 50309-2901

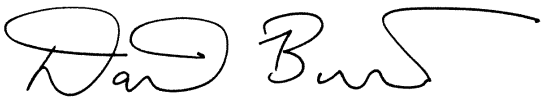
ARTICLE 7
BLUE CROSS AND BLUE SHIELD DISCLOSURE

7.1 **Blue Cross and Blue Shield Disclosure Statement**. Account on behalf of itself and its Members, hereby expressly acknowledges its understanding this Policy constitutes a contract solely between Account and Wellmark, which is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (BCBSA), permitting Wellmark to use the Blue Cross and Blue Shield Service Marks in the state of Iowa, and that Wellmark is not contracting as the agent of BCBSA. Account on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than Wellmark and that no person, entity, or organization other than Wellmark shall be accountable or liable to Account for any of Wellmark's obligations to Account created under this Policy. This section shall not create any additional obligations whatsoever on the part of Wellmark other than those obligations created under other provisions of this Policy.

ARTICLE 8
EFFECTIVENESS OF POLICY AND WAIVER OF JURY TRIAL

THIS POLICY shall be deemed to be effective and in full force as of the date indicated on the first page of the Policy and upon the affixation of Wellmark's authorized signature below and the Account's payment to Wellmark of the premium required by this Policy. **ACCOUNT AND WELLMARK WAIVE ANY RIGHT TO A JURY TRIAL WITH RESPECT TO AND IN ANY ACTION, PROCEEDING, CLAIM, COUNTERCLAIM, DEMAND OR OTHER MATTER WHATSOEVER ARISING OUT OF THIS POLICY.**

Wellmark, Inc.

By: 

David S. Brown
Executive Vice President, Chief Financial Officer and Treasurer

Wellmark, Inc.
Stop Loss Policy
Exhibit "A" - Stop Loss Premiums and Financial Terms

Account/Plan Sponsor Full Legal Name and Legal Address

City of Fort Dodge
Municipal Building
819 1st Ave S
Fort Dodge, IA 50501

Benefit Services Administrator(s)

Wellmark Blue Cross and Blue Shield of Iowa

Stop Loss Period:

The Stop Loss Period begins on 1/01/2015 and ends on 12/31/2015.

Claims Eligible for Reimbursement. Claims under this Policy shall be considered for reimbursement only if all of the following conditions are completely satisfied as determined by Wellmark.

Stop loss coverage is administered as a 12/18 arrangement, which means:
- The Claims shall have Incurred Dates within the Stop Loss Period; and
- The Claims shall have Paid Dates within the Stop Loss Period or within 6 months following the end of the Stop Loss Period. If an Independent Review Organization completing an external review overturns the Benefit Services Administrator's adverse benefit determination regarding a previously denied claim, Wellmark will consider the date the claim was originally denied by the Benefit Services Administrator as the Paid Date under this Policy.

Monthly Stop Loss Premiums-Health (subject to any policy limitations listed below)**:**

$181.32 per Plan Member per month based on active Plan Members on last day of billing month.

Individual Stop Loss Coverage (subject to any policy limitations listed below)**:**

Individual Deductible: $50,000 per Member

Covered Benefits: [X] **Health** [X] **Drug Card**

Aggregate Stop Loss Coverage (subject to any policy limitations listed below)**:**

Aggregate Deductible: 120 % of expected Paid Claims.

Covered Benefits: [X] **Health** [ ] **Dental** [X] **Drug Card**

Attachment Point: per Plan Member per month based on active Plan Members on last day of billing month.

	Single	Family
Alliance Select $2500	$387.05	$1,029.55
Alliance Select $500	$562.22	$1,495.51

Policy Limitation(s):

Claims in excess of the Account's Individual Stop Loss deductible level will not be covered under the Aggregate Stop Loss coverage.

Any adjustments to monthly stop loss premiums and attachment points due to membership or eligibility changes shall be reflected on the billing for the month in which the membership or eligibility change is made and shall be limited to a period of three (3) months prior to the date Wellmark processes the Member eligibility change.

Exhibit "A" Issue Date: 11/24/2014