



RECEIVED APR 25 2025

GINA HARKNESS
CITY OF LEEDS
221 Main St W
LEEDS, ND 58346

April 10, 2025

Final Contract Renewal Document - Signature Required

Dear Gina,

Thank you for choosing Blue Cross Blue Shield of North Dakota (BCBSND) for your group's health insurance needs.

Please sign the final enclosed document to complete your renewal. This is in addition to the documents that you have previously signed. Sign in both the Plan Administrator and Plan Sponsor locations and return the signature page of your contract to BCBSND. The signature page can be returned by mail or email:

Mail

Blue Cross Blue Shield of North Dakota
4510 13th Ave S
Fargo, ND 58121

Email

Email a signed scanned copy of your medical plan contract signature page to your local BCBSND representative.

Signatures on health contract(s) are required.

If you are contracting for dental and vision services too, the contract(s) do not need to be signed or returned. Payment of premium and utilization of services ties your company to the contract(s).

Again, thank you for choosing BCBSND, we appreciate the opportunity to serve the insurance needs of your company. Please call your BCBSND representative with any questions.

Sincerely,

Your BCBSND Team



CITY OF LEEDS

Benefit Plan Agreement



Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross Blue Shield Association.



BENEFIT PLAN AGREEMENT

This Benefit Plan Agreement ("Agreement") is entered into between CITY OF LEEDS ("the Plan Sponsor"), CITY OF LEEDS ("the Plan Administrator") and Blue Cross Blue Shield of North Dakota ("BCBSND"). Throughout this Agreement, BCBSND is referred to as the "Company."

The Plan Sponsor has established and maintains a fully insured group health plan (the Plan) which provides, among other things, various benefits to Members in the Plan, as set forth in the Certificate of Insurance provided to plan Members. The Plan Administrator is the administrator of the Plan established through this Agreement.

In consideration of payment of required premium and acceptance of applications, the Company enters into this Agreement with the Plan Sponsor and the Plan Administrator. The Company agrees to provide plan Members the benefits set forth in the Certificate of Insurance, in accordance with its terms and conditions. This Agreement also includes the Certificate of Insurance, applications, Identification Cards and any endorsements, supplements, attachments, addenda or amendments.

FOR VALUABLE CONSIDERATION, THE PARTIES AGREE AS FOLLOWS:

1. EFFECTIVE DATE AND PLAN YEAR

This Agreement is effective **April 1, 2025**, through **March 31, 2026**, unless terminated as provided in Section 8. TERMINATION.

For the purposes of the costs of any and all benefits and services extended through this Benefit Plan, including the implementation of any benefit changes required under federal or state law, the Plan Administrator agrees that the Plan Year shall commence on **April 1**, unless it is terminated by one of the parties as specified in Section 8. TERMINATION.

2. TYPE OF COVERAGE

Health

Product Name: **BlueCare Gold 70 1800**

3. DEFINITIONS

This section defines the terms used in this Agreement. These terms will be capitalized throughout this Agreement when referred to in the context defined.

- 3.1 **CLAIM** - notification in a form acceptable to the Company that services have been provided or furnished to a Member.
- 3.2 **DATA AGGREGATION** - the combining of Protected Health Information the Company creates or receives for or from the Plan and for or from other health plans or health care providers for which the Company is acting as a business associate to permit data analyses that relate to the Health Care Operations of the Plan and those other health plans or providers.
- 3.3 **HEALTH CARE OPERATIONS** - any of the activities of a health plan to the extent the activities relate to those functions that make it a health plan.
- 3.4 **MEMBER** - the Subscriber and any dependent of a Subscriber or any other person designated by a Subscriber or by the terms of the Plan who is or may become entitled to a benefit under the Plan. The term shall also include any proprietor, partner, or owner of the Plan Sponsor, if any, who is designated by the terms of the Plan who is or may become entitled to a benefit under the Plan. In no case shall the term Member include any person not otherwise entitled to coverage under the terms of the Plan.

For the purposes of determining the various benefits and restrictions or other limitations thereto made available to a Member under the terms of this Agreement, all benefits under any Plan option or tier (and any restrictions or other limitations thereto) made available to or received by a Member shall accumulate toward that Member's benefits and any restrictions and other limitations thereto.

- 3.5 **PAYMENT** - activities undertaken to obtain premiums, determine or fulfill coverage and benefits, or obtain or provide reimbursement for health care services.
- 3.6 **PROTECTED HEALTH INFORMATION (PHI)** - individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:
 - A. is created by or received from a Health Care Provider, health care employer, or health care clearinghouse;
 - B. relates to a Member's past, present or future physical or mental health or condition;
 - C. relates to the provision of health care to a Member;
 - D. relates to the past, present, or future payment for health care to or on behalf of a Member; or
 - E. identifies a Member or could reasonably be used to identify a Member.

Educational records and employment records are not considered PHI under federal law.

- 3.7 **SECURITY INCIDENT** - any attempted or successful unauthorized access, use, disclosure, modification, or destruction of a Member's electronic PHI or interference with the Company's system operations in the Company's information systems.
- 3.8 **STANDARD TRANSACTIONS** - health care financial or administrative transactions conducted electronically for which standard data elements, code sets and formats have been adopted in accordance with federal or state law.
- 3.9 **SUBSCRIBER** - any employee of the Plan Sponsor who is or may become eligible to receive a benefit under the Plan. The term includes all common law employees as well as any proprietors, partners, or other owners who work for the Plan Sponsor, if any, and who are otherwise entitled to coverage under the Plan. Notwithstanding the above, in no case shall the term Subscriber include any person not otherwise entitled to coverage under the terms of the Plan.
- 3.10 **SUCCESSFUL SECURITY INCIDENTS** - Security Incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.
- 3.11 **UNSUCCESSFUL SECURITY INCIDENTS** - Security Incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

4. **PREMIUMS**

- 4.1. Premiums for the Type of Coverage selected in Section 2 by the Plan Administrator are set forth in the initial billing statement forwarded to the Plan Administrator by the Company.
- 4.2. All premium is due and payable before the first of each month. If payment of premium is not received before the date due, a grace period of 31 days is allowed. The Plan Administrator remains responsible for payment of any premium due during the grace period. If the Plan Administrator provides written notice of cancellation during the grace period, the Plan Administrator will be charged a pro rata premium.
- 4.3. The Company will advise the Plan Administrator of any change in required premium at least 31 days prior to the effective date of change, unless otherwise specifically agreed to by the parties. In addition, the Company reserves the right, upon providing at least 31 days notice, to change the required premium in response to any change in the rate of insurance premium tax assessed by the state of North Dakota or if the Plan Administrator should choose to offer a dual choice option.

5. **PRIVACY USE AND DISCLOSURE RESPONSIBILITIES**

5.1 **RESPONSIBILITIES OF THE COMPANY**

A. Privacy of Protected Health Information (PHI)

1. The Company will keep confidential all Claim records and all other PHI the Company creates or receives in the performance of its duties under this Agreement. Except as permitted or required by this Agreement for the Company to perform its duties under this Agreement, the Company will not use or disclose such Claim information or other PHI without the authorization of the Member who is the subject of such information or as required by law.
2. The Company will neither use nor disclose Members' PHI (including any Members' PHI received from a business associate of the Plan) except (1) as permitted or required by this Agreement, (2) as permitted in writing by the Plan Administrator, (3) as authorized by Members, or (4) as required by law.
3. The Company will be permitted to use or disclose Members' PHI only as follows:
 - a. The Company will be permitted to use and disclose Members' PHI (a) for the management, operation and administration of the Plan that the Plan Administrator offers Members, and (b) for the services set forth in the Plan, which include Payment activities, Health Care Operations, and Data Aggregation as these terms are defined under federal law. The Company also may de-identify PHI it obtains or creates in the course of providing services for the Plan Administrator.
 - (1) The Company will be permitted to use Members' PHI as necessary for the Company's proper management and administration or to carry out the Company's legal responsibilities.
 - (2) The Company will be permitted to disclose Members' PHI as necessary for the Company's proper management and administration or to carry out the Company's legal responsibilities only if (i) the disclosure is required by law, or (ii) before the disclosure, the Company obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written Agreement, that the entity will hold Members' PHI in confidence, use or further disclose Members' PHI only for the purposes for which the Company disclosed it to the entity or as required by law, and notify the Company of any instance the entity becomes aware of where the confidentiality of any Members' PHI was breached.
 - b. The Company will make reasonable efforts to use, disclose, or request only a limited data set where practical. Otherwise, the minimum necessary amount of Members' PHI to accomplish its intended purpose.
4. Other than disclosures permitted by Section 5.1(A)3, the Company will not disclose Members' PHI to the Plan Administrator or to the Plan's business associate except as directed by the Plan Administrator in writing.
5. The Company will require each subcontractor and agent to which the Company is permitted by this Agreement or in writing by the Plan Administrator to disclose Members' PHI to provide reasonable assurance, evidenced by written contract, that such other entity will comply with the same privacy and security obligations with respect to Members' PHI as this Agreement applies to the Company.
6. The Company will not disclose any Members' PHI to the Plan Sponsor, except as permitted by and in accordance with Section 5.1(A)3.

7. Disposition of Protected Health Information

The parties agree that upon termination, cancellation, expiration or other conclusion of this Agreement, the Company will return or destroy all PHI received or created by the Company on the Plan Administrator's behalf as soon as feasible. Due to various regulatory and legal requirements, the Plan Administrator acknowledges that immediate return or destruction of all such information is not feasible. The Company agrees that upon conclusion of this Agreement for any reason, it will use or disclose the PHI it received or created on the Plan's behalf only as necessary to meet the Company's regulatory and legal requirements and for no other purposes unless permitted in writing by the Plan Administrator. The Company will destroy PHI received or created by the Company on the Plan Administrator's behalf that is in the Company's possession under such circumstances and upon such schedule as the Company deems consistent with its regulatory and other legal obligations.

These responsibilities agreed to by the Company and related to protecting the privacy and safeguarding the security of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and, where applicable, shall govern the Company's receipt, use or disclosure of PHI pursuant to the terms of this Agreement.

8. The Company will meet all obligations imposed upon it by the HIPAA Privacy Rule.

B. Information Safeguards

1. The Company will maintain reasonable and appropriate administrative, technical and physical safeguards to protect the privacy of Member PHI. The safeguards must reasonably protect Member PHI from any intentional or unintentional use or disclosure in violation of federal law and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement.
2. The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI the Company creates, receives, maintains, or transmits on behalf of the Plan Administrator as required by federal law.

C. Inspection of Books and Records

The Company will make its internal practices, books, and records relating to its use and disclosure of PHI created or received for or from the Plan Administrator available to the U.S. Department of Health and Human Services to determine compliance with federal law or this Agreement.

- D. The Company will prepare and distribute a notice of privacy practices appropriate for the Plan to meet its notice obligations under federal law. The Plan Administrator authorizes the Company to disclose the minimum necessary PHI to the Plan Sponsor for plan administration functions specified in the Plan documents as amended.

E. Information Privacy and Safeguard Provisions Survive Termination of Agreement

These responsibilities agreed to by the Company and related to protecting the privacy of PHI, as well as any terms directly related thereto, shall survive the termination of this Agreement and where applicable, shall govern the Company's receipt and use of PHI obtained pursuant to the terms of this Agreement.

F. Specific Cost or Quality of Care Information or Data

The parties agree, notwithstanding the foregoing, that nothing in Section 5 of this Agreement shall be construed as restricting or otherwise limiting the provision of specific cost or quality of care information or data through a consumer engagement tool or any other means anticipated through Section 9.14.



5.2 RESPONSIBILITIES OF THE PLAN SPONSOR

- A. The Plan Sponsor retains full and final authority and responsibility for the Plan and its operation. The Company is empowered to act on behalf of the Plan only as stated in this Agreement or as mutually agreed in writing by the Plan Sponsor and the Company.
- B. The Plan Sponsor will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations, including any licensing, filing, reporting, and disclosure requirements, that may apply to the Plan. The Company will have no responsibility for or liability with respect to the Plan's compliance or noncompliance with any applicable federal, state, or local law, rule, or regulation.

If the Group offers a high deductible health plan, the Plan Sponsor assumes sole responsibility for determining whether the Plan qualifies as a high deductible health plan under Section 223(c)(2) of the U.S. Internal Revenue Code. THE COMPANY MAKES NO WARRANTY, EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE REGARDING THE PLAN.

If the Group offers a high deductible health plan, the Company does not provide legal or tax advice, and expressly disclaims responsibility for determining, on behalf of any individual or group, the legal and tax implications of: (1) establishing a health savings account; (2) eligibility for a health savings account; (3) the contributions made to a health savings account; (4) the deductibility of contributions to a health savings account; and (5) withdrawals from a health savings account and related taxation.

- C. By executing this Agreement, the Plan Sponsor certifies to the Company that its Plan documents have been amended to incorporate the provisions required by and under federal law, and agrees to comply with the Plan Administrator's plan documents.

The Company may rely on Plan Sponsor's certification and Plan Administrator's written authorization, and will have no obligation to verify (1) that the Plan Administrator's plan documents have been amended to comply with the requirements of federal law or this Agreement or (2) that the Plan Sponsor is complying with the Plan Administrator's plan document as amended.

- D. By executing this Agreement, the Plan Sponsor also certifies to the Company that its Plan does not contain a waiting period, as defined under applicable federal HIPAA portability regulations, exceeding 60 days. The Plan Sponsor acknowledges that the Company will rely on the Plan Sponsor's certification and that the Plan Sponsor shall have a continuing obligation to immediately notify the Company if any revisions are made to the Plan's waiting period.

6. INTER-PLAN ARRANGEMENTS

BCBSND has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever a Member accesses health care services outside of the geographic area BCBSND serves, the claim for those services may be processed through one of these Inter-Plan Arrangements and presented to BCBSND for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

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

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits and vision care benefits (except when paid as medical claims/benefits), and those prescription drug benefits that may be administered by a third party contracted by BCBSND to provide the specific service or services.

A. **BlueCard Program**

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating health care providers. The financial terms of the BlueCard Program are described generally below.

Liability Calculation Method Per Claim:

Unless subject to a fixed dollar copayment, the calculation of Member liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the Host Blue's participating health care provider's billed charges or the negotiated price made available to BCBSND by the Host Blue.

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's health care provider contracts. The negotiated price made available to BCBSND by the Host Blue may represent one of the following:

1. the actual price. An actual price is a negotiated rate of payment without any other increases or decreases; or
2. an estimated price. An estimated price is a negotiated rate of 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
3. an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its 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 determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may 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 or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the BlueCard Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by BCBSND in determining premiums.

B. **Value-Based Programs**

BCBSND has included a factor for bulk distributions from Host Blues in the Plan Administrator's premium for Value-Based Programs when applicable under this Agreement. "Value-Based Program" means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local health care providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

C. **Return of Overpayments**

Under the Inter-Plan Arrangements, recoveries from a Host Blue or from participating health care providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some

cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts, which generally require correction on a claim-by-claim or prospective basis. The fees of such a third party may be charged to the Plan Administrator as a percentage of the recovery.

D. Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSND will include any such surcharge, tax or other fee in determining premiums.

E. Nonparticipating Health Care Providers Outside the BCBSND Service Area

1. Member Liability Calculation

When Covered Services are provided outside of BCBSND's service area by nonparticipating health care providers, the amount the 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 BCBSND will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services are governed by applicable federal and state law.

BCBSND may calculate the Allowed Charge for Covered Services from nonparticipating health care providers in several ways, including:

- a. pricing determined by the Host Blue;
- b. pricing based upon a percentage of billed charges;
- c. pricing based on health care provider reimbursement for Covered Services;
- d. pricing as agreed upon with health care providers; and
- e. as required by federal law (including the median contracted rate)

The Allowed Charge calculations for Covered Services do not represent a usual, customary and reasonable charge. For Covered Services provided outside of the BCBSND service area, the Allowed Charge for Covered Services from nonparticipating health care providers is commonly determined by the Host Blue. From time to time, BCBSND may change its process for determining the Allowed Charge for Covered Services rendered by nonparticipating health care providers but will provide notice to the Group and revise any information in the Benefit Plan or other Member communications that describes this process. BCBSND shall determine the interpretation and application of the Allowed Charge calculations for Covered Services in each and every situation.

2. Exceptions

In certain situations, BCBSND may pay claims based on the payment BCBSND would make if the Covered Services had been obtained within the BCBSND service area. Such situations include where a Member did not have reasonable access to a participating health care provider, as determined by BCBSND in its sole and absolute discretion or by applicable state law. In other situations, BCBSND may pay such a claim based on the payment BCBSND would make if BCBSND were paying a nonparticipating health care provider inside of BCBSND's service area (as described in the Member's Certificate of Insurance) where the Host Blue's corresponding payment would be more than BCBSND's payment to a nonparticipating health care provider within the BCBSND service area. BCBSND may also in its sole and absolute discretion, negotiate a payment with such a health care provider on an exception basis. In any of these situations, the Member may be responsible for the difference between the amount that the nonparticipating health care provider bills and payment BCBSND will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands ("BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is not served by a Host Blue.

1. Inpatient Services

In most cases, if a Member contacts the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require the Member to pay for covered inpatient services, except for Cost Sharing Amounts. In such cases, the hospital will submit the Member's claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services.

2. Outpatient Services

Physicians, urgent care centers and other outpatient health care providers located outside the BlueCard service area will typically require a Member to pay in full at the time of service. The Member must submit a claim to obtain reimbursement for Covered Services.

3. Submitting a Blue Cross Blue Shield Global Core Claim

When a Member pays for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the health care provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSND, the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com.

7. RETROSPECTIVE DISCOUNT PAYMENT/PHARMACEUTICAL MANUFACTURER ADMINISTRATIVE FEES

Regarding prescription medications or drugs purchased by Members under the terms of the Plan, the Company will pay the amount due to the pharmacy (or other prescription drug retailer) under the terms of the pharmacy provider participating agreement. The amount due to the pharmacy under the terms of the pharmacy provider participating agreement is that which is due at the time the prescription medication or drug is purchased by the Member. The amount due to the pharmacy under the pharmacy provider participating agreement is calculated without regard to any subsequent, retrospective manufacturer discount that may apply to the cost of the prescription medication or drug. The Plan Administrator acknowledges and agrees that, in some cases but not all, drug manufacturers may offer retrospective discounts to the Company on prescription medications and drugs purchased under the terms of the Plan. If a drug manufacturer makes a retrospective discount payment available, the Plan Administrator acknowledges and agrees that a portion of any such retrospective discount may be retained by an entity that performs manufacturer discount program services on behalf of the Company under the terms of this Agreement. The Plan Administrator further acknowledges and agrees that, when made available by the drug manufacturer, another portion of the retrospective discount payment is retained by the Company. The pharmaceutical manufacturer administrative fees are any amount paid by a pharmaceutical manufacturer for the administration of the formulary rebate program. In its sole discretion, the Company may periodically refund to the Plan all or part of any rebate payments or pharmaceutical manufacturer administrative fees received. The calculation of any refund rests in the sole discretion of the Company.

8. TERMINATION

8.1 This Agreement will automatically terminate without notice on the last day of the month in which the grace period expires if premiums are not paid within the grace period. In the event of termination for nonpayment of premiums, reinstatement of this Agreement will be at the sole discretion of and subject to conditions established by the Company. The Plan Administrator assumes any obligation to provide notice to all Subscribers regarding termination of this Agreement due to nonpayment of premiums.



- 8.2 This Agreement may be terminated by the Plan Administrator providing the Company with written notice of termination at least 31 days in advance of the requested date of termination. Termination will be effective on the last day of the month. If the requested date of termination is other than the last day of the month, termination will be effective the last day of the month of the requested date of termination.
- 8.3 In the event of a breach by either party, other than for nonpayment of premium, the other party may terminate this Agreement by written notice to the breaching party. The breaching party has 31 days to fully cure the breach. If the breach is not cured within 31 days after written notice, this Agreement will immediately terminate.
- 8.4 The Plan Administrator will have the right to terminate this Agreement if the Company has engaged in a pattern of activity or practice that constitutes a material breach or violation of the Company's obligations regarding PHI under this Agreement and, on notice of such material breach or violation from the Plan Administrator, fails to take reasonable steps to cure the breach or end the violation.

If the Company fails to cure the material breach or end the violation after the Plan Administrator's notice, the Plan Administrator may terminate this Agreement by providing the Company written notice of termination setting forth the uncured material breach or violation serving as the basis for the termination and specifying the effective date of the termination.

- 8.5 The Company may decide to discontinue offering the Benefit Plan that is the subject of this Agreement, or all of its group health benefit plans including the Benefit Plan that is the subject of this Agreement, at any time. If the Benefit Plan that is the subject of this Agreement is discontinued, the Company will provide the Plan Administrator and Subscribers with at least 90 days prior written notice of the decision to cancel coverage. This Agreement shall automatically terminate on the date of discontinuation identified in the written notice. The Plan Administrator will be given the option to purchase any other group health benefit plans currently offered by the Company in the market. If all group health benefit plans are discontinued including the Benefit Plan that is the subject of this Agreement, the Company will provide the Plan Administrator and Subscribers with at least 180 days prior written notice of the decision to cancel coverage. This Agreement shall automatically terminate on the date of discontinuation identified in the written notice.

9. GENERAL PROVISIONS

- 9.1 The Plan Administrator agrees to furnish the Company with any information required by the Company for the purpose of enrollment. Any change affecting a Member's eligibility must be provided to the Company immediately, but in any event the Plan Administrator will notify the Company of any changes in a Member's eligibility within 31 days of the change. The Plan Administrator acknowledges and agrees that in the event there are premium payments made to the Company by the Plan Administrator based upon a failure by the Plan Administrator to notify the Company of any changes in enrollment or eligibility within 31 days of the change, the Company may retain any and all premium payments made by the Plan Administrator as consideration for the Company's administrative costs and burden incurred by said failure to notify the Company of the change.
- 9.2 The Plan Administrator acknowledges that the administration of the Benefit Plan that is the subject of this Agreement may be subject to regulation under federal and/or state law. The Plan Administrator agrees to furnish the Company with any and all information necessary to comply with any applicable federal and/or state laws and to certify that this information is accurate. If there are any changes in the employer contribution rate for benefits and services available under this Agreement, the Plan Administrator agrees that it is its obligation to provide information related to the change in contribution rates immediately to the Company.
- 9.3 The Plan Administrator agrees to abide by all underwriting requirements established by the Company as these underwriting requirements relate to, including but not limited to, rating factors, the minimum participation of eligible Members, minimum employer contributions, reporting employer contribution rates and provider network restrictions, as permitted and restricted under federal and/or state laws.

- 9.4 The Company will provide formal policy and procedure guidelines to the Plan Administrator for the conduct of external audits or reviews commissioned by the Plan Administrator. The Company shall cooperate with all external audit or review teams.

The Plan Administrator shall provide the Company with the scope and requirements of any audit or review prior to the commencement of the audit or review. If a sample of claims is required, the Company will provide the Plan Administrator with a statistically valid computerized sample of claims.

All audit or review findings shall be discussed with the Company upon discovery to allow further investigation or implementation of corrective action.

Subject to any other requirements related to the sharing of data and information as set forth in this Agreement, all Member records shall be kept confidential and considered proprietary. Such records shall be available for audit or review only after disclosure statements have been signed by the external audit or review team to ensure the information remains confidential and is utilized for the stated purpose only. If any records are removed from the Company's office for purposes of the audit or review, approval must be granted. All records will be subject to the minimum necessary requirements.

- 9.5 No change in this Agreement is valid unless approved by the President and Chief Executive Officer of BCBSND and a designated representative of the Plan Administrator.
- 9.6 Where federal law is not applicable, this Agreement shall be governed by and construed according to the laws of the state of North Dakota.
- 9.7 Any notice required under this Agreement shall be in writing and shall be effective when delivered in person or sent by certified mail to a party at its respective address.
- 9.8 The Plan Administrator hereby expressly acknowledges and understands that BCBSND is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCBSND to use the Blue Cross and Blue Shield Service Marks in the state of North Dakota, and that BCBSND is not contracting as an agent of the Association. The Plan Administrator further acknowledges and agrees this legal agreement was not entered into based upon representations by any person or entity other than BCBSND and that no person, entity, or organization other than BCBSND shall be held accountable or liable to the Plan Administrator for any of BCBSND's obligations to the Plan Administrator created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSND other than those obligations created under other provisions of this agreement.
- 9.9 The Company will distribute the Certificate(s) of Insurance to the Subscriber of the Plan. It shall be the sole responsibility of the Plan Administrator to distribute a Summary Plan Description to Subscribers of the Plan and to advise Members of their rights under ERISA, including, but not limited to claims appeals procedures. In the event a claim is paid due to the Summary Plan Description not being distributed to the Subscriber, the Plan Administrator shall be liable for all such claims. The Certificate of Insurance is not the Summary Plan Description.
- 9.10 If the Plan Administrator has a digital or online version of the Certificate(s) of Insurance available to its employees, the Plan Administrator agrees that it will not alter, modify or change the language of the Certificate(s) of Insurance, and further agrees the Certificate(s) of Insurance will be the controlling document in the event of any conflict or liability that might arise as the result of any alterations, modifications or changes made by the Plan Administrator. In the event a claim is paid based on the Plan Administrator's digital or online Certificate of Insurance, the Plan Administrator is liable for all such claims. The Plan Administrator further agrees that no waiver of this agreement is valid unless in writing and approved by the Company.
- 9.11 The Company will prepare Summaries of Benefits and Coverage for distribution to applicants and Members by the Plan Administrator so that the Company, the Plan and the Plan Administrator may all satisfy related disclosure obligations under federal law. It shall be the sole responsibility of the Plan Administrator to distribute the Summaries of Benefits and Coverage in accordance with federal law, and

the Plan Administrator acknowledges and agrees that the Company will rely upon the Plan Administrator for compliance with the requirements for distribution of the Summaries of Benefits and Coverage to applicants and Members.

- 9.12 Upon the effective date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of health information or other aspects of the Health Insurance Portability and Accountability Act of 1996 applicable to this Agreement, this Agreement will automatically amend such that the obligations imposed on the Plan Sponsor, the Plan Administrator and the Company remain in compliance with such regulations, unless the Company elects to terminate this Agreement by providing the Plan Sponsor and the Plan Administrator notice of termination in accordance with this Agreement at least thirty-one (31) days before the effective date of such final regulation or amendment to final regulations.
- 9.13 When coverage under this Agreement is terminated, BCBSND will, within a reasonable period of time, issue a notification of termination of coverage to the Subscriber. Upon notification by the Subscriber of the ineligibility of a dependent, a notification of termination of coverage will be issued to the affected Member within a reasonable period of time. Termination notices may also be obtained from BCBSND upon request within 24 months after coverage is terminated.
- 9.14 The parties agree that nothing in this Agreement shall be construed as restricting the Plan Administrator or the Company from providing Health Care Provider specific cost or quality of care information or data through a consumer engagement tool or any other means, to referring Health Care Providers, a Plan Sponsor, Subscribers or Members, or individuals eligible to become Subscribers or Members of any Group Health Plan; electronically accessing deidentified claims and encounter information or data for each Subscriber or Member in a Group Health Plan or that has coverage through the Company, upon request and consistent with all applicable state and federal privacy regulations or directing that such data be shared with business associates of the Group Health Plan or the Company consistent with applicable state and federal privacy regulations. Nothing in this provision shall be construed as: 1) preventing Health Care Providers from placing reasonable restrictions on the public disclosure of the information as described; 2) permitting any modification or elimination of existing privacy protections and standards under state and federal law, or 3) limiting access by the Group Health Plan or the Company to data as permitted under applicable state and federal privacy regulations.
- 9.15 The parties agree that the Group Health Plan and the Company are each required to annually submit a Gag Clause Prohibition Compliance Attestation on behalf of the Group Health Plan, however, the Company agrees to submit this attestation on behalf of the Group Health Plan, which will satisfy the attestation submission requirement for the Group Health Plan.

10. INDEMNIFICATION CLAUSE

Each party agrees to indemnify and hold harmless the other party for all causes of action, suits, claims, judgments, settlements, liabilities, damages of any kind, penalties, losses, expenses, court costs and attorneys' fees resulting from or arising out of any duty under this Agreement, if the liability was the consequence of the actions of the indemnifying party.

11. BINDING EFFECT

This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

12. **INCORPORATION STATEMENT**

The Certificate(s) of Insurance is incorporated herein by reference. In case of a conflict between the Certificate(s) of Insurance and the Benefit Plan Agreement, the provisions of the Benefit Plan Agreement will control.

CITY OF LEEDS
GROUP HEALTH PLAN (PLAN ADMINISTRATOR)
221 Main St W
LEEDS, ND 58346

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA*
4510 13TH AVENUE SOUTH
FARGO, NORTH DAKOTA 58121

By: _____



Title: _____

Its President and CEO

Date: _____

April 10, 2025

CITY OF LEEDS
(PLAN SPONSOR)
221 Main St W
LEEDS, ND 58346

By: _____

Title: _____

Date: _____

**By remitting the required premium, I agree to and
acknowledge effect of this Agreement.**

Benefit Plan Agreement
04/01/2025 – 03/31/2026
305962

*An Independent Licensee of the Blue Cross Blue Shield Association.

