ADMINISTRATIVE SERVICES AGREEMENT

For

CITIZENS PROPERTY INSURANCE CORPORATION

Administered by:

Blue Cross and Blue Shield of Florida, Inc.*

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

ADMINISTRATIVE SERVICES AGREEMENT

between

CITIZENS PROPERTY INSURANCE CORPORATION

and

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

This Administrative Services Agreement, including Exhibits thereto (hereinafter referred to as the "Agreement"), is entered into and effective January 1, 2023 between Blue Cross Blue Shield of Florida, Inc., a Florida corporation having its principal place of business at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 (hereinafter referred to as "BCBSF") and Citizens Property Insurance Corporation at 2101 Maryland Circle, Tallahassee, Florida 32303 (hereinafter referred to as the "Employer") on behalf of itself and its Group Health Plan(s). Together known as the ("Parties").

This Agreement, including the Exhibits attached hereto, is intended to set forth the entire agreement between BCBSF and the Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect; notwithstanding, the fully executed Agreements entered into by the Parties prior to this Agreement shall remain in effect only for those claims incurred prior to the Effective Date of this Agreement.

WHEREAS, the Employer has established and currently sponsors a self-funded employee welfare benefit plan, to provide certain benefits (attached hereto as Exhibit A and hereinafter referred to as the "Plan"); and,

WHEREAS, the Employer is or has designated a Plan Administrator, the Plan Administrator and the Employer may be the same; however, the Plan Administrator shall not be BCBSF; and,

WHEREAS, the Employer, on behalf of itself and the Plan Administrator, has requested that BCBSF furnish services as defined in this Agreement; and,

WHEREAS, it is the purpose of this Agreement to establish an agency relationship whereby BCBSF will undertake to act as an agent for the Employer in (1) receiving and processing claims for benefits under the Plan, (2) disbursing claim payments under the Plan, and (3) performing such additional duties as set forth herein; and,

WHEREAS, it is understood and agreed that BCBSF may contract with other entities to perform certain functions and/or services in the administration of this Agreement.

NOW, THEREFORE, in consideration of the mutual agreements and conditions contained herein, the Parties, intending to be legally bound hereby, agree as follows.

Initial Term

The initial term of this Agreement shall be from January 1, 2023 (the Effective Date) and shall end on December 31, 2025 (the Termination Date), unless the Agreement is terminated earlier in accordance with the provisions of this Agreement.

Renewal Terms

This Agreement may be renewed for three (3) one (1) year renewal periods or alternatively, a three (3) year renewal period either: (a) by Employer, at its discretion upon (90) calendar days prior written notice to BCBSF; or, (b) by mutual agreement of the Parties. Renewals shall be subject to the same terms and conditions set forth in this Agreement at the time of renewal, including any written Amendments executed by the Parties and subject to any reduction in the administrative fee through negotiation mutual agreement.

Section I: Obligations of the Employer

A. The Employer shall have the obligation to furnish any information required in accordance with the Exhibits to this Agreement. Such information shall include, but is not limited to, member's social security numbers in order to comply with Medicare secondary payer provisions of federal law.

B. BCBSF and/or their designated agent's performance of the services will require prompt discharge by the Employer of such obligation. Therefore, BCBSF shall not be considered to have failed to perform obligations under this Agreement if any delay or non-performance is due, in whole or in part, to the Employer's failure to promptly discharge such obligations**.** BCBSF**'s** Designated Agent is an entity that has contracted with BCBSF to perform a function and/or service in the administration of this Agreement.

C. The Employer shall provide BCBSF with the names of individuals, together with the scope of their authority, authorized to act for the Employer in connection with this Agreement.

D. The Employer shall fund the Plan and pay all claims in accordance with its terms and as provided in Exhibit B.

E. The Employer, BCBSF, and their Designated Agent shall comply with all material federal or state laws applicable to the Plan and Employer shall comply with such reporting and disclosure laws as may be applicable thereto.

F. The Employer shall directly furnish BCBSF with sufficient information regarding claims incurred under the Plan before January 1, 2023, to allow BCBSF to determine the liability of the Plan for related claims filed thereafter (i.e., applicable deductibles).

G. The Employer shall provide BCBSF, in a format reasonably acceptable to BCBSF, the member's information. Employer will notify BCBSF as soon as possible of a change of a member's employment or a change in coverage, including notifying BCBSF of terminated employees, new employees, and termination of coverage. It is the Employer's responsibility to ensure any retroactive member termination forwarded to BCBSF is in compliance with federal law, specifically, that such termination was due to either a member's: (i) fraudulent act, practice or omission; (ii) intentional misrepresentation of material fact, or (iii) failure to timely pay required premiums or contributions towards the cost of coverage. The Employer is solely responsible for providing to the member any notice related to retroactive terminations or rescissions that are required by law.

H. Confidential and Trade Secret Information.

BCBSF maintains proprietary and confidential information and competitively sensitive trade secret information, which information may be disclosed to Employer for the purposes of analyzing such information in conjunction with the services performed under the Agreement. Employer agrees to hold such confidential and/or trade secret information in confidence and only disclose such information to employees of Employer who have a need to know such information; provided however that such employees of Employer agree to maintain the confidentiality of the confidential and/or trade secret information and take all steps necessary to safeguard the confidential and/or trade secret information against unauthorized access, use, and disclosure to at least the extent Employer maintains the confidentiality of its proprietary and confidential information.

As set forth in this Section H, Employer shall not disclose such confidential and/or trade secret information to any third party without the express written permission of BCBSF. If BCBSF, in its sole discretion, approves release of confidential and/or trade secret information to a third party, the third party and Employer may be required to execute a Confidentiality & Indemnity Agreement, in a form specified by BCBSF, prior to the release of the confidential information and/or trade secret information to the third party.

Public Records Laws

BCBSF acknowledges that Employer is subject to Florida public records laws, including Chapter 119, Florida Statutes, (collectively, "Florida's Public Records Laws"). Therefore, any information provided to Employer or maintained by BCBSF in connection with this Agreement may be subject to disclosure to third parties.

Protection of BCBSF's Confidential Information.

Section 627.351(6)(x)1. e., Florida Statutes, provides that proprietary information licensed to Employer under a contract providing for the confidentiality of such information is confidential and exempt from the disclosure requirements of Florida's Public Records Law. Other Florida Statutes allow for various protection of BCBSF's trade secrets and financial information. In order to protect any information provided to Employer that BCBSF considers to be protected from disclosure under Florida law ("BCBSF's confidential information") BCBSF should clearly label and mark each page or section containing such information as "Confidential", "Trade Secret" or other similar designation.

Responding to Request for BCBSF Confidential Information

If Employer receives a Public Records Request ("PRR") or a request from any regulatory or legislative entity regarding BCBSF's confidential information, it shall promptly notify BCBSF in writing, or electronically. To the extent permitted by law, Employer shall not produce BCBSF's confidential information unless authorized by BCBSF, or by order of a court of competent jurisdiction. In the event a legal proceeding is brought to compel the production of BCBSF's confidential information, the Parties agree that Employer is authorized to deliver BCBSF's confidential information to the court or other legal tribunal for disposition. If BCBSF continues to assert in good faith that BCBSF's confidential information is confidential or exempt from disclosure or production pursuant to Florida's Public Records Laws, then BCBSF shall be solely responsible for defending its position or seeking a judicial declaration. Nothing in this Agreement shall create an obligation or duty for Employer to defend or justify BCBSF's position. BCBSF also agrees to indemnify and hold harmless any of Employer Indemnitee for any Claims, including attorneys' fees, costs, and expenses incidental thereto, incurred by Employer in connection with this Section.

BCBSF's Duty to Forward Records Requests to Citizens

BCBSF receives a PRR that is in any way related to this Agreement, BCBSF agrees to immediately notify Employer's Records Custodian and forward the PRR to Employer's Records Custodian for logging and processing. Employer's Records Custodian's email address is: Recordsrequest@citizensfla.com. Employer shall be the Party responsible for coordinating the response and production to the PRR. BCBSF shall communicate with Employer to determine whether requested information is confidential and/or exempt from public records disclosure requirements. BCBSF agrees to assist Employer in responding to any PRR in a prompt and timely manner as required by Florida's Public Records Laws.

Additional Duties

To the extent BCBSF is "acting on behalf of" Employer as provided under Section 119.011(2), Florida Statutes, BCBSF must: (a) keep and maintain public records required by Employer to perform the Services; (b) upon request of Employer's Records Custodian, provide Employer with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law; (c) ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law, for the duration of the term of this Agreement and following the completion of this Agreement if BCBSF does not transfer the records to Employer; and, (d) upon completion of this Agreement, transfer at no cost to Employer all public records in possession of BCBSF or, alternatively, BCBSF may keep and maintain all records required by Employer to perform the Services. If BCBSF transfers all public records to Employer upon completion of this Agreement, BCBSF shall destroy any duplicate public records that are exempt, or confidential and exempt from public records disclosure. If BCBSF keeps and maintains public records upon completion of this Agreement, BCBSF shall meet all applicable requirements for retaining public records. All public records stored electronically must be provided to Employer, upon request by Employer's Records Custodian, in a format that is compatible with the information technology systems of Employer.

IF BCBSF HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, OF FLORIDA BLUE'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, PLEASE CONTACT CITIZENS' RECORDS CUSTODIAN AT (i) (850) 521-8302; OR (ii) RECORDSREQUEST@CITIZENSFLA.COM; OR (iii) RECORDS CUSTODIAN, CITIZENS PROPERTY INSURANCE CORPORATION, 2101 MARYLAND CIRCLE, TALLAHASSEE, FL 32303.

BCBSF's Failure to Respond to Public Records Request. BCBSF must comply with Employer's request for records, including all documents, papers, letters, emails, or other materials in conjunction with this Agreement, within thirty (30) calendar days of Employer's request. BCBSF's failure to comply with Employer's request may be subject to penalties in accordance with Chapter 119.10, Florida Statutes. BCBSF will hold Employer harmless from any actions resulting from BCBSF's non-compliance with Florida's Public Records Laws. Without limiting Employer's other rights of termination as further described in this Agreement, Employer may unilaterally terminate this Agreement for refusal by BCBSF to comply with this Section unless the records are exempt from Section 24(a) of Article I of the State Constitution and Section 119.07(1), Florida Statutes.

BCBSF shall implement and maintain appropriate safeguards to: (1) reasonably ensure the security and confidentiality to Employers confidential information; (2) reasonably protect against any anticipated threats or hazards to the security or integrity of Employers confidential information; and (3) reasonably protect against unauthorized access to or use of Employer's confidential information that could cause harm or inconvenience to Employer or any customer of Employer. The Public Records Addendum is attached hereto as Addendum 1.

I. Summary of Benefits and Coverage (SBC):

Employer agrees:

(1) to promptly provide to BCBSF information necessary to complete the SBC and understands that Employer's failure to provide information in a timely manner may substantially delay and/or jeopardize the timely delivery of the SBC;
(2) to distribute the SBC required under the Patient Protection and Affordable Care Act (PPACA) to members;
(3) to ensure that electronic access to the SBC shall be restricted to a "read-only" or similar basis;
(4) to replace any hard-copy SBC that is modified by BCBSF and understands that the hard-copy SBC on file with BCBSF shall control in the event of any discrepancy;
(5) that the Employer remains solely responsible for the content of the SBC and all other legal requirements related to the SBC. To the extent that BCBSF incurs any liability as a result of the preparation or distribution of the SBCs to Employer's members, Employer shall fully indemnify BCBSF; and,
(6) that if Employer contracts with a third party to accomplish any of the requirements in this Section I. I., Employer shall remain liable for above actions.

J. With respect to any fees and taxes imposed on Employer under PPACA (including, but not limited to, the Reinsurance Fee and the Patient Centered Outcomes Research Trust Fund Fee), calculation and

payment of such fees and taxes to the applicable agency shall be the sole responsibility of Employer and will not be separately calculated by BCBSF, paid by BCBSF on behalf of Employer or otherwise collected by BCBSF.

Section II: Obligations of BCBSF

A. BCBSF agrees to provide, either directly or indirectly, the following services to the Employer for administration of the Plan:

(1) Claim Payments and Claim Control: While the Agreement is in effect, all claims for benefits under the Plan for which proof of claim is furnished, in form satisfactory to the BCBSF, shall be accepted for processing and payment or denial, as hereinafter provided. Claim services will be furnished in connection with the Plan as to those classes of persons as agreed to by BCBSF and the Employer.

(2) Claim Processing: the claim must be received within ninety (90) calendar days after the beginning of care or, if by a participating provider, within the filing period permitted under the participating provider's contract, however, failure to file the claim within such period will not prevent payment of benefits if the member shows that it was not reasonably possible to timely file the claim, provided the claim is filed as soon as is reasonably possible, in no event, except in the absence of legal capacity, no later than twelve (12) months from the date services were rendered. Claims will be adjudicated in the order received and will not be re-adjudicated due to out of sequence dates of services. A claim is "incurred" on the date the service or supply, giving rise to such claim, is rendered or furnished. A claim is deemed "paid" on the date the claim payment check is issued.

"Allowed Amount" and "Allowable Charge" mean the amount BCBSF, its Designated Agent or a Licensee of the Blue Cross and Blue Shield Association ("BCBSA") agrees to pay a provider as payment in full for a service, procedure, supply or equipment. Additionally:

(a) The Allowed Amount shall not exceed the maximum payment, unless otherwise required by applicable law;
(b) The Allowed Amount for emergency services (including air ambulance services) provided by non-participating or non-contracting Providers, as well as non-emergency services provided by non-participating or non-contracting providers at participating or contracting hospitals, hospital outpatient departments, critical access hospitals, or ambulatory surgical centers, will pay in accordance with applicable federal law; and,
(c) In addition to the member's liability for benefit year deductibles, copayments and/or coinsurance, the member may be balance billed by the non-participating or non-contracting provider for any difference between the Allowed Amount and the Billed Amount, except where prohibited by applicable law.

For covered items and services provided by non-participating or non-contracting providers described in this Agreement, the Allowed Amount will be the Recognized Amount (less any applicable benefit year deductible, copayment and/or coinsurance). If the provider disputes such Allowed Amount and initiates a thirty (30) calendar day open negotiation and/or independent

dispute resolution ("IDR") process in accordance with applicable federal law, BCBSF or its Designated Agent will have the exclusive discretion and authority to administer such processes on behalf of the Group Health Plan, including but not limited to negotiating and agreeing with the provider upon a revised Allowed Amount for the claim(s) that BCBSF or its Designated Agent, in its sole discretion, believes to be appropriate under the circumstances, and administering the IDR process as necessary and appropriate, where applicable. BCBSF or its Designated Agent will have no obligation to inform, confer with, or obtain the consent of Employer in negotiating with the provider, agreeing upon a revised Allowed Amount, or administering the open negotiation and/or IDR process in any way, in accordance with this Section. For the avoidance of doubt, the provisions of this Agreement apply to any damages, including a reasonable attorneys' fee (for attorneys chosen by BCBSSC), resulting from, arising out of, based on, or in connection with, any claim relating to the administration or result of any such negotiation or IDR process. Employer agrees that its exclusive liability, and agreement to hold BCBSF or its Designated Agent harmless, for any and all claims amounts that are not reimbursed by any Stop-Loss Insurance carrier that is not affiliated with BCBSF or its Designated Agent includes any additional claims amount that may result from BCBSF's or its Designated Agent's administration of any provider negotiation or IDR process described in this Section.

Notwithstanding anything herein to the contrary, the member's liability for benefit year deductibles, copayments and/or coinsurance for covered items and services provided by non-participating or non-contracting providers described in this Agreement will be calculated as if the item or service was furnished by a participating or contracting provider, and based on the Recognized Amount, which may differ from the Allowed Amount.

"Recognized Amount" means, in accordance with federal law, the lesser of the non-participating or non-contracting provider's billed amount or BCBSF's or its Designated Agent's median contracted rate for participating or contracting providers for the same or similar item or service furnished in the same or similar specialty in the same geographic region; provided that, except in connection with air ambulance services, if there is a recognized amount specified for this purpose under an applicable All-Payer Model Agreement under Section 1115A of the Social Security Act, or if not, under applicable state law, then such amount, as applicable, will instead serve as the Recognized Amount.

Employer acknowledges that BCBSF's Designated Agent may have incentive-based agreements with providers located in the State of South Carolina related to compensation for services provided as a part of a Value-Based Program. Pursuant to such compensation arrangements, the provider may be subject to performance or risk-based compensation including, but not limited to, withholds, bonuses, incentive payments, provider credits and member management fees. The provider incentive amount may be translated and passed to the Employer as part of the claims amount invoiced to the Employer. Often the compensation amount is determined after the medical service has been performed and after Employer has been invoiced. Provider incentives may include payment for services not otherwise covered under the Plan of Benefits. For Value-Based Programs in other Blue Cross and/or Blue Shield Licensees service areas see the "Inter-Plan Programs" section in Exhibit B.

(3) Recovery of Claims Amounts: BCBSF may not seek recovery of claims amounts for members who are terminated more than sixty (60) calendar days retroactively. In the event of retroactive addition or termination of members, BCBSF shall not be responsible for denials of claims under Employer's stop Loss insurance. BCBSF will not be responsible for collection of claims amounts paid to providers or members prior to notification of a member's termination. BCBSF will pursue recoveries in accordance with BCBSF's policies. Any such recovered amount shall be credited to the Employer except as otherwise provided in Exhibit B. The Employer shall hold BCBSF and the Designated Agent harmless for any such payment not recovered.

(4) Benefit Determination: the determination of the extent of the benefit to which any claimant is entitled under the Plan shall initially rest with BCBSF or the Designated Agent. However, in the event that the Employer determines that BCBSF or the Designated Agent has misinterpreted the Plan and so informs BCBSF in writing, all claims reported after delivery of such writing to the Designated Agent shall be processed and paid in accordance with the Employer's interpretation as set forth in such writing.

(5) Determination of Eligibility: every member designated by the Employer to the Designated Agent shall be eligible for coverage.

(6) Enrollment: the Designated Agent will enroll and maintain enrollment for members. Benefits will be paid pursuant to records supplied by Employer.

(7) Overpayments:

(a) If BCBSF becomes aware of an overpayment made under the Plan of Benefits, BCBSF or its Designated Agent shall use its standard overpayment identification and collection processes and procedures to attempt to recover any overpayment. The fee for standard overpayment identification and collection of retroactive termination of members shall be based on a percentage of the amount recovered, is listed on Exhibit B and is not included in the Administrative Fee or any other fee described herein. BCBSF's or its Designated Agent's services for its standard overpayment identification and collection services for coordination of benefits under a pay and chase model are included in the Administrative Fee listed in Exhibit B.

(b) BCBSF or its Designated Agent, in its sole discretion, shall settle and resolve overpayments on any basis it determines is reasonable (provided that BCBSF or its Designated Agent may only pursue litigation in accordance with Section II. A. 7 (c), including payment of less than the entire overpayment amount.

(c) Notwithstanding the foregoing, BCBSF is not required to initiate court proceedings to comply with Section II, A. 7 (a) and (b). However, if BCBSF determines that litigation is necessary to collect the overpayment, BCBSF or its Designated Agent will notify Employer, and Employer will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees.

(d) If BCBSF or its Designated Agent becomes aware of an overpayment made to a member, provider or to Employer, BCBSF or its Designated Agent shall be entitled to offset such amounts against any amounts owed by BCBSF or its Designated Agent to such member, provider or Employer.

(8) Account Management: BCBSF shall provide account management services including account transition, implementation and the relationship management and issue resolution for the Employer and its designated consulting firm.

(9) Customer Service: BCBSF shall provide customer service administration including providing a toll-free telephone line.

(10) Identification Cards ("ID cards"): BCBSF shall provide standard ID cards to persons participating under the Plan. At Employer's expense, Employer may (within guidelines) personalize the standard cards furnished by BCBSF. BCBSF reserves the right to charge for reissuing identification cards as a result of an independent action caused by Employer.

(11) Plan of Benefits:

(a) BCBSF shall prepare and deliver to the Employer, for the distribution to persons who are participating or eligible to participate in the Plan, the Plan of Benefits which will describe the benefits and such other conditions of the Plan as are agreed to by BCBSF and the Employer.

(b) The Plan of Benefits is the document attached as Exhibit A, which is not the Summary Plan Description, unless so designated by the Employer or Plan Administrator, and which describes the terms and benefits to be provided to members. Revision of the Plan of Benefits shall be prepared whenever required by revisions in the Plan under this Agreement.

(c) The Summary Plan Description is a document which is prepared by the Employer, Plan Administrator or their designee, and which, among other things, describes the eligibility requirements for participation in the Plan, the benefits to be administered by BCBSF, identification of fiduciaries, and information on members' rights.

(d) Employer is responsible for: (i) reviewing the Plan of Benefits, (ii) determining whether the Plan of Benefits meets all of Employer's legal and business obligations (and advising BCBSF of any necessary revisions) and (iii) distributing the Plan of Benefits to members.

(12) Web Portal: BCBSF shall provide maintenance of a Web site providing Plan information for employees and their dependents including information on providers participating in the preferred provider organization networks.

(13) Consultation Services: BCBSF shall provide consultation services to Employer on benefit plan development and overall Plan administration.

(14) Reporting:

(a) Upon request of the Employer and receipt of any required information, BCBSF will prepare a report of the cost of any proposed modification or extension of the Employer's Plan. In connection therewith, BCBSF will notify the Employer of any changes in Exhibit B under this Agreement which would be required if the Plan under the Agreement were so modified or extended.

(b) Upon request of the Employer, BCBSF will prepare the following standard reports:

1. An analysis of Benefit costs for the immediately preceding term of the Agreement,
2. Annual data required for federal disclosure reporting.
3. Each of BCBSF's "standard" quarterly reports that Employer requests.

(c) Additional reports may be available upon Employer's reasonable request for an additional fee and Employer shall reimburse BCBSF for any and all costs (including internal and out of pocket costs) incurred by BCBSF in providing any non-standard data and reports not expressly included under this Section II.

B. Records: BCBSF shall maintain such records as are needed to perform the services set forth in this Agreement and shall ensure that their Designated Agent shall maintain claim records and such other records as are needed to perform such services.

C. Third Party Liability (Subrogation/Reimbursement/Workers' Compensation):

(1) If BCBSF or its Designated Agent becomes aware of a subrogation, reimbursement or workers' compensation claim (hereinafter collectively referred to as "subrogation"), BCBSF or its Designated Agent shall use its standard processes and procedures to attempt to recover the subrogation claim. BCBSF or its Designated Agent shall charge an additional fee based on a percentage of the subrogation amount recovered (hereinafter the "Subrogation Fee"). The Subrogation Fee is listed on Exhibit B and is not included in the Administrative Charge or any other fee described herein. BCBSF or its Designated Agent, in its sole discretion, shall settle and resolve all such claims on any basis it determines as reasonable, including collection of less than the entire amount of such claim and contributions to the member's attorney's fees. Notwithstanding the foregoing, BCBSF or its Designated Agent is not required to initiate court proceedings to comply with this Section II. C. In the event BCBSF or its Designated Agent determines litigation is necessary to recover a subrogation or workers' compensation claim, BCBSF or its Designated Agent will notify Employer, and Employer will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees.

(2) In the event of termination of this Agreement, in whole or in part, BCBSF or its Designated Agent will continue to work as outlined above all third-party liability cases within its possession as well as any additional cases identified by BCBSF or its Designated Agent with dates of services incurred prior to the date of termination. The fees charged for the third-party liability services will be at the rate listed in Exhibit B at the time of termination for such third-party liability services.

Section III: Financial Obligations

A. In exchange for the obligations undertaken by BCBSF in this Agreement, Employer agrees to pay BCBSF fees in the amounts and in the manner specified in Exhibit B, which is attached and incorporated herein ("Administrative Fees"). The Parties agree that Administrative Fees may be amended from time to time by the mutual agreement of the Parties hereto, and that any such amendments will be signed, dated and made a part of this Agreement.

B. BCBSF may change the Administrative Fees set forth in Exhibit B as of any date on or after the first anniversary of the Agreement's Effective Date as provided in this section and Exhibit B. III. (C). If such a change is in connection with a modification of the Plan, it will become effective on the Effective Date of the modification. If such change is not in connection with a modification of the Plan, it will become effective on the date specified, provided BCBSF has given written notice of the change at least sixty (60) calendar days prior thereto, and unless the Employer has notified BCBSF in writing at least thirty (30) calendar days prior to the Effective Date of the applicable change in Administrative Fees of its intention to terminate this Agreement in conformity with Section IV. A (5) below. However, in the event there is a ten percent (10%) increase or decrease in enrollment or projected enrollment (number of lives covered by BCBSF under the Employer's benefit program) BCBSF reserves the right to revise Administrative Fees.

C. In addition to the Administration Fees set forth in Exhibit B, the Employer shall reimburse BCBSF for the amount of any taxes, or other charges or fees in connection therewith, assessed against BCBSF with respect to any benefit payments made under the Plan.

D. Performance guarantees are set forth in Exhibit D, apply to medical claims only and are for the initial term of the Agreement only. BCBSF shall apply its standard methodology to measure performance guarantees. Employer acknowledges and agrees that performance guarantees will be considered null and void if this Agreement is not executed and/or the Agreement is not effective at the time any performance guarantee payment amount is otherwise due under this Agreement. In the event of a conflict between the terms of this Section III.D. and other provisions of the Agreement, the terms of this Section III.D shall control.

   Performance guarantee results will be available on a quarterly basis for informational purposes only with final settlement made no earlier than second quarter of the following year. The payment amount, if any, shall be paid by a credit to Employer on their monthly Administrative Fee bill. Upon prior written notice to Employer, BCBSF may offset the payment amount against any payments owned by Employer to BCBSF.

   In the event there is a ten percent (10%) increase or decrease in enrollment or projected enrollment (number of lives covered by BCBSF under the Group's benefit program) for the Effective Date of the performance guarantees or if Employer makes a material change in benefits during the term of this Agreement, as reasonably determined by BCBSF, that affects the performance being measured in the performance guarantees, BCBSF reserves the right to revise or void the performance guarantees. BCBSF may replace or modify performance guarantee measures or goals if necessitated by a change in the way BCBSF systematically tracks or measures the applicable measure.

E. Discount guarantees are set forth in Exhibit F and are for the first year of the Agreement only. Employer acknowledges and agrees that discount guarantees will be considered null and void if this Agreement is not executed and/or the Agreement is not effective at the time of any discount guarantee payment amount is otherwise due under this Agreement. In the event of a conflict between the terms of this Section III, paragraph E and other provisions of the Agreement, the terms of this Section III, paragraph E shall control. Discount Guarantee results will be available on a quarterly basis with results and settlement made no earlier than the second quarter of the following year.

Section IV: Termination of Agreement

A. This Agreement shall terminate at the expiration of the day prior to any anniversary of its Effective Date if BCBSF or the Employer has given at least twelve (12) months prior written notice to the other of its intention to terminate this Agreement on that anniversary date. Furthermore, this Agreement shall terminate upon the first to occur of the following:

(1) The expiration of thirty-one (31) calendar days after written notice has been given by BCBSF or the Employer of the other's breach of material obligations under this Agreement; provided such breach has not been cured within such thirty-one (31) calendar day period;

(2) The date specified in a written notice given by BCBSF to the Employer of its intent to terminate this Agreement because of the Employer's failure to remit claims payment or Administrative Fees for services, as set forth in Exhibit B;

(3) Termination of the Plan;

(4) Modification of the Plan, but such modification of the Plan shall not operate to terminate this Agreement (a) if this Agreement is changed to make such modified plan the Plan under this Agreement, or (b) while this Agreement is being continued, by mutual agreement between BCBSF and the Employer, provide that such modification shall not apply to this Agreement during such continuation;

(5) Either BCBSF or Employer may terminate this Agreement at any time upon twelve (12) months written notice to the others; or,

(6) If any law or regulation is enacted which prohibits the continuance of this Agreement or any existing law or regulation is interpreted to so prohibit the continuance of this Agreement, the Agreement shall terminate automatically on the Effective Date of such law, regulation, or interpretation. BCBSF shall reasonably make the determination of the effect and Effective Date of any such law, regulation, or interpretation.

B. In the event of termination of this Agreement, BCBSF will continue to process claims incurred prior to, but received after, the termination of this Agreement, unless the Employer notified BCBSF in writing at the time of such termination that such services are not required. The administration of the processing of run out claims by BCBSF following termination of this Agreement will be subject to the Employer's continued funding of claims payment. "Run out claims" refers to those claims incurred for services performed prior to the termination of this Agreement, but not yet paid and/or not

submitted for payment to BCBSF prior to the termination of this Agreement. There is a separate and distinct Administrative Fee for BCBSF providing administrative services to pay run out claims. This is set out in Exhibit B.

Section V: Insurance Provisions

A. During the term of this Agreement, BCBSF will maintain at its sole expense the following insurance:

(1) Workers' Compensation which provides coverage for BCBSF's employees and independent contractors' employees, regardless of the state of hire, in at least the minimum statutory limits required by the State of Florida, and Employers' Liability with limits of $1 million per accident; provided, however, that such workers' compensation policy may exclude coverage for independent contractor employees who are covered by a workers' compensation policy that meets the requirements (including Employers' Liability coverage) set forth herein.

(2) Commercial General Liability with minimum limits of $1 million per occurrence (to include contractual liability) and $2 million in the aggregate.

(3) Umbrella Excess General Liability insurance with minimum limits of $4 million in the aggregate; the umbrella excess policy must afford coverage equivalent to the commercial general liability coverage required in subsection V.A 2.; the policy inception date must also be concurrent with the inception dates of the underlying general liability policy; if vendor maintains commercial general liability coverage that exceeds the minimum limits identified in V.A.2., then BCBSF may reduce its umbrella excess coverage limit by the corresponding amount;

(4) Professional Liability (errors and omissions) with minimum limits of $1 million per claim and $2 million in the aggregate: Coverage must be renewed for three (3) years after completion of the Services. The "retroactive date" for this policy, and any subsequent policies purchased as renewals or replacements, shall coincide with or precede the Effective Date of this Agreement. If the policy is terminated for any reason, BCBSF agrees to purchase, or cause its professional staff and consultants to purchase, an extended reporting provision of at least three (3) years to report claims arising from Services performed prior to the termination of the policy and allow for reporting of incidents that might give rise to future claims]; and,

(5) Information Security/Cyber Liability insurance written on a "claims-made" basis covering Vendor and Vendor Staff for expenses, claims and losses resulting from wrongful acts committed in the performance of, or failure to perform, all Services, including, without limitation, claims, other demands and any payments related to electronic or physical security, breaches of confidentiality and invasion of or breaches of privacy. The Information Security/Cyber Liability Insurance must include internet media liability including cloud computing and mobile devices for protection of confidential information and customer data whether electronic or non-electronic, network security and privacy; privacy against liability for system attacks, digital asset loss, denial or loss of service, introduction, implantation or spread of malicious software code, security breach, unauthorized access and use, including regulatory action expenses, and notification and credit monitoring expenses with at least the minimum

limits listed below. Coverage must be renewed for _____ years after completion of the Services.

- Each occurrence - $1,000,000
- Network Security/Privacy Liability - $1,000,000
- Breach Response/ Notification Sublimit - a minimum limit of fifty percent (50%) of the policy aggregate

B. Insurance Company Qualifications. Any company issuing policies required under Section V. must: (a) be licensed to transact business in the State of Florida; and, (b) have an AM Best Financial Strength rating of "A-" or above.

C. Defense Costs. The limits of indemnity coverage required under Section V. shall not include costs incurred in defending against a claim and shall not be reduced by the payment of such costs; provided, however, that with respect to professional liability and Information Security/ Cyber Liability coverage as set forth in Section V.A.5., BCBSF may alternatively maintain coverage with minimum limits of $2 million per claim and $4 million in the aggregate.

D. BCBSF's Insurance is Primary. The insurance required under Section V.A. shall apply on a primary basis to, and shall not require contribution from, any other insurance or self-insurance maintained by Employer, any Employer Board Member, or any Employer.

E. Employer to be an Additional Insured. The Commercial General Liability policy in Section V.A.2. shall include Citizens as an additional insured. For Commercial General Liability coverage, the policy must include ISO Form #CG 20 10 10 01 or a comparable company specific endorsement.

F. Waiver of Subrogation. The insurance required under Section V.A, except Professional Liability (errors and omissions) and Information Security/Privacy Liability shall include a provision waiving the insurer's rights of recovery or subrogation against Citizens.

G. Notice of Cancellation. BCBSF will provide that the insurance will not be cancelled, non-renewed or materially changed without at least thirty (30) calendar days prior written notice to Employer.

H. Proof of Coverage. Within ten (10) calendar days of written request, and upon renewal or reissuance of coverage thereafter, BCBSF must provide current and properly completed in-force certificates of insurance to Employer that evidence the coverages required in Section V. The agent signing the certificate must hold an active Insurance General Lines Agent license (issued within the United States).

Section VI: Miscellaneous Provisions

A. It is understood that the Employer retains all final authority and responsibility for the Plan and its operation including, but not limited to, the benefits structure of the Plan, compliance with the requirements of the COBRA (Consolidated Omnibus Budget Reconciliation Act), compliance with the requirements of HIPAA (Health Insurance Portability Administration Act of 1996), and

compliance with any other state and federal law or regulation applicable to the Employer or the administration of the Plan and that BCBSF is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Agreement or as mutually agreed to in writing by BCBSF and the Employer.

B. Employer delegates to BCBSF fiduciary authority to determine claims for benefits under the Plan as well as the authority to act as the appropriate fiduciary to determine appeals of any adverse benefit determinations under the Plan. BCBSF shall administer complaints, appeals and requests for independent review according to BCBSF's complaint and appeals policy, and any applicable law or regulation unless otherwise provided in the Plan of Benefits. In carrying out this authority, BCBSF is delegated full, final, binding and exclusive discretion to determine eligibility for benefits under the Plan and to interpret the terms of the Plan. In making its decision, BCBSF will rely on the Plan and will rely on eligibility data provided by the Employer. BCBSF shall be deemed to have properly exercised such authority unless a Member proves that BCBSF has abused its discretion or that its decision is arbitrary and capricious. BCBSF is a fiduciary of the Plan only to the extent necessary to perform its obligations and duties as expressed in this Agreement. BCBSF shall not act as the administrator of the Plan nor shall it have any fiduciary responsibility in connection with any other element of the administration of the Plan.

C. The terms of this Section V. B. shall not be applicable to claims and appeals related to pharmacy benefits.

D. If a Continuing Oversight Team (COST) is established in accordance with s. 287.057(26), Florida Statute, Vendor's Contract Manager will attend the initial meeting of the COST (in person or remotely) and will respond to any written questions from the COST within ten (10) business days.

E. Any of the functions to be performed by BCBSF under this Agreement may be performed by BCBSF or their Designated Agent or any of their respective subsidiaries or affiliates and any reference in Section V. C. to BCBSF, their Designated Agent, and/or their directors, officers and employees shall also include such an affiliate or subsidiary, their directors, officers or employees.

F. Employer shall have the right, at its sole discretion, to procure and contract separately with a Pharmacy Benefits Manager, (PBM), of its own choosing (the "Employer's PBM"). Where Employer makes such election, Employer shall provide timely written notice to BCBSF. Upon such notice, BCBSF shall fully and timely cooperate with the transition to the Employer's PBM and to amend the Agreement accordingly. Upon the completion of the transition to the Employer's PBM, BCBSF shall fully and timely cooperate with Employer and Employer's PBM to ensure that the services of the Employer's PBM are coordinated with the Group Health Plan and the claims processing and administrative services of BCBSF as further described herein. BCBSF shall continue to pay any Rebates or guaranteed minimum amounts attributed to drug claims made by Employer's group members incurred prior to the currently contracted PBM's transition cutoff date.

G. BCBSF may assign this Agreement (including all obligations and liabilities associated with the Agreement) as well as the right to perform under this Agreement (and to receive payment from Employer) to any of its subsidiaries or affiliates without prior consent or notice to Employer. After the first anniversary date of the Agreement, and if the assignment involves BCBSSC's services, BCBSF will provide Employer with 120 calendar days' notice of such assignment.

H. In fulfilling its obligations under this Agreement, BCBSF reserves the right to contract with third parties it deems necessary to administer the Employer's Plan; therefore, Employer hereby authorizes BCBSF to do all things and to perform all acts which BCBSF deems necessary or appropriate to properly administer and facilitate claims processing with respect to the Employer's Plan and there is no obligation for BCBSF to obtain prior approval from Employer herein as a condition precedent to entering into any such contract. BCBSF shall remain liable for the performance of any and all such subcontracted duties. Employer acknowledges that BCBSF has contracted with a third party (Blue Cross and Blue Shield of South Carolina "BCBSSC") to provide certain services to Employer from their Columbia Service Center in connection with the Agreement as follows:

- Maintaining eligibility records and handling claims processing;
- Providing claims and utilization reports;
- Responding to member correspondence; and,
- Handling all member telephone services.

I. Further, as BCBSF's Designated Agent, BCBSSC is authorized to receive payment directly from the Employer.

J. It is understood that BCBSF and its designated agents have no liability under the Plan and will only pay benefits pursuant to the Plan, as funds are made available by the Employer.

K. It is mutually recognized that BCBSF and its designated agents, in performing their obligations under this Agreement, are acting only as agents of the Employer and shall not be designated or deemed the administrator or fiduciary with respect to the purposes of any Federal or State law of similar nature.

L. This Agreement is made in, governed by, and shall be construed in accordance with the applicable laws of the State of Florida. Each party consents and submits to the exclusive jurisdiction of the Circuit Court of Duval County, Florida, for all purposes under this Agreement and waives any defense to the assertion of such jurisdiction based on inconvenient forum or lack of personal jurisdiction.

Both Parties agree Employer is a political subdivision of the State of Florida, and as such, has sovereign immunity pursuant to 768.28, Florida Statutes, and both Parties agree that nothing in this Agreement shall be construed as a waiver of any right, defense or immunities accorded to Employer by said statute, or any other applicable law.

M. For each calendar year during the term of this Agreement, upon request, BCBSF shall submit to Employer, via email to Employer's Contract Manager or designee a copy of its annual American Institute of Certified Public Accountants Service Organization Control (SOC) 1 type 2 report and complete the Citizens IT Security Questionnaire in lieu of the SOC 2 type 2 report.

Without limiting any other rights of Employer herein, Employer shall have the right to review BCBSF's privacy and security controls prior to the commencement of Services and from time to time during the term of this Agreement. BCBSF shall implement any reasonably required

safeguards as identified by Employer or by any audit of BCBSF's privacy and security controls.

N. During the term of this Agreement and for a period of six (6) months following its termination, Employer, or its designated claims auditing representative (unless BCBSF objects to the auditing representative in writing), shall have the right to examine records of BCBSF or their Designated Agent relating only to the Plan of Benefits. Any such audit shall be conducted during regular business hours at BCBSF's Designated Agent's offices, and upon sixty (60) calendar days prior written notice and receipt of a signed external claim audit agreement. Audits will be based on a sample not to exceed 250 claims per audit. Any examination of individual member's health benefit payment records shall be carried out in a manner specifically designed to protect the confidentiality of the member's medical information in compliance with all federal and state laws governing confidentiality and privacy of health information and as outlined in the separate audit policy that is executed prior to any audit. All audits shall not exceed 18 months (of service dates) and shall be limited to claims paid in the current calendar year in which the audit is conducted and /or the immediately preceding calendar year. An annual audit will be allowed at no charge to Employer. For subsequent audits during twelve (12) months following the audit, Employer shall pay an additional fee determined by BCBSF for any administrative costs and out-of-pocket expenses incurred by BCBSF in connection with the audit. Audits during the run-out period will also be subject to cost. Employer will not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (whether characterized as "savings", or "uncovered recoveries" or otherwise) discovered by such third party. BCBSF will not pay any amounts based on audit results.

O. The Employer agrees that the names, logos, symbols, trademarks, trade names, and service marks of BCBSF whether presently existing or hereafter established, are the sole property of BCBSF and BCBSF retains the right to the use and control thereof. The Employer shall not use BCBSF's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of BCBSF and shall cease any such usage immediately upon written notice by BCBSF or upon termination of this Agreement, whichever is sooner.

P. BCBSF agrees that the name, logos, symbols, trademarks, trade names, and service marks of the Employer, whether presently existing or hereafter established, are the sole property of the Employer and the Employer retains the right to the use and control thereof. Notwithstanding, BCBSF may reference Employer as a customer in marketing materials used by BCBSF in the course of its business operation.

Q. Any notice required to be given pursuant to this Agreement shall be in writing, postage prepaid, and shall be sent by certified or registered mail, return receipt requested, or overnight mail delivery for which evidence of delivery is obtained by the sender, to the Parties at the addresses below, or such other addresses that the Parties may hereafter designate. The notice shall be effective on the date the notice was received.

To: Blue Cross Blue Shield of Florida
4800 Deerwood Campus Parkway
Jacksonville, FL 32246
Attention: Vice President, Major/National Accounts

To: Employer Name: Citizens Property Insurance Corporation
Address: 2101 Maryland Circle
Tallahassee, Florida 32303
Attention: Lori Newman
Title: Vendor Relationship Administrator, Sr

R. BCBSF must execute a Conflict of Interest Form as required by Employer from time to time. BCBSF shall not have a relationship with Employer officer or employee that creates a conflict of interest. If there is the appearance of a conflict of interest, BCBSF will promptly contact Employer's Contract Manager or designee to obtain a written decision as to whether action needs to be taken to ensure a conflict does not exist or that the appearance of a conflict is not significant.

S. This Agreement, including the Exhibits attached hereto, is intended to set forth the entire agreement between BCBSF and the Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect; notwithstanding, the fully executed Agreements entered into by the Parties prior to this Agreement shall remain in effect only for those claims incurred prior to the Effective Date of this Agreement.

T. Headings used in this Agreement are for reference purposes only and shall not be used to modify the meaning of the terms and conditions of this Agreement.

U. If any provision of this Agreement is in conflict with any statute or rule of law or may be determined by a court of competent jurisdiction to be illegal or unenforceable, then such provision will be deemed inoperative to the extent that it may conflict therewith or be illegal or unenforceable, and each provision not so affected will be enforced to the full extent provided by law.

V. If either Party becomes unable to perform any or all of their obligations under this Agreement because of or caused by (in whole or in part) any act of God, including without limitation storms, floods, earthquakes, ice storms, blizzards, natural disasters, actions or decrees of governmental bodies, damage to or breakdown of equipment, destruction of equipment, interruption of public utility services (such as power, heat, or telecommunications), or any other cause or condition whether similar or dissimilar to the foregoing beyond such Party's reasonable control (any of which is hereafter referred to as a "Force Majeure Event"), then the Party suffering the Force Majeure Event shall give the other Party notice of such Force Majeure Event, and diligently pursue restoration of the ability to perform hereunder. Any such Force Majeure Event shall excuse the affected Party's performance of this Agreement for the duration of the Force Majeure Event as well as the period of time that is required to recover from such event. However, excuse under a Force Majeure Event is only available with respect to events that are not within a Party's control and that cannot be reasonably anticipated and appropriately planned for in advance. Items within a Party's control shall include, but not be limited to, reasonable staffing assumptions and prudent contingency planning. Notwithstanding the forgoing, neither party shall be excused for payment obligations for more than a ten (10) calendar day period, notwithstanding the continuation of a Force Majeure Event.

W. Employer and Plan Administrator acknowledge and agree that BCBSF shall serve as a "Business Associate" of the Plan (as that term is defined in 45 C.F.R. § 160.501). Accordingly, Employer

shall, for and on behalf of the Plan, agree to and execute a "Business Associate Addendum" (Exhibit C) to this Agreement. Employer and Plan Administrator further acknowledge and agree that this Agreement along with the Business Associate Addendum shall thereafter govern BCBSF's obligations regarding the use and disclosure of "Protected Health Information" (as that term is defined in 45 C.F.R. § 160.103 when performing the functions delegated herein.

X. The delay or failure by a Party to exercise or enforce any of its rights under this Agreement shall not constitute or be deemed a waiver of the Party's right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

Y. The Employer on behalf of itself and its participants hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Employer and BCBSF, that BCBSF 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 BCBSF to use the Blue Cross and Blue Shield service mark in the State of Florida, and that BCBSF is not contracting as the agent of the Association.

Z. The Employer further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSF and that no person, entity or organization other than BCBSF shall be held accountable or liable to the Employer for any of BCBSF's or it's Designated Agent obligations to the Employer created under this Agreement. This paragraph should not create any additional obligations whatsoever on the part of BCBSF other than those obligations created under other provisions of the Agreement.

AA. The delay or failure by a Party to exercise or enforce any of its rights under this Agreement shall not constitute or be deemed a waiver of the Party's right thereafter to enforce those rights, nor shall any single or partial exercise of any such right preclude any other or further exercise thereof or the exercise of any other right.

BB. BCBSF is an independent contractor with no authority to contract for Employer or in any way to bind or to commit Employer to any agreement of any kind or to assume any liabilities of any nature in the name of or on behalf of Employer. Under no circumstances shall BCBSF or BCBSF Staff hold itself out as or be considered an agent, employee, joint venturer, or partner of Employer. In recognition of BCBSF's status as an independent contractor, Employer shall carry no Workers' Compensation insurance or any health or accident insurance to cover BCBSF or BCBSF Staff. Employer shall not pay any contributions to Social Security, unemployment insurance, federal or state withholding taxes, any other applicable taxes whether federal, state, or local, nor provide any other contributions or benefits which might be expected in an employer-employee relationship. Neither BCBSF nor BCBSF Staff shall be eligible for, participate in, or accrue any direct or indirect benefit under any other compensation, benefit, or retirement plan of Employer.

CC. BCBSF shall not give a gift or make an expenditure to or for the personal benefit of an Employer's officer or employee.

DD. If a court deems any provision of this Agreement void or unenforceable, that provision shall be enforced only to the extent that it is not in violation of law or is not otherwise unenforceable and all

other provisions shall remain in full force and effect

EE. The defense of any legal action instituted on a claim for benefits under the Plan shall not be an obligation of BCBSF or its designated agents. Rather, such defense shall be the obligation of the Employer. However, BCBSF and its designated agents shall cooperate with the Employer by furnishing such evidence as it has available in connection with the defense of any such action.

FF. In all events, Employer shall be liable for the full amount of any benefits paid as a result of plan benefits litigation. In no event shall BCBSF or its designated agents be liable for any amount of benefits paid as a result of plan benefits litigation.

GG. By entering into this Agreement, the Parties waive any right to jury trial and any right to maintain claims arising out of this Agreement as a class action. The Parties agree that a single judge sitting as finder of fact and law will determine any claims arising out of this Agreement.

HH. Employer may accept the terms and provisions of the Agreement either by returning a signed copy of this Agreement to BCBSF or by making any of the required payments to BCBSF. Such acceptance renders all terms and provisions stated in this Agreement binding on BCBSF and Employer.

II. Contract Managers. Each Party will designate a Contract Manager during the term of this Agreement whose responsibility shall be to oversee the Party's performance of its duties and operational obligations pursuant to the terms of this Agreement. As of the Effective Date, Citizens' and Vendor's Contract Managers are as follows:

Vendor's Contract Manager
Adrian Olivo
Blue Cross Blue Shield of Florida, Inc
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246
941-378-7326
Adrian.olivo@bcbsfl.com

Citizens' Contract Manager
Merrio Tornillo
Citizens Property Insurance Corporation
2101 Maryland Circle
Tallahassee, Florida 32303
850-513-3895
Merrio.tornillo@citizensfla.com

Each Party shall provide prompt written notice to the other Party of any changes to their Contract Manager; such changes shall not be deemed Agreement amendments.

JJ. Public Records Addendum ("Addendum"). BCBS agrees that the Addendum attached hereto is hereby incorporated into this Agreement in order to address the public posting of this Agreement and its disclosure to third parties.

IN WITNESS WHEREOF, BCBSF and the Employer have caused this Agreement to be executed in duplicate by their respective officers duly authorized to do so. This Agreement may be executed in counterparts, each of which shall be deemed an original, and all of which together shall constitute but one and the same Agreement. The Parties agree that a faxed or scanned signature may substitute for and have the same legal effect as the original signature.

CITIZENS PROPERTY INSURANCE CORPORATION

BY: DocuSigned by: Violet Bloom F390B38167024A0...

NAME: Violet Bloom

TITLE: CHRO

DATE: 10/19/2022

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

BY: DocuSigned by: 4234BA3698C64FB...

NAME: Warren Mills

TITLE: VP Sales Operations

DATE: 10/19/2022

CITIZENS PROPERTY INSURANCE CORPORATION

BY: DocuSigned by: 7B9C7AA80097483...

NAME: Kelly Booten

TITLE: Chief Operating Officer

DATE: 10/19/2022

EXHIBIT A

Plan of Benefits

EXHIBIT B

Financial Arrangement

It is mutually understood and agreed that Exhibit B of the Administrative Services Agreement between BCBSF and the Employer becomes a part of said Agreement with all other terms of said Agreement remaining in full force and effect. This Exhibit applies to the method of payment for services for all benefits payable under this Agreement.

I. While this Agreement is in effect services will be furnished in connection with the Plan including claims processing and payments of the amount due with respect to claims incurred on or after January 1, 2023, that qualify under the Employer's Plan. The Designated Agent shall be fully reimbursed for the payment of such claims by the Employer as specified in this Exhibit.

II. BCBSF will pay Employer a wellness contribution for wellness, communications, technology, and audit related issues or activities in the amount of:

2023	2024	2025	2026	2027	2028

III. Employer will receive a 1st Fee Waiver of 3 months of ASO Fees.

IV. BCBSF will pay Employer an annual $_____ PEPM Fund to offset programs for January 1, 2023 through December 31, 2028.

V. The Administrative Fees applicable to this Agreement include a base Administrative Fee and Administrative Fees for other services as described in Sections A and B directly below.

A. The base Administrative Fees are as follows for the Employer's Plan. If Stop Loss coverage is not renewed through BCBSF, a Stop Loss reporting coordination fee may apply.

2023	2024	2025	2026	2027	2028

B. In addition to the base Administrative Fee, the charges for the listed additional services will be as stated below. These charges, together with the base Administrative Fee will be called the "Administrative Fees" under this Agreement. Charges listed in this paragraph III. B. and the "No Additional Fee" services listed below apply and are guaranteed for the term of the Agreement including renewals and may change for subsequent years.

Claims Fiduciary Services	_____ per employee per month
Standard Care Management	No Additional Fee
24/7 Nurseline	No Additional Fee
HR Advocate Program Dedicated advocate for high touch members	No Additional Fee

Identified by Citizens HR Team	
CareCor+ *(Formerly My Health Essentials Suite)* • *Prevention and Wellness* • *Maternity Care Program* • *Gaps in Care for the Entire Population* • *Precision Care Solutions* • *Chronic Condition Support* • *Complex Care Management* • *Quarterly High Cost Claim Calls and Reports Available*	_____ PEPM
Care Connected • *Chronic Condition Support focused on diabetes, heart failure, and COPD* • *Maternity Care* • *Complex Case Management* • *Utilization Management* • *Gaps in Care* • *Precision Care Solutions* • *ER Diversion and Readmission Avoidance* • *Specialty Case Management* • *24-Hour Nurseline* • *Concierge Customer Service* • Clinical Performance Guarantees	_____PEPM
Stop Loss Coordination	_____ PEPM
Teladoc Claims Costs in addition	_____PEPM
Radiology Management (NIA)	_____ PEPM
Bundled Program: *Radiology, Musculoskeletal, Radiation Oncology and Hip, Knee Shoulder Programs (in lieue of individual programs listed below)*	_____ PEPM
My Health Novel Chapter 1 – Weight Management	
Pharmacy Carve-In Credit	_____ PEPM
New Wellness Platform with Virgin Pulse	_____ PEPM
Radiation Oncology Management	_____ PEPM
Musculoskeletal Management	_____ PEPM
Hip, Knee, Shoulder Management Program	_____ PEPM
Specialty Care Management Cancer Care **$560 per patient per month billed as a claim**	
Specialty Care Management Renal Care **$330 per patient per month billed as a claim**	

Access fees of up to _____% of Network Savings for PPO provider claims and _____% of Network savings for Traditional provider claims may be assessed for claims incurred in states under the BlueCard program as explained in more detail under Section XIV below. This access fee will not exceed _____ dollars (____) for any one claim and will not apply in Florida, South Carolina or in Consortium Plan service areas where enrolled members reside as long as enrollment continues to be equal to or greater than one thousand (1,000) contracts. On the first

anniversary date after enrollment falls below one thousand (1,000) contracts, access fees will apply in those Consortium Plan service areas where enrolled members reside and Consortium fees were not previously established. Access fees will also apply in Consortium Plan service areas where no enrolled members reside. A determination of the Consortium Plan service areas that will not apply access fees for services rendered to members will be made on the basis of enrollment on each subsequent anniversary of this Agreement's Effective Date. Access fees will be applied on the basis of where the service was incurred, and not where the member resides.

Network Savings is defined as the total of the amounts computed by subtracting each "allowed amount" for a particular service under the terms of a participating provider's written agreement from each "billed amount" for such service. In no event shall the term "Network Savings" include duplicate charges or billed amounts for services or supplies not covered under the Employer's Plan. The term "allowed amount" means the amount received as payment in full by a participating provider, under that provider's written agreement, from both BCBSF and covered individuals under Employer's Plan for claims submitted to, and paid by BCBSF for a particular covered service, and the term "billed amount" means the amount which would be received by such provider for the same covered service utilizing that provider's charges.

C. The base Administrative Fee is guaranteed through the term of the Agreement including renewals, however, BCBSF may:

(1) Revise the base Administrative Fee, at any time, if any change in law or regulation or interpretation of law or regulation by Federal, State or Local governmental agency or entity imposes greater material duties, obligations or costs on the Designated Agent and/or BCBSF than contemplated by this Agreement;

In addition, the Employer shall assume the liability for any tax, assessment or cost based upon the existence of the Employer's Plan, including all fines, penalties, losses, damages, costs, expenses, attorneys' fees and court costs incurred in connection with any assessment. Furthermore, if BCBSF shall pay, pursuant to the demand of an appropriate official of any state, any tax, assessments or costs based on the amounts paid into or from the Plan, the Employer shall reimburse BCBSF, upon demand, the full amount of such taxes, assessments or costs paid together with the additional amounts specified in connection with such assessment, including any interest added thereto and paid by BCBSF. The Employer agrees to recognize and abide by BCBSF's disposition of such demands for the payment of any taxes, assessments or costs whether paid, compromised, settled or litigated.

(2) Revise the base Administrative Fee as of the Effective Date of a modification of the Plan that imposes greater duties, obligations or costs on BCBSF and/or its Designated Agent than contemplated by this Agreement.

VI. The Employer agrees to remit its payment for the monthly Administrative Fees within fifteen (15) calendar days after the receipt of an accurate invoice. Late charges will be assessed on late payments, at the option of BCBSF, as described herein and as called for in Section V of this Agreement. Late charges will begin to accrue on the day following the applicable due date.

VII. Beginning the second week of this Agreement and each Tuesday thereafter, BCBSF's Designated Agent will notify the Employer of the amount of benefits paid (benefits shall be deemed paid when the Designated Agent issues its claim payment checks) for the previous week. The Employer will remit this amount by the close of business Thursday of the same week. Late charges will be assessed on late payments, at the option of BCBSF, as described herein and as called for in Section VII of this Exhibit. Late charges will begin to accrue on Monday of the following week if the transfer of funds is not received by 12 p.m. on Friday of the same week.

In addition, each week, BCBSF's Designated Agent will provide to the Employer a detailed listing showing the amount of benefits paid since the previous statement for each member.

VIII. There will be no interest accrued or payable by BCBSF on any funds held pursuant to this Agreement. However, during the term of this Agreement, should the Employer not make payment in accordance with the provisions of this Exhibit, amounts due shall be subject to a late charge of 1.0% per month. The late charge shall be billed separately to the Employer. The Employer warrants and agrees that the late charge will be paid solely from Employer's funds and not from the funds of any employee welfare plan or trust.

IX. Employer understands and acknowledges that BCBSF may deny any claims that are processed while any amount is past due or delinquent under this Agreement.

X. In the event of default in reimbursements directly to BCBSF and/or its Designated Agent as required under the terms of this Agreement, and if such default remains uncured for a period of thirty (30) calendar days after written notice of such default is provided to Employer, BCBSF shall have the right to terminate the Agreement. Such right to terminate shall be in addition and not limitation of any right to terminate under the other provisions of this Agreement.

XI. Stop Loss Insurance, the insurance procured by Employer that insures Employer against claims made in excess of certain amounts, shall be provided in conformity with the terms of the separate agreement with BCBSF and paid by the Employer as the Plan Administrator.

XII. BCBSF may receive rebates and/or other amounts from drug manufacturers and/or through a Pharmacy Benefit Manager (PBM) ("Credits"). Credits are payable to Employer as noted in the PBM Addendum. Amounts paid to pharmacies, or discounted prices charged at pharmacies, are not affected by these Credits. Any co-insurance percentage that a member must pay for prescription drugs is based on the allowable charge at the pharmacy and does not change due to receipt of any Credit by BCBSF. Co-payments are not affected by any Credits.

Pharmacy rates may vary and the proposed retail rates do not necessarily reflect the pharmacy contracted rate between the PBM and the pharmacy chain. Employer acknowledges that the amount paid to the pharmacy may not be equal to the amount billed to Employer. Additionally, the amount charged by BCBSF to Employer for a prescription drug may vary from the amount charged by the PBM to BCBSF. Employer acknowledges that BCBSF will retain any such difference as compensation for administrative services and that no portion of such difference shall be deemed to belong to any other person or entity other than BCBSF.

XIII. This Agreement may be terminated or amended pursuant to the provisions of the Agreement. In the event of such termination, BCBSF's Designated Agent will continue to pay benefits for claims incurred prior to the date of termination ("Run-out claims") for a period of twelve months, unless the Employer notifies BCBSF in writing at the time of such termination that the Employer does not require such services.

Employer shall pay BCBSF for these services as set forth below. The Parties agree that such fees shall not be payable nor shall such services be provided by BCBSF unless Employer provides weekly wire funding for the claims.

The Administrative Fees paid to BCBSF for post-termination services under this Agreement shall be calculated as follows, based upon the Administrative Fees and enrollment in place at the time of termination: _____ months per employee per month.

These amounts will be paid to BCBSF by the Employer in the manner mutually agreed to by both Parties at the time of notification of termination. At the end of the _____ month period following such termination and upon receipt by BCBSF of payment in full of all statements as specified above, BCBSF will refund the advanced deposit, if any.

XIV. A. Inter-Plan Arrangements

BCBSF and its Designated Agent have 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 members access healthcare services outside the geographic area BCBSF's Designated Agent serves (i.e., South Carolina), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSF's Designated Agent serves (i.e., South Carolina), members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSF remains responsible for fulfilling our contractual obligations to Employer. BCBSF's and/or its Designated Agent's payment practices in both instances are described below. For purposes of Inter-Plan Arrangements, BCBSF is a Host Blue for services provided within Florida.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. (Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSF and/or its Designated Agent to provide the specific service or services are not processed through Inter-Plan Arrangements.)

B. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when members access covered healthcare 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 healthcare providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue.

b. Employer Liability Calculation

The calculation of Employer liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue (under the contract between the Host Blue and the provider). Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's provider contracts. The negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue may be represented by one of the following:

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

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

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

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

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

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

3. BlueCard Program Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which BCBSF is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in this Exhibit B. BlueCard Program Fees and compensation may be revised from time to time.

Only the BlueCard Program access fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program related fees are included in the Base Administrative Fee.

The access fee is charged by the Host Blue to BCBSF and/or its Designated Agent for making its applicable provider network available to Employer's members. The access fee will not apply to nonparticipating provider claims. The access fee is charged on a per claim basis and is charged as a percentage of the discount/differential BCBSF and/or its Designated

Agent receives from the applicable Host Blue subject to a maximum of $_____ per claim. When charged BCBSF and/or its Designated Agent pass the access fee directly on to Employer.

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

A Base Administrative Fee encompasses fees BCBSF and/or its Designated Agent charge to Employer for administering Employer's benefit plan. They may include both local (within BCBSF's Designated Agent's service area, i.e., South Carolina) and Inter-Plan fees. For purposes of this Agreement, they include the following BlueCard Program related fees other than the BlueCard Program access fee: namely, administrative expense allowance (AEA) fee, central financial agency fee, ITS transaction fee, toll free number fee, PPO provider directory fee and Blue Cross Blue Shield Global Core Program fees, if applicable.

C. Special Cases: Value-Based Programs

Value-Based Programs Definitions

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Value-Based Programs Overview

Employer's members may access covered healthcare services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of

Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed upon cost/quality goals in the following ways:

The Host Blue may pass these provider payments to BCBSF and/or its Designated Agent, which BCBSF and/or its Designated Agent will pass directly on to Employer as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

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

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

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

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per member per month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BCBSF and/or its Designated Agent will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings; or,
- Where Host Blues pass on the costs of Value-Based Programs to BCBSF and/or its Designated Agent as PMPM amounts not attached to specific claims, BCBSF and/or its Designated Agent may elect to pass these amounts to Employer as a claim amount.

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

At the end of the Value-Based Program payment and/or reconciliation measurement period for

these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.

- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

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

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

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

Care Coordinator Fees

Host Blues may also bill BCBSF and/or its Designated Agent for care coordinator fees for provider services which we will pass on to Employer as follows:

1. PMPM billings; or

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

As part of this Agreement, BCBSF and Employer will not impose member cost sharing for care coordinator fees.

D. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BCBSF and/or its Designated Agent they will be

credited to Employer. 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 charged to Employer as a percentage of the recovery.

E. Inter-Plan Programs: 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 self-funded accounts. If applicable, BCBSF and/or its Designated Agent will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability.

F. Nonparticipating Providers Outside BCBSF's Designated Agent's Service Area (i.e., South Carolina)

1. Member Liability Calculation

a. In General

When covered healthcare services are provided outside of BCBSF's Designated Agent's service area (i.e., South Carolina) by nonparticipating providers, the amount(s) a member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay claims from nonparticipating healthcare providers outside of BCBSF's Designated Agent's service area (i.e., South Carolina) based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to a participating provider, as determined by BCBSF and/or its Designated Agent in BCBSF's and/or its Designated Agent's sole and absolute discretion, or by applicable state law. In other exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay such claims based on the payment BCBSF and/ or its Designated Agent would make if BCBSF and/or its Designated Agent were paying a nonparticipating provider inside BCBSF's Designated Agent's service area (i.e., South Carolina), as described elsewhere in this Agreement. This may occur where the Host Blue's corresponding payment would be more than BCBSF's Designated Agent's in-service area nonparticipating provider payment. BCBSF and/or its Designated Agent may choose to negotiate a payment with such a provider on an exception basis.

The member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

G. Blue Cross Blue Shield Global Core® Program

1. General Information

If members are outside the United States, (the Commonwealth of Puerto Rico and the U.S. Virgin Islands) (hereinafter: "BlueCard service area"), they may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing covered healthcare services. The Blue Cross Blue Shield Global® Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global® Core assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- Inpatient Services

  In most cases, if members contact the Blue Cross Blue Shield Global® Core Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit member claims to the Blue Cross Blue Shield Global® Core Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered healthcare services. Members must contact BCBSF and/or its Designated Agent to obtain precertification for non-emergency inpatient services.

- Outpatient Services

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a Blue Cross Blue Shield Global® Core Claim

  When members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global® Core International claim form and send the claim form with the 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 BCBSF and/or its Designated Agent, the Blue Cross Blue Shield Global® Core Service Center, or online at www.bcbsglobalcore.com. If members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global® Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. Blue Cross Blue Shield Global® Core -Related Fees

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer under the Blue Cross Blue Shield Global® Core are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

EXHIBIT C

HIPAA-AS ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

This addendum ("Addendum") is effective upon execution and amends that Administrative Services Agreement ("Agreement") made as of date of last signature of the Agreement by and among Blue Cross and Blue Shield of Florida, Inc. ("Administrator"); Citizens Property Insurance Corporation ("Employer") and Citizens Property Insurance Corporation Group Health Plan ("GHP").

WHEREAS, Employer has established and maintains GHP as a self-insured employee welfare benefit plan, as described in GHP's Plan Document (referred to in the Agreement as the Group Health Plan); and

WHEREAS, Employer and GHP desire to retain Administrator to provide certain claim processing and administrative services with respect to GHP; and

WHEREAS, Administrator and Administrator's Designated Agent (hereinafter, collectively referred to as "Administrator") have entered into an Agreement whereby Administrator's Designated Agent provides certain services for Administrator so that Administrator may satisfy its obligation to Employer and GHP; and,

WHEREAS, Employer, GHP, and Administrator agree to modify the Agreement to incorporate the provisions of this Addendum to address applicable requirements of the implementing regulations, codified at 45 Code of Federal Regulations ("C.F.R.") Parts 160-64, for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 (collectively, "HIPAA-AS"), so that GHP may meet its compliance obligations under HIPAA-AS, and to include additional provisions that Employer, GHP, and Administrator desire to have as part of the Agreement;

NOW, THEREFORE, in consideration of the mutual promises contained herein, Employer, GHP, and Administrator hereby agree as follows:

PART 1—DEFINITIONS

I. DEFINITIONS

All capitalized terms in this Addendum that are not defined by this Addendum will have the meaning ascribed to them by 45 C.F.R. Parts 160-64. The following terms have the following meanings when used in this Addendum:

A. "Breach" means the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of PHI

B. "Covered Employee" means the person to whom coverage under GHP has been extended by Employer.

C. "Covered Person" means the Covered Employee and any other persons to whom coverage has been extended under GHP as specified by GHP's Plan Document.

D. "Creditable Coverage Certificate" means a certificate disclosing information relating to an individual's creditable coverage under a health care benefit program for purposes of reducing any preexisting condition limitation or exclusion imposed by any group health plan coverage.

E. "Disclose" and "disclosure" mean, with respect to Protected Health Information, release, transfer, providing access to or divulging to a person or entity not within Administrator.

F. "Electronic Protected Health Information" means Protected Health Information that is (1) transmitted by electronic media or (2) maintained in electronic media.

G. "Protected Health Information" means the Protected Health Information, as that term is defined in 45 C.F.R. § 160.103, that Administrator creates or receives for, on behalf of, or from GHP (or from a GHP Business Associate) in the performance of Administrator's duties under the Agreement and this Addendum. For purposes of this Addendum, Protected Health Information encompasses Electronic Protected Health Information.

H. "Plan Document" means GHP's written documentation that informs Covered Persons of the benefits to which they are entitled from GHP and describes the procedures for (1) establishing and carrying out funding of the benefits to which Covered Persons are entitled under GHP, (2) allocating and delegating responsibility for GHP's operation and administration, and (3) amending the Plan Document. Employer and GHP represent and warrant that GHP's Plan Document provides for the allocation and delegation of the responsibilities assigned to Administrator under the Agreement.

I. "Unsecured PHI" means PHI that is not secured through the use of technology or methods approved by the Secretary of Health and Human Services to render the PHI unusable, unreadable or indecipherable to unauthorized individuals.

J. "Use" means, with respect to Protected Health Information, utilization, employment, examination, analysis or application within Administrator.

PART 2--ADMINIATRATOR'S RESPONSIBILITIES

II. SERVICES PROVIDED BY ADMINISTRATOR

During the continuance of the Agreement, Administrator will perform the services set forth in the Agreement with respect to the benefits offered to Covered Persons by GHP.

III. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

A. Preservation of Privacy

Administrator will keep confidential all Protected Health Information that Administrator creates or receives on GHP's behalf or receives from GHP (or another Business Associate of GHP) in the performance of its duties under the Agreement and this Addendum.

B. Prohibition on Non-Permitted Use or Disclosure

Administrator will neither use nor disclose Protected Health Information (including any Protected Health Information that Administrator may receive from a GHP Business Associate) except (1) as permitted or required by this Addendum, (2) as permitted or required in writing by GHP, or (3) as Required by Law.

C. Permitted Uses and Disclosures

Administrator will be permitted to use or disclose Protected Health Information only as follows:

1. Functions and Activities on GHP's Behalf

Administrator will be permitted to use and disclose Protected Health Information for the performance of services set forth in the Agreement, which the Parties agree are intended to include, but are not limited to, Payment activities and Health Care Operations, and which shall hereby also include Data Aggregation.

2. Another Covered Entity's Payment Activities and Health Care Operations

Administrator will be permitted to disclose Protected Health Information in accordance with 45 C.F.R. § 164.506(c) for the Payment activities of another Covered Entity or Health Care Provider and for the qualifying Health Care Operations of another Covered Entity.

3. Provider's Treatment Activities

Administrator will be permitted to disclose Protected Health Information in accordance with 45 C.F.R. § 164.506(c) for the Treatment activities of a Health Care Provider.

4. Covered Person Permission

Administrator will be permitted to use or disclose Protected Health Information in accordance with an authorization or other permission granted by an Individual (or the Individual's Personal Representative) in accordance with 45 C.F.R. § 164.508 or 45 C.F.R. § 164.510, as applicable.

5. Administrator's Own Management and Administration

a. Protected Health Information Use

Administrator will be permitted to use Protected Health Information as necessary for Administrator's proper management and administration or to carry out Administrator's legal responsibilities.

b. Protected Health Information Disclosure

Administrator will be permitted to disclose Protected Health Information as necessary for Administrator's proper management and administration or to carry out Administrator's legal responsibilities only (i) if the disclosure is Required by Law, or (ii) if before the disclosure, Administrator obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will (1) hold Protected Health Information in confidence, (2) use or further disclose Protected Health Information only for the purposes for which Administrator disclosed it to the entity or as Required by Law; and (3) notify Administrator of any instance of which the entity becomes aware in which the confidentiality of any Protected Health Information was breached.

6. De-Identified Health Information

Administrator may use Protected Health Information to create De-Identified Health Information in conformance with 45 C.F.R. § 164.514(b). Administrator may use and disclose De-Identified Health Information for any purpose, including after any termination of the Agreement and this Addendum.

7. Limited Data Set

a. Creation of Limited Data Set. Administrator may use Protected Health Information to create a Limited Data Set:

i. that contains the minimum amount of Protected Health Information reasonably necessary to accomplish the purposes set out in Paragraph b of this Section III.C.7, below; and

ii. from which have been removed all of the direct identifiers, as specified in 45 C.F.R. § 164.514(e)(2), of the Individuals whose Protected Health Information is included in the Limited Data Set and of the relatives, household members and employers of those Individuals.

b. Administrator's Permitted Uses and Disclosures. Administrator may use and disclose the Limited Data Set for only Health Care Operations permitted by this Addendum.

c. Prohibition on Unauthorized Use or Disclosure.

i. Administrator will neither use nor disclose the Limited Data Set for any purpose other than as permitted by Paragraph b of this Section III.C.7, as otherwise permitted in writing by GHP, or as Required by Law.

ii. Administrator is not authorized to use or disclose the Limited Data Set in a manner that would violate the Privacy Rule, 45 C.F.R. Part 164, Subpart E, if done by GHP.

iii. Administrator will not attempt to identify the information contained in the Limited Data Set or contact any Individual who may be the subject of information contained in the Limited Data Set.

d. **Information Safeguards.** Administrator will adopt and use appropriate administrative, physical, and technical safeguards to preserve the integrity and confidentiality of the Limited Data Set and to prevent its use or disclosure other than as permitted by this Section III.C.7.

e. **Permitted Subcontractors, and Agents.** Administrator will require any agent or subcontractor to which it discloses the Limited Data Set, to agree to comply with the same restrictions and conditions that apply to Administrator's use and disclosure of the Limited Data Set pursuant to this Section III.C.7.

f. **Breach of Privacy Obligations.** Administrator will report to GHP any use or disclosure of the Limited Data Set that is not permitted by this Section III.C.7 of which Administrator becomes aware.

D. Minimum Necessary

Administrator will, in the performance of its functions and activities on GHP's behalf under the Agreement and this Addendum, make reasonable efforts to use, to disclose, or to request of a Covered Entity only the minimum necessary amount of Protected Health Information to accomplish the intended purpose of the use, the disclosure, or the request, except that Administrator will not be obligated to comply with this minimum necessary limitation with respect to:

1. Disclosures to GHP, as distinguished from disclosures to Employer;

2. Disclosure to or request by a health care provider for Treatment;

3. Use with or disclosure to a Covered Person who is the subject of Protected Health Information, or that Covered Person's Personal Representative;

4. Use or disclosure made pursuant to an authorization compliant with 45 C.F.R. § 164.508 that is signed by an Individual who is the subject of Protected Health Information to be used or disclosed, or by that Individual's Personal Representative, as defined in 45 C.F.R. § 164.502(g);

5. Disclosure to the United States Department of Health and Human Services ("DHHS") in accordance with Section VIII below;

6. Use or disclosure that is Required by Law; or

7. Any other use or disclosure that is excepted from the minimum necessary limitation as specified in 45 C.F.R. § 164.502(b)(2).

E. Disclosure to GHP and GHP's Business Associates

Other than disclosures permitted by Section III.C. above, Administrator will not disclose Protected Health Information to GHP, a GHP Business Associate, or a GHP Vendor, except as directed by GHP in writing.

F. Disclosure to Administrator's Subcontractors and Agents

Administrator may disclose Protected Health Information to a subcontractor or agent. Administrator will require each subcontractor and agent to which Administrator may disclose Protected Health Information to provide reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy and security obligations with respect to Protected Health Information as this Addendum applies to Administrator.

G. Disclosure to Employer

Administrator will not disclose any Protected Health Information to Employer, except as permitted by and in accordance with PART 3 below.

H. Reporting Non-Permitted Use or Disclosure and Security Incidents

1. Privacy Breach

Administrator will report to GHP any use or disclosure of Protected Health Information not permitted by this Addendum or in writing by GHP, including Breaches of Unsecured PHI, of which Administrator becomes aware in accordance with relevant legal requirements. Administrator will cooperate with GHP in GHP's performance of investigation or assessments necessary to determine whether a Breach of Unsecured PHI has occurred. GHP shall bear sole responsibility for determining the need for and implementing notification concerning any Breach of Unsecured PHI,

2. Security Incidents

Administrator will report to GHP any incident of which Administrator becomes aware that is (a) a successful unauthorized access, use or disclosure of Electronic Protected Health Information; or (b) a successful major (i) modification or destruction of Electronic Protected Health Information or (ii) interference with system operations in an Information System containing Electronic Protected Health Information. Upon GHP's request, Administrator will report any incident of which Administrator becomes aware that is a successful minor (a) modification or destruction of Electronic Protected Health Information or (b) interference with system operations in an Information System containing Electronic Protected Health Information.

I. Duty to Mitigate

Administrator will mitigate to the extent practicable any harmful effect of which Administrator is aware that is caused by any use or disclosure of Protected Health Information in violation of this Addendum.

J. Termination of Addendum

GHP will have the right to terminate the Agreement and this Addendum if Administrator has engaged in a pattern of activity or practice that constitutes a material breach or violation of Administrator's obligations regarding Protected Health Information under this Addendum and, on notice of such material breach or violation from GHP, fails to take reasonable steps to cure the breach or end the violation. If Administrator fails to cure the material breach or end the violation within 90 calendar days after receipt of GHP's notice, GHP may terminate the Agreement and this Addendum by providing Administrator written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the Effective Date of the termination.

K. Disposition of Protected Health Information

1. Return or Destruction Feasible

Upon termination of the Addendum, Administrator will, if feasible, return to GHP or destroy, all Protected Health Information in Administrator's custody or control (or in the custody or control of any subcontractor or agent to which Administrator disclosed Protected Health Information). Administrator will complete such return or destruction as promptly as practical after termination of the Addendum.

2. Return or Destruction Not Feasible

Administrator will identify for GHP any Protected Health Information that Administrator (or any subcontractor or agent to which Administrator disclosed Protected Health Information) cannot feasibly return to GHP or destroy upon termination of the Addendum and will describe the purposes that make the return to GHP or destruction infeasible. Administrator will limit its (and, by its written contract pursuant to Section III.F. above, any subcontractor's or agent's) further use or disclosure of Protected Health Information after termination of the Addendum to the purposes that make return to GHP or destruction infeasible and to those uses or disclosures Required by Law.

3. Ongoing Privacy and Security Obligations

Administrator's obligations to preserve the privacy and safeguard the security of Protected Health Information as specified in this Addendum will survive termination or other conclusion of the Agreement and this Addendum.

IV. ACCESS, AMENDMENT, AND DISCLOSURE ACCOUNTING FOR PROTECTED HEALTH INFORMATION

A. Access

Administrator will, consistent with 45 C.F.R. § 164.524(b)(2), make available to the Covered Person (or the Covered Person's Personal Representative) for inspection and copying any of the Protected Health Information about the Covered Person that qualifies as part of a Designated Record Set that Administrator has in its custody or control, and that is not exempted from access by 45 C.F.R. § 164.524(a), so that GHP can meet its access obligations under 45 C.F.R. § 164.524.

B. Amendment

Administrator will, consistent with 45 C.F.R. § 164.526(b)(2), amend, pursuant to a Covered Person's written request to amend (or a written request to amend by the Covered Person's Personal Representative), any portion of Protected Health Information about the Covered Person that qualifies as part of a Designated Record Set that Administrator has in its custody or control, so that GHP can meet its amendment obligations under 45 C.F.R. § 164.526.

C. Disclosure Accounting

So that GHP may meet its disclosure accounting obligations under 45 C.F.R. § 164.528, Administrator will do the following:

1. Disclosure Tracking

Administrator will, consistent with 45 C.F.R. § 164.528(b), record each disclosure of Protected Health Information that is not excepted from disclosure accounting under 45 C.F.R. § 164.528(a) that Administrator makes to GHP or to a third party ("Accountable Disclosures").

2. Disclosure Tracking Time Periods

Administrator will have available for Covered Person the disclosure information for each Accountable Disclosure for at least six (6) years immediately following the date of the Accountable Disclosure (except Administrator will not be required to have disclosure information for disclosures occurring before April 14, 2003).

3. Provision of Disclosure Information

Administrator will, consistent with 45 C.F.R. § 164.528©(1), make available to the Covered Person (or the Covered Person's Personal Representative) the disclosure information regarding the Covered Person, so that GHP can meet its disclosure accounting obligations under 45 C.F.R. § 164.528.

D. Restriction Requests

GHP will direct a Covered Person to promptly notify Administrator in the manner designated by Administrator of any request for restriction on the use or disclosure of Protected Health Information about a Covered Person that may affect Administrator. Consistent with 45 C.F.R. § 164.522(a), and on behalf of GHP, Administrator will agree to or deny any such restriction request. Administrator will not be in breach of the Agreement or this Addendum for failure to comply with a restriction request on the use or disclosure of Protected Health Information about a Covered Person unless GHP or the Covered Person (or the Covered Person's Personal Representative) notifies Administrator in the manner designated by Administrator of the terms of the restriction and Administrator agrees to the restriction request in writing.

E. Confidential Communications

Administrator will provide a process for a Covered Person to request that Administrator communicate with the Covered Person about Protected Health Information about the Covered Person by confidential alternative location, and Covered Person to provide Administrator with the information that Administrator needs to be able to evaluate that request. Consistent with 45 C.F.R. § 164.522(b) and on behalf of GHP, Administrator will agree to or deny any confidential communication request. Furthermore, Administrator will develop policies and procedures consistent with 45 C.F.R. § 164.522(b) to fulfill its obligations under this paragraph.

Administrator will provide a process for termination of any requirement to communicate with the Covered Person about Protected Health Information about the Covered Person by confidential alternative location.

F. Complaint Process

Administrator will, consistent with 45 C.F.R. § 164.530(d) and on behalf of GHP, provide a process for Covered Persons (or Covered Person's Personal Representative) to make complaints concerning Administrator's policies and procedures, which policies and procedures GHP hereby adopts as its own so that GHP can meet its compliance obligations under 45 C.F.R. Part 164.

V. GHP'S PRIVACY PRACTICES NOTICE

A. Preparation of GHP's Privacy Practices Notices

GHP shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, Administrator shall provide GHP with its NPP that GHP may use as a template to develop its own NPP attached as **EXHIBIT 1**. GHP shall modify this NPP to the specific aspects of GHP.

B. Distribution of GHP's Privacy Practices Notice

GHP shall distribute its NPP to each new enrolled individual, and any material revisions to its NPP to all individuals in accordance with its policies and procedures. GHP represents and warrants that its policies and procedures regarding the distribution of the NPP comply with 45

C.F. R. § 164.520(c). GHP shall bear full responsibility for distributing its own NPP as required by the Privacy Rule.

C. Administrator to Comply with Notices

Administrator will neither use nor disclose Protected Health Information in any manner inconsistent with the content of GHP's then current Privacy Practices Notice applicable to the benefit plans that Administrator administers for GHP under the Agreement.

VI. ISSUANCE OF CERTIFICATE OF CREDITABLE COVERAGE

At the written or electronic direction of Employer or GHP, Administrator may use and disclose Protected Health Information to issue to each Covered Person, whose coverage under a benefits plan administered pursuant to the Agreement terminates during the term of the Agreement, a Certificate of Creditable Coverage. The Certificate of Creditable Coverage will be based upon the coverage that the Covered Person had under the benefits plan administered pursuant to the Agreement and the information that Employer or GHP provides to Administrator regarding the Covered Person's coverage eligibility and coverage termination under that benefits plan.

VII. SAFEGUARDING PROTECTED HEALTH INFORMATION

A. Privacy of Protected Health Information

Administrator will maintain reasonable and appropriate administrative, physical, and technical safeguards, consistent with 45 C.F.R. § 164.530(c) and any other implementing regulations issued by DHHS that are applicable to Administrator as GHP's Business Associate, to protect against reasonably anticipated threats or hazards to and to ensure the security and integrity of Protected Health Information, to protect against reasonably anticipated unauthorized use or disclosure of Protected Health Information, and to reasonably safeguard Protected Health Information from any intentional or unintentional use or disclosure in violation of this Addendum.

B. Security of Electronic Protected Health Information

Administrator will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that Administrator creates, receives, maintains, or transmits on behalf of GHP consistent with the Security Rule, 45 C.F.R. Part 164, Subpart C.

VIII. INSPECTION OF INTERNAL PRACTICES, BOOKS, AND RECORDS

Administrator will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information available to GHP and to DHHS to determine GHP's compliance with 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

PART 3—EMPLOYER'S RESPONSIBILITIES

IX. DATA EXCHANGE BETWEEN EMPLOYER AND ADMINISTRATOR

A. Enrollment Data

Administrator may disclose to Employer the minimum necessary information regarding whether an individual is a Covered Person participating in GHP or enrolled or disenrolled from coverage under the GHP.

Employer may electronically exchange data with Administrator regarding the enrollment and disenrollment of Covered Persons as participants in GHP using the Enrollment and Disenrollment in Health Plan Standard Transaction (ASC X12N 834-Benefit Enrollment and Maintenance) as specified in 45 C.F.R. Part 162, Subpart O.

B. Other Data Exchanges and Notifications

Employer will exchange with Administrator all data not otherwise addressed in this Section IX and any notification by using such forms, tape formats, or electronic formats as Administrator may approve. Employer will furnish all information reasonably required by Administrator to effect such data exchanges or notifications.

X. SUMMARY HEALTH INFORMATION

Upon Employer's written request for the purpose either (A) to obtain premium bids for providing health insurance coverage under GHP, or (B) to modify, amend, or terminate GHP, Administrator will provide Summary Health Information regarding the Covered Persons participating in GHP to Employer.

XI. EMPLOYER'S CERTIFICATION

Employer hereby makes the certification specified in **EXHIBIT 2** so that Employer may request and receive the minimum necessary Protected Health Information from Administrator for those plan administration functions that Employer will perform for GHP. GHP therefore authorizes Administrator to disclose the minimum necessary Protected Health Information to those authorized representatives of Employer as specified in **EXHIBIT 3** for the plan administration functions that Employer will perform for GHP as specified in GHP's Plan Document as amended and in **EXHIBIT 3**. Administrator may rely on Employer's certification and GHP's authorization that Employer has provided the requisite certification and will have no obligation to verify (1) that GHP's Plan Document has been amended to comply with the requirements of 45 C.F.R. § 164.504(f)(2), 45 C.F.R. § 164.314(b)(2), or this Section XI, or (2) that Employer is complying with GHP's Plan Document as amended.

PART 4—MISCELLANEOUS

XII. AUTOMATIC AMENDMENT TO CONFORM TO APPLICABLE LAW

Upon the compliance date of any final regulation or amendment to final regulation with respect to Protected Health Information, Standard Transactions, the security of Health Information, or other aspects of HIPAA-AS applicable to this Addendum or to the Agreement, this Addendum will automatically

amend such that the obligations imposed on Employer, GHP, and Administrator remain in compliance with such regulations, unless Administrator elects to terminate the Agreement by providing Employer and GHP notice of termination in accordance with the Agreement at least **90** calendar days before the compliance date of such final regulation or amendment to final regulation.

XIII. CONFLICTS

The provisions of this Addendum will override and control any conflicting provision of the Agreement. All nonconflicting provisions of the Agreement will remain in full force and effect.

XIV. ADD GHP AS A PARTY TO AGREEMENT

In order to make clear the respective HIPAA-AS compliance obligations of Administrator, GHP, and Employer, as set forth in this Addendum, GHP shall hereby be added as a separate party to the Agreement.

XV. REVISION TO SECTION IV

In order for GHP to be able to comply with its obligations under the HIPAA-AS Privacy and Security Rules and for Employer and Administrator to be able to comply with their obligations hereunder, the terms and conditions of Section IV of the Agreement, and any subsequent amendments made thereto by the Parties, shall be made subject to this Addendum.

XVI. COMPLIANCE DATE FOR SECURITY OBLIGATIONS

Administrator's security obligations as set forth in Sections III.F, III.H.2, and VII.B herein shall take effect the later of (A) the last date set forth in PART 5 below or (B) the compliance deadline of the HIPAA-AS Security Rule (which is, as of the date hereof, April 20, 2005 or April 20 2006 for Small Health Plans).

XVII. HITECH COMPLIANCE

Administrator shall comply with all applicable requirements of Title XIII, Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), 42 U.S.C. Sections 17921 - 17954 and all applicable HITECH implementing regulations issued by the Department of Health and Human Services as of the date by which Administrator must comply with such statutory and regulatory requirements.

SIGNATURES FOLLOW ON NEXT PAGE

PART 5—SIGNATURES

ADMINISTRATOR:

Blue Cross and Blue Shield of Florida, Inc.

By: DocuSigned by: 4234BA3698C64FB...

Title: VP Sales Operations

Date: 10/19/2022

GROUP HEALTH PLAN:

By: DocuSigned by: Violet Bloom F390B38167024A0...

Title: CHRO

Date: 10/19/2022

EMPLOYER:

By: DocuSigned by: 7B8C7AA60097483...

Title: Chief Operating Officer

Date: 10/19/2022

EXHIBIT 1—SAMPLE NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 03, 2013.

We (Blue Cross and Blue Shield of Florida, Inc.), understand the importance of, and are committed to, maintaining the privacy of your protected health information (PHI). PHI is health and nonpublic personal financial information that can reasonably be used to identify you and that we maintain in the normal course of either administering your employer's self-insured group health plan or providing you with insured health care coverage and other services. PHI also includes your personally identifiable information that we may collect from you in connection with the application and enrollment process for health insurance coverage.

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to provide you with this Notice which describes our privacy practices, our legal duties, and your rights concerning your PHI. We are required to follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time and to make the terms of our revised Notice effective for all of your PHI that we either currently maintain or that we may maintain in the future. If we make a significant change in our privacy practices, we will post a revised Notice on our web site by the Effective Date, and provide the revised Notice, or information about the change and how to get the revised Notice, to covered individuals in our next annual mailing.

How we protect your PHI:

- Our employees are trained on our privacy and data protection policies and procedures;
- We use administrative, physical and technical safeguards to help maintain the privacy and security of your PHI;
- We have policies and procedures in place to restrict our employees' use of your PHI to those employees who are authorized to access this information for treatment or payment purposes or to perform certain healthcare operations; and
- Our corporate Business Ethics, Integrity & Compliance division monitors how we follow our privacy policies and procedures.

How we must disclose your PHI:

- **To You:** We will disclose your PHI to you or someone who has the legal right to act on your behalf (your personal representative) in order to administer your 'Individual Rights' under this Notice.
- **To The Secretary of the Department of Health and Human Services (HHS):** We will disclose your PHI to HHS, if necessary, to ensure that your privacy rights are protected.
- **As Required by Law:** We will disclose your PHI when required by law to do so.

How we may use and disclose your PHI without your written authorization:

We may use and disclose your PHI without your written authorization in a number of different ways in connection with your treatment, the payment for your health care, and our health care operations. When

using or disclosing your PHI, or requesting your PHI from another entity, we will make reasonable efforts to limit such use, disclosure or request, to the extent practicable, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The following are only a few examples of the types of uses and disclosures of your PHI that we may make without your written authorization.

- **For Treatment:** We may use and disclose your PHI as necessary to aid in your treatment or the coordination of your care. For example, we may disclose your PHI to doctors, dentists, hospitals, or other health care providers in order for them to provide treatment to you.
- **For Payment:** We may use and disclose your PHI to administer your health benefits policy or contract. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors, dentists or hospitals. We may disclose your PHI to a health care provider or another health plan so that the provider or plan may obtain payment of a claim or engage in other payment activities.
- **To Family, Friends, and Others for Treatment or Payment:** Our disclosure of your PHI for the treatment and payment purposes described above may include disclosures to others who are involved in your care or the administration of your health benefits policy or contract. For example, we may disclose your PHI to your family members, friends or caregivers if you direct us to do so or if we exercise professional judgment and determine that they are involved in either your care or the administration of your health benefits policy. We may send an explanation of benefits to the policyholder, which may include claims paid and other information. We may determine that persons are involved in your care or the administration of your health benefits policy if you either agree or fail to object to a disclosure of your PHI to such persons when given an opportunity. In an emergency or in situations where you are incapacitated or not otherwise present, we may disclose your PHI to your family members, friends, caregivers or others, when the circumstances indicate that such disclosure is authorized by you and is in your best interests. In these situations, we will only disclose your PHI that is relevant to such other person's involvement in your care or the administration of your health benefits policy.
- **For Health Care Operations:** We may use and disclose your PHI to support other business activities. For example, we may use or disclose your PHI to conduct quality assessment and improvement activities, to conduct fraud and abuse investigations, to engage in care coordination or case management, or to communicate with you about health-related benefits, products or services or treatment alternatives that may be of interest to you. We may also disclose your PHI to another entity subject to federal privacy laws, as long as the entity has or had a relationship with you and the PHI is disclosed only for certain health care operations of that provider, plan, or other entity. We may use and disclose your PHI as needed to conduct or arrange for legal services, auditing, or other functions. We may also use and disclose your PHI to perform underwriting activities, however, we are prohibited from using or disclosing your genetic information for underwriting purposes.
- **To Business Associates for Treatment, Payment or Health Care Operations:** Our use of your PHI for treatment, payment or health care operations described above (or for other uses or disclosures described in this Notice) may involve our disclosure of your PHI to certain other entities with which we have contracted to perform or provide certain services on our behalf (Business Associates). We may allow our Business Associates to create, receive, maintain, or transmit your PHI on our behalf in order for the Business Associate to provide services to us, or for the proper management and administration of the Business Associate or to fulfill the Business Associate's legal responsibilities. These Business Associates include lawyers, accountants, consultants, claims clearinghouses, and other third parties. Our Business Associates may re-disclose your PHI to subcontractors in order for these

subcontractors to provide services to the Business Associates. These subcontractors will be subject to the same restrictions and conditions that apply to the Business Associates. Whenever such arrangement with a Business Associate involves the use or disclosure of your PHI, we will have a written contract with our Business Associate that contains terms designed to protect the privacy of your PHI.

- **For Public Health and Safety:** We may use or disclose your PHI to the extent necessary to avert a serious and imminent threat to the health or safety of you or others. We may also disclose your PHI for public health and government health care oversight activities and to report suspected abuse, neglect or domestic violence to government authorities.
- **As Permitted by Law:** We may use or disclose your PHI when we are permitted to do so by law.
- **For Process and Proceedings:** We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Criminal Activity or Law Enforcement:** We may disclose your PHI to a law enforcement official with regard to crime victims and criminal activities. We may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose your PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Special Government Functions:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of determination by the Department of Veterans Affairs of your eligibility for benefits, or (iii) to foreign military authorities if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized to receive such governmental protection.
- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **To Plan Sponsors, if applicable (including employers who act as Plan Sponsors):** We may disclose enrollment and disenrollment information to the plan sponsor of your group health plan. We may also disclose certain PHI to the plan sponsor to perform plan administration functions. We may disclose summary health information to the plan sponsor so that the plan sponsor may either obtain premium bids or decide whether to amend, modify or terminate your group health plan. Please see your plan documents, where applicable, for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI in providing plan administration functions for your group health plan.
- **For Coroners, Funeral Directors, and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research purposes and established protocols to ensure the privacy of your PHI, or as otherwise permitted by federal privacy law.
- **Fundraising:** We may use your PHI to contact you in order to raise funds for our benefit. You have the right to opt out of receiving such communications.
- **Limited data sets and de-identified information:** We may use or disclose your PHI to

create a limited data set or de-identified information and use and disclose such information as permitted by law.

- **For Workers' Compensation:** We may disclose your PHI as permitted by workers' compensation and similar laws.

Uses and disclosures of PHI permitted only after authorization is received:

We will obtain your written authorization, as described below, for: (i) uses and disclosures of your PHI for marketing purposes, including subsidized treatment communications (except for certain activities otherwise permitted by federal privacy law, such as face-to-face communications or promotional gifts of nominal value); (ii) disclosures of your PHI that constitute a sale of PHI under federal privacy law and that requires your authorization; and (iii) other uses and disclosures of your PHI not described in this Notice.

There are also other federal and state laws that may further restrict our disclosure of certain PHI (to the extent we maintain such information) that is deemed highly confidential. Highly confidential PHI may include information pertaining to:

- psychotherapy notes;
- alcohol and drug abuse prevention, treatment and referral;
- HIV/AIDS testing, diagnosis or treatment;
- sexually transmitted diseases; and
- genetic testing.

Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected PHI with your prior written authorization except when our disclosure of this information is permitted or required by law.

Authorization: You may give us written authorization to use your PHI or disclose it to anyone for any purpose not otherwise permitted or required by law. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

Individual Rights:

To exercise any of these rights, please call the customer service number on your ID card.

- **Access:** With limited exceptions, you have the right to inspect, or obtain copies of, your PHI. We may charge you a reasonable fee as permitted by law. We will provide you a copy of your PHI in the form and format requested, if it is readily producible in such form or format or, if not, in a readable hard copy form or such format as agreed to by you and us. Where your PHI is contained in one or more designated record sets electronically, you have the right to obtain a copy of such information in the electronic form and format requested, if it is readily producible in such form and format; or if not, in a readable electronic form and format as agreed to by us and you. You may request that we transmit the copy of your PHI directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and where to send the copy of the PHI.
- **Amendment:** With limited exceptions, you have the right to request that we amend your PHI.
- **Disclosure Accounting:** You have the right to request and receive a list of certain disclosures made of your PHI. If you request this list more than once in a 12-month period, we may charge you a reasonable fee as permitted by law to respond to any additional request.
- **Use/Disclosure Restriction:** You have the right to request that we restrict our use or

disclosure of your PHI for certain purposes. We are required to agree to a request to restrict the disclosure of your PHI to a health plan if you submit the request to us and: (i) the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law; and (ii) the PHI pertains solely to a health care item or service for which you, or a person on your behalf other than the health plan, has paid the covered entity out-of-pocket in full. We may not be required to agree to all other restriction requests and, in certain cases, we may deny your request. We will agree to restrict the use or disclosure of your PHI provided the law allows and we determine the restriction does not impact our ability to administer your benefits. Even when we agree to a restriction request, we may still disclose your PHI in a medical emergency and use or disclose your PHI for public health and safety and other similar public benefit purposes permitted or required by law.

- **Confidential Communication:** You have the right to request that we communicate with you in confidence about your PHI at an alternative address. When you call the customer service number on your ID card to request confidential communications at an alternative address, please ask for a "PHI address."
  Note: If you choose to have confidential communications sent to you at a PHI address, we will only respond to inquiries from you. If you receive services from any health care providers, you are responsible for notifying those providers directly if you would like a PHI address from them.
- **Privacy Notice:** You have the right to request and receive a copy of this Notice at any time. For more information or if you have questions about this Notice, please contact us using the information listed at the end of this Notice.
- **Breach:** You have the right to receive, and we are required to provide, written notification of a breach where your unsecured PHI has been accessed, used, acquired, or disclosed to an unauthorized person as a result of such breach, and which compromises the security or privacy of your PHI. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first class mail or, if necessary, by such other substituted forms of communication permitted under the law.
- **Paper Copy:** You have the right to receive a paper copy of this Notice, upon request, even if you have previously agreed to receive the Notice electronically.

Complaints

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address for the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Business Ethics, Integrity & Compliance**
Blue Cross and Blue Shield of Florida
PO Box 44283
Jacksonville, FL 32203-4283
1-888-574-2583

Si usted desea una copia de esta notificación en español, por favor comuníquese con un representante de servicio al cliente utilizando el número telefónico indicado en su tarjeta de asegurado.

72656 0913R

EXHIBIT 2—EMPLOYER'S CERTIFICATION

PART 1 – Employer to Amend Plan Documents for Privacy provisions

Employer certifies that Employer has amended GHP's Plan Document to incorporate the provisions required by 45 C.F.R. § 164.504(f)(2), as set forth below, and agrees to comply with GHP's Plan Document as amended.

1. Neither use nor further disclose Protected Health Information, except as permitted or required by GHP's Plan Document or as required by law.

2. Neither use nor disclose Protected Health Information for any employment-related action or decision, or in connection with any other benefit or employee benefit plan of Employer.

3. Ensure adequate separation between Employer and GHP by (a) describing those employees or classes of employees or other persons under Employer's control who will be given access to Protected Health Information to perform plan administration functions for GHP, (b) restricting the access to and use of Protected Health Information by such employees or other persons to the plan administration functions that Employer will perform for GHP, and (c) instituting an effective mechanism for resolving any noncompliance with GHP's Plan Document by such employees or other persons.

4. Ensure that any subcontractor or agent to which Employer provides Protected Health Information agrees to the restrictions and conditions of GHP's Plan Document with respect to Protected Health Information.

5. Report to GHP any use or disclosure of Protected Health Information of which Employer becomes aware that is inconsistent with the uses and disclosures allowed by GHP's Plan Document.

6. Make Protected Health Information available to GHP or, at GHP's direction, to the Covered Person who is the subject of Protected Health Information (or the Covered Person's Personal Representative) so that GHP can meet its access obligations under 45 C.F.R. § 164.524.

7. Make Protected Health Information available to GHP for amendment and, on notice from GHP, amend Protected Health Information, so that GHP can meet its amendment obligations under 45 C.F.R. § 164.526.

8. Record Disclosure Information as defined above for each disclosure that Employer makes of Protected Health Information that is not excepted from disclosure accounting and provide that Disclosure Information to GHP on request so that GHP can meet its disclosure accounting obligations under 45 C.F.R. § 164.528.

9. Make its internal practices, books, and records relating to its use and disclosure of Protected Health Information available to GHP and to DHHS to determine GHP's compliance with 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

10. Return to GHP or destroy if feasible all Protected Health Information in whatever form or medium that Employer (and any subcontractor or agent of Employer) received from GHP or Administrator,

including all copies thereof and all data, compilations, and other works derived there from that allow identification of any present or past Covered Person who is the subject of Protected Health Information, when Employer no longer needs Protected Health Information for the plan administration functions for which the Employer received Protected Health Information. Employer will limit the use or disclosure of any of Protected Health Information that Employer (or any subcontractor or agent of Employer) cannot feasibly return to GHP or destroy to the purposes that make its return to GHP or destruction infeasible.

PART 2 - Employer to Amend Plan Documents for Security provisions

Employer further certifies that Employer has amended GHP's Plan Document to incorporate the provisions required by 45 C.F.R. § 164.314(b)(2), as set forth below, and agrees to comply with GHP's Plan Document as amended.

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information that Employer creates, receives, maintains or transmits on GHP's behalf.

2. Ensure that the adequate separation between Employer and GHP required by 45 C.F.R. § 164.504(f)(2)(iii) (as described in item 3 above) is supported by reasonable and appropriate Security Measures.

3. Ensure that any subcontractor or agent to which Employer provides Electronic Protected Health Information agrees to implement reasonable and appropriate Security Measures to protect the Electronic Protected Health Information.

4. Report to GHP any incident of which Employer becomes aware that is (a) a successful unauthorized access, use or disclosure of Electronic Protected Health Information; or (b) a successful major (i) modification or destruction of Electronic Protected Health Information or (ii) interference with system operations in an Information System containing Electronic Protected Health Information. Upon GHP's request, Employer will report any incident of which Employer becomes aware that is a successful minor (a) modification or destruction of Electronic Protected Health Information or (b) interference with system operations in an Information System containing Electronic Protected Health Information.

EXHIBIT 3— DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATION

Group Health Plan ("GHP") must promptly notify Administrator in writing if any of the information contained in EXHIBIT 3 changes.

PART 1

Name(s) and Title(s) of Employer representatives (i.e., employees of Employer) authorized to request and receive the minimum necessary Protected Health Information from Administrator:

for the performance of the following plan administration functions for GHP unless otherwise indicated by GHP:

- Actuarial and statistical analysis
- Claims/membership inquiries
- Procurement of reinsurance or stop loss coverage
- Quality assessment and improvement activities
- Performance monitoring
- Other health care operations
- Payment activities

PART 2

Identify the name(s), title(s) and company name(s) of any individual(s) from organizations other than Employer or Group Health Plan ("GHP") (examples of such "GHP Vendor" types of services include, but are not limited to, stop-loss carriers; reinsurers; agents, brokers or consultants; or external auditors) that Employer or GHP hereby authorizes to request and receive the minimum necessary Protected Health Information to perform plan administration functions and/or assist with the procurement of reinsurance or stop-loss coverage:

Company Name	Type of Service Performed (Example: stop-loss carrier, reinsurer, agent, broker)	Name of Individual Performing Service	Title of Individual Performing Service

PART 3

GHP affirms that all authorization forms that may be required from GHP's participants authorizing the use and/or release of protected or other confidential personal health information by BlueCross and BlueShield of Florida or its Designated Agent in order to perform its obligations under the Agreement have been obtained.

EXHIBIT D
Performance Guarantees Citizens Property Insurance Corporation

MEASUREMENTS	STANDARD GOALS	PERCENT AT RISK
MEMBER TOUCH POINTS		
Abandon Rate: Number of calls that reach the call center and are placed in queue but do not reach the final destination because the caller hangs up before a representative becomes available.		% % %
Average ACD Phone Queue Time: (Group Specific) Actual length of time a member waits to speak with a customer service associate after all ACD options have been chosen.		% % %
Blockage Rate: (Group Specific) Percentage of calls blocked during business hours.		% % %
Enrollment Timeliness: Percentage of ID cards mailed by Effective Date provided that the enrollment data is received from the employer 30 calendar days prior to the Effective Date of coverage.		% % %
Claims Processing Timeliness: Percentage of provider and subscriber claims processed within 30 calendar days from receipt to the date that a claim has passed all edits and is pending the issuance of a check, voucher or denial.		% % %
Claims Processing Accuracy: Percentage of claims processed accurately.		% % %
Claims Dollar Accuracy: Percentage of claim dollars paid accurately.		% % %
Inquiry Timeliness Percentage of inquiries finalize within 7 calendar days		%
Eligibility Loading - Files to be loaded within an average of 3 business days or less form receipt of a clean file		% %
ACCOUNT MANAGEMENT Group's perception of responsiveness to Communication, Issue Resolution, Meetings and Reporting. Group is expected to provide feedback quarterly via a scorecard point system. If feedback is not provided on this measure, the assumption will be that the measure was met.	If annual score is:	
Communication: Response to telephone messages and e-mails provided within one (1) business day.	= Exceeds Expectations = Meets Expectations = Less than Expectations = Significantly less than Expectations	

Issue Resolution: Acknowledges issues within one (1) business day and resolve them in a timely manner. Resolution timeframe will be determined jointly between Account and Account Manager on a case-by-case basis	= Exceeds Expectations = Meets Expectations = Less than Expectations = Significantly less than Expectations
Quarterly Meetings: The Strategic Account Executive and/or Account Management Specialist will attend and participate in all mutually agreed upon quarterly meetings.	= Exceeds Expectations 30 pts = Meets Expectations = Less than Expectations = Significantly less than Expectations
Open Enrollment/Benefit Fairs Provide effective support at annual open enrollment meetings and/or benefits fairs.	= Exceeds Expectations = Meets Expectations = Less than Expectations = Significantly less than Expectations
Reporting: Provide timely and accurate account specific reports as requested	= Exceeds Expectations = Meets Expectations = Less than Expectations = Significantly less than Expectations

EXHIBIT E

Pharmacy Addendum

I. PHARMACY BENEFIT MANAGEMENTSERVICES ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

This Addendum ("**Addendum**") to the Administrative Services Agreement (the "**Agreement**")dated as of the 1st day of January, 2023 entered into between Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") and Citizens Property on behalf of itself and its Group Health Plans (collectively "**Purchaser**") (the "**Agreement**") shall be effective on the 1st day of January, 2023 (the "**Addendum Effective Date**"). The terms and conditions of this Addendum are incorporated by reference into and made a part of the Agreement.

II. RECITALS

WHEREAS, Purchaser has established a Group Health Plan for Members; and

WHEREAS, BCBSF and Purchaser have entered into the Agreement (as amended from time to time) whereby BCBSF provides certain services for the Group Health Plan established by Purchaser; and

WHEREAS, Purchaser desires to retain BCBSF to furnish pharmacy benefit management services ("PBM Services" as defined herein); and

WHEREAS, BCBSF, pursuant to an Administrative Services Agreement (as amended) with Blue Cross and Blue Shield of South Carolina ("BCBSSC"), has delegated certain health insurance claims administration and related services for Purchaser's Group Health Plan, including, but not limited to, pharmacy benefit management services, and directs BCBSSC, in its capacity as BCBSF's designated subcontractor, to perform the PBM Services outlined herein; and

WHEREAS, BCBSSC has contracted with a PBM to provide prescription benefit management and/or specialty pharmacy services to Members; and

WHEREAS, the parties desire to enter into this Addendum to govern the provision of PBM Services.

NOW, THEREFORE, in consideration of the mutual promises contained herein, Purchaser and BCBSF hereby agree as follows:

- **Definitions.** All terms in this Addendum shall have the meaning assigned to it in either the Schedule of Definitions attached as **Exhibit A** or as otherwise defined herein. Terms not defined in this **Exhibit A** or otherwise in this Addendum shall have the meaning ascribed to them in the Agreement and the corresponding Plan of Benefits. In the event of a conflict between the terms of this Addendum and the Agreement, the terms of this Addendum shall control with respect to PBM Services.

- **PBM Services.** Purchaser desires to engage BCBSF as its provider of the prescription drug benefit services specified in **Exhibit B** ("**PBM Services**") to support Purchaser's Benefit Plans. Purchaser and BCBSF agree to comply with the terms and conditions specified in this Addendum, including the exhibits, with respect to provision of the PBM Services. Purchaser and BCBSF acknowledge and agree that BCBSF, in turn, will satisfy the terms and conditions specified herein by contracting with BCBSSC, who will contract with its pharmacy benefits manager for the PBM Services. Although

certain terms and conditions herein reflect performance by BCBSSC or its PBM, both BCBSF and Purchaser agree that neither BCBSSC nor its PBM are parties to this Addendum.

- **Term and Termination**
  - **Term.** For purposes of this Addendum, the term and conditions shall commence on the Addendum Effective Date and shall continue for a period of thirty-six (36) months ("**Initial Term**"). Upon expiration of the Initial Term, this Addendum will automatically renew for additional twelve (12) month periods (each a "**Renewal Term**") unless either party provides the other party with written notice of non-renewal no later than ninety (90) days before the end of the Initial Term or a Renewal Term, such non-renewal to be effective at the expiration of the Initial Term or Renewal Term as applicable. The Initial Term and Renewal Term(s) may be collectively referenced herein as the "**Term**."

  - **Termination.** This Addendum may be terminated as follows:
    - Either party may terminate this Addendum following written notice of breach of material obligations (including failure to pay any Administrative Fee identified herein or other fees, charges or non-Claim amounts due under the terms of this Addendum) under this Addendum has been given by one party to the other; provided that such breach has not been cured within ten (10) days of the notice. Notwithstanding the foregoing, Purchaser's default in any payment of Claim amounts under this Addendum shall be subject to immediate termination under Section 3.b.ii. below.
    - If Purchaser fails to make payment for any Claims amounts as required under this Addendum and payment remains outstanding for three (3) days from the due date, BCBSF may immediately terminate this Addendum.
    - In the event the Agreement is terminated for any reason, this Addendum shall terminate concurrent with the Agreement's termination date.
    - If a Force Majeure Event, as specified in Section 7 of this Addendum, exceeds thirty (30) days, the other party may terminate this Addendum upon notice.
    - If Purchaser provides a self-certification that it is an eligible organization as described in Section 1.1.3 of **Exhibit B**, BCBSF may terminate this Addendum upon notice to Purchaser effective on or after the date of the Contraceptive Coverage (as defined in Section 1.1.3 of **Exhibit B**), even if the date is retroactive.

  - **Effect of Termination.** Termination of this Addendum for any reason will not affect the rights and obligations of the parties arising out of any transactions occurring before the effective date of the termination, except as follows: (i) BCBSF will have no obligation under any guarantees under this Addendum for the contract year (i.e., each twelve (12)-month period measured from the Addendum Effective Date or an anniversary of the Addendum Effective Date) in which this Addendum terminates, if the portion of the contract year before the effective date of termination is less than 12 full months; (ii) if Purchaser terminates this Addendum in violation of the provisions herein or if BCBSF terminates this Addendum for default by Purchaser prior to the end of the Term, because of the difficulty in determining the amount of harm to BCBSF in the event of such a breach or default, BCBSF will be entitled to recover as liquidated damages and not as a penalty $_____ prorated for the remainder of the then current Term and such amount shall become immediately due and payable upon notice from BCBSF; or (iii) as otherwise specified in this Addendum. Termination of this Addendum shall not impact the Agreement, the terms of which shall remain in full force and effect.

- **PBM Transition Assistance.** Upon termination of this Addendum for any reason, BCBSF will, as directed by Purchaser, provide Purchaser (or will direct the PBM to provide Purchaser) the following files to the extent applicable: (i) existing Home Delivery or Specialty Pharmacy open refill transfer files for Members, as based upon Purchaser's most current eligibility files; (ii) Purchaser's claims history file; (iii) Purchaser's prior authorization files; and (iv) Purchaser accumulator files. Each file will be in BCBSF's standard format and delivered using a media agreed to by the parties. The PBM shall be solely responsible to process only those Claims that are for prescriptions dispensed before the termination date and received by the PBM from Network Pharmacies no later than thirty (30) days after the termination date and from Members no later than sixty (60) days after the termination date. Purchaser shall be responsible for any and all fees billed to BCBSF by PBM for such files.

- **Financial Terms.**

  - **Rates and Fees.** The parties agree to the rates, fees, reimbursements, credits and guarantees set forth on **Exhibit C** ("**Financial Terms**") for the PBM Services. Except as set forth in Section 4.c. and Section 4.e. below, the Financial Terms are effective for the Initial Term of this Addendum.

  - **Payment Terms**. Purchaser agrees to make payment of amounts due under this Addendum as set forth in the payment terms section(s) of the Agreement. All payment terms set forth in the payment terms section of the Agreement shall apply to Purchaser's payment obligations hereunder, unless expressly stated otherwise in this Addendum.

  - **Reservation of Rights.** BCBSF reserves the right to modify or amend the Financial Terms in **Exhibit C** of this Addendum and/or the financial exhibit(s) of the Agreement if any of the following occur:

    - any government-imposed change in federal, state or local laws or BCBSF's interpretation thereof or industry-wide change that makes BCBSF's or the PBM's performance of its duties hereunder more burdensome or expensive, including a change resulting from the elimination or material modification of historic Drug Manufacturer Rebate pricing models or changes made to the AWP benchmark or methodology; or

    - the unexpected movement of a Brand Drug to off-patent or where there are Generic Drugs, authorized Generic Drugs, low priced Brand Drugs or over-the-counter substitutes available; or

    - a change in the scope of PBM Services to be performed or Benefit Plan design upon which the financial provisions included in this Addendum are based; or

    - a reduction of greater than _____ percent (____%) in the total number of Members as compared to the total Members identified in the data provided by Purchaser or its representative at the time the final quote sheet was prepared, upon which the Financial Terms are based; or

- the addition of, or growth in, one hundred percent (100%) Member paid plans or consumer directed health plans (e.g., high deductible plans); or

- any substantive change in Formulary requested by Purchaser, which may impact Rebates.

- **Renewal Term.** BCBSF may modify the Financial Terms in **Exhibit C** upon expiration of the Initial Term or on each twelve (12) month anniversary of the Renewal Term. The change in the Financial Terms will become effective on the first day of the Renewal Term. This Addendum will automatically be amended to replace **Exhibit C**, accordingly.

- **Data Sharing.** Upon Purchaser's written request, BCBSF or the PBM may provide up to two (2) standard electronic claims files to Purchaser's third-party service provider, subject to the third party's execution of BCBSSC's form confidentiality agreement. Data Sharing fees apply to file requests which exceed the aforementioned two(2) in a given year and will be quoted upon request.

- **Audit Rights.** On an annual basis during the Term of this Addendum and for a period of six (6) months following its termination, Purchaser, at its sole expense, may conduct an audit of Plan Specifications and Financial Terms specified in this Addendum. Any such audit shall be conducted during regular business hours at BCBSSC's offices. The audit may be performed by an independent auditor with pharmacy management knowledge, subject to the prior approval of BCBSF and the PBM. The mutually agreed upon auditor will execute a confidentiality and non-disclosure agreement with BCBSSC, PBM and Purchaser prior to conducting an audit. Audits require: (a) ninety (90) days prior written notice, (b) receipt of a fully executed confidentiality and non-disclosure agreement, (c) a detailed audit scope document, and (d) a complete statistically valid Claims sample, if applicable. In the event on-site audit support is requested during an audit, such on-site support shall only be provided during normal business hours, following thirty (30) days written notice, and without undue interference to BCBSSC business activity. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year. Notwithstanding the foregoing, no audits of any type will be initiated or conducted during the months of December and January. In no event will an audit include a review of the Pharmacy Benefit Management Services Agreement between PBM and BCBSSC nor any Drug Manufacturer agreements held by the PBM on behalf of BCBSSC. The parties agree that Purchaser shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.), which may be found by the third party in its audit. Should Purchaser so contract with a third party to perform such contingent fee audit, BCBSF has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit.

- **Force Majeure**. Except for payment obligations of Purchaser as set forth in this Addendum, the obligations of the parties hereunder shall be suspended to the extent that all or part of this Addendum cannot be performed due to causes which are outside the reasonable control of a party, could not be avoided by the exercise of due care, and are not the result of the fault or negligence of such party, including, but not limited to acts of God, fire, flood, earthquake, riots, acts of terrorism, whether applicable to BCBSF, BCBSSC, the PBM or Purchaser (a "**Force Majeure Event**"), provided such party gives reasonably prompt notice to the other party of the Force Majeure Event and

relatedconditions and uses reasonable efforts to rectify such conditions. If the Force Majeure Event exceeds thirty (30) days, the unaffected party may terminate this Addendum upon notice.

- **Ratification**. Except as specifically set forth herein, the terms and conditions of the Agreement (as amended) remain in full force and effect. In the event of a conflict between the terms of this Addendum and the Agreement, the terms of this Addendum shall control with respect to the subject matter herein.

- **Entire Agreement**. Purchaser and BCBSF acknowledge and agree that this Addendum, together with all Exhibits, contains the entire agreement between the parties with respect to the PBM Services provided herein and further agree that it shall supersede any offer including a Pharmacy Benefit Management Services Addendum that may have been made effective on a date prior to the Addendum Effective Date. Except as otherwise provided herein, this Addendum can only be modified by mutual written agreement of the parties.

In Witness Whereof, Purchaser and BCBSF have read this Addendum and agree to be bound by it and therefore have caused it to be executed by their duly authorized representatives.

Citizens Property

By: DocuSigned by: Violet Bloom F390B38167024A0... DocuSigned by: Kelly Booten 7B9C7AA80097483...

Print Name: Violet Bloom Kelly Booten

Title: CHRO Chief Operating Officer

Date: 10/19/2022 10/19/2022

Blue Cross and Blue Shield of Florida, Inc.

By: DocuSigned by: 4234BA3698C64FB...

Print Name: Warren Mills

Title: VP Sales Operations

Date: 10/19/2022

III. Exhibit A Definitions

340B Claims means Claims submitted by 340B pharmacies that price at a 340B price.

Average Wholesale Price or "**AWP**" means the average wholesale price, as reflected on the Pricing Source, for the Prescription Drug or other pharmaceutical products or supplies for the product dispensed on the date dispensed based on the actual 11-digit NDC reported by the Network Pharmacy.

Benefit Plan means the benefit plan(s) established and/or sponsored by Purchaser under which Purchaser is obligated to provide Covered Prescription Services.

Brand Drug means those Prescription Drugs identified by Medi-Span as having a multisource code of "M" (a branded drug product that is co-branded and not considered generic, nor is available as a generic), "N" (a single-source brand name drug product available from one manufacturer), "O" (an original branded drug product available from one or more manufacturers as a generic product), and/or with a Trademark Code of "T". The parties agree that when a drug is identified as a Brand Drug, it shall be considered a Brand Drug for all purposes under this Addendum.

Claim means each prescription or refill thereof ordered and issued by a Provider and submitted to PBM by a Member or a Network Pharmacy for adjudication.

Clean Claim means a Claim prepared in accordance with the NCPDP-promulgated standard format that contains all information necessary for processing for a Claim and submitted by Network Pharmacies for payment no later than one hundred eighty (180) days after the date of service, or a longer period of time if required by Laws. Member submitted Claims will be submitted within the timeframes specified in the applicable Plan of Benefits.

Compound Prescription Drug means a Prescription Drug that is prepared by a pharmacist who mixes or adjusts one or more Prescription Drugs to customize a medication to meet a Member's individual medical needs. Purchaser's payment to BCBSF for providing a Compound Prescription Drug to a Member will include the Network Pharmacy contracted rate for each Prescription Drug included in the medication and one contracted dispensing fee minus any Cost-Sharing amount plus the applicable level of effort fee payable to the Network Pharmacy.

Cost-Sharing Amount means the coinsurance, copay, deductible or other cost sharing amount, either a specified dollar amount or a percentage of eligible expenses, that a Network Pharmacy may collect from a Member for Covered Prescription Services in accordance with the Member's Benefit Plan.

Covered Prescription Services means Prescription Drugs or other pharmaceutical products, services, devices, or supplies dispensed by a Network Pharmacy to a Member for which coverage is provided in accordance with the Member's Benefit Plan.

Dispensing Fee means the portion of the Claim cost attributable to payment to a Network Pharmacy for professional services to dispense a prescription or authorized refill in an amount set forth in **Exhibit C**.

Drug Manufacturer means an entity that manufactures, sells, markets or distributes Prescription Drugs; provided "Drug Manufacturer" shall not include wholesalers engaged in the sale and distribution of Prescription Drugs.

Enhanced Savings Program. Enhanced Savings Program means a program administered by PBM where Members may utilize their existing prescription drug identification cards to access negotiated pricing (where applicable) for certain prescription claims which are not covered by Purchaser's Plan Specification and are dispensed at Network Pharmacies.

FDA means the United States Food and Drug Administration.

Formulary means the list of Prescription Drugs covered by the applicable Benefit Plan as developed by BCBSF or the PBM and approved and adopted by Purchaser for use with the Benefit Plans.

Generic Drug means a non-patent drug identified by Medi-Span as having a multisource code of "Y" (a generic drug product available from one or more manufacturers), and/or with a Trademark Code of "B" or "G". Medi-Span shall be the sole basis of drug classifications for all purposes in regard to this Addendum. The parties agree that when a drug is defined as a Generic Drug, it shall be considered a Generic Drug for all purposes under this Addendum.

Governmental Authority means the Federal government, any state, county, municipal or local government or any governmental department, political subdivision, agency, bureau, commission, authority, body, instrumentality, or court that regulates the applicable party's activities or operations.

Home Delivery Pharmacy means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Members. Home Delivery Pharmacy includes pharmacies that PBM owns or operates.

Laws means all applicable common laws and any and all state, Federal or local statutes (including, without limitation ERISA (the Employee Retirement Income Security Act of 1974)), ordinances, codes, rules, regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any Governmental Authority, as amended, modified, revised or replaced, interpreted or enforced by any Governmental Authority, as applicable to each respective party.

Limited Distribution Drugs means Specialty Drugs which are distributed to either one or a very limited number of pharmacies, distributors or wholesalers as determined by the Drug Manufacturer.

Manufacturer Administrative Fees means the administrative fees paid by Drug Manufacturers to PBM for PBM's provision of Rebate administration services.

NCPDP means the National Council for Prescription Drug Programs.

NDC means the National Drug Code that is the identifying Prescription Drug number maintained by the FDA.

Net Paid Claim means all Clean Claims approved for payment minus reversals for a single prescription fill.

Network Pharmacy means a retail pharmacy, Home Delivery Pharmacy, Specialty Pharmacy, third-party pharmacy or other facility that (i) is duly licensed to operate as a pharmacy at its location and to dispense

Prescription Drugs to individuals, including Members, and (ii) has entered into a Network Pharmacy Agreement.

Network Pharmacy Agreement means the agreement between a Network Pharmacy and PBM or BCBSSC to provide Covered Prescription Services.

Pharmacy & Therapeutics Committee means the committee formed by BCBSSC and/or PBM that reviews the clinical effectiveness of a legend drug for inclusion on the Formulary and creates criteria, policies and procedure for such inclusion including, but not limited to, clinically-appropriate quantity restrictions, step therapies and prior authorizations.

PBM means the pharmacy benefit manager with whom BCBSSC contracts to perform certain PBM Services as agreed to between BCBSSC and the PBM.

Plan Specifications means information provided by the Purchaser which BCBSF and PBM reasonably need to perform the PBM Services, as further specified in **Exhibit B**.

Prescription Drug means a Generic Drug or Brand Drug that is approved by the FDA and required under Laws to be dispensed only as authorized by a written or oral order to dispense a Prescription Drug by an appropriately licensed and qualified health care professional in accordance with Laws.

Pricing Source means the Medi-Span Prescription Pricing Guide (with supplements) or another nationally recognized pricing source determined by PBM and BCBSSC.

Rebates means any discount, rebate, price protection amount or Manufacturer Administrative Fee that BCBSSC receives from Drug Manufacturers and/or the PBM that is contingent upon and related directly to Member use of a Prescription Drug during the Term. "Rebate" does not include any discount, price concession or other direct or indirect compensation received by the PBM or BCBSSC for the purchase of a Prescription Drug or for the provision of any product or service.

Specialty Drug means the Prescription Drugs that include at least one or more of the following: (a) biotechnology drugs; (b) orphan drugs used to treat rare diseases; (c) typically high-cost drugs; (d) drugs administered by oral or injectable routes, including infusions in any outpatient setting; (e) drugs requiring on-going frequent patient management or monitoring or focused, in-depth Member education; (f) drugs that require specialized coordination, handling and distribution services for appropriate medication administration; (g) infusion or health care injectable professionally administered by a healthcare professional or in a healthcare setting (but excluding supplies or the cost of administration); or (h) therapy requiring management and/or care coordination by a healthcare provider specializing in the Member's condition, as identified by BCBSF. Specialty Drugs shall not include any Prescription Drugs that: (x) require nuclear pharmacy sourcing; (y) are preventive immunizations; or (z) are administered only in the inpatient setting.

Specialty Pharmacy means a facility that is duly licensed, credentialed, and accredited to operate as a pharmacy at its location and to dispense Specialty Drugs to individuals, including Members. Specialty Pharmacy includes pharmacies that PBM owns or operates.

U&C means the Network Pharmacy's usual non-covered customer selling price for a drug if the product were not eligible for coverage by a third party as reported by the Network Pharmacy. Claims that pay at U&C are not subject to a Dispensing Fee.

Exhibit B
Pharmacy Management Services

BCBSF and the PBM, will provide the PBM Services, including administrative, management, consultative, claims processing and other general pharmacy benefit management support services outlined herein in conjunction with administration and operation of the pharmacy benefits provided under the Benefit Plan(s).

1. **SERVICES**

1.1 **Administrative Support**

1.1.1 **General.** BCBSF and the PBM will provide PBM Services in accordance with the most current Plan Specifications that Purchaser has provided to BCBSF and which has been approved by BCBSF.

1.1.2 **Benefit Plan Responsibility.** Although BCBSF will perform PBM Services under this Addendum to support the Benefit Plans, with respect to pharmacy Claims: (i) Purchaser retains complete and exclusive discretionary authority over the Benefit Plans, and is the "administrator" (as defined in 29 U.S.C. § 1002(16)) of the Benefit Plans and (ii) Purchaser will comply fully with all applicable federal and state laws with respect to the Benefit Plans and is responsible ultimately for administering, managing and operating the Benefit Plans, adopting the Formulary and utilization management programs specified in this **Exhibit B**, controlling or directing appeals conducted by an independent outside party or independent review organization ("***IRO***") and determining, interpreting and amending all Benefit Plan structures and terms. Purchaser is at all times liable for Claims amounts under this Addendum. The parties specifically agree that, with respect to pharmacy Claims related to PBM Services, (a) neither BCBSF, the PBM nor any of their affiliates or subcontractors is acting on behalf of any "employee welfare benefit plan" (as defined in 29 U.S.C. § 1002(1)) or participants or beneficiaries in any such plan, or on behalf of a "fiduciary" (as defined in 29 U.S.C. § 1002(21)(A)) of any such plan under this Addendum; (b) Purchaser will not name or deem BCBSF or the PBM as a fiduciary for any purpose under this Addendum; (c) BCBSF's, the PBM's and their affiliates' and subcontractors' role in all respects under this Addendum will be limited to that of a provider of "ministerial functions" (as described in 29 C.F.R. § 2509.75-8, D-2) and will be performed within the framework of policies and interpretations established by Purchaser, such that the PBM Services under this Addendum will not include the power to exercise discretionary authority over any Benefit Plan's management or operations or plan assets (if any); (d) Purchaser has selected and is solely responsible for each Benefit Plan's benefits and design; and (e) Purchaser retains all discretionary authority for each Benefit Plan, Benefit Plan assets (if any) and administration of each Benefit Plan. Purchaser acknowledges that changes in Benefit Plan benefits and designs or enrollment may result in a change to the Financial Terms, as set forth in Section 4.c. of the Addendum.

1.1.3 **Contraceptive Coverage.** Despite any contrary provisions in this Addendum or the Agreement, Purchaser represents that it is not an eligible organization with respect to contraceptive coverage under Public Health Service Act section 2713 and any related regulations or similar Laws ("**Contraceptive Coverage**"), and that it will be responsible for providing any Contraceptive Coverage and will not provide a self-certification that Purchaser is an eligible organization with respect to Contraceptive Coverage during the Term of the Addendum. The PBM Services set forth in this Addendum do not include PBM providing Contraceptive Coverage if Purchaser self-certifies as an eligible organization.

BCBSF may terminate this Addendum effective on or after the date of the Contraceptive Coverage, even if the date is retroactive, upon notice to Purchaser, if Purchaser provides a self-certification that it is an eligible organization.

1.1.4 **Benefit Plan Eligibility Data.** Purchaser shall furnish to BCBSF all of the Member's eligibility information pursuant to the terms of the Agreement. BCBSF will provide the PBM with the electronic eligibility information (as well as Member personal address, phone number and email and work email, if available), for all Members who are entitled to Covered Prescription Services under the Benefit Plans. BCBSF and the PBM will rely on the accuracy and completeness of the Member eligibility data supplied by Purchaser. Purchaser will be solely responsible for any errors in Member eligibility data that BCBSF furnishes to PBM.

1.1.5 **Member Notification.** BCBSF will make available electronically and/or via a BCBSF website, a list of Network Pharmacies, Home Delivery Pharmacy information, the Formulary and other pharmacy benefit related information to Members, providers and other appropriate third parties. BCBSF will distribute, as appropriate, ID cards to Members.

1.1.6 **Plan Specifications.** Purchaser will provide BCBSF with the information regarding the Benefit Plan(s) BCBSF and the PBM reasonably need to perform the PBM Services, including, but not limited to benefit definitions, Formulary, Pharmacy Networks, utilization management programs, applicable Cost-Sharing Amounts, number of days' supply for acute and maintenance medications, dispensing and other limitations, manuals and other Benefit Plan or Member information (collectively, "**Plan Specifications**"), as reflected in the Benefits Checklist. Purchaser will provide BCBSF with the Plan Specifications no later than ninety (90) days before the PBM Services start date identified by the parties, unless the parties otherwise agree. Plan Specifications must be approved by BCBSF in writing prior to the PBM Services being rendered. Purchaser must submit any changes to the Plan Specifications in writing to BCBSF at least ninety (90) days prior to the desired implementation date for BCBSF's review and approval. The parties acknowledge and agree that email confirmation by the parties of the change request and approval are sufficient under this provision. If a Governmental Authority requires changes to the Plan Specifications, such Plan Specifications will automatically be amended to comply with such requirement. Purchaser's failure to provide the Plan Specifications or changes to the Plan Specifications within the time periods stated in this section may delay implementation of the PBM Services and guarantees, and implementation of the requested changes. Purchaser is responsible for the accuracy, completeness and timeliness of all Plan Specifications, and acknowledges BCBSF's reliance on the Plan Specifications. The initial Plan Specifications, as well as any subsequent updates, will be maintained by BCBSF in the benefit detail report

1.2 **Pharmacy Network Administration**

1.2.1 **Pharmacy Network.** BCBSF will provide Members access toa network of pharmacies ("***Pharmacy Network***"). Upon request, BCBSF will make available to Purchaser a current list of Network Pharmacies in the Pharmacy Network. Purchaser acknowledges that BCBSF and/or the PBM may add or remove Network Pharmacies from the Pharmacy Network.

1.2.2 **Pharmacy Network Rates and Payments.** Pharmacy rates may vary and the proposed network rates in **Exhibit C** do not necessarily reflect the actual contracted rate between the PBM and the Network Pharmacy. Purchaser acknowledges that the amount paid to the Network Pharmacy may

not be equal to the amount billed to Purchaser by BCBSF. Purchaser acknowledges PBM and BCBSSC will retain any such difference as compensation for PBM Services.

1.2.3 **Standard Pharmacy Audit Services.** BCBSF will instruct the PBM, in accordance with the PBM's standard audit program and as required by Laws, to conduct real-time and retrospective desk audits and selected on-site audits of the Network Pharmacies to determine whether the Network Pharmacies are submitting appropriate billings for payment by Purchaser or Members. BCBSF will apply as a credit to invoices payable by Purchaser to BCBSF, the amounts recovered from these audits which are applicable to Purchaser's Benefit Plan. Purchaser will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by Purchaser that are not required by Laws. BCBSF and the PBM will use commercially reasonable efforts to collect amounts owing as a result of these standard pharmacy audits, provided that neither BCBSF nor the PBM shall be required to initiate court proceedings to comply with this Section 1.2.3.

1.3 **Claims Processing and Adjudication.** PBM will adjudicate, process or pay Claims for Covered Prescription Services in accordance with the Plan Specifications. PBM will pay in accordance with Plan Specifications and applicable Laws, only Clean Claims (a) submitted by the Network Pharmacies in a timely manner through PBM's point-of-service system in accordance with NCPDP guidelines, and (b) properly submitted by Members as requests for reimbursement for Covered Prescription Services.

1.4 **Benefits Administration and Support**

1.4.1 **Utilization Management Program**

1.4.1.1. **Development and Support.** Purchaser will implement for the Benefit Plans, BCBSF's standard utilization management programs designed to promote cost-effective drug utilization management and to discourage Prescription Drug over and under-utilization. BCBSF or the PBM may, on behalf of Purchaser, (a) communicate with Members to describe health-related products or services (or payment for the products or services) provided by or included in the Benefit Plan through the PBM Services, including communications about Network Pharmacies, and health-related products or services available only to Members that add value to and are not part of the Benefit Plan; (b) conduct population-based activities relating to improving the health of Members and reducing their healthcare costs; and (c) contact Members with health education information and information about Prescription Drugs, treatment alternatives, and related functions.

1.4.1.2. **Prior Authorization Services.** BCBSF or the PBM will conduct prior authorizations as specified herein and will approve or deny the Claim, as applicable, for the fees set forth in **Exhibit C**. BCBSFand the PBM will respond to properly submitted prior authorization requests from Providers or Members using utilization management standards and guidelines established in accordance with Section 1.4.1.1 of this **Exhibit B**. Purchaser retains complete and exclusive discretionary authority over approval of prior authorization requests, including Benefit Plan overrides (subject to the professional judgement of the dispensing pharmacist); however, to the extent that Purchaser-directed overrides impact BCBSF's (a) compensation, (b) cost to provide PBM Services or (c) ability to satisfy a guarantee under this Addendum, BCBSF may amend the Financial Terms in **Exhibit C** to the extent needed to compensate BCBSF for the effect of such overrides.

1.4.2 **Quality Assurance Program.** The PBM will implement its standard quality assurance program for the Benefit Plan(s) that includes quality measures and reporting systems targeted at reducing medical errors and adverse drug interactions. In addition, PBM will develop and implement systems or require Network Pharmacies to implement systems to: (a) offer Member counseling, when appropriate; (b) identify and reduce internal medication errors; and (c) maintain up-to-date Member quality assurance and patient safety program information.

1.4.3 **Administrative Grievances and Appeals.** At Purchaser's request, and subject to Section 1.1.2 of this **Exhibit B**, BCBSF will process initial Benefit Plan coverage determinations and exception requests and support Purchaser in connection with Benefit Plan appeals and grievances, as mutually agreed upon, and in accordance with Plan Specifications, this Section 1.4.3, and to the extent required by Laws.

1.4.4 **Changes Due to Shortages, Recall or Public Health and Safety Concern.** In the event of a Prescription Drug shortage or recall or public health and/or other material safety concerns impacting or related to the distribution or dispensing of Prescription Drugs, Purchaser acknowledges and agrees that BCBSF may make temporary clinically appropriate changes to the Formulary status and/or tiering of Prescription Drugs, days' supply limitations, Pharmacy Network access, utilization management programs or similar programs or initiatives to address such concerns. Prescriptions Drugs impacted by such changes shall be excluded from all financial and performance guarantees.

1.4.5 **Other Clinical Services.** Upon Purchaser's request and for an additional charge to Purchaser, BCBSF will help Purchaser develop and implement additional quality initiatives, intervention programs or other clinical services.

1.5 **Formulary**

1.5.1 **Formulary Adoption**. Purchaser will adopt as the Formulary one or more of the formularies offered by BCBSF that are developed and maintained by the Pharmacy & Therapeutics Committee, as described in Section 1.5.4 of this **Exhibit B**.

1.5.2 **Formulary Management.** BCBSF will make the Formulary available to Purchaser, plan providers or other appropriate parties via the applicable BCBSF website. Except as provided in this Addendum, Purchaser will not copy, distribute, sell or otherwise provide the Formulary, to another party without BCBSF's prior written approval.

1.5.3 **Formulary Changes.** Purchaser acknowledges and agrees that BCBSF may include in the Formulary new FDA-approved medications according to the following schedule: (a) if an open formulary, all new covered FDA-approved medications (formulary and non-formulary) will be included in the Formulary upon publication in the Pricing Source pricing index and loading into PBM's systems or (b) if a closed formulary, all new covered FDA-approved medications (formulary only) may be included in the Formulary after review and addition to the Formulary by the Pharmacy & Therapeutics Committee. Following changes to the Formulary, BCBSF will provide or make available appropriate notifications of Formulary changes to Purchaser, Members and prescribing physicians as required by Laws or as agreed to by the parties.

1.5.4 **Pharmaceutical and Therapeutics Committee.** The Pharmacy & Therapeutics Committees will develop and maintain the formularies offered by BCBSF by: (a) selecting Prescription Drugs to include

in formularies; (b) periodically reviewing the formularies, evaluating new and therapeutically equivalent Prescription Drugs for inclusion in the formularies; (c) establishing programs and procedures to address cost-effective drug therapy; (d) reviewing requests to include non-formulary Prescription Drugs in formularies; (e) implementing educational programs; (f) advising BCBSFon other matters about the use of Prescription Drugs; (g) overseeing drug utilization review programs or quality assurance programs or auditing and reviewing the programs' results; and (h) reviewing adverse drug reactions and making recommendations to minimize their occurrence. The Pharmacy & Therapeutics Committee's functions, deliberations and results, including development and maintenance of the formularies, constitute opinions only of the Pharmacy & Therapeutics Committee and will not bind BCBSF or the PBM.

1.5.5 **No Endorsement.** The development and maintenance of the formularies offered by BCBSF will not be construed as an endorsement of any Prescription Drug product or drug manufacturer. Neither BCBSF, BCBSF nor the PBM will be responsible for any actions or omissions of the Pharmacy & Therapeutics Committee or any adverse consequences that may relate, directly or indirectly, to Purchaser's or a Member's reliance on the Pharmacy & Therapeutics Committee.

1.6 **Rebate Management**

1.6.1 **Rebate Eligibility.** Purchaser acknowledges and agrees that BCBSSC may contract with a PBM and/or Drug Manufacturers for Rebates during the Term of this Addendum. BCBSFwill remit Rebates to Purchaser if: (a) **Exhibit C** specifies that Purchaser will be eligible for Rebates; (b) Purchaser satisfies the minimum Rebate contract criteria specified in Section 1.E. of **Exhibit C**; and (c) PBM has received Rebates resulting directly from Purchaser's satisfaction of the foregoing clause (b). PBM, in its sole and absolute discretion, may enter into agreements for Rebates concerning Prescription Drugs on the formularies offered pursuant to this Addendum. Rebates are negotiated based upon PBM's book of business rather than a Purchaser-specific basis. Purchaser acknowledges that many factors affect the amount of Rebates, including benefit design, arrangements with Drug Manufacturers, volume of Claims, formulary structure, patent expiration, and PBM's overall business strategy. Purchaser understands that not all Brand Drugs and not all Prescription Drugs are eligible for Rebates, and BCBSF and the PBM are not obligated to submit for Rebates Claims that it does not believe are eligible to receive Rebates. Claims that may not be eligible to receive Rebates include Claims: (a) with invalid service provider identification or prescription numbers; (b) paid _____ percent (_____%) by a Member as a result of Purchaser's implementation or addition of a Benefit Plan requirement for any category of Claims (except specific items excluded from coverage); (c) for devices without a Prescription Drug component or claims that are not for Prescription Drugs (except for insulins or diabetic test strips); (d) that are re-packaged NDCs; (e) over one hundred eighty (180) days old; (f) for compounds; (g) Claims under section 340B of the Public Health Service Act which typically receive a discount or rebate directly from Drug Manufacturers; (h) from entities eligible for federal supply schedule prices (e.g., Department of Veterans Affairs, U.S. Public Health Service, Department of Defense); (i) for long term care facility; (j) vaccines; (k) for Medicaid Managed Care in states where the state law prohibits PBM from collecting supplemental rebates; or (l) for utilization pursuant to a consumer card or discount card program (i.e. Enhanced Savings Program) where the Benefit Plan had no cost liability on the claim or the Claims are otherwise not eligible for Rebates under a rebate agreement with the applicable Drug Manufacturer.

1.6.2 **Rebate Guarantees.** Except for any Rebate amounts described in **Exhibit C**, BCBSF has no

obligation to obtain any particular Rebates for Purchaser. Rebate guarantees are subject to Purchaser's eligibility for Rebates and the Rebate guarantee contingencies under this Addendum, including the requirements and contingencies described in this Section and in Section I.E. of **Exhibit C**.

1.6.3 **Collection.** To the extent of any overpayment or erroneous payment to Purchaser by BCBSF, Purchaser will immediately refund such payment or permit BCBSF to recover such amount via offset from other sums due to Purchaser under the Agreement or this Addendum.

1.6.4 **Disbursement.** Provided Purchaser is in compliance with the terms of this Addendum, BCBSF will reconcile, allocate and credit or disburse all Rebates based upon the provisions set forth in this Addendum. Purchaser does not have a right to interest on any Rebate payments received by BCBSSC or the PBM.

1.6.5 **Other Relationships.** Purchaser acknowledges and agrees that BCBSF may receive and retain credits, payments, or other amounts from the PBM, Drug Manufacturers, or other third parties, and unless otherwise expressly set forth in this Addendum, such amounts are not payable to Purchaser or Members and BCBSF will retain these payments to help stabilize overall rates and offset expenses. Amounts paid to Network Pharmacies, discounted prices charged at Network Pharmacies, and any Cost-Sharing Amount that a Member must pay for Covered Prescription Services are not affected by these retained amounts.

1.7 **Purchaser Incentives and Purchase Discounts**. If Purchaser, or its affiliates, contracts with another party, including a Drug Manufacturer, for a discount, utilization limit, rebate or other incentive associated with the utilization of a Prescription Drug, Purchaser will be in breach of this Addendum, and BCBSF, in addition to any other remedies available to it under this Addendum or in law or equity, may determine in its sole discretion that Purchaser will not be eligible for any applicable Rebates and adjust any Financial Terms described in **Exhibit C** of this Addendum and/or the financial exhibit(s) of the Agreement. Purchaser will accept only amounts due under this Addendum applicable to eligible Members. Upon request, Purchaser will cooperate fully with BCBSF, the PBM or a Drug Manufacturer to verify Purchaser's participation in any Rebate program and that all Rebate-related payments were made solely for Covered Prescription Services to eligible Members.

1.8 **E-Prescribing**. PBM will provide prescribers with electronic access to Benefit Plan information, including: (a) Member eligibility status: (b) Member medication history; (c) Formulary status of the Prescription Drug being prescribed; (d) listing of Generic Drug or Brand Drug Formulary alternative medications; (e) Member coverage information where applicable; (f) applicable Cost-Sharing Amount; and (g) drug classification information required by the Centers for Medicare & Medicaid Services or successor Governmental Authority.

2. **HOME DELIVERY PHARMACY SERVICES**

2.1 **Home Delivery Services**. Home Delivery Pharmacies will provide Home Delivery Pharmacy Covered Prescription Services to Members in accordance with the Plan Specifications. Once a prescription for a Covered Prescription Service has been transmitted to a Home Delivery Pharmacy in accordance with Laws, such Home Delivery Pharmacy will promptly prepare, package and ship the applicable Covered Prescription Service to the Member or other authorized person or entity. Home Delivery Pharmacies will provide customer service support for Members who use Home Delivery Pharmacy Services. BCBSF will make available to Members Home Delivery Pharmacy information via the applicable BCBSF website.

2.2 **Control by PBM**. PBM will solely and exclusively control and supervise the operation and maintenance of PBM's Home Delivery Pharmacies and their respective facilities and equipment and provision of Home Delivery Pharmacy Covered Prescription Services. All decisions respecting the provision of Home Delivery Pharmacy Covered Prescription Services by PBM's Home Delivery Pharmacies will be made solely by PBM's Home Delivery Pharmacy and its duly authorized personnel, and not by Purchaser. The relationship between a Member and a Home Delivery Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship. PBM may exclude from coverage by a Home Delivery Pharmacy under this Addendum a Prescription Drug that cannot be dispensed under PBM's Home Delivery pharmacy dispensing protocols or requires special record-keeping procedures.

2.3 **Home Delivery Rates**. Prices for Covered Prescription Services dispensed by the Home Delivery Pharmacy are specified in **Exhibit C**. Specialty Drugs are not available at Home Delivery Pharmacy rates, even if dispensed by a Home Delivery Pharmacy. If Member requests or requires expedited or alternative shipping methods other than PBM's standard method, Member will be solely responsible for those costs.

3. **SPECIALTY PHARMACY SERVICES**

3.1 **Specialty Services.** PBM will provide Specialty Drug Covered Prescription Services as follows: Purchaser will receive Specialty Drug Covered Prescription Services exclusively from PBM's Specialty Pharmacy and not from any other retail, mail, specialty or other pharmacy, including a Network Pharmacy, provided that Limited Distribution Drugs not dispensed by PBM's Specialty Pharmacy are excluded from the Specialty Services and excluded from any Specialty Drug pricing guarantees.

3.2 **Specialty Drugs.** On a periodic basis, BCBSF will review the Specialty Drugs covered under this Addendum. BCBSF will make available to Purchaser the list of Specialty Drugs electronically or via an applicable BCBSF website.

3.3 **Control by PBM**. PBM will solely and exclusively control and supervise the operation and maintenance of PBM's Specialty Pharmacies and their respective facilities and equipment and provision of Covered Prescription Services. All decisions respecting the provision of Covered Prescription Services by PBM's Specialty Pharmacies will be made solely by PBM and its duly authorized personnel, and not by Purchaser. The relationship between a Member and a Specialty Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship.

4. **ENHANCED SAVINGS PROGRAM**

4.1 **Enhanced Savings Program.** Under the Enhanced Savings Program, Members will receive access to available discounts on Prescription Drugs that are on the Formulary or associated drug list, but not covered under the Member's Benefit Plan when the Member presents their existing prescription drug identification card for the Benefit Plan and a valid prescription to a Network Pharmacy. Members are informed at the point of sale of any available discounts by the Network Pharmacy and will be responsible for paying the Network Pharmacy the full (discounted, if applicable) price of the drug, including any dispensing fees or other applicable fees. Except as set forth in Exhibit D, claims processed through Client's Enhanced Savings Program will be excluded from any financial, network, rebate and performance guarantees in the Agreement. Optum agrees to provide access to the Enhanced Savings Program at no charge to Members or Client. Optum, its affiliates, subcontract service providers, brokers, consultants, and administrators, may receive and retain fees, proceeds, and/or other revenues in connection with the Enhanced Savings.

Exhibit C
Financial Terms

I. Pricing Terms and Conditions

A. **Base Administrative Fees.** The Base Administrative Fee is the amount Per Employee Per Month (PEPM) payable to BCBSF for the performance of PBM Services under this Addendum as set forth in this **Exhibit C**.

B. **Pharmacy Pricing Definitions.** In addition to the defined terms set forth in **Exhibit A**, the following definitions shall apply with respect to pharmacy pricing:

1. **"Qualified Claims"** mean all Net Paid Claims for the applicable measurement period except Excluded Claims. For avoidance of doubt, the following Claims are "Qualified Claims" and are included in the pricing guarantee calculations: U&C Claims; Claims paid 100% through Member Cost-Sharing Amounts; Specialty Drug Claims, and over the counter Covered Prescription Service Claims.

2. **"Excluded Claims"** mean Compound Prescription Drug Claims, direct Member submitted Claims, secondary payer COB Claims, 340B Claims, ITU Claims, LTC Claims, HIF Claims, vaccine prescription Claims, in-house/direct pharmacy Claims, Claims filled outside of the Pharmacy Network, Enhanced Savings Program claims and Specialty Drug Claims filled at retail.

3. **"Pricing Component"** means, each individually: (i) Minimum Brand Effective Rate Guarantee; (ii) Minimum Generic Effective Rate Guarantee; (iii) Maximum Brand Aggregate Dispensing Fee; (iv) Maximum Generic Aggregate Dispensing Fee.

4. **"Maximum Allowable Cost (MAC)"** means the proprietary unit price that has been established by the PBM and BCBSF for a multisource drug included on the BCBSFMAC list. The MAC may be adjusted from time to time by BCBSF in order to perform its obligations under this Addendum.

5. **"Maximum Brand Aggregate Dispensing Fee Guarantee"** means the following:

   a. The formula for this guarantee will be Total Dispensing Fees of Brand Drug Qualified Claims/Total number of Brand Drug Qualified Claims.

   b. "Total Dispensing Fees" mean the total of all Brand Drug Dispensing Fees charged on Brand Drug Qualified Claims before the application of Cost-Sharing Amount.

6. **"Maximum Generic Aggregate Dispensing Fee Guarantee"** means the following:

   a. The formula for this guarantee will be Total Dispensing Fees of Generic Drug Qualified Claims/Total number of Generic Drug Qualified Claims.

   b. "Total Dispensing Fees" mean the total of all Dispensing Fees charged on Generic Drug Qualified Claims before the application of Cost-Sharing Amount.

7. **"Minimum Brand Effective Rate Guarantees**" means the following:

   a. The formula for this guarantee will be 1-(Total Discounted Ingredient Cost/ Total Undiscounted AWP).

   b. Total Discounted Ingredient Cost before the application of Cost-Sharing Amount will be used in this calculation.

   c. Dispensing Fees and taxes will not be included in the Total Discounted Ingredient Cost.

   d. Both the Total Discounted Ingredient Cost and Total Undiscounted AWP will be based on the date of dispensing (meaning delivered to the Member or his/her representative) for each Qualified Claim.

   e. "Total Undiscounted AWP" means the AWP of the 11-digit NDC of the Covered Prescription Service dispensed, and in no event shall average AWP or average of averages of AWP be used.

   f. All single source and all multi-source Brand Drug Qualified Claims will be included in the calculation with the exception of DAW5 Claims.

8. **"Minimum Generic Effective Rate Guarantees"** means the following:

   a. The formula for this guarantee will be 1-(Total Discounted Ingredient Cost/ Total Undiscounted AWP).

   b. Total Discounted Ingredient Cost before the application of Cost-Sharing Amount will be used in this calculation.

   c. Dispensing Fees and taxes will not be included in the Total Discounted Ingredient Cost.

   d. Both the Total Discounted Ingredient Cost and Total Undiscounted AWP will be based on the date of dispensing (meaning delivered to the Member or his/her representative) for each Qualified Claim.

   e. "Total Undiscounted AWP" means the AWP of the 11-digit NDC of the Covered Prescription Service dispensed, and in no event shall average AWP or average of averages of AWP be used.

   f. All single source Generic Drug Claims, multi-source Generic Drug Claims, authorized Generic Drug Claims, Generic Drugs with patent litigation, house Generic Drugs, Generic Drugs available in limited supply, and Claims that process with a DAW5 code that are Qualified Claims will be included in the calculation.

C. Pricing Terms and Conditions.

1. **Pharmacy Network Pricing Reporting, Reconciliation, and Payments.** On an annual basis within one hundred and twenty (120) days after the close of the calendar year, BCBSF will provide to Purchaser a report setting forth the pricing achieved for each Pricing Component set forth this **Exhibit C** in accordance with the definitions set forth herein. Pharmacy pricing commitments and guarantees are measured on a Pricing Component basis and will be aggregated annually. Any dollar savings generated in excess of any Pricing Component may be used to offset a short fall for any other Pricing Component. Within sixty (60) days after the guarantees are measured and reconciled, BCBSF shall pay to Purchaser the amount equal to any shortfall between the actual result and the minimum pricing commitment / guarantee on a dollar-for-dollar basis.

2. **"Lesser Of" Pricing**. Purchaser and/or Members will always pay the lesser of (i) AWP less the applicable percentage discount plus the applicable Dispensing Fee plus applicable tax, (ii) the MAC List price plus applicable Dispensing Fee plus applicable tax, (iii) (excluding Home Delivery Pharmacies and Specialty Pharmacies) the Network Pharmacy's U&C charge plus applicable tax, or (iv) the Network Pharmacy submitted cost, and (v) for Members, or the applicable Cost-Sharing Amount.

3. **No Minimum Charge.** No minimum charge shall apply for any Home Delivery Pharmacy orders or Specialty Pharmacy orders.

D. Specialty Drug Pricing

Exclusive Specialty Pharmacy Program. Purchaser represents and warrants, to the extent that is allowed by Law, PBM's Specialty Pharmacies will be the exclusive Specialty Pharmacy provider under this Addendum. Such network exclusivity shall not apply to Specialty Drugs that PBM's Specialty Pharmacy does not distribute and cannot access.

E. Rebate Guarantees.

For purposes of the Rebate Guarantees: (i) "Retail Pharmacy " includes Rebates on Claims (excluding Specialty Drugs) dispensed from retail pharmacies, LTC pharmacies, ITU pharmacies, HIF pharmacies, and in-house/direct pharmacies (regardless of days' supply or network),
(ii) "Retail Maintenance" includes Rebates on Claims (excluding Specialty Drugs) dispensed from Retail 90 pharmacies, (iii) "Home Delivery" includes Rebates on Claims (excluding Specialty Drugs) dispensed from Home Delivery Pharmacies; and (iv) "Specialty" includes Rebates on Specialty Drug Claims regardless of dispensing pharmacy (*e.g.,* includes Specialty Drugs dispensed from retail pharmacies, Retail 90 pharmacies, Home Delivery Pharmacies, Specialty Pharmacies, in-house/direct pharmacies, or any other Network Pharmacy).

1. **Rebate Guarantee Payment and Reconciliation.** BCBSF will remit to Purchaser the Rebates set forth herein with respect to Claims related to Members under this Addendum. Rebate Guarantees do not assume or require an average daily supply.

2. **Rebate Payments.** Rebate payments due to Purchaser shall be calculated ninety (90) days after the end of the calendar quarter and paid and reported within thirty (30) days after that.

F. Pharmacy Pricing and Rebate Guarantee Periods

Year 1: January 1, 2023 through December 31, 2023
Year 2: January 1, 2024 through December 31, 2024
Year 3: January 1, 2025 through December 31, 2025

Retail Pharmacy Network Offerings

Broad Retail Pharmacy Network			
	Year 1	Year 2	Year 3
Minimum Brand Effective Rate Guarantee			
Minimum Generic Effective Rate Guarantee			
Maximum Brand Aggregate Dispensing Fee Guarantee			
Maximum Generic Aggregate Dispensing Fee Guarantee			

Retail 90 Broad Pharmacy Network			
	Year 1	Year 2	Year 3
Minimum Brand Effective Rate Guarantee			
Minimum Generic Effective Rate Guarantee			
Maximum Brand Aggregate Dispensing Fee Guarantee			
Maximum Generic Aggregate Dispensing Fee Guarantee			

Mail Service Network Offerings

Mail Service/Home Delivery Pharmacy			
	Year 1	Year 2	Year 3
Minimum Brand Effective Rate Guarantee			
Minimum Generic Effective Rate Guarantee			
Maximum Brand Aggregate Dispensing Fee Guarantee			
Maximum Generic Aggregate Dispensing Fee Guarantee			

Specialty Network

PBM Specialty Pharmacy Exclusive			
	Year 1	Year 2	Year 3
Minimum Brand Effective Rate Guarantee			
Minimum Generic Effective Rate Guarantee			
Specialty Drug Dispensing Fee Guarantee			

PNPC= per Net Paid Claim

II. Rebates

Rebate Management – BlueCross Premium Formulary			
Fixed Rebates	Year 1	Year 2	Year 3
Retail Pharmacy - PNPB			
Retail Maintenance - PNPB			
Home Delivery – PNPB			
Specialty – PNPB			

PNPB = per Net Paid Brand Drug Claim

BlueCross Premium Formulary: The BlueCross Premium Formulary is a national formulary, with a limited number of exclusions that drive highly competitive rebates. The Premium Formulary rebates are contingent upon: Client's adoption, without deviation, of formulary and drug exclusions which may change from time to time; implementation of the utilization management programs that correspond to the formulary, quantity limitations, the Prescription Drug Benefit Program and a minimum of $10 difference in copayment, or 10 percent difference in coinsurance between preferred and nonpreferred Brand Drugs.

III. Administrative Fees

Administrative Fee	
	Administrative Fee
Base Administrative Fee	_____ PEPM
Clinical Program Admin Fee	_____PEPM

Clinical Program Administration Fee includes the following programs:

- **Prior Authorization**

The prior authorization program is a quality and safety program that includes both Specialty and non-Specialty drugs and requires providers to document Medical Necessity before drugs in the program will be covered.

- **Quantity Management**

This quality and safety program limits the amount of certain Prescription Drugs which will be covered in a given period of time. Members can get a prescription filled for up to the allowed limit, but the program requires the Member's provider to document Medical Necessity before quantities above the limit will be covered.

- **Step Therapy**

The step therapy program requires the use of certain "first choice" medications before "second choice" medications will be covered. The claims system automatically searches for evidence of first choice drugs in the Member's prescription history. If none is found, the provider can request coverage for a particular drug, based on Medical Necessity.

- **Opioid Risk Management Solution**

In keeping with the national effort to stem the tide of this epidemic, the opioid management program confronts all aspects of the opioid epidemic by addressing clinical opportunities and engaging consumers, prescribers and pharmacies across the entire care continuum and/or life count. The program consists of prevention and education, daily quantity limits specific to each covered opioid drug and prior authorization requirements for certain prescribing situations.

- **Safety Management**

This is a retrospective DUR program that delivers prescription savings by targeting unsafe and clinically inappropriate therapy utilization. Advanced analytics conduct medication evaluation of every claim for all Members to alert physicians to potentially severe drug therapy issues.

- **Retrospective Gaps in Care**

The retrospective DUR program delivers incremental health care savings by closing gaps in medication therapy for treating chronic disease. Advanced analytics conduct medication evaluation of every claim to alert physicians to potential gaps in care.

- **Medication Adherence Program**

The medication adherence program leverages analytics and timely interventions to improve adherence. It supports outreach to the right Members at the right time using the right approach: Identification of Members who are at risk of poor adherence such as low-adherence rates and providing targeted timely interventions such as physician notifications.

- **Specialty Medical Benefit Management**

The specialty medical benefit management suite includes prior authorization, site of care steerage and channel management for drugs that are administered by a health care provider and billed under the medical benefit. The prior authorization component seeks to apply consistency under the medical and pharmacy benefit, in prior authorization of certain Specialty Drugs across the benefit spectrum. The prior authorization process is also used to steer Members on certain specialty drugs to appropriate, lower-cost sites of care such as infusion centers or the Member's home. The program also works to steer certain self- administered Specialty Drugs from the provider setting to the pharmacy benefit.

EXHIBIT F

DISCOUNT GUARANTEES
CITIZENS PROPERTY INSURANCE
EFFECTIVE JANUARY 1, 2023 THROUGH DECEMBER 31, 2023

Administrative Fee	Discount Achieved	Fee Credit	Net Administrative Fee

Assumptions:
Applies to In-Network provider claims only.
BCBSFL Network and Program Savings Report will be used for validation of results.
No significant benefit changes or membership changes by geographical regions.
BlueOptions products only, excluding Rx.
Inpatient hospital claims in excess of $_____ will be removed in their entirety form the discount guarantee calculation.
Does not include any ancillary products or AOR fees.
Does not include nationwide BlueCard.
Discount ranges are account specific and apply to total discounts only.
Results will be provided on a quarterly basis with final annual settlement no earlier than 4/1/2024.
One year only offer on in-network providers

ADDENDUM 1
PUBLIC RECORDS ADDENDUM ("ADDENDUM")

Company Name ("Vendor"): Blue Cross Blue Shield of Florida, Inc.
Agreement Name/Number ("Agreement"): Agreement for Administrative Services 2221002200
Primary Vendor Contact Name: Adrian Olivo
Telephone: 941-378-7326
Email: Adrian.olivo@bcbsfl.com

Citizens is subject to Florida public records laws, including Chapter 119, Florida Statutes. As a part of providing public access to Citizens' records, Citizens makes its contracts available on Citizens' external website located at www.citizensfla.com/contracts. This Addendum is incorporated into the Agreement in order to address Citizens' public posting of the Agreement and its disclosure to third parties.

If Vendor asserts that any portion of the Agreement is exempt from disclosure under Florida public records laws, (the "Redacted Information"), such as information that Vendor considers a protected "trade secret" per Section 815.045, Florida Statutes, then Vendor must select the corresponding declaration below and provide the following to Vendor.ManagementOffice@citizensfla.com:

(1) A copy of the Agreement in PDF format with the Redacted Information removed (the "Redacted Agreement"); and,

(2) A dated statement on Vendor's letterhead in PDF format clearly identifying the legal basis for Vendor's redaction of the Redacted Information (the "Redaction Justification").

Vendor must select one of the two declarations below. If Vendor does not select one of the two declarations below, or if Vendor fails to provide the Redacted Agreement and Redaction Justification within thirty (30) calendar days of Vendor's receipt of the fully executed Agreement, then without further notice to Vendor, Citizens may post the non-redacted version of the Agreement on its public website and may release it to any member of the public.

Vendor Declaration:
☐ Vendor WILL NOT SUBMIT a Redacted Agreement. Citizens may post Vendor's full, complete, and non-redacted Agreement on its public website, and may release the Agreement to any member of the public without notice to Vendor. Or ☒ Vendor asserts that a portion of the Agreement is confidential and/or exempt under Florida Public Records law. Therefore, Vendor WILL SUBMIT a Redacted Agreement and a Redaction Justification within thirty (30) calendar days of receipt of the fully executed Agreement. Citizens may post Vendor's Redacted Agreement on its public website, or release it to any member of the public, without notice to Vendor. If Citizens receives a public records request for the Agreement, Citizens will provide only the Redacted Agreement and Redacted Justification to the requestor. Vendor acknowledges that, in the event of any legal challenge regarding these redactions, Vendor will be solely responsible for defending its position or seeking a judicial declaration.