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EC-26-20

CITY OF ALBUQUERQUE
Albuquerque, New Mexico
Office of the Mayor

Mayor Timothy M. Keller

INTER-OFFICE MEMORANDUM 01/05/2026

TO: Klarissa J. Peña, President, City Council

FROM: Timothy M. Keller, Mayor

SUBJECT: Mayor's Recommendation of Award for RFP-2025-710-HRM-CG Fully Insured & Self-Funded Group Dental Insurance for the Human Resources Department

The City of Albuquerque's Human Resources Department, in conjunction with the Department of Finance and Administration Services, Purchasing Division, issued the RFP for Fully Insured & Self-Funded Group Dental Insurance.

The RFP was posted on the Purchasing e-Procurement, Bonfire website on July 21, 2025, and advertised on Social Media. The City received five (5) responses to this solicitation. The Ad Hoc evaluation committee evaluated and scored the proposals received in accordance with the evaluation criteria published in the RFP. After thoroughly reviewing and scoring the proposals, the Ad Hoc committee found Delta Dental of New Mexico and BCBSTX to be both responsive and qualified and recommend an award to Delta Dental of New Mexico and BCBSTX based on the highest scores.

I concur with this recommendation. The City of Albuquerque's Human Resources Department will manage this contract.

Mayor's Recommendation of Award for RFP-2025-710-HRM-CG Fully Insured & Self-Funded Group Dental Insurance.

Approved:

Samantha Sengel, EdD 1/26/26
Samantha Sengel, EdD Date
Chief Administrative Officer

Approved as to Legal Form:

DocuSigned by:
Lauren Keefe
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1/26/2026 | 1:49 PM MST
City Attorney Date

Recommended:

DocuSigned by:
Ian Stoker
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1/20/2026 | 3:05 PM MST
Director Date

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Cover Analysis

1. What is it?

Approval of Recommendation of Award for Self-Funded Dental Benefits Administration by Blue Cross & Blue Shield (BCBS) and Delta Dental.

2. What will this piece of legislation do?

Approve the negotiation and execution of the contracts with the recommended Self-Funded Dental Benefits Administrators.

3. Why is this project needed?

This Project is needed to provide Dental Benefits Administration to the employees and dependents of the City of Albuquerque and Participating Entities.

4. How much will it cost and what is the funding source?

Under the new agreement, the Human Resources Department will partner with a Third-Party Administrator to manage Dental Benefits as part of the Health Benefits Program. For Fiscal Year 2027, it is estimated that the Administrative Services Only (ASO) fees and Dental Claims will total approximately $5 million. The fund is structured to generate revenues sufficient to cover these projected expenses.

The funding will be provided through an internal service fund dedicated to health benefits.

5. Is there a revenue source associated with this contract? If so, what level of income is projected?

The fund expects to generate sufficient revenue to cover the projected expenses.

6. What will happen if the project is not approved?

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The project is in response to employee survey results recognizing a demand for expanded Dentist access. If the project is not approved, enhanced dentist will not occur.

7. Is this service already provided by another entity?

Yes. BCBS currently provides Dental Insurance for the City of Albuquerque and Participating Entities.

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FISCAL IMPACT ANALYSIS

TITLE: Award "Fully Insured & Self-Funded Group Dental Insurance"

R: O:
FUND: 710

DEPT: Human Resources

[ ] No measurable fiscal impact is anticipated, i.e., no impact on fund balance over and above existing appropriations.

[x] (If Applicable) The estimated fiscal impact (defined as impact over and above existing appropriations) of this legislation is as follows:

	Fiscal Years 2026	2027	2028	Total
Base Salary/Wages				-
Fringe Benefits at				-
Subtotal Personnel	-	-	-	-
Operating Expenses		726,000	150,000	876,000
Property		-	-	-
Indirect Costs	-	-	-	-
Total Expenses	$ -	$ 726,000	$ 150,000	$ 876,000
[ ] Estimated revenues not affected				
[ ] Estimated revenue impact				
Revenue from program		726,000	150,000	876,000
Amount of Grant			-	
City Cash Match				
City Inkind Match				
City IDOH	-	-	-	-
Total Revenue	$ -	$ 726,000	$ 150,000	$ 876,000

These estimates do not include any adjustment for inflation.

* Range if not easily quantifiable.

Number of Positions created

COMMENTS: The Human Resources Department will contract with a Third Party Administrator to provide the Dental Benefit within the Health Benefits Program. FY27 it is estimated that the Administrative Service Only (ASO) and Dental Claims to be $5 million. The fund will bring in revenues to cover the projected expense. In FY28, there is an estimated increase in services and dental claims of approximately 3%.

COMMENTS ON NON-MONETARY IMPACTS TO COMMUNITY/CITY GOVERNMENT:

PREPARED BY:
DocuSigned by:
Tanya E. Gallegos
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FISCAL ANALYST

APPROVED:
DocuSigned by:
Ian Stoker
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1/20/2026 | 3:05 PM MST
DIRECTOR

REVIEWED BY:
DocuSigned by:
Haiyan Zhao
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EXECUTIVE BUDGET ANALYST

Signed by:
Donna Sandoval
08F4D687C3CA4E2...
BUDGET OFFICER

Signed by:
Christine Boerner
BA2C41AA2D954FD...
CITY ECONOMIST

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City of Albuquerque

Department of Finance and Administrative Services

Timothy M. Keller, Mayor

Interoffice Memorandum

Date

TO: Dr. Samantha Sengel, Chief Administrative Officer

FROM: Ian Stoker, Human Resources Department

DS
IS

SUBJECT: **Recommendation of Award –**
RFP Number: RFP-2025-710-HRM-CG
RFP Name: Fully Insured & Self-Funded Group Dental Insurance

The Department of Finance and Administrative Services, Purchasing Division, issued the subject solicitation in conjunction with the Department of Human Resources and developed an RFP for Fully Insured & Self-Funded Group Dental Insurance.

The solicitation was posted on the Purchasing website. The number of responses received for evaluation were five (5)

The Ad Hoc Evaluation Committee evaluated and scored the responses in accordance with the evaluation criteria published in the RFP and recommends awarding a contract to both Delta Dental of New Mexico and BCBSTX.

I concur with this recommendation. Listed below are the composite scores for the top responses received:

COMPANY NAME	SCORE
Delta Dental of New Mexico	881.5
BCBSTX	865
Sun Life Financial	712.75
UnitedHealthcare	695.75
MetLife	679.5

The Department that will be managing this contract is Human Resources

Approved:

DocuSigned by:
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11/13/2025 | 12:28 PM MST

Dr. Samantha Sengel (Date)
Chief Administrative Officer

Attachment: Scoring Summary

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RFP-2025-710-HRM-CG - Fully Insured & Self-Funded Group Dental Insurance
Scoring Summary

Submissions

	Total	A - Technical Proposal	A-1 - Experience and qualifications	A-2 - Adequacy of proposed plan design	A-3 - The Offeror's general approach	B - Cost Proposal	B-1 - Cost Proposal
Supplier	/ 1,100.00 pts	/ 700 pts	/ 200 pts	/ 200 pts	/ 300 pts	/ 300 pts	/ 300 pts
Delta Dental of New Mexico	881.5	672.5	200	195	277.5	209	209
BCBSTX	865	590	175	158.75	256.25	275	275
Sun Life Financial	712.75	453.75	130	133.75	190	259	259
UnitedHealthcare	695.75	483.75	132.5	150	201.25	212	212
MetLife	679.5	427.5	136.25	135	156.25	252	252

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City of Albuquerque

Request for Proposals

Solicitation Number: RFP-2025-710-HRM-CG

"Fully Insured & Self-Funded Group Dental Insurance"

RFP Open Date July 21, 2025

Deadline for Receipt of Proposals: August 20, 2025 4:00 p.m. (Mountain Time)
The City eProcurement System will not allow Proposals to be submitted after this date and time.

City of Albuquerque
Department of Finance and Administrative Services

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Purchasing Division
V2024.07.10 JLB

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Appendix A	Dental Eligibility, Participation and Rates	Located in Bonfire
Appendix B	Dental Questionnaire	Located in Bonfire
Appendix C	Census	Located in Bonfire
Appendix D	Current Plan Design	Located in Bonfire
Appendix E	Enrollment and Claims	Located in Bonfire
Appendix F	Technical Workbook	Located in Bonfire
Appendix G	Offerors Financials	Offeror to Upload in Bonfire
Appendix H	Cost Proposal	Located in Bonfire

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INTRODUCTION

City Background

The City of Albuquerque ("City") is the largest city in New Mexico with a population of over 560,000. The City employs a Mayoral-Council form of government. The City Council is comprised of nine (9) Councilors who serve staggered four (4) year terms. The City has over 6,500 employees in thirty-one (31) municipal departments located in both the City Hall complex and throughout the City limits.

For more information about the City, please visit our website at http://www.cabq.gov/

In addition, the City has intergovernmental agreements with eighteen (18) government agencies within the State of New Mexico. These entities range in size from four (4) to 625 employees. The agreements allow the entities ("Participating Entities") to offer the same employee benefit options to their employees for the same rates that the City has contracted for its employees. Total covered lives for the City and all Participating Entities are approximately 16,400.

Purpose

The City is seeking proposals that offer fully insured and self-funded dental benefit program(s) provided to employees and their dependents of the City and Participating Entities. For the remainder of the solicitation, any reference to City includes Participating Entities. The proposed dental benefit program should promote cost-effective, value-based directions and patient-oriented care to lower collective health risks by improving individual lifestyles.

The coverage will be available for employees of the City during the fiscal year, which begins July 1, 2026 (Fiscal Year 27). Offerors shall submit proposals in response to this solicitation with the understanding that the City may, at its discretion, offer the plan either as a stand-alone or as a dual carrier option to its employees. If there is more than one carrier (vendor) selected, the City will conduct a positive open enrollment, requiring each employee to elect coverage without defaulting them to current coverage.

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The City is the contracting entity. The Participating Entities affiliated with this Request for Proposals (“RFP”) are:

	Employees
Albuquerque Bernalillo County Water Utility Auth	641
Albuquerque Housing Authority	71
City of Belen	109
Middle Rio Grande Conservancy District	196
Southern Sandoval County Arroyo Flood Control Authority	12
Town of Bernalillo	107
Town of Cochiti Lake	5
Town of Edgewood	27
Town of Mountainair	17
Village of Bosque Farms	45
Village of Corrales	59
Village of Cuba	17
Village of Jemez Springs	7
Village of Los Ranchos de Albuquerque	15
Village of San Ysidro	4
Village of Tijeras	24

Offerors shall assume participation by all Participating Entities for proposal purposes. Participation in any of the benefits the City offers is not mandatory for any Participating Entities; however, participation in dental insurance has been constant.

Additional government entities located in reasonable proximity to the Albuquerque service area may request to participate in the City’s plans. The City reviews such requests based on available experience data to make a determination that such requests are not expected to negatively impact the City’s rates in the future.

The census data (Appendix C) is available on the City’s eProcurement website.

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Participant Eligibility

- Regular employees (both part-time and full-time, including those on probation)
- Elected officials
- Unclassified employees scheduled to work twenty (20) hours or more each week
- Legal spouse of an employee (must provide most current federal tax return (front page only) or marriage certificate and two forms of joint financial relationship)

- Domestic partner of an employee* (must provide City's Affidavit of Domestic Partnership)
- Children (must provide birth certificate) married, or unmarried, to the last day of the month in which the child attains age twenty-six (26) AND meet at least one (1) of the following criteria:
- Natural child of the employee, spouse or domestic partner
- Adopted child or a child placed in the employee's home and in process for being adopted by the employee, spouse or domestic partner
- Court order that requires the employee, spouse or domestic partner provide health coverage for the child. (i.e. Qualified Medical Child Support Order (QMCSO))
- Child under legal guardianship: court document that shows the employee, spouse or domestic partner has full, permanent custody of the child
- Children age twenty-six (26), and older, may continue participating in the group insurance plans if they are permanently and totally physically or mentally disabled, unmarried, covered under the plan on the day before their twenty-sixth (26th) birthday, eligible for tax free coverage as a qualified child or qualified relative. A child who has terminated coverage due to reaching the age limit, and then becomes disabled, is not eligible to re-enroll for coverage

* A domestic partner is defined as a person of the same or opposite sex who lives with the employee in a long-term relationship of indefinite duration. There must be an exclusive mutual commitment similar to that of marriage, in which the partners agree to be financially responsible for each other's welfare and share financial obligations. These benefits are also available to the domestic partner's children provided that the child meets the definition of eligibility stated above.

Effective Date of Coverage (May have slight variations for participating entities)

- New Employees – Coverage begins on the employee's hire date. Employees have thirty-one (31) days from their hire date to enroll through Employee Self Service and provide verification of dependent eligibility.

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- Qualifying Events – Coverage begins on the event date as long as the employee enrolls through Employee Self Service and provides verification of the event and of dependent eligibility within thirty-one (31) days of the event. Losing or gaining eligibility for Medicare and Medicaid allows a sixty (60)-day enrollment period. An ex-spouse is not eligible to continue participation in the insurance program, except through COBRA. Therefore, when the divorce decree is submitted to the City of Albuquerque Human Resources Department's Benefits Office the end of coverage will be back dated to the day following the court stamped date on the decree.

- Reinstatement – An employee who is terminated from the City and subsequently reinstated is eligible to have the same benefits started up again in which he/she was enrolled prior to termination. If termination was prior to the last open enrollment period, then the employee may elect to participate in the benefit options as a new employee. The employee must enroll through Employee Self Service with documentation of the reinstatement. The effective date of coverage will be the date of reinstatement.

- Open Enrollment – Benefit changes elected during open enrollment are effective on July 1st or if cancelling coverage then the last day of coverage will be June 30th.

- Termination of Coverage

- Insurance ends at the end of the pay period in which the event that results in termination of coverage occurs. Exceptions to this are:
    - Retirement coverage stops at the end of the month prior to the PERA retirement date
    - Dependents reaching the age limit lose coverage at the end of the month of their 26th birthday
    - Ex-spouses lose coverage the day after the divorce

Additionally, it is important to note that at annual renewal, Participating Entities have the option to add additional lines of coverage or drop lines of coverage. The City requires the entities to provide a ninety (90)-day notice before making any such changes.

Current Dental Insurance Plans

The City currently offers BCBS's Dental PPO plan to employees and Participating Entities on a fully insured basis. The current vendor, BCBS, has been under contract with the City for a total of 1 year, with the prior twenty-four (24) years under contract with Delta Dental. As of August 1, 2025, the total covered employees by the City and the Participating Entities are more than 6,000 employees in the City's group dental insurance

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As identified in the City's census (Appendix C) there are four tiers of coverage:

Employee only (Coverage Code 1)
Couple (two (2) adults) (Coverage Code 2)
Single parent (one (1) adult plus one or more children) (Coverage Code 3)
Family (two (2) adults plus one (1) or more children) (Coverage Code 4)

The City is asking that Offerors quote the current plan design provided in the RFP (See Page 8). Identify any deviations as instructed in 2.1.3 of this RFP. It is anticipated that the proposed coverage(s) will meet or exceed those provided by the current provider. The City is seeking self-insured and fully insured proposals.

Contributions

The City contributes eighty percent (80%) of the premium for all four (4) tiers of coverage for dental. The City will continue to provide the eighty percent (80%) premium contribution to any new plan(s). Participating entities have the authority to select their own contributions. The City reserves the right to modify employer contributions.

Dental Plan Notes

Proposals will be accepted from carriers capable of offering a fully insured or self-insured plan that matches or exceeds the current plan design.

The City may modify benefits for 2026/2027. It is expected that the plan designs will remain relatively the same or be enhanced

Deductible: $50 Deductible per person total per Benefit Period limited to a maximum Deductible of $150 per family per Benefit Period

Maximum Benefit Amount: $1,500 per person total per Benefit Period Orthodontic Lifetime Maximum: $1,200 per person total per lifetime

The City reserves the right to select more than one dental insurance provider.

Note: Please provide a self-funded and a fully insured quote as well as an implementation timeline. The City reserves the right to select more than one insurance provider.

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PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist MAC
Benefit Period Maximum: Plan Year	$1,500	$1,500
Deductible: Plan Year	$50 Individual $150 Family	$50 Individual $150 Family
Three Month Deductible Carryover Applies	☒ Yes ☐ No	☒ Yes ☐ No
Prior Carrier Deductible Credit Applies	☐ Yes ☒ No	☐ Yes ☒ No
COVERED SERVICES		
Class 1: Preventive Services ***(Deductible does not apply)*** Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations Prophylaxis/routine cleanings X-rays Full-Mouth, Pano, Bitewing, Periapical Sealants Topical Fluoride Space maintainers Perio Peridontal Maintenance Full Mouth Debridement Palliative Treatment (emergency care to relieve pain)	100%	80%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Scaling & Root Planning Denture Reline/Rebase Repairs – Crown & Bridge Oral Surgery & Surgical Extractions Endodontics (root canal) Major Periodontics	85%	85%
Class 3: Major Restorative Services Bridges & Dentures Implants: Yes ☒ No ☐ Crowns, Inlays, Onlays Deep Sedation/General Anesthesia Diagnostic imaging and appliances for the diagnosis and/or treatment of TMJ (Temporomandibular joint dysfunction)	50%	50%
Class 4: Orthodontics Orthodontic Diagnostic Procedures & Treatment Coverage for Adults & Dependent Children (to age 26) **Lifetime Maximum Ortho Benefit per Participant**	50% **$1,200**	50% **$1,200**

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PART 1

INSTRUCTIONS TO OFFERORS

1.1.1 RFP Number and Title: RFP-2025-710-HRM-CG, " Fully Insured & Self-Funded Group Dental Insurance"

1.2 Proposal Due Date: August 20, 2025 - NLT 4:00 PM (Local Time)

1.3 Purchasing Division: This Request for Proposals ("RFP") is issued on behalf of the City of Albuquerque by its Purchasing Division, which is the sole point of contact during the entire procurement process.

1.4 Authority: Chapter 5, Article 5 of the Revised Ordinances of the City of Albuquerque, 1994, ("Public Purchases Ordinance"). The City Council, pursuant to Article 1 of the Charter of the City of Albuquerque and Article X, Section 6 of the Constitution of New Mexico, has enacted this Public Purchases Ordinance as authorized by such provisions and for the purpose of providing maximum local self-government. To that end, it is intended that this Public Purchases Ordinance shall govern all purchasing transactions of the City and shall serve to exempt the City from all provisions of the New Mexico Procurement Code, as provided in Section 13-1-98K, NMSA 1978.

1.5 Acceptance of Proposal: Acceptance of Proposal is contingent upon Offeror's certification and agreement by submittal of its Proposal, to comply and act in accordance with all provisions of the following:

1.5.1 City Public Purchases Ordinance

1.5.2 City Purchasing Rules and Regulations: These Rules and Regulations ("Regulations") are written to clarify and implement the provisions of the Public Purchases Ordinance. These Regulations establish policies, procedures, and guidelines relating to the procurement, management, control, and disposal of goods, services, and construction, as applicable, under the authority of the Ordinance.

1.5.3 Civil Rights Compliance: Acceptance of Proposal is contingent upon the Offeror's certification and agreement by submittal of its Proposal, to comply and act in accordance with all provisions of the Albuquerque Human Rights Ordinance, the New Mexico Human Rights Act, Title VII of the U.S. Civil Rights Act of 1964, as amended, and all federal statutes and executive orders, New Mexico statutes and City of Albuquerque ordinances and resolutions relating to the enforcement of civil rights and affirmative action. Questions regarding civil rights or affirmative action compliance requirements should be directed to the City of Albuquerque Human Rights Office.

1.5.4 Americans with Disabilities Act Compliance: The Offeror certifies and agrees, by submittal of its Proposal, to comply and act in accordance with all applicable provisions of the Americans With Disabilities Act of 1990 and federal

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regulations promulgated thereunder.

1.5.5 Insurance and Bonding Compliance: Acceptance of Proposal is contingent upon Offeror's ability to comply with the insurance requirements as stated herein. Please include a certificate or statement of compliance in your Proposal and bonds as required.

1.5.6 Ethics:

1.5.6.1 Fair Dealing. The Offeror warrants that its Proposal is submitted and entered into without collusion on the part of the Offeror with any person or firm, without fraud and in good faith. Offeror also warrants that no gratuities, in the form of entertainment, gifts or otherwise, were, or will be offered or given by the Offeror, or any agent or representative of the Offeror to any officer or employee of the City with a view toward securing a recommendation of award or subsequent contract or for securing more favorable treatment with respect to making a recommendation of award.

1.5.6.2 Conflict of Interest. The Offeror warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under the contract resulting from this RFP. The Offeror also warrants that, to the best of its knowledge, no officer, agent or employee of the City who shall participate in any decision relating to this RFP and the resulting contract, currently has, or will have in the future, a personal or pecuniary interest in the Offeror’s business.

1.5.7 Participation/Offeror Preparation: The Offeror may not use the consultation or assistance of any person, firm company who has participated in whole or in part in the writing of these specifications or the Scope of Services, for the preparation of its Proposal or in the management of its business if awarded the contract resulting from this RFP.

1.5.8 Debarment or Ineligibility Compliance: By submitting its Proposal in response to this RFP, the Offeror certifies that (i) it has not been debarred or otherwise found ineligible to receive funds by any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States; and (ii) should any notice of debarment, suspension, ineligibility or exclusion be received by the Offeror, the Offeror will notify the City immediately.

Any Proposal received from an Offeror that is, at the time of submitting its Proposal or prior to receipt of award of a contract, debarred by or otherwise ineligible to receive funds from any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States, shall be rejected.

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Upon receipt of notice of debarment of an Offeror awarded a contract as a result of this RFP ("Contractor"), or other ineligibility of the Contractor to receive funds from any agency of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States, the City shall have the right to cancel the contract with the Contractor resulting from this RFP for cause in accordance with the terms of said contract.

1.5.9 Goods Produced Under Decent Working Conditions: It is the policy of the City not to purchase, lease, or rent goods for use or for resale at City owned enterprises that were produced under sweatshop conditions. The Offeror certifies, by submittal of its Proposal in response to this solicitation, that the goods offered to the City were produced under decent working conditions. The City defines "under decent working conditions" as production in a factory in which child labor and forced labor are not employed; in which adequate wages and benefits are paid to workers; in which workers are not required to work more than 48 hours per week (or less if a shorter workweek applies); in which employees are free from physical, sexual or verbal harassment; and in which employees can speak freely about working conditions and can participate in and form unions. [*Council Bill No. M-8, Enactment No. 9-1998*]

1.5.10 Graffiti Free: When required, the Contractor will be required to furnish equipment, facilities, or other items required to complete these services, that are graffiti-free. Failure of Contractor to comply with this requirement may result in cancellation of the contract resulting from this RFP.

1.6 City Contact: The sole point of contact for this RFP is the City of Albuquerque Purchasing Division. Questions regarding this RFP should be directed to the following Purchasing representative unless otherwise specified in the solicitation. The City Contact will communicate with Offerors through its e-procurement system, Bonfire. Offerors will receive e-mail notifications from Bonfire to the e-mail that Offeror included in its Bonfire registration. Offerors are responsible for monitoring any communications sent through Bonfire and responding to any requests for information or directives within stated deadlines. Offerors who fail to abide by this instruction may be deemed nonresponsive.

- Cassaundra Gomez, Senior Buyer, Department of Finance and Administrative Services, Purchasing Division
- Phone: (505) 768-3329 or E-Mail: cgomez@cabq.gov
- Post Office Box 1293, Albuquerque, New Mexico 87103

1.7 Contract Management: The contract resulting from this RFP will be managed by the Human Resources Department, Benefits Division.

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1.8 Clarification: Any explanation desired by an Offeror regarding the meaning or interpretation of this RFP must be requested in writing not less than ten (10) working days prior to the deadline for the receipt of Proposals to allow sufficient time for a reply to reach all Offerors before the submission of their Proposals. No extension of time will be granted based on submission of inquiries subsequent to the required date nor will such inquiries be answered. All inquiries must be directed to the Purchasing Division as stated herein and must be submitted through the City's eProcurement system Bonfire. **The City will not respond to questions that are submitted by any other means than electronically through the City's eProcurement system**. Oral explanations or instructions given before the award of the contract or at any time will not be binding. Purchasing shall prepare answers to questions in the form of Addenda to this RFP and shall post all such Addenda to the online eProcurement System.

1. 9 Submission of Proposals. The Offeror's Proposal must be submitted **electronically** through the eProcurement system pursuant to the following requirements:

1.9.1 Electronic Copy. Submit your complete Proposal including all forms, attachments, exhibits, Technical Proposal, Cost Proposal, etc. using the eProcurement System at https://cabq.bonfirehub.com/portal/?tab=openOpportunities. Please allow a minimum of two (2) business days to submit your proposal. If you do not have a username and password, please register as this is the only method to submit electronically on the Bonfire portal. Please make sure to register on the system in order to receive notices and submit a response to a solicitation. For assistance, please contact support@gobonfire.com or 1-800-354-8010. **Failure to submit your proposal electronically through the City's eProcurement system shall result in your proposal being deemed nonresponsive.**

1.9.2 Format. Each file uploaded to the eProcurement System shall be in single PDF format unless otherwise indicated. The City's preferred format is Optical Character Recognition (OCR) searchable PDF format. Do not encrypt files and do not password protect the documents submitted.

1.9.3 ALL PROPOSALS MUST BE RECEIVED BY THE CITY PURCHASING DIVISION AS SPECIFIED HEREIN. IF YOU FAIL TO COMPLY WITH THE SUBMISSION REQUIREMENTS IN THIS SECTION 1.9, THE CITY SHALL DEEM YOUR PROPOSAL NONRESPONSIVE.

1.9.4 No other methods of Proposal delivery. Neither telephone, facsimile, nor telegraphic Proposals shall be accepted.

1.9.5 Modification. Proposals may be modified or withdrawn only by written notice, provided such notice is received prior to the Proposal Due Date.

1.9.6 Receipt of Proposals. The only acceptable evidence to establish the time of receipt of Proposals by City Purchasing Office is the time-date stamp of the eProcurement System.

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1.9.7 Acknowledgment of Addenda to the Request for Proposals. Receipt of Addenda to this RFP by an Offeror must be acknowledged in the City's eProcurement system. Failure to acknowledge an Addendum may result in your response being deemed non-responsive.

1.10 Modifications to Scope of Services: In the event that sufficient funds do not become available to complete each task in the Scope of Services, the Scope of Services may be amended, based upon the cost breakdown required in the Cost Proposal.

1.11 Required Contract Terms: The Required Contract Terms can be accessed at this link https://www.cabq.gov/dfa/purchasing-division/vendor-services/terms-and-conditions, click on "Request for Proposals Required Contract Terms". The Offeror certifies that it accepts the Required Contract Terms, or has uploaded its exceptions to the Required Contract Terms in the City's e-Procurement system, under "Requested Information" "Exceptions to Section 1.11 Required Contract Terms." Any exceptions shall be identified by the RFP Section, Subsection, and must state the specific exception the Offeror has, as well as any alternative language. The City's receipt of exceptions in a response is not an acceptance of any requested changes to the Required Contract Terms. The Required Contact Terms may differ from the terms in the final contract awarded under this RFP.

1.12 Contract Term: The contract resulting from this solicitation is anticipated to have a term of four (4) with no extensions.

1.13 Evaluation Period: The City reserves the right to analyze, examine and interpret any Proposal for a period of ninety (90) days after the hour and date specified for the receipt of Proposals. The City reserves the right to extend the evaluation period if it feels, in its sole discretion, such an extension would be in the best interest of the City.

1.14 Evaluation Assistance: The City, in evaluating Proposals, reserves the right to use any assistance deemed advisable, including City contractors and consultants.

1.15 Rejection and Waiver: The City reserves the right to reject any or all Proposals and to waive informalities and minor irregularities in Proposals received.

1.16 Award of Contract:

1.16.1 When Award Occurs: Award of contract occurs when a Purchase Order is issued or other evidence of acceptance by the City is provided to the Offeror. A Recommendation of Award does not constitute award of contract.

1.16.2 Award: If a contract is awarded, it shall be awarded to the responsive and responsible Offeror whose Proposal conforming to this RFP will be most advantageous to the City as set forth in the Evaluation Criteria.

1.17 Cancellation: This RFP may be canceled for any reasons and any and all Proposals may be rejected in whole or in part when it is in the best interests of the City.

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1.18 Negotiations: Negotiations may be conducted with the Offeror(s) recommended for award of contract.

1.19 City-Furnished Property: No material, labor, or facilities will be furnished by the City unless otherwise provided for in this RFP.

1.20 Public Records:

1.20.1 The Purchasing Division's procurement file and any documents relating to this RFP, including the Proposals submitted by Offerors, shall be open to public inspection in accordance with applicable law after the recommendation of award of a contract has been approved by the Mayor or the Mayor's designee.

1.20.2 An Offeror who chooses to submit material they consider a "Trade Secret" must do so in a segregated file clearly designated as containing trade secrets both in the file name and within the contents of the file itself. These segregated files are to be used by the City for reference only. An Offeror's failure to segregate such materials constitutes a failure to reasonably, under the circumstances, maintain the materials' secrecy and Offeror indemnifies and holds the City harmless for any and all liability resulting from the disclosure of any materials not segregated as described above.

1.20.3 If an Offeror submits with a proposal material required by law to be kept confidential, the Offeror must segregate such material in a separate file. Such a file should be clearly designated as "Legally Confidential" in both the file name and within the contents of the file. The contents of the file must include a description and citation to the legal basis for why the material must be kept confidential. Failure to segregate the material and describe the legal basis for why it is to be kept confidential may result in the information being disclosed. Designating the entire proposal confidential is not acceptable without providing the legal basis and may result in the information being disclosed. Offeror indemnifies and holds the City harmless for any and all liability resulting from such disclosure resulting from information not segregated as described above.

1.20.4 Pricing, makes and models or catalog numbers of items offered, delivery terms, and terms of payment shall not be designated as trade secrets or required to be kept confidential by law.

1.20.5 The City will endeavor to restrict the release of material segregated and designated as "Trade Secret" or "Legally Confidential to only those individuals involved in the review and analysis of the Proposals, and to any other party as required by law or court order. Under the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq, NMSA 1978) ("Act") the City may redact trade secrets and other material required to be kept confidential by law, but may not redact proprietary or confidential information. Any Proprietary or Confidential Data provided as part of a Proposal is subject to public inspection under the Act.

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Notwithstanding any provision of this RFP, the City shall not be responsible or liable to the Offeror for any disclosure of records required by the Act or an order of a court or other tribunal with jurisdiction over the City.

1.21 Procurement Preferences: A Pay Equity Preference as provided in Section 5-5-31 R.O.A. 1994 (as amended by C/S O-17-33) and the State Preferences as provided in 13-1-21 NMSA 1978 are applicable to this solicitation. To request the application of a preference, as applicable, Offeror shall submit with its Proposal a City Pay Equity Preference Form or the New Mexico State Certification for the requested preference.

1.22 Request for Proposals Protest Process:

1.22.1 RFP Documents: If the protest concerns the specifications for the RFP or other matters pertaining to the solicitation documents, the protest must be filed with the Chief Procurement Officer no later than 5:00 p.m., ten (10) business days prior to the deadline for the receipt of Proposals.

1.22.2 Recommendation of Award: If the protest concerns the Recommendation of Award, the protest must be filed with the Chief Procurement Officer no later than 5:00 p.m. of the tenth (10^{th}) business day after the receipt of notice of the Recommendation of Award.

1.22.3 Timely Protests: Protests must be received by the Chief Procurement Officer prior to the appropriate deadline as set out herein, or they will be rejected. The Chief Procurement Officer may waive the deadline for good cause, including a delay caused by the fault of the City. Late delivery by the U.S. Postal Service or other carrier shall not be considered good cause.

1.22.4 How to File a Protest: Any Offeror who is aggrieved in connection with a competitive solicitation or recommendation of award of a contract may protest to the City Chief Procurement Officer. The protest shall be addressed to the Chief Procurement Officer, must be submitted in written form and must be legible. Protests may be electronically delivered via email or mailed. Facsimile, telephonic, telegraphic or any other type of electronic protests will not be accepted.

1.22.5 Required Information: The protest shall contain at a minimum the following:

1.22.5.1 The name and address of the protesting party;

1.22.5.2 The number of the competitive solicitation;

1.22.5.3 A clear statement of the reason(s) for the protest detailing the provisions believed to have been violated;

1.22.5.4 Details concerning the facts, which support the protest;

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1.22.5.5 Attachments of any written evidence available to substantiate the claims of the protest; and

1.22.5.6 A statement specifying the ruling requested.

1.22.6 Delivery of Protests:

1.22.6.1 By Mail: Protests may be mailed in an envelope marked "PROTEST" with the solicitation number. Protests which are mailed should be addressed as follows:

Chief Procurement Officer
City of Albuquerque, Purchasing Division
P.O. Box 1293
Albuquerque, NM 87103
PROTEST, RFP Number

1.22.6.2 By Electronic Mail: Protests may be emailed to:

Kathleen Oney, Chief Procurement Officer
koney@cabq.gov

The message should clearly indicate "PROTEST" and the RFP number in the subject line.

1.22.7 Protest Response by Chief Procurement Officer: The Chief Procurement Officer will, after evaluation of a protest, issue a response. Only the issues outlined in the written protest will be considered by the Chief Procurement Officer.

1.22.8 Protest Hearing: If a hearing is requested, the request must be included in the protest and received within the time limit. Only the issues outlined in the protest will be considered by the Chief Procurement Officer, or may be raised at a protest hearing. The granting of a hearing shall be at the discretion of the Chief Procurement Officer following review of the request.

1.23 Insurance:

1.23.1 General Conditions: The City will require the successful Offeror, referred to as the Contractor, to procure and maintain at its expense during the term of the contract resulting from the RFP, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations of the Contractor under the contract. Upon execution of the contract and on the renewal of all coverages, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City as well as the rider or endorsement showing that it has complied with these insurance requirements. All certificates of insurance shall provide that thirty (30) days written notice be given to the Risk Manager, Department of Finance and Administrative

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Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico, 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than professional liability or workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided.

1.23.2 Approval of Insurance: Even though the Contractor may have been given notice to proceed, it shall not begin any work under the contract resulting from this RFP until the required insurance has been obtained and the proper certificates (or policies) are filed with the City. Neither approval nor failure to disapprove certificates, policies, or the insurance by the City shall relieve the Contractor of full responsibility to maintain the required insurance in full force and effect. If part of the contract is sublet, the Contractor shall include any or all subcontractors in its insurance policies, or require the subcontractor to secure insurance to protect itself against all hazards enumerated herein, which are not covered by the Contractor's insurance policies.

1.23.3 Coverage Required: The kinds and amounts of insurance required are as follows:

1.23.3.1 Commercial General Liability Insurance. A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$2,000,000	Per Occurrence
$2,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage shall specifically insure the hold harmless provisions of the contract resulting from this RFP.

1.23.3.2 Automobile Liability Insurance. A comprehensive automobile liability insurance policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. The policy must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

1.23.3.3 Workers' Compensation Insurance. Workers' compensation

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insurance policy for the Contractor's employees, in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico, (the "Act"). If the Contractor employs fewer than three employees and has determined that it is not subject to the Act, it will certify, in a signed statement, that it is not subject to the Act. The Contractor will notify the City and comply with the Act should it employ three or more persons during the term of the contract resulting from this RFP.

1.23.3.4 Cyber Liability Coverage: Cyber liability insurance in an amount not less than $2,000,000 combined single limit of liability per occurrence with a general aggregate of $2,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor may have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems.

1.23.3.5 Professional Liability/Medical Malpractice: Professional liability/medical malpractice insurance policy shall be not less than $5,000,000.

1.23.4 Increased Limits: During the life of the contract the City may require the Contractor to increase the maximum limits of any insurance required herein. In the event that the Contractor is so required to increase the limits of such insurance, an appropriate adjustment in the contract amount will be made.

1.23.5 Additional Insurance: The City may, as a condition of award of a contract, require a successful Offeror to carry additional types of insurance. The type and limit of additional insurance is dependent upon the type of services provided via the contract by the successful Offeror.

1.24 Pay Equity Documentation. All Proposals shall include a Pay Equity Reporting Form that can be accessed at https://www.cabq.gov/gender-pay-equity-initiative. Offerors who believe they are exempt because they are an out-of-state contractor (meaning that you have no facilities and no employees working in New Mexico) are not required to report data, but must still submit a Pay Equity Reporting Form with the box verifying the exempt status checked. **Any Proposal that does not include a Pay Equity Reporting Form shall be deemed nonresponsive, as stated in the Public Purchases Ordinance, 5-5-31.** A Pay Equity Reporting Form will be automatically issued within two (2) business days of completing your information at the link above. To ensure you have your form before the deadline for solicitation close, please access the link at least three (3) business days prior to the solicitation deadline. Please contact the "City Contact" identified above in Section 1.6 with any questions about the Pay Equity Reporting Form.

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PART 2

PROPOSAL FORMAT

A "Proposal" consists of two distinct sections—a "Technical Proposal" and a "Cost Proposal"—that are submitted separately in Bonfire.

Failure to submit the Technical Proposal and Cost proposal separately shall result in the City deeming your submission non-responsive.

2.1 Technical Proposal Format, Section One

2.1.1 Offeror Identification: State name and address of your organization or office and nature of organization (individual, partnership or corporation, private or public, profit or non-profit). Subcontractors, if any, must be identified in a similar manner. Include name, email address and telephone number of person(s) in your organization authorized to execute the contract resulting from this RFP. Submit a statement of compliance with all laws stated herein. Submit a statement of agreement to the Required Contract Terms; state exceptions as directed in Section 1.11. Show receipt of Addenda if applicable. Provide a statement or show ability to carry the insurance specified.

2.1.2 Experience:

2.1.2.1 Current Experience. State relevant experience of the company and person(s) who will be actively engaged in the proposed project, including experience of subcontractors. Submit resumes for the individuals who will be performing the services for the City.

2.1.2.2 Past Experience. Describe a minimum of three (3) projects of similar scope and size, which are now complete; state for whom the work was performed, year completed, and a letter of reference for each regarding the work. References must be for work performed in the past three to five (3 to 5) years. DO NOT use City employees or any City elected officials as a reference. The City will not contact and will not assign any evaluation points for references from City employees or elected officials. State relevant experience with other municipalities or government entities.

2.1.2.3 The minimum information that must be provided about each reference is:

1. Name of the individual or company the services were provided for
2. Address of individual or company
3. Name of contact person
4. Telephone number of contact person
5. Type of services provided and dates services were provided

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2.1.3 Client Management Team Qualifications: Submit resumes of key proposed professional staff members who will be performing services under the contract awarded under this RFP. Experience narratives shall be attached that describe the specific relevant experience of the staff members in relation to the role that the member will perform for the contract resulting from this solicitation. The narrative(s) must include the name of the individual(s) proposed and should include a thorough description of the education, knowledge, and relevant experience, as well as certifications or other professional credentials that clearly show how they are qualified to provide the required services to the City.

2.1.4 Management Summary: Describe individual staff and subcontractor's responsibilities with lines of authority and interface with the City of Albuquerque staff. Describe resources to be drawn from in order to complete tasks.

2.1.5 Organizational Strength:

2.1.5.1 Submit a statement of relevant corporate qualifications, strengths, and experience, including similar experience of subcontractors. The documentation must thoroughly describe how the Offeror has supplied expertise for similar contracts and work related to dental services.

2.1.5.2 Provide a copy of the company's most recent audited financial report labeled Appendix G.

2.1.6 Proposed Approach to Tasks: Discuss fully your proposed approach to each of the tasks described in Part 3, Scope of Services.

2.1.7 Proposed Plan Design: Discuss fully your proposed plan design.

2.1.8 Implementation Plan: Discuss fully your proposed approach to the services described in Part 3, Scope of Services to fulfill all requirements of the Scope of Services. Offerors shall provide with their proposals a detailed implementation plan assuming a July 1, 2026, effective date or Alternate January 1, 2026 effective date.

2.1.9 Proposed Plan design: Provide information demonstrating that your plan design has the size and service capability with management systems and procedures capable of providing benefits to a major employer of the magnitude encompassed by the City and its Participating Entities. Offerors must demonstrate a fully insured and/or self-funded plan that matches or exceeds the current plan design.

2.1.10 Utilization Management: Show your demonstrated commitment to providing consistent, valuable and timely utilization information, which must comply with data requirements and reporting frequency as defined in Part 3, Scope of Services, of this RFP. The City wishes to identify cost drivers within its program and develop action plans to increase awareness or engagement in activities that demonstrate a reduction in healthcare costs.

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2.1.11 Wellness programs: Provide detailed information about your wellness programs.

2.1.12 Broad Provider Network: Provide detailed information regarding the maintenance and the composition of a broad provider network to include but not limited to the following:

a. Outline with specificity how plan members will be provided with comparable or superior geographic access (See Appendix B and F.)

b. Describe how the Offeror's provider network will result in minimum disruption to current plan member services (See Appendix B and F.)

2.1.13 Network Composition and Access: Provide comprehensive information on their provider networks. This information shall indicate where provider networks are directly contracted and where they are leased from another entity. Do not provide hard copy provider directories Provide the website address where such directories can be viewed. Where requested, geo-access and disruption analysis shall be included (refer to RFP Appendix F.) Further, the details on the management and operation of the network shall be included. Information on the expected provider and network membership shall be provided.

2.1.14 Questionnaire: Complete Questionnaire, Appendix B. Any response of "No" to Minimum Contractual Requirements shall result in lower scoring. Your response to the Deviations may result in lower scoring

2.1.15 Technical Workbook: Complete Technical Workbook, Appendix F. Any response of "No" to Minimum Contractual Requirements shall result in lower scoring. Your response to Deviations may result in lower scoring.

2.2 Cost Proposal Format, Section Two

2.2.1 Total Cost: Submit your Cost Proposal (Appendix A) separately from your Technical Proposal (upload Appendix A in the City's eProcurement system). **Failure to submit your cost separately from your Technical Proposal shall result in your proposal being deemed non-responsive.**

2.2.2 All Costs: All costs to be incurred and billed to the City should be described by the Offeror for each item, to allow for a clear evaluation and comparison, relative to other Proposals received. All costs should include any applicable gross receipts taxes. The Offeror should understand that the City will not pay for any amounts not included in the cost Proposal -- for example, insurance or taxes -- and that liability for items not included remains with the Offeror.

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PART 3
SCOPE OF SERVICES

The successful Offeror shall provide the following Services:

3.1 The successful Offeror shall maintain all provider records, contracts, terms and conditions, and maintain a recordkeeping system for the administration of the City's dental plan.

3.2 The successful Offeror shall align incentives and a business model that drives value for the City and its members.

3.3 The successful Offeror shall provide comprehensive account management and designated customer service representatives including resources and personnel as necessary to support the City's broader health care strategy.

3.4 The successful Offeror's account management shall attend all enrollment meetings, entity meetings, and health fairs.

3.5 The successful Offeror shall provide effective coordination and integration with the City's other external vendor partners.

3.6 The successful Offeror shall comply with the detailed process measurement model/performance guarantees that will evaluate the successful Offeror's performance and hold it accountable for certain guaranteed standards.

3.7 The successful Offeror shall prepare summary plan descriptions, and any other employee notices required by State or Federal Law; and shall provide recommendations and advice on the City's benefit plan design.

3.8 The successful Offeror shall assist in preparation of publishing of City's benefit booklet and pay a pro rata share of the benefit booklet.

3.9 The successful Offeror shall provide best in class enrollee focus with staff that are determined to get any issues resolved in a timely manner.

3.10 The successful Offeror shall adjudicate and pay claims according to the City's benefit plan design including the application of benefit determinations and other cost saving value-based measures.

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3.11 The successful Offeror shall provide a customer service call center, online member access website, and other support services for members.

3.11.1 The successful Offeror shall ensure that members at a minimum are able to access a member portal which houses plan information on plan design, claims payment and year to date deductible and out of pocket maximum levels, locate a provider, and lookup basic educational materials via provider's secured website.

3.11.2 The successful Offeror shall handle customer service calls related to the plan and provide a dedicated toll-free customer service number for City members. Trained staff must be available for member inquires at minimum between the hours of 8:00 am and 5:00 pm Mountain Time.

3.11.3 The successful Offeror shall provide sufficient staff and technology to be able to run ad hoc financial and utilization reporting, assist the City in development and distribution of plan materials to members regarding plan design features, wellness initiatives, educational information, and member service information.

3.11.4 The successful Offeror shall provide a standard report package which includes at a minimum the following reports and frequency:

- **Monthly Reporting**
  - Premium and paid claims by entity
  - Enrollment, both contracts and members, by entity and coverage tier

- **Quarterly Reporting**
  - Utilization data
  - Financial data, to include billed charges, allowed charges, paid amounts year to date, member share, etc.
  - Enrollment data contract year to date
  - Top providers for dental offices, physicians, etc.

- **Annual Reporting**
  - Dental 36-month claim lag report
  - Performance Guarantee Reporting

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PART 4

EVALUATION OF PROPOSALS

4.1 Selection Process. The Mayor of Albuquerque shall name, for the purpose of evaluating the Proposals, an Ad Hoc Advisory Committee. On the basis of the evaluation criteria established in this RFP, the committee shall submit to the Mayor a list of qualified firms in the order in which they are recommended. Proposal documentation requirements set forth in this RFP are designed to provide guidance to the Offeror concerning the type of documentation that will be used by the Ad Hoc Advisory Committee. Offerors should be prepared to respond to requests by the Purchasing Office on behalf of the Ad Hoc Advisory Committee for oral presentations, facility surveys, demonstrations or other areas deemed necessary to assist in the detailed evaluation process. Offerors are advised that the City, at its option, may award this request on the basis of the initial Proposals.

4.1.1 Selection of Finalist Offerors (If Applicable). The Ad Hoc Advisory Committee may select Finalist Offerors (also known as the “short list”). The Purchasing Office will notify the Finalist Offerors. Only Finalist Offerors will be invited to participate in the subsequent steps of the procurement if this Finalist process is used.

4.1. 2. Oral Presentation or Demonstrations by Finalists (If Applicable). Finalist Offerors may be required to present their proposals to the Ad Hoc Advisory Committee (“Oral Presentation”). The Purchasing Office will schedule the time for each Finalist Offeror’s presentation. All Finalist Offeror Oral Presentations will be held remotely via Zoom unless notified otherwise. Each Oral Presentation will be limited to one (1) hour in duration unless notified otherwise. NOTE: The scores from the initial proposal evaluation will only carry over to the Oral Presentation evaluation in the case of a tie score after Oral Presentations.

4.2 Evaluation Criteria. The following general criteria, not listed in order of significance, will be used by the Ad Hoc Advisory Committee in recommending contract award to the Mayor. The Proposal factors will be rated on a scale of **0-1000** with weight relationships as stated below.

4.2.1 Evaluation Factors:

200 -- Experience and qualifications of the Offeror and personnel as shown on staff resumes to perform tasks described in Part 3, Scope of Services. This will include Sections 2.1.1, 2.1.2, 2.1.3, 2.1.4, and 2.1.5.

200 -- Adequacy of proposed plan design, utilization management and wellness programs to be utilized by the Offeror, including response to Appendix F Dental Technical Workbook. This will include Sections .2.1.7, 2.1.9, and 2.1.0.

300 -- The Offeror’s general approach and plans to meet the requirements of the RFP. This will include Sections 2.1.6, 2.1.8, 2.1.11, 2.1.12, 2.1.13, and 2.1.14.

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300 -- Cost Proposal –The costs proposed by the Contractor as described in Section 2.2 of this RFP to perform the tasks listed in Part 3, Scope of Services, Appendix H Cost Proposal. The evaluation of this section will occur after the technical evaluation, based on a cost/price analysis.

4.2.2 Evaluation Factor: The evaluation of cost factors in the selection will be determined by a cost analysis using your proposed figures (Appendix H). Please note that the lowest cost is not the sole criterion for recommending contract award.

4.2.3 Cost Evaluation. The cost/price evaluation will be performed by the City Purchasing Division or designee. A preliminary cost review will ensure that each Offeror has complied with all cost instructions and requirements. In addition, Proposals will be examined to ensure that all proposed elements are priced and clearly presented. Cost Proposals that are incomplete or reflect significant inconsistencies or inaccuracies will be scored accordingly or may be rejected by the Ad Hoc Advisory Committee if lacking in information to determine the value/price/cost relative to the services proposed.

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2.1 Technical Proposal

2.1.1 Offeror Identification

Delta Dental of New Mexico, 100 Sun Avenue NE, Ste 400, Albuquerque NM 87109, a nonprofit 501(c)(4) organization.

The person authorized to execute a contract resulting from this RFP is:

Louis Volk III, President and CEO

lvolk@deltadentalnm.com

505-872-5332

- **Compliance with all state laws as outlined in the RFP**.
  DDNM confirms compliance with all applicable laws.
- **Statement of agreement with required contract terms**
  DDNM confirms legal review of the required contract terms with comments shown on attached contract document.
- **Receipt of addenda**
  DDNM confirms receipt of Addendum #1 Typo and Close Date Correction issued July 30, 2025.
  DDNM confirms receipt of Addendum #1 Q&A addendum and extra documents issued August 14, 2025.
- **Statement of ability to carry insurance specified in RFP.**
  DDNM confirms ability to carry specified insurance-please see insurance documents included.

2.1.2 Experience

2.1.2.1 Current Experience

New Mexicans Caring for New Mexicans

Headquartered in Albuquerque, NM, Delta Dental of New Mexico (DDNM) values the long-standing partnership we have had with the City of Albuquerque. We look forward to the challenge of evolving and improving the oral health of the City's employees and their families. We do this every day for 370 New Mexico Public Sector organizations, which are part of the 62% of the overall New Mexico commercial market we serve. We show support to our members through best-in-class provider networks (91% of all licensed, practicing providers in New Mexico), excellent customer service (above industry standard metrics), and a local presence without comparison. Our mission that we live each day is "To improve oral health and overall wellness for New Mexicans through accessible, high quality, and affordable dental benefits supported by exceptional provider and customer service". We have served New Mexico since 1971, leveraging over 50 years of experience to meet this mission. We do this through our innovative products (Preventive Care Security, Evidence Based Dentistry, Teledentistry, Dental Action Report, Plan Action Report), advocacy, education, and philanthropy.

We bring the best to New Mexicans through our work, as well as through the Delta Dental Plans Association (DDPA). As part of DDPA, your employees will be included in the more than 80 million Americans who have access to over 154,000 dentists which constitutes the largest nationwide network of participating providers.

DDNM leverages national resources while delivering local expertise. Our independence and nonprofit structure allow us to reinvest in our mission, support underserved communities, and respond directly to New Mexico's evolving needs. We

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proudly served the employees and families of the City of Albuquerque for over 20 years, and we are grateful for the opportunity to continue our partnership in the future.

DDNM serves a broad and diverse portfolio of members:

Delta Dental of New Mexico serves over 2,200 employer groups including 370 governmental/public sector employers with 81,503 members and insuring over 412,000 total members throughout New Mexico. Our local dedicated Account Management team members have over 20 years of individual insurance industry experience.

- Large employer groups – ASO and Risk
- Small businesses
- State and local governments
- Educational institutions
- Tribal governments and community-based organizations
- Individual Plans

2.1.2.2 & 2.1.2.3 Past Experience & References

1. **NMRHCA**
   Neil Kueffer, Executive Director
   6300 Jefferson St NE, Ste 150
   Albuquerque, NM 87109
   505-222-6408
   NMRHCA has been a fully insured client of DDNM since 2008 with the last formal RFP awarded for a 7/1/2024 effective date.

2. **Central New Mexico Community College**
   Mark Tyndall, Director of Benefits
   525 Buena Vista Dr SE
   Albuquerque, NM 87106
   505-224-4000 ext. 54455
   CNM has been a fully insured client of DDNM since 2018 with the last formal RFP awarded for a 1/1/2022 effective date.

3. **PNM Resources**
   Victoria Archuleta, Benefits Administrator
   414 Silver Ave SW
   Albuquerque, NM 87102
   505-241-4973
   PNM has been an ASO (Administrative Services Only) client of DDNM since 1997 with the last contract awarded for a 1/1/2025 effective date.

Reference letters are attached.

2.1.3 Client Management Team Qualifications

Client Management Team Qualifications included under **2.1.2.1-Current Experience**

Please see the attached Client Management Team Bios and Resumes.

2.1.4 Management Summary

The City of Albuquerque's Account Management team will be led by Anthony Moya and Dolores Pina. This designated team of Senior Account Managers will oversee all aspects of the client relationship, implementation and renewal

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process including member and client education and communication. They are the key contacts and client advocates with expertise in self-funded/fully insured governmental clients. Senior Account Managers have direct access to all local Senior Leadership within DDNM including Provider Relations, Business Intelligence, Operations, and Legal and Compliance. Keith Witt Director of Sales and Account Management and James Dickey, VP Business Development are escalation resources for Dolores and Anthony and the City of Albuquerque and will attend strategic meetings with the COA and their consultant.

2.1.5 Organizational Strength

2.1.5.1

We are Your Local New Mexico Dental Plan

Headquartered in Albuquerque, NM, Delta Dental of New Mexico (DDNM) values the long-standing partnerships we have in the community and continue to support all New Mexicans to become and stay healthy. As the only local not-for-profit insurance company providing dental insurance and services domiciled in New Mexico since 1971, over 50 years of experience, our focus has always been on improving the overall health and wellness of the people in the communities we serve. We do this through our innovative products (Preventive Care Security, Evidence Based Dentistry, Teledentistry, Dental Action Report, Plan Action Report), advocacy, education, and philanthropy.

As part of the Delta Dental Plans Association, one of America's largest and most experienced dental benefits system. Members of the Delta Dental Plans Association provide combined coverage to more than 80 million Americans and operate two of the nation's largest networks of participating dentists.

DDNM leverages national resources while delivering local expertise. Our independence and nonprofit structure allow us to reinvest in our mission, support underserved communities, and respond directly to New Mexico's evolving needs. We proudly served the employees and families of the City of Albuquerque for over 20 years, and we are grateful for the opportunity to continue our partnership in the future.

DDNM serves a broad and diverse portfolio of members:

Delta Dental of New Mexico serves over 2,200 employer groups including 370 governmental/public sector employers with 81,503 members and insuring over 412,000 total members throughout New Mexico. The local dedicated Account Management team members have over 20 years of individual insurance industry experience.

- Large employer groups – ASO and Risk
- Small businesses
- State and local governments
- Educational institutions
- Tribal governments and community-based organizations
- Individual Plans

Fiscal Responsibility

Delta Dental of New Mexico's commitment to the state and financial stability are affirmed in our A- (Excellent) A.M. Best Company Rating. The A- (Excellent) A.M. Best Company Rating is the highest rating achievable by a mono-line mono-state organization.

Philanthropy and Community Engagement

At Delta Dental of New Mexico, our mission has always been to improve the oral health and the overall health of the communities we serve by engaging and investing in programs that expand access to care, advance health equity, build resilient communities, and innovate for a healthier tomorrow. As a not-for-profit organization, a portion of our residuals each year go back into communities across New Mexico. Delta Dental of New Mexico has proudly contributed $9 million to impact New Mexico communities over the past 5 years.

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- **Smiles Across New Mexico Grant Program**
  Smiles Across New Mexico is a Delta Dental of New Mexico small grant program that supports community-based oral health programs and initiatives across New Mexico.
- **Mouth Guard Program**
  We've partnered with the New Mexico Activities Association (NMAA) to provide the Delta Dental Athletic Mouth Guard to students in high schools in New Mexico - completely free
- **Community Partners**
  At Delta Dental of New Mexico, we build strategic partnerships with nonprofit organizations, educational programs, athletic associations, and other corporate giving programs.

2.1.5.2

Appendix G, DDNM's most recent audited financial report is attached.

2.1.6 Proposed Approach to Tasks

3.1 The successful Offeror shall maintain all provider records, contracts, terms and conditions, and maintain a recordkeeping system for the administration of the City's dental plan.

- **DDNM agrees to maintain all provider records, contracts, terms and conditions, and maintain a recordkeeping system for the administration of the City's dental plan in accordance with state law and insurance regulations.**

3.2 The successful Offeror shall align incentives and a business model that drives value for the City and its members.

- **DDNM is an innovative business partner and will engage with the City of Albuquerque to ensure incentives align regarding improving the oral health of the City's membership while implementing cost containment measures.**

3.3 The successful Offeror shall provide comprehensive account management and designated customer service representatives including resources and personnel as necessary to support the City's broader health care strategy.

- **As New Mexico's only local dental insurance carrier, our experienced Senior Account Management and Leadership Team are available to support the City's overall health-care strategy. Our local Customer Service and Provider Relations Teams have established relationships in the community and have unique insights specific to New Mexico's health-care environment.**

3.4 The successful Offeror's account management shall attend all enrollment meetings, entity meetings, and health fairs.

- **DDNM confirms attendance at all City sponsored events.**

3.5 The successful Offeror shall provide effective coordination and integration with the City's other external vendor partners.

- **DDNM confirms we are open to exploring opportunities to support the City's strategic goals.**

3.6 The successful Offeror shall comply with the detailed process measurement model/performance guarantees that will evaluate the successful Offeror's performance and hold it accountable for certain guaranteed standards.

- **DDNM confirms compliance with the proposed performance guarantees included in the RFP response.**

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3.7 The successful Offeror shall prepare summary plan descriptions, and any other employee notices required by State or Federal Law; and shall provide recommendations and advice on the City's benefit plan design.

- **DDNM confirms acceptance and will engage the City regarding any plan recommendations and advice on the benefit plan design.**

3.8 The successful Offeror shall assist in preparation of publishing of City's benefit booklet and pay a pro rata share of the benefit booklet.

- **DDNM confirms our commitment to assist in the preparation and paying a pro rata share of the benefit booklet.**

3.9 The successful Offeror shall provide best in class enrollee focus with staff that are determined to get any issues resolved in a timely manner.

- **As New Mexico's only local dental insurance carrier, our local Customer Service and Provider Relations Teams have established relationships in the community and have unique insights specific to New Mexico's health-care environment. First level resolution is the expectation for all member and provider inquiries. DDNM's customer experience is stellar, and performance statistics are far above industry standards.**

3.10 The successful Offeror shall adjudicate and pay claims according to the City's benefit plan design including the application of benefit determinations and other cost saving value-based measures.

- **DDNM confirms we shall adjudicate and pay claims according to the City's benefit plan design including the application of benefit determinations and other cost saving value-based measures.**

3.11 The successful Offeror shall provide a customer service call center, online member access website, and other support services for members.

- **DDNM confirms all required items have been included in the RFP response and will be provided to members.**
- **Please see additional information in the attached Value-Added Flyers.**

3.11.1 The successful Offeror shall ensure that members at a minimum are able to access a member portal which houses plan information on plan design, claims payment and year-to-date deductible and out of pocket maximum levels, locate a provider, and look up basic educational materials via provider's secured website.

- **DDNM confirms all required items have been included in the RFP response and will be provided to members.**
- **Please see Member Portal and Mobile App information in the attached Value-Added Flyers.**

3.11.2 The successful Offeror shall handle customer service calls related to the plan and provide a dedicated toll-free customer service number for City members. Trained staff must be available for member inquiries at minimum between the hours of 8:00 am and 5:00 pm Mountain Time.

- **DDNM confirms the designated Customer Service Team will be trained and equipped to provide superior service to all City members. Our standard business hours are 8:00 am to 4:30 pm. We are closed during most federal holidays. The Integrated Voice Response (IVR) is available 24/7 to assist with eligibility, coverage and out-of-pocket expense questions. Members have access to the Member Portal 24/7 for benefit, coverage, and oral wellness information. TeleDentistry is available 24/7 for members to access care after hours.**

3.11.3 The successful Offeror shall provide sufficient staff and technology to be able to run ad hoc financial and utilization reporting, assist the City in development and distribution of plan materials to members regarding plan design features, wellness initiatives, educational information, and member service information.

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- **DDNM confirms all listed requirements will be met or exceeded. All City specific educational and plan communications will be created in conjunction with the City and approved by the City before distribution.**

3.11.4 The successful Offeror shall provide a standard report package which includes at a minimum the following reports and frequency:

- Monthly Reporting
  - Premium and paid claims by entity
  - Enrollment, both contracts and members, by entity and coverage tier
- Quarterly Reporting
  - Utilization data
  - Financial data, to include billed charges, allowed charges, paid amounts year to date, member share, etc.
  - Enrollment data contract year to date
  - Top providers for dental offices, physicians, etc.
- Annual Reporting
  - Dental 36-month claim lag report
  - Performance Guarantee Reporting

DDNM agrees to all required reporting requirements. In addition, this includes the Dental Action Report outlined in Section 2.1.9

2.1.7 Proposed Plan Design

This proposal outlines a comprehensive dental plan designed to provide high-quality, affordable dental care for all employees and their families. The plan is structured to encourage preventive care, reduce out-of-pocket costs, and ensure access to a wide network of qualified dental professionals. We understand that provider access and mitigation of any disruption is a priority of the City of Albuquerque leadership team. Our proposal addresses this concern by including access to PPO and Premier providers at the same in-network benefit level. Our proposed plan can be administered on a fully insured or self-funded basis.

Key Features of the Proposed Plan:

- **Preventive Care at 100% Coverage with In-Network PPO and Premier Providers:** The plan covers preventive services when accessing in-network providers such as routine check-ups, cleanings, and X-rays at 100%, with no deductible and no balance billing. This encourages regular dental visits, which can help prevent more serious and costly issues down the line.
- **Broad Network of Providers:** DDNM has the largest network of contracted providers in New Mexico and nationwide. This gives employees the flexibility to choose a dentist that is convenient for them, with the added benefit of negotiated rates for services.
- **Predictable Out-of-Pocket Costs:** The plan uses a co-insurance model for basic and major procedures. After meeting a low annual deductible, the plan covers a significant portion of the costs for fillings, root canals, crowns, and other services. This helps employees budget for dental expenses.
- **Annual Maximums and Deductibles:** A low annual deductible and a generous annual maximum benefit are included to provide a balance of affordability and comprehensive coverage. Our proposal includes a 3-month deductible carryover.
- **Orthodontic Coverage:** For children and adults, the plan includes coverage for orthodontic services, with a lifetime maximum benefit per covered individual.
- **Easy Administration:** The plan is designed for seamless integration with our existing benefits administration system. Employees will have access to a user-friendly online portal to find dentists, view claims, and manage their benefits.

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Benefit Enhancements:

- **Preventive Care Security (PCS)** - an oral health benefit enhancement that allows members to receive Diagnostic and Preventive (D&P) Services without reducing the Maximum Benefit Amount. This feature encourages preventive care and ensures full plan benefits are available when other types of services are needed.
- **Evidence-based Dentistry (EBD)** – provides enhanced dental coverage for enrollees with certain high-risk medical conditions.
- **24/7 Access to Delta Dental Virtual Visits** delivered by TeleDentistry.com.
- **Seamless access to the largest dental provider networks in the country** - PPO and Premier Providers are In-Network – consistent coinsurance levels with no balance billing.

2.1.8 Implementation Plan

1. Confidence Built on our Partnership
Delta Dental of New Mexico (DDNM) is uniquely positioned to deliver a seamless and simplified transition process for plan implementation. Our longstanding relationship with the City of Albuquerque and deep understanding of your member population, operational preferences, and program goals allow us to build upon an already-successful foundation. This results in a minimally disruptive and highly efficient implementation experience for your team, your members, and your stakeholders.

2. Implementation Timeline – Streamlined and Focused

Phase	Timeline	Activities
Kick-Off & Planning	Week 1	Confirm plan design, key contacts, timelines
Materials & Communications Review	Weeks 2 - 3	Draft member materials and benefit documents
Systems Configuration	Weeks 3 - 5	Load plan design, test eligibility interfaces if applicable
Training & Readiness	Weeks 5 - 6	Internal staff training on benefit plan, customized for COA's needs
Final Validation & Go-Live	Week 7	Final review, parallel processing (if applicable), Go-Live confirmation

3. Member-Focused Communication
We will proactively support COA with branded communications and open enrollment resources, including:

- Summary of Benefits tailored to plan design
- Digital and print communications highlighting benefit enhancements
- Dedicated Open Enrollment microsite, if desired, for streamlined access to resources
- Live and recorded webinars for benefit administrators and members

4. Dedicated Implementation & Account Management Team
You will work with your local Delta Dental account management team, who understand your organization, your population's unique needs, and the expectations of the COA.

5. System and Data Integrity

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Our systems are fully configured to support COA's unique eligibility files and plan structure. Our IT and configuration teams will:

- Validate new plan designs with test claims
- Ensure no loss of existing data, history, or access
- Conduct a parallel run if changes are significant

This ensures flawless continuity of care and claims adjudication.

6. Value to COA
Delta Dental of New Mexico is committed to making this transition easy for COA. As your trusted partner, we're ready to execute plan implementation with speed, clarity, and care ensuring your members continue to receive high-quality, uninterrupted dental coverage.

We look forward to serving the COA with the same dedication and excellence that have defined our partnership.

2.1.9 Proposed Plan Design

DDNM will demonstrate our ability to provide dental plan services, either fully insured or self-funded to the City of Albuquerque by showcasing our robust combination of management systems and procedures that ensure efficient, high-quality, and scalable benefits administration.

Comprehensive and Flexible Plan Administration

- **Plan Design and Customization:** DDNM is offering a plan design that has been tailored to meet the specific needs of the City.
- **Seamless Onboarding and Enrollment:** DDNM's ability to seamlessly integrate with the City's existing HR and benefits management systems is crucial. This includes efficient and secure processes for new hire enrollment, ongoing plan administration, and employee communications.
- **Fully Insured or Self-Funded Options:** DDNM can support either funding model.

Advanced Technology and Management Systems

- **Integrated Claims Processing:** DDNM's modern and efficient claims processing system includes the ability to process claims electronically, with a focus on fast turnaround times and high financial accuracy. 98% of claims are auto adjudicated or processed without manual intervention.
- **Real-time Eligibility Verification:** DDNM's eligibility system allows dental providers to verify a patient's eligibility and benefits in real-time. This reduces billing errors for both the provider and the employee and helps ensure that the patient understands their out-of-pocket costs.
- **Member and Employer Portals:** DDNM offers a secure, user-friendly online portal and mobile app. These platforms allow employees to easily access their benefit information, check claim status, find in-network dentists, and manage their dental care. For the City, the Benefit Manager Toolkit (BMT) portal provides administrative tools and reporting.

The Strongest National Network of Providers

- **Network Size and Accessibility:** DDNM's large and robust network of participating dentists is a key consideration for the City. Our broad network increases the likelihood that employees can find an in-network dentist, which results in lower out-of-pocket costs and protection from balance billing.
- **Network Management and Quality Assurance**: Our local Provider Relations Network Management team focuses on retaining and growing the network of providers on an ongoing basis. This team engages with in-network providers twice a year and with out-of-network providers annually. In addition, regular evaluations of the New Mexico Regulation and Licensing Department (NMRLD) to identify potential new providers or those

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not currently part of our network are completed. This process aims to enhance and expand our provider network effectively.

DDNM's claim system and policies are designed to detect fraud, waste, and abuse while optimizing a Member's dental benefits and assuring medical necessity and appropriateness of covered dental services. Specifically, InFocus represents DDNM's ability to detect aberrant billing and treatment patterns through data analytics and continuous audit in coordination with DDNM's claim system. InFocus detects potential billing and treatment abuse patterns, allowing DDNM to evaluate billing and treatment patterns using factors from data mining, integrated reporting and visualization to evaluate the provider's practice in relation to a particular peer group. Depending on the generated Suspicion Index, DDNM may place the provider on focused review or initiate an investigation into a provider's treatment and billing practices. In addition, DDNM requires all participating dental providers to complete fraud-waste-abuse, compliance, and cultural competency training annually. Fraud-waste-abuse training provides a general overview as well as detection and prevention controls. DDNM employees are also required to complete annual fraud, waste, and abuse training.

Robust Reporting and Analytics

- **Data-driven Insights:** DDNM will demonstrate our value to the City by providing comprehensive reports and analytics. These reports will offer insights into plan utilization and claims data that help the City understand the value of the dental benefits program and make informed decisions for future plan design. The Dental Action Report (DAR) is a proprietary, industry-leading analytical tool to identify utilization trends. DAR tracks members' oral health progression, utilization that creates positive outcomes, and develops recommendations.

Designated Customer Service and Support

- **Multichannel Support:** DDNM offers a high level of support to both the City and its employees. This includes dedicated account managers for the City, as well as a variety of support channels for employees, such as a local Customer Service team, an Integrated Voice Response (IVR) system for 24/7 assistance with eligibility, coverage, and out-of-pocket expense questions. Members have access to the Member Portal 24/7 for benefit, coverage, and oral wellness information. TeleDentistry is available 24/7 for members to access care after hours.
- **Educational Resources:** DDNM provides employees with educational resources on how to use their benefits, the importance of oral health, and how to find a dentist which can significantly enhance the employee experience and demonstrates our commitment to promoting wellness.

2.1.10 Utilization Management

DDNM's claim systems and policies are configured to verify coverage and that treatment is medically necessary & appropriate based upon the available information and records provided and in accordance with generally accepted dental standards and CDT codes. (This is in addition to fraud-waste-abuse controls.) The claim system automatically reviews and processes claims that result in over 98% reimbursement within a few business days. All claims that are not covered require further supporting documentation or raise medical necessity & appropriateness issues are reviewed by a licensed and qualified Dental Consultant. Any denial can be appealed by a member for further internal review by another Dental Consultant or Panel pursuant to our appeals and grievances policies procedures, as well as external review by the New Mexico Superintendent of Insurance, as appropriate. We agree and are committed to providing utilization and financial reporting. Our Business Intelligence team is available to create customized reporting to meet the City's requirements. This includes ensuring delivery by agreed upon deadlines.

2.1.11 Wellness Programs

At DDNM, we know that keeping your smile healthy is an important part of keeping your body healthy! As part of our Wellness Initiative, DDNM included the enhancements and resources below in our response at no additional cost.

- **Dental Action Report (DAR) -** a proprietary, industry leading analytical tool to identify utilization trends. DAR tracks member's oral health progression, utilization that creates positive outcomes, and develops recommendations.

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- **Preventive Care Security (PCS)** - an oral health benefit enhancement that allows members to receive Diagnostic and Preventive (D&P) Services without reducing the Maximum Benefit Amount. This feature encourages preventive care and ensures full plan benefits are available when other types of services are needed.
- **Evidence-based Dentistry (EBD)** – provides enhanced dental coverage for enrollees with certain high-risk medical conditions.
- **24/7 Access to Delta Dental Virtual Visits** delivered by **TeleDentistry.com**.
- **Dental Care Cost Estimator tool** - provides estimated cost ranges for common dental care needs.
- **Access to EOBs** - convenient through the mobile app, online or by calling customer service.
- Members are encouraged to focus on their oral health and overall health through DDNM's dental related online articles, blog content, informative videos, recipes, nutritional tips & more.
- **Member access to dental wellness tools -** 24/7 access whether they are in the office or on the go at deltadentalnm.com/wellness.
- Topics include but are not limited to:
    - Oral Health Wellness Cards
    - Oral Health Videos
    - Oral Health Teaching Tools for Children
    - Tooth Fairy Tips
    - Information about Using Dental Benefits
    - Health & Fitness Information
    - Fear Free Dental Visits

2.1.12 Broad Provider Network

Our local Provider Relations Network Management team focuses on retaining and growing the network of providers on an ongoing basis. This team engages with in-network providers twice a year and with out-of-network providers annually. In addition, regular evaluations of the New Mexico Regulation and Licensing Department (NMRLD) to identify potential new providers or those not currently part of our network are completed. This process aims to enhance and expand our provider network effectively.

- 93% of New Mexico providers and 92% of all providers utilized by City of Albuquerque are DDNM participating providers.
- Access to Affordable Quality Dental Services delivers higher quality.
- Ensuring extensive access to contracted providers and controlling plan costs and avoiding high out-of-network costs from non-contracted providers.
- 99% net provider retention rate in 2024.
- 91% of the 939 practicing New Mexico Dental Providers participate in the Delta Dental New Mexico Provider network.
- Delta Dental New Mexico Provider network is bolstered by 154,000+ Dental Providers nation-wide under the National Delta Dental Provider System.
- Local Provider Relations Team – Focuses on retention and recruitment of out-of-network providers through individualized outreach, education, training and in-person meetings annually.
- GeoAccess Report (Appendix B) and Disruption Report (Appendix F) are attached.

2.1.13 Network Comparison and Access

Delta Dental does not lease or subcontract any aspects of network management services. We believe having a local board, leadership team, provider relations, customer service and account management are key attributes to providing the highest level of service to our providers, members and employers. Delta Dental directly contracts and builds relationships with all contracted providers.

Members can view network providers at www.deltadentalnm.com.

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- Provider directories are updated daily to ensure accuracy.
- GeoAccess Report (Appendix B) and Disruption Report (Appendix F) are attached.

New Mexico Network Access	National Network Access
Delta Dental Premier®	**Delta Dental Premier®**
851 of 939 of unique licensed providers across New Mexico	More than **154,000** providers nationwide
91% of practicing licensed providers participate	
Delta Dental PPO™	**Delta Dental PPO™**
763 of 939 unique licensed providers across New Mexico	More than **117,000** providers nationwide
82% of practicing licensed providers participate	

2.1.14 Questionnaire

Appendix B attached.

2.1.15 Technical Workbook

Appendix F attached.

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NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

BOARD OF DIRECTORS:
LEE CARUANA
PRESIDENT
TOMAS SALAZAR
VICE PRESIDENT
LANCE PYLE
SECRETARY
NEIL KUEFFER
EXECUTIVE DIRECTOR

Neil Kueffer
Executive Director
New Mexico Retiree Health Care Authority
6300 Jefferson St. NE, Ste 150
Albuquerque, NM 87109
neil.kueffer@rhca.nm.gov | 505-222-6408

Date: August 5, 2025

City of Albuquerque
Procurement Department
Albuquerque, NM

RE: Reference for Delta Dental of New Mexico

To Whom It May Concern,

On behalf of the New Mexico Retiree Health Care Authority (NMRHCA), I am pleased to provide this letter of reference for Delta Dental. Our organization has maintained a longstanding partnership with Delta Dental for more than 17 years to administer both Basic and Comprehensive dental plans to our retirees and their dependents.

Since I began my tenure with NMRHCA in 2015, I have had the opportunity to work closely with Delta Dental and have found them to be a dependable and committed partner. Their provider network has consistently met the needs of our diverse retiree population across New Mexico, offering accessible and quality dental care.

Throughout the years, Delta Dental's account management team has demonstrated professionalism, responsiveness, and a willingness to collaborate. Their support has been instrumental in helping us serve our members effectively and resolve any issues that have arisen with clarity and care.

NMRHCA values the relationship we have built with Delta Dental and considers them a reliable and service-oriented provider. We are confident in their ability to continue delivering high-quality service and coverage to the communities they serve.

Please feel free to reach out should you require any additional information.

Sincerely,

Neil Kueffer

Executive Director
New Mexico Retiree Health Care Authority

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August 5, 2025

To Whom It May Concern,

On behalf of Central New Mexico Community College (CNM), I am pleased to provide this letter of reference for Delta Dental of New Mexico (DDNM) in support of their response to the City of Albuquerque's Dental RFP.

CNM has partnered with Delta Dental of New Mexico for over eight years to provide dental benefits to our employees and their families. Throughout our relationship, DDNM has demonstrated exceptional professionalism, responsiveness, and dedication to service. DDNM's account management and implementation teams have been highly engaged, collaborative, and proactive. Their communication is timely and transparent, and they regularly go above and beyond to ensure our employees understand and access their benefits with ease. Questions and concerns are addressed quickly and thoroughly, and their team consistently provides thoughtful guidance and data driven support for benefit decisions.

What stands out most about our partnership is DDNM's deep commitment to the well-being of our employees and to the broader New Mexico community. They have supported employee education, provided valuable reporting and analytics, and shown genuine interest in aligning with CNM's mission to serve and uplift New Mexicans.

We value our relationship with Delta Dental of New Mexico and confidently recommend them as a reliable and trusted dental benefits partner. Their long-standing presence in the state, nonprofit mission, and high touch service model make them a strong resource for any employer.

Please feel free to contact me if further information is needed.

Sincerely,

Mark Tyndall
Director of Benefits
Central New Mexico Community College
mtyndall@cnm.edu
Phone: (505) 224-4000 ext. 54455
Fax: (505) 224-4710

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August 7, 2025

City of Albuquerque

To Whom It May Concern

We are pleased to provide a recommendation for Delta Dental of New Mexico for Self-Funded Group Dental Administrative Services. As you know, providing comprehensive dental coverage is essential for employee well-being and satisfaction, and based on our experience, we believe Delta will deliver great benefits and customer service to your team.

Delta Dental of New Mexico has been our third-party administrator, serving our active employees and retiree members in New Mexico and Texas for over 20 years. Our dental plans are customized and require close attention to detail which our Delta team manages well. They are well attuned to our Summary Plan Description and adhere to it seamlessly when processing claims and this is exactly what we want them to do.

The Delta Dental team is courteous, professional and they really care about providing good service and we see this when they participate in our events, host meetings to provide important updates and in any interaction. They provide excellent support for Open Enrollment and events we have throughout the year. Lastly, we have a large population consisting of both Active and Retiree membership and are rarely dealing with issues and we attribute this to their Customer Service and extensive network of providers.

We recognize the importance of offering quality benefits to our workforce and we believe with confidence that our employees are satisfied with their dental coverage. Additionally, our Benefits Department has been impressed with the account management and overall support from day one. Thank you for considering our recommendation. If you have any additional questions or need clarification, please feel free to contact me.

Sincerely,

Victoria Archuleta

Victoria Archuleta
Human Resources Benefits Analyst
505-241-4973

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DELTA DENTAL of New Mexico

Client Management Team

We are Your Local New Mexico Dental Plan

Headquartered in Albuquerque, NM, Delta Dental of New Mexico (DDNM) values the long-standing partnerships we have in the community and continue to support 412,000 members throughout New Mexico. As the only local not-for-profit insurance company providing dental insurance and services domiciled in New Mexico since 1971, over 50 years of experience, our focus has always been on improving the overall health and wellness of the people in the communities we serve. We do this through our products, advocacy, education, and philanthropy. We proudly served the employees and families of the City of Albuquerque for over 20 years, and we are grateful for the opportunity to continue our partnership in the future.

Delta Dental of New Mexico's commitment to the state and financial stability are affirmed in our A- (Excellent) A.M. Best Company Rating. Delta Dental of New Mexico proudly serves over 2,200 employer groups including 370 governmental/public sector employers. The local dedicated Account Management team members have over 20 years of individual insurance industry experience.



Lisa Whitney - Sales Executive & Implementation Manager

Lisa is a dedicated and enthusiastic sales professional with over 25 years of experience in the employee benefits arena. Her in-depth knowledge of her clients' needs and industry trends allows her to provide the best results and exceed customer expectations. She is skilled at developing the right solutions for each of her client's unique needs and is committed to helping them choose the best options. If awarded to DDNM, Lisa will be instrumental in the successful implementation of City of Albuquerque's dental benefits and providing a seamless transition experience. Lisa earned her Bachelor of Science degree from the University of Arizona.

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Dolores Piña - Senior Account Manager & Implementation Manager

Dolores brings nearly 16 years of dedicated service to Delta Dental of New Mexico (DDNM), where she has played a pivotal role in customizing and implementing dental insurance solutions for large employer groups. Her extensive background in customer service and her bilingual fluency in Spanish have made her an indispensable liaison for diverse client populations. Dolores's deep understanding of benefit structures and her commitment to client satisfaction have consistently supported DDNM's mission to improve community health outcomes. She is licensed in Life, Accident, and Health insurance in New Mexico and is an active member of both the New Mexico Health Underwriters and the National Association of Health Underwriters. Dolores currently manages a book-of-business of 32 groups and is supported by the entire local account management team and organization.



Anthony Moya - Senior Account Manager & Implementation Manager

Anthony is an accomplished, reliable, and results-oriented professional with over 22 years of experience in the health insurance industry. He brings his knowledge, optimism, and dedication to building strong, long-term relationships with Delta Dental's clients and members. His robust account management background allows him to evaluate problems from all angles to find the best solutions. Anthony's experience in working with his customers, including 18 public sector accounts, has led to his well-rounded understanding of the many variables that will continue to enhance the partnership with the City of Albuquerque. Anthony will continue to provide exceptional service as one of designated Account Managers for COA. Anthony currently manages a book-of-business of 44 groups and is supported by the entire local account management team and organization.

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Keith Witt – Director of Sales and Account Management

Keith brings over 20 years of experience in New Mexico's health care industry, spanning all employer sectors, sizes, and funding arrangements. His deep understanding of public sector needs stems from managing high-profile medical and dental accounts, leading large group account teams, and serving as Deputy Director of a major state health care agency. A native of Albuquerque, he earned dual degrees in General Management and Entrepreneurial Studies from the Robert O. Anderson School of Business at the University of New Mexico. As a graduate of Leadership ABQ's Class of 2009, Keith is well-versed in the economic and quality-of-life issues impacting New Mexicans. He is a passionate leader focused on relationship management, mentoring, and the professional growth of his team.



James Dickey – Vice President of Business Development

James brings over a decade of experience in New Mexico's health care sector, spanning both clinical practice and hospital administration. He later joined a Fortune 500 company, where he led U.S. benefits strategy and managed global health and wellness operations, including oversight of a major manufacturing site. Transitioning into consulting, he advised key clients such as the State of New Mexico Employee Benefit Program, University of New Mexico, and Albuquerque Public Schools. His work has consistently focused on aligning health strategy with organizational goals, driving innovation, and engaging stakeholders. A Hobbs native, James earned both his Bachelor's degree and MBA from New Mexico State University.

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Juan Galindo – Operations Manager

Juan is the Operations Manager for Customer Service and Group Administration at Delta Dental of New Mexico, where he leads a high-performing team committed to delivering exceptional service to members, providers, and clients. He oversees daily operations, manages hiring and training, and ensures consistent achievement of performance standards. Juan plays a key role in strategic planning and cross-functional coordination, while actively coaching and developing staff. He also supports executive leadership in policy implementation, reporting, and long-term goal execution. His work is driven by a strong focus on service quality, operational efficiency, and organizational excellence.



Jessica Taylor – Manager of Provider Relations & Network Strategy

Jessica brings over a decade of experience in Provider Relations, with a strong background in contracting, credentialing, and cultivating provider partnerships across New Mexico. Her early career included work with physical health, mental health, and long-term care providers for various healthcare insurance companies, giving her deep insight into the health and insurance landscape. As a lifelong New Mexican, she offers a nuanced understanding of the state's diverse communities, including rural and underserved areas. Jessica is known for her commitment to generating positive outcomes and building lasting relationships with the providers she supports. Her work is driven by a passion for service, collaboration, and community impact.

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Tina Tomlin – Vice President of Operations

Tina is a transformative operations leader with deep expertise in customer experience, process optimization, and strategic execution. As Vice President of Operations at Delta Dental of New Mexico, she oversees key functions including customer service, claims, enrollment, and provider network operations. Her prior leadership roles at NFP Health, Nusenda Credit Union, Bernalillo County, and Cardinal Health reflect a strong track record of driving operational excellence through Lean methodologies, innovation, and change management. Tina holds an MBA in Human Resources from the College of Santa Fe and is certified as a LEAN Six Sigma Black Belt and Change Management Specialist. She is known for delivering measurable results through cross-functional leadership and a relentless focus on member experience.

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LISA WHITNEY

Lwhitney792@gmail.com
505-270-0278
NPN-7248611

Self-motivated sales professional with a proven record of success in driving sales growth in a highly competitive market. Seeking an opportunity to utilize extensive and diverse experience to positively impact client experience.

PROFESSIONAL EXPERIENCE

SALES EXECUTIVE – DELTA DENTAL OF NEW MEXICO
2/2018-6/2022 & 6/2023-PRESENT

- Consistently interact with brokers and clients to solidify relationships
- Achieve sales goals in an increasingly competitive environment-DDPA sales award recipient
- Proactively prospect for new business in all market segments
- Assess competition and report findings to leadership
- Respond to all RFPs in a timely manner
- Follow up on all quotes issued to determine status and provide any needed alternatives
- Account manage 41 mid-market clients
- Effectively manage workload to meet deadlines
- Participate in product development to anticipate evolving market needs
- Train brokers on new dental and vision products as they come to market
- Collaborate with internal team members to improve processes

ANCILLARY SALES EXECUTIVE – BLUE CROSS BLUE SHIELD OF NEW MEXICO
6/2022-6/2023

- Responsible for driving sales growth of ancillary products including dental and vision within New Mexico
- Focused on relationships with the BCBSNM medical team to promote ancillary sales to new and renewing clients in all market segments
- Educated the broker community about the advantages of BCBSNM ancillary coverages and train on new products and processes
- Successfully managed the sales process from RFP through implementation
- Leveraged internal contacts throughout the Enterprise to learn nuances of products and processes as the sole Ancillary Sales Executive in New Mexico
- Selected as charter member of the newly formed BCBSNM Field Advisory Council

PUBLIC SECTOR ACCOUNT MANAGER – HP INC.
7/2010-2/2018

- Developed and managed partnerships with 54 significant government and education accounts in South Texas
- Implemented marketing campaign to heighten company profile and bring attention to innovative new products
- Managed pipeline using Salesforce to accurately demonstrate sales opportunities and wins

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- Worked closely with key contacts to present timely and competitive proposals for large education hardware and software procurements
- Selected to coach and mentor account managers
- Consistently led team in quota performance and total revenue generated

SALES EXECUTIVE – BLUE CROSS BLUE SHIELD OF NEW MEXICO
8/2004-7/2010

- Managed small group and individual sales activities in Central and Northeastern New Mexico
- Oversaw new product rollouts, account management and development of customer relationships
- Collaborated with brokers and business owners in successful implementations of health care and ancillary benefit plans
- Educated business associates and consumers in achieving cost effective solutions to their health care needs
- Consistently exceeded sales and professional development goals

ACCOUNT REPRESENTATIVE – ROGERS BENEFIT GROUP
3/1991-8/2004 *Rogers Benefit Group is a third-party marketing organization which specialized in sales of health care and ancillary benefit plans primarily offered through Principal Financial Group*

- Acted as a liaison between the broker community and the insurance carrier in sales and implementation of group health and ancillary benefits
- Essential in the promotion of products as the sole sales professional in the state representing RBG
- Key to underwriting, orientation and implementation of policies
- Consistently exceeded sales goals

EDUCATION

BACHELOR OF SCIENCE
UNIVERSITY OF ARIZONA

SKILLS

- Time Management – I possess the discipline to tune out distractions, meet deadlines and get the most out of the workday
- Leadership – I inspire and motivate team members, and act with integrity, fairness and a strategic mindset
- Adaptable – I quickly acclimate to different environments and am open to new processes and technologies
- Communication – My verbal, writing and presentation skills allow me to successfully interact with different audiences

ACTIVITIES

Leadership Santa Fe-2020
Charter member of DDNM Values Committee
Charter member of BCBSNM Field Advisory Council

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Dolores Pina
Albuquerque, New Mexico• 505-934-0645 • dpina0824@gmail.com
Bilingual: English & Spanish

Professional Summary

Experienced and bilingual account management professional with a strong background in health insurance, customer service, and sales. Over a decade of progressive roles within Delta Dental of New Mexico, demonstrating consistent success in client retention, benefit administration, and broker relationship building. Skilled at managing large group accounts, leading renewal strategies, and promoting product value to diverse stakeholders.

Professional Experience

Delta Dental of New Mexico – Albuquerque, NM
Senior Account Manager Large Groups
June 2022 – Present

- Serve as primary liaison between Delta Dental and large group clients, brokers, and consultants.
- Retain and manage high-value accounts through strategic planning, benefit education, and renewal support.
- Lead client and broker meetings, develop meeting materials, and ensure accurate communication of plan benefits, underwriting requirements, and premium structures.
- Support sales and marketing teams to drive retention and achieve corporate goals.

Account Manager Large Groups
2017 - 2022

- Managed existing group accounts, ensuring timely renewals and accurate eligibility/enrollment processing.
- Delivered professional service and client support, including training on benefit tools and resolving complex service inquiries.
- Maintained strong communication with brokers and internal departments to meet renewal timelines and administrative standards.

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- Promoted use of the Benefit Manager Toolkit to group administrators and supported departmental initiatives.

Sales Executive & Account Manager Mid-Market

- Generated new business opportunities through prospecting and client engagement.
- Responded to RFPs, conducted product presentations, and represented Delta Dental at enrollment events and external meetings.
- Built and maintained strong broker/consultant relationships to drive product satisfaction and market growth.
- Tracked and managed sales activity in Salesforce; follow-ups and proposal documentation.

Education & Certifications

High School Diploma
Class of 1986

New Mexico Accident & Health Insurance License
Member: New Mexico Health Underwriters & National Association of Health Underwriters

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Skills

- Bilingual: English & Spanish
- Client Relationship Management
- Group Benefits & Health Insurance
- Salesforce & CRM Software
- Microsoft Word, Excel, Outlook
- Oral & Written Communication
- Time Management & Organization
- Benefit Presentation & Training

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ANTHONY L. MOYA

Address: 6315 Corte Alzira NW, Albuquerque, NM 87114
Personal Cell Phone: (505) 715-0009
Personal Email: anthony.moya@rocketmail.com

PROFILE OF QUALIFICATIONS

- Senior Account Manager who offers proven experience with large accounts including designing, developing, and implementing forward-thinking presentations, processes, and procedures to achieve continued membership growth and retention.
- Top performer who excels at analyzing operation needs, identifying growth opportunities, and defining strategies for existing clients and potential membership.
- Ambitious self-starter, who plans, prioritizes, manages, and completes tasks within fast-paced, deadline-driven situations.
- Excellent communicator who interfaces with senior leadership, executives, public-sector officials, sales/business teams, members, internal and external customers.

PROFESSIONAL SYNOPSIS

Delta Dental of New Mexico, ALBUQUERQUE, NM

Senior Account Manager June 2024-Present

I am currently responsible to service, grow, and retain 44 clients, which are some of the largest with Delta Dental of New Mexico and act as a liaison between DDNM, agents, consultants, and clients to ensure program administration, growth, implementation and retention. I act in a consultative role providing ongoing training and education on market updates, innovative benefit designs, and cost savings options. I build and maintain relationships with key individuals throughout my client and consultant/agent community to ensure the retention and growth of clients and prospects. I organize, prepare, and carry out activities related to RFPs, and renewals including plan design, presentation, rate negotiations, and work effectively with our internal teams such as underwriting. I work with key internal and external clients to develop, review, and present data to group benefits departments to show value of DDNM through enhanced benefits, cost savings, and other markers important to clients. I prepare contractual and client requested data requirements by reviewing, ordering, tracking and delivering, custom or standard reports, including client-specific satisfaction surveys. I assist in the development and implementation of short-term and long-term strategies, goals, and objectives. I also train and mentor non-senior account managers to achieve personal growth, client satisfaction, growth and retention goals. I assist in the development, recommend, and enforce policies, procedures, guidelines, and standards of operations and adhere to departmental and corporate policies and procedures, serve internal customers, and support the goals of other departments and the company.

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POMS & ASSOCIATES INSURANCE BROKERS, ALBUQUERQUE, NM

Client Executive July 2016-May 2024

My primary role and responsibility as the Client Executive has been managing and assisting the Producer/Broker in retention and service with our new and existing clients. In conjunction with the Producer, I have maintained a book of business while assisting with the processing of client and prospects needs. I have participated in the bid process which involves, initiating requests for quotes, compiling correspondence related to quotes, following up on requests for quotes, and compiling spreadsheets as bids are received. I have assisted in the proposal process which involves, preparing written proposals from bids received from carriers, fielding questions from clients and carriers, maintaining professional correspondence, and attending meetings with clients. I have managed and compiled monthly, quarterly, and annual reports as needed for clients. Also included in my role as a Client Executive is the role of Risk Services Coordinator. My primary function in this role has been to coordinate the risk service value-added benefits with our clients. I continue to work with the Producer and coordinate appropriate services and training for our existing and new clients.

HUB INTERNATIONAL INSURANCE SERVICES, INC., ALBUQUERQUE, NM

Account Manager October 2014-June 2016

My primary role and responsibility for this Account Manager role has been managing and assisting the Producer/Broker in retention and service. In conjunction with the Sales Executives and Service Team, I have maintained a book of business while assisting with the processing of client and prospects needs. I have participated in the bid process which involves, initiating requests for quotes, compiling correspondence related to quotes, follow-up on requests for quotes and compile spreadsheets as bids are received. I have assisted in the proposal process which involves, preparing written proposals from bids received from carriers, field questions from clients and carriers, maintain professional correspondence and attend meetings with clients. I have managed and compiled monthly, quarterly and annual reports as needed for clients. Attend appropriated training and seminars for Health Care Reform along with provide all appropriate documents as needed for each client with regards to the Affordable Care Act. I have managed the internal process and handling of clientele, and have serviced the accounts as necessary.

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LOVELACE HEALTH PLAN, ALBUQUERQUE, NM

Interim Account Executive (Senior Account Service Representative) 2012-March 2014
Account Service Representative – June 2009-2012

Interim Account Executive between Lovelace Health Plan, national and large accounts, as the primary account management team leader, primarily 51+ members. Accounts managed include the City of Rio Rancho, PNM Resources, Pueblo of Isleta and Casino, UNM (University of New Mexico), and the IBAC (Interagency Benefits Advisory Committee) which consists of APS (Albuquerque Public Schools), NMPSIA (NM Public Schools Insurance Authority), NMRHCA (NM Retiree Health Care Authority) and SoNM (State of New Mexico). Management and job duties include but are not limited to handling account issues from members and or accounts requiring research and follow-up to the accounts and or the members. Analyze monthly, quarterly, and annual reports on utilization of the plans and premiums. Daily/Weekly interaction with clients/accounts, internal and external customers to include claims, Underwriting/Actuaries, customer service, Case Management/Utilization Management, Appeals and Grievance, Legal, marketing and eligibility, and membership departments. Involved in decision-making with regard to renewals, meetings and discussions. Involved in all aspects of open/switch enrollment meetings to include presentations, summaries, benefit booklet revisions, mailings and enrollment. Training includes Group Representative for the SONM account. Travel statewide to conduct enrollment meetings and educating account representatives and members on health insurance benefits specific to each account and industry. Involved with presentations at various health fairs, events, enrollment meetings and account meetings. Internal training and testing in the Medicare Improvement for Patients and Providers Act (MIPPA). Completed Health Care Informed Training as certified as Subject Matter Expert for Health Care Reform.

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, ALBUQUERQUE, NM

Major Account Representative, 2004 – May 2009
Account Coordinator, September 2002 – 2004

Liaison between BCBSNM (Blue Cross Blue Shield of New Mexico) and large accounts (51+). Handling of account issues from members and or accounts requiring research and follow up to the accounts and or the members. Daily/Weekly interaction with accounts and internal customers to include claims, customer service and membership departments. Involved in all aspects of the account enrollments including benefit booklet revisions, mailings, ordering of materials and supplies and enrollment meetings. Also assists in Group Representative Trainings for the SONM (State of New Mexico) account. Responsible for reports on a monthly, quarterly and yearly basis which includes compiling the data, delivery and review. Web Coordination team member for accounts. Travel statewide educating account representatives on health insurance benefits specific to each agency. Involved with presentations at various health fairs, nurses conferences and account meetings. Supported with the IBAC RFP and Medicaid Division RFP. Appeals and Grievance specialist for incoming appeals and grievances for NMRHCA and APS. Coordinated for the Operation Back to School Campaign including meetings and supply counts for the unit. Assisted unit with administrative duties while helping in the hiring of an administrative assistant. Web Coordination team member for accounts.

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CARDINAL HEALTH, (FORMERLY ALLEGIANCE HEALTHCARE), ALBUQUERQUE, NM

Conversion Pricing Analyst, Contract Administration, 2001-August 2002

Pricing Analyst, Contract Administration, August 1999-2001

Responsibilities include converting pricing files from Bergen Brunswick Medical Company to the Allegiance Pricing System (APS). Access and interpret contracts and contract information. Able to perform audits on all contracts, pricing and price compares for accurate loading. Share responsibility for coverage of workload with a large team.

Responsibilities are to administer and implement contractual agreements between Allegiance customers and merchants. Serve as a primary contact for sales generalist and field. Download all local pricing, access and interpret contract information, perform audits and resolve issues within the Southwest Regions.

BERNALILLO COUNTY PARKS AND RECREATION, ALBUQUERQUE, NM

Supervisor, 1999-August 1999

Assistant Supervisor, 1999-1999

Arts and Crafts Leader, April 1999-1999

Planned and conducted meetings to coordinate daily activities, field trips for children and staff. Strong communication with parents, participants and managers. Prepared and documented forms for program accuracy and children accountability. Supervised six to eight employees and 75-125 children. Teaching and instructing participants in arts and crafts activities and events. Implemented programs that involved children's creativity in arts and crafts, including an Arts and Crafts Fair in which children displayed their talents.

ZALES JEWELRY, ALBUQUERQUE, NM

Sales Associate, November 1998-April 1999

Customer relations and sales position, with cashier, budgeting and purchasing experience. Accountability and knowledge of high value items. Strong customer focus and efficient, strong vendor relations.

DEPARTMENT OF DEFENSE, UNITED STATES ARMY, BAMBERG, GERMANY

E-4, Specialist, Combat Engineer, Honorable Discharge, 1995 – 1998

Decorations, Medals, Badges, Citations, and Campaign Ribbons Awarded or Authorized;

Army Achievement Medal, National Defense Service Medal, Army Service Ribbon, Expert Marksmanship Badge (Rifle M-16), Expert Marksmanship Badge (Machine gun), Expert Marksmanship Badge (Grenade), Driver and Mechanic Badge (w/Driver-W and Driver-T), Armed Forces Service Medal, Army Lapel Button, NATO Medal, Superior Unit Award

Military Education;

Combat Engineer Course (13 weeks), Combat Lifesaver Certification Course

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EDUCATION, LICENSES, CERTIFICATIONS AND TECHNICAL SUMMARY

ALBUQUERQUE TECHNICAL VOCATIONAL INSTITUTE

ALBUQUERQUE, NM – 2009-2010

Working toward a degree in Computer Science and Animation

New Mexico Insurance Division, Public Regulation Commission

Life, Accident, and Health – Agent License No. 247748 – 12/11/2009 through current
Notary Public of the State of New Mexico – Commission #: 1128741 – 5/23/2022 through current

- Early Learning Preschool (ELP) – Board President
- Lovelace Health Plan – NextLevel Certification
- Self-Development: Improving Your Memory Certification
- Self-Development: Positively Influencing Others Certification
- Personal Effectiveness Improvement Program Certificate
- Extensive knowledge in Microsoft Excel, Microsoft Word, Microsoft PowerPoint, Microsoft Outlook, Microsoft Access, CCMail (Lotus Notes)
- Communicate effectively in both written and verbal form
- Strong organization skills and conflict resolution
- Ability to work as part of a team or independently
- Progressive work experience in related field

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Keith Witt

Rio Rancho, NM 87124 ♦ (505) 525-1568 ♦ kwitt2@deltadentalnm.com

SUMMARY OF QUALIFICATIONS

- Proficient in encompassing strategic management, mentorship, and team leadership, contributing to the over success of diverse projects and initiatives.
- Possess in-depth expertise in navigating and optimizing both self-funded and fully insured funding arrangements, ensuring comprehensive understanding and effective management of financial arrangements.
- Experience in client relationship management across both the public and private sectors, with a proven track record of strategic planning, fostering strong partnerships, and delivering solutions aligned with the organizations objectives.
- Skilled in client retention and customer service, ensuring unparalleled customer satisfaction using effective communication and strategic approaches.
- Adept in problem solving and decision analysis.
- Strategic planning and oversight of new product development and deployment to the market.

EDUCATION:

University Of New Mexico — Albuquerque, NM
Bachelor of Business Administration, May 2004, Cum Lade Honors, 3.52 GPA

Albuquerque Chamber of Commerce — Albuquerque, NM
Leadership Albuquerque Graduate, 2009

New Mexico Life, Health and Accident License 2005-Present — Albuquerque, NM

PROFESSIONAL EXPERIENCE

Delta Dental of New Mexico, *Albuquerque, NM* — August 2024-Present
Director, Sales and Account Management

- Develop and implement market-based sales and retention strategies, aligning with organizational goals to exceed membership, revenue, and growth targets.
- Lead and manage a high-performing sales and account management team, driving individual and departmental accountability to achieve key performance objectives.
- Build and maintain strategic industry relationships, ensuring strong partnerships with customers, brokers, and stakeholders to enhance market presence.
- Oversee product design, financial performance analysis, and underwriting decisions, ensuring competitive market positioning and sustainable financial growth.
- Direct successful RFP response processes and strategic initiatives, leveraging business intelligence and industry insights to secure key business opportunities.

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New Mexico Retiree Health Care Authority, Albuquerque*, NM*
Deputy Director September 2022-August 2024

- Managed retiree health care benefits for 67,000 public employment retirees in New Mexico, overseeing comprehensive coverage including medical, dental, vision, and life insurance.
- Managed the finance and customer service departments, $400 million budget and leading a team of 27 staff members.
- Participated in strategic planning by developing and implementing initiatives that positively impacted the agency's objectives and financial outcomes.
- Conducted staff trainings and development programs, enhancing team capabilities and ensuring a high standard of service delivery.
- Engaged in the recruitment and selection processes to identify and onboard new employees effectively.
- Actively participated in contract review and evaluation, ensuring comprehensive analysis of contractual agreements for accuracy, compliance, and alignment with organizational objectives.
- Resolved escalations effectively, fostering a positive and collaborative work environment.
- Engaged with the board, maintaining productive relations, and providing key insights to support the decision-making processes.
- Educated stakeholders on legislative initiatives, ensuring transparency, and understanding of key policy changes.
- Actively engaged in the end-to-end process of Request for Proposal (RFP) development, evaluation, selection, contracting, and implementation.

Presbyterian Health Plan, *Albuquerque, NM* Nov. 2014 – Sept. 2022
Manager, Large Group Account Management

- Led and directed self-funded account management team, fostering a high-performance culture and ensuring efficient day-to-day operations.
- Directly managed over key accounts with Book of Business (BOB) covering over 135,000 lives, demonstrating adept strategic oversight, and contributing to annual revenue in excess of $50,000,000.
- Oversaw public and private sector health benefits, providing strategic development and ensuring meticulous oversight of benefit programs.
- Spearheaded strategic planning initiatives, including the development of Requests for Proposals (RFPs) and the implementation of effective employee development and training programs.
- Implementation and deployment of new products and services aligned with organizational goals and client needs including cost benefit analysis and return on investment (ROI).
- Managed key accounts with a focus on delivering exceptional services, fostering strong client relationships, and ensuring client satisfaction.
- Successfully led the implementation and training of a new Data and Analytics system department-wide in 2018, enhancing data driven decision making capabilities.
- Orchestrated the successful conversion, implementation, and training of a new claims and eligibility system in 2021, ensuring a seamless transition and improved operational efficiency.
- Led the conversion, implementation, and training of a new reporting and analytics platform in 2021, enhancing the organizations' ability to extract actionable insights from data.

Presbyterian Health Plan, *Albuquerque, NM* Sept.2013 – Nov. 2014
Account Manager III

- Orchestrated key leadership responsibilities and initiatives, demonstrating a proactive and strategic approach to team management.

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- Provided mentorship to ASO account managers, fostering their professional growth and contributing to the overall success of the team.
- Led account management responsibilities for substantial Book of Business (BOB), ensuring client relations, retention, and the achievement of key business objectives.

Presbyterian Health Plan, *Albuquerque, NM* Oct. 2008 – Sept. 2013

Account Manager II

- Led the management of the largest self-funded accounts and house accounts while demonstrating proficiency in navigating complex client portfolios.
- Managed employee benefits for substantial membership of 45,000, ensuring the delivery of comprehensive and impactful benefits packages.
- Achieved continual year-over-year growth in the BOB membership, showcasing a results-driven approach to business development.
- Coordinated internal and external training initiatives, showcasing organizational leadership, and facilitated off-site meetings to enhance team collaboration and development.
- Successfully resolved group and member issues, demonstrating a proactive and solution-oriented approach to addressing challenges and ensuring client satisfaction.

Delta Dental of New Mexico, *Albuquerque, NM* Aug. 2005 – Oct. 2008

Retention Account Manager

- Supervision of retention and renewal process for all Delta Dental accounts.
- Account management and retention of prominent Delta Dental accounts.
- Daily servicing of self-funded and fully insured accounts in the public and private sector.

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James P. Dickey

Albuquerque, NM | 505-525-2964 | Jdickey1@deltadentalnm.com

I help companies achieve world-class performance in benefits and operations by applying my proven management, process improvement, strategy development and leadership skills to in create innovative solutions that help people

I have a diverse background in health, benefits and operations, beginning in managing clinical operations and then driving innovation in global benefits, and now working for the New Mexico's only stand-alone dental organization. I am a hands-on leader with a passion for learning and developing those around me. My goal is to always magnify the impact of my efforts by developing people and helping them grow.

Satisfaction comes from seeking to understand the current state, defining the ideal state, and then executing strategies to achieve and then evolve. I believe that any operation can be managed on five key indicators. Typically, they are financial, performance, productivity, customer, and employee satisfaction based. Working with stakeholders, customers, and peers I work to identify these metrics and form the foundation for operational excellence.

Specialties: Benefit Strategies - Performance Management - Strategic Planning - Budget Management & Forecasting - Negotiations - Quality Assurance - Process Optimization

PROFESSIONAL EXPERIENCE

Delta Dental of New Mexico **2024 to Present**
VICE PRESIDENT -BUSINESS DEVELOPMENT
Albuquerque, NM
Serve on senior leadership team of the state's only dental insurance company.
Lead all areas of sales, account management, marketing and communication.
Support corporate strategic planning and execution.
Directed strategic planning for business development activities.

- Developed strategies to exceed Open Enrollment goals within the first quarter of joining the company, yielding additional windfall of over $700,000
- Restructured team and job descriptions to optimize outcomes for key stakeholders
- Worked with direct managers to establish metrics for business development operations

Aon Corporation **2019 to 2024**
SENIOR VICE PRESIDENT -ACCOUNT EXECUTIVE/ACCOUNT EXECUTIVE LEADER
Albuquerque, NM **(2022 – 2024)**
Initiated operational infrastructure for a new office to support Account Executives. Oversaw ongoing business planning and training for all 12 Account Executives impacting 150 clients. Assisted in planning multiple office wide development functions. Continued to support multiple clients representing a book of business in excess of $1,000,000

- Developed Phase 1 Infrastructure to support Mountain States Account Executives
- Facilitated client satisfaction and innovation

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- Created a roadmap of savings for one client by over $30 million over 3 years by engaging and leveraging Third Party Administrators
- Led vendor management for a client leading to more than 1 year savings of $15 million
- Encouraged development of team and skills to meet client expectation
- Mentored in excess of 7 colleagues at any given time
- Exceeded in sales goals by over 100%

VICE PRESIDENT/ACCOUNT EXECUTIVE, Albuquerque, NM (2019–2022)
Grew book of business by over 200% in 18 months with focus on large market clients. Provided strategic direction and operational performance recommendation to reduced cost across all client. Developed and acted as a mentor for client team members and other colleagues.

- Facilitated client satisfaction and innovation
- Helped client through the implementation of Accountable Care Organization
- Assisted in client expansion by 600% through a merger while harmonizing all benefits
- Saved client over 200% through marketing efforts for new Stop Loss Policies
- Encouraged development of team and skills to meet client expectation
- Led regional training for over 300 colleagues, facilitating trainers and coordinating a team to provide sessions
- Mentored in excess of 5 colleagues at all times
- Exceeded sales goals over a 2-year period more than 120% on average

Intel Corporation 2005 to 2018
HUMAN RESOURCE MANAGER, Chandler, AZ (2017 to 2018)
Created and executed quarterly and annual HR business plan and oversaw a team of 4. Created employee support groups to serve millennial, women and under-represented minorities. Planned and led multiple leadership development functions across all levels of the organization. Coordinated HR resources around staffing, compensation and benefits and other core functions. Advises senior leadership on strategic issues around plant workforce management.

- Developed 3-pillar strategy of integration, retention and resiliency with ongoing focus on leadership development items. Developed infrastructure for HR Business operations through process improvement efforts, targeted savings of $250,000.
- Facilitated improvements to new employee integration, yielding increased efficiencies, saving approximately $300,000 in labor costs. Crafted approach to move to a 1-day onboarding: satisfaction with orientation at 98%, an increase in the “feeling integrated” metric by 50%, and new hire turnover holding below 2%.

GLOBAL HEALTH & WELLNESS MANAGER, Hillsboro, OR (2013 to 2017)
Managed global and complex scope with a team of 6 program managers and over 20 vendors spanning wellness, healthcare & EAP issues. Facilitated alignment with regional business leaders. Restructured team around new charter and mission integrating health and wellness. Managed budget and spends of $30 million. Led project to build benefits for McAfee (Medical, Dental, Vision, Life, Leave, Retirement)

- Increased stakeholder satisfaction by 18% and employee satisfaction by 12%. Developed synergies across programs and countries to gain efficiencies and improve employee experience.
- McAfee Benefits were implemented within 8 months and under budget, with 100% global compliance. Coordinated the development of a new benefit office (health, retirement, and voluntary) for McAfee at divestiture.

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Intel (cont'd)
SENIOR HEALTH PROGRAM MANAGER, Albuquerque, NM (2005 to 2013)
Co-developed new strategy that shifted healthcare industry focus and positively impacted employees. Led team of 3 to implement a comprehensive approach to healthcare. Assisted with escalations and planning for health, life, FSA, HSA, and DCAP. Created analysis that influenced senior leadership to invest in health and wellness initiatives.

- With business partners and team, saved over $75 million in healthcare cost in 5 years
- Created Onsite primary care program that saved $12 million over 3 years. Facilitated Lean approach to lower back pain that saved $3 million over 5 years.
- Over $3 million in savings realized by converting HMOs and introducing managed care techniques. Decreased ER utilization by 15% in over-used markets with structured, value-based incentive program.

Hospital Services Corporation, Albuquerque, NM 2004 to 2005
DIRECTOR OF BUSINESS DEVELOPMENT
Led a team of business development professionals and worked closely with senior leaders of customer base across multiple business lines. Interfaced with peers to ensure programs were operating smoothly. Evaluated programs for innovation and growth. Developed first Business Development department including multiple business plans, sales force, marketing plans and new business lines.

- Expanded into emerging markets and new business lines, increasing revenue by 40%.

Memorial Medical Center, Las Cruces, NM 2000 to 2004
DIRECTOR OF BUSINESS DEVELOPMENT
Crafted and implemented business plans for physician practices and clinical lines of service. Developed and implemented physician strategic plan to develop volume. Introduced multiple treatments with physician champions increasing volume and revenue.

- Collaborated with lobbyist and state officials to secure funding in excess of $11 million.

HealthSouth Hospital, Albuquerque, NM 1999 to 2000
DIRECTOR OF BUSINESS DEVELOPMENT
Directed marketing including tactical and strategic planning, territory management of 4 liaisons, event coordination, markets and program development/ assessment

St. Joseph Healthcare, Albuquerque NM 1995 to 1999
MARKET RESEARCH/PLANNING MANAGER - CONTRACT MANAGER

EDUCATION

Master of Business Administration New Mexico State University Las Cruces, NM

Bachelor of Business Administration, Management New Mexico State University Las Cruces, NM

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Juan Galindo

JuanGalindo31595@gmail.com | (505) 720-1473

Objective

A dedicated, bilingual professional with a proven track record in operations management, customer service, and team leadership seeks an opportunity to leverage strong organizational, analytical, and communication skills to drive the success of an organization.

Key Skills & Certifications

- Bilingual: English & Spanish
- Leadership & Team Development
- Operations Management
- Communication & Interpersonal Skills
- Time Management & Planning
- IT Support & Epic MyChart Expertise
- Customer Service Excellence
- Data Analysis & Reporting
- Salesforce CRM & Microsoft Office Suite Proficiency
- ServiceNow & CA Service Desk Ticketing
- Report Writing & Documentation
- Management Certification

Education

Brookline College, Albuquerque, NM
Associate of Science in Criminal Justice – September 2014

Professional Experience

Operations Manager

Delta Dental of New Mexico | Albuquerque, NM | 2025 – Present

- Lead and manage the claims, group administration, and customer service departments.
- Recruit, train, coach, and evaluate team members to ensure high performance and accountability.
- Set and monitor departmental goals to meet performance standards including SL%, claims turnaround time, and call metrics.
- Collaborate with executive leadership to design and implement strategic initiatives, long-term planning, and budget management.
- Maintain cross-departmental alignment to improve efficiency and service quality.

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- Oversee policy and procedure adherence to support operational excellence.
- Foster a positive, fun, and success-driven team culture while upholding company values and mission.

Operations Manager
NFP Health | Albuquerque, NM | *2022 – Present*

- Lead and manage a hybrid team of customer experience representatives, ensuring operational efficiency and top-tier customer satisfaction.
- Recruit, hire, and train representatives to meet business needs, especially during open enrollment periods.
- Develop and execute schedules, policies, and performance guidelines to meet and exceed contractual service level agreements (SLAs).
- Analyze and report on team performance metrics, conducting regular one-on-one coaching and development sessions.
- Oversee payroll tracking and contractor invoice review for accurate and timely processing.
- Collaborate directly with clients to present performance metrics, quality audits, and resolve ad hoc project needs.

Key Achievements:

- Successfully managed open enrollment operations, increasing team efficiency by 15%.
- Improved SLA adherence through strategic scheduling and performance monitoring.

Patient Support Supervisor
UnityBPO | Albuquerque, NM | *2018 – 2022*

- Supervised a team of 25 Tier I analysts across multiple contracts, ensuring efficient service delivery and client satisfaction.
- Established procedures for help request identification, prioritization, and resolution, improving response times by 20%.
- Conducted training programs to ensure analysts were well-equipped to meet contractual requirements and client expectations.
- Provided detailed service updates and solutions to clients, resolving pain points and improving client relationships.
- Handled payroll tracking, corrective actions, and department collaboration to streamline operations.

Key Achievements:

- Reduced client-reported issues by 25% through enhanced team training and communication protocols.
- Recognized for excellence in maintaining contractual SLAs across multiple accounts.

Additional Training & Certifications

- Management Certification
- IT Support Professional Training (Epic MyChart, Salesforce CRM)

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JESSICA TAYLOR

505-480-8810
Jessicataylor1983@msn.com

OBJECTIVE

Seeking a position to leverage my expertise in the healthcare and health insurance sectors. Proven track record as a high-performing professional in Healthcare Insurance, Customer Service Management, and Supervision across diverse industries including Call Centers (Wireless), Commercial Real Estate, Salon and Spa, and Medical Practices. Adept at coaching best practices, enhancing customer service, and fostering a positive work environment that promotes diversity and inclusion. Demonstrates a strong work ethic, attention to detail, and effective management of teams and projects. Possesses excellent problem-solving and decision-making skills, along with integrity and professionalism. Proficient in Microsoft Office Suite, with strong organizational and multi-tasking abilities.

SKILLS & ABILITIES

Value Based Care, HEDIS Star Measures (Medicare Advantage Star Ratings), CAHPS and HOS, HCC Coding, Claims processing, attention to detail, analysis & research, communication, critical thinking, data visualization, leadership, management, project management, strategic thinking, and time management.

EXPERIENCE

June 2024 – Current

Manager of Provider Relations and Network Strategy
Delta Dental of New Mexico

- Proactively built and nurtured dental provider relations, supporting innovative strategies for general dentists and specialists in urban, rural, and frontier communities of New Mexico.
- Assisted in gathering information and analyzing fee schedule and unit cost assessment data to design, implement, and monitor contracting and reimbursement strategies. (maybe include the metrics here)
- Promoted compliance assurance, operational process improvement, financial integrity, and strategic business opportunities to grow value and improve the dental provider experience.
- Designed, set, and managed all aspects of DDNM provider networks, balancing public and private customer expectations, business impacts, and corporate requirements.
- Recruited dental providers (how many) and facilitated business expansion by negotiating different payment model contracts.
- Led contract and reimbursement negotiations and strategies, ensuring compliance and resolving complex provider disputes.
- Led and advised a team of provider network representatives, ensuring provider network adequacy and member access to quality and affordable dental care.
- Motivated and encouraged department staff through effective communication and regular feedback.
- Developed and recommended updates to policies, procedures, and controls, ensuring that Dental Provider Manuals and Directories were accurate and up to date.

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Interim Operations Call Center Manager: Served as the interim Operations call center manager for 2 months.

March 2023 – May 2024

Network Performance Manager
Optum of New Mexico / NM IPA

- Assist providers in understanding Value Based Care, Quality and CMS-HCC Risk Adjustment driven payment methodology and the importance of proper chart documentation of procedures and diagnosis coding. Deliver diagnosis and coding tools to providers and staff.
- Collaborate with doctors, coders, facility staff and a variety of internal and external personnel on a wide scope of Risk Adjustment and Quality education efforts.
- Responsible for managing relationships with Medical Providers and Provider groups and staff. Work independently with outreach to provider groups to discuss Optum tools and programs focused on improving the quality of care for Medicare Advantage, Medicaid and ACA Members.
- Develop and provide training and support to provider staff to assist them in understanding performance metrics and implement operational and clinical improvements. Identify, develop, and establish key performance metrics to measure performance of providers related to their value-based contracts.
- Provide support for Risk and Quality Client Programs such as Healthcare Patient Assessment Form by ensuring accurate payments are occurring for each provider based on client contract.

February 2020 – March 2023

Provider Relations Representative
Blue Cross Blue Sheild of NM

- Served as a liaison with providers through education, training, claims assistance and all ongoing provider services.
- Direct contact for physical health providers in New Mexico and Colorado with a focus on Specialist Providers including but not limited to PT, OT, ST provider groups, Anesthesiologist Providers, Radiologist, and Chiropractors.
- Direct contact for 5+ hospitals in New Mexico and Colorado not including their clinics and additional facilities.
- Responsible for maintaining the continued collaboration efforts between BCBSNM and our large provider network within the BCBSNM provider group.
- Assisted with claims and customer service issue escalations with 100% position feedback as well as accountable for maintaining the relationships within BCBS and all internal departments.
- Assist with daily functions within our network team including projects from management and internal partners.

May 2017 – February 2020

Senior Provider Liaison, Behavioral Health
Magellan Healthcare (Presbyterian Health Plan)

- Monitor daily claims processing issues and provider relations for

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all of NM including inpatient facilities, FQHCs and all ABA providers that resulted in elimination of escalations.
- Assisted with claims and customer service issue escalations with 100% position feedback.
- Implemented network development initiatives around telemedicine recruitment and recruitment to the Medicare Dual Special Needs Program in New Mexico
- Direct role in provider credentialing review and contract negotiations for value-based arrangements
- Responsible for functioning as a liaison between behavioral health providers and Presbyterian Health Plan. Responded to and resolved provider claims and roster issues and concerns and training on PHP policies and procedures.
- Team lead for reporting that includes weekly network reporting and monthly state file reporting to confirm/update NPI status with Conduent.
- Drafted provider training documents, including creating the MCOs training for ABA providers.
- Experience in critical incident reporting, directory maintenance, member grievances, state encounter rejections and claims reporting.

EDUCATION

June 2016 University of NM

CORE STRENGTHS

Strong written and verbal communication skills, including the ability to provide constructive feedback, education and training and collaborate effectively with doctors, APC's, clinical staff, clinical management, internal leadership and colleagues. I have demonstrated the ability to assist with process implementation for new documentation requirements, contract review and training and development of CMS guidelines for V28, HEDIS Star Measures and HCC coding.

REFERENCES

Fernando Galindo, Director of Quality, Population Health, Employed Clincs and NM IPA Optum NM IPA
Luis.Galindo@optum.optumcare.com
915-300-8118

Jake Segura, Network Performance Manager Optum
NM IPA
J.Segura@optum.com
505-917-3106

Patricia Chavez, Manager Contract Administrator Ops Blue
Cross Blue Sheild
Patricia.Chavez@bcbsnm.com
505-702-5591

Raquel Aragon, Provider Relations Manager Centene
Raquel.j.aragon@westernskycommunitycare.com 505-
459-3733

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Tina M. Tomlin

Albuquerque, NM • ***tinamarietomlin@gmail.com*** • *(505) 659-0050* • ***LinkedIn.com/in/tina-tomlin-107a116b/***

Transformational Contact Center & Customer Experience Leader Who Implements Lean Workforce Frameworks Without Sacrificing Service & Satisfaction

Accomplished, customer-focused contact center and customer experience leader with diverse technical and practical background. Proven expertise in designing and executing high-functioning operational policies, strategies, and communications while incorporating a LEAN workforce framework. Champion of change management and continuous improvement who thrives in fast-paced, challenging environments. Passionate about building excellent customer experiences in contact center and service desk environments. Fair, collaborative leader who coaches and upskills talent to bolster retention and employee engagement.

Areas of Expertise…

- ✓ Customer Experience
- ✓ Change Management
- ✓ Business Continuity
- ✓ Remote Workforce Management
- ✓ Client Enablement
- ✓ Business Collaboration
- ✓ Service Level Agreements
- ✓ Project Management
- ✓ Contact Center Leadership
- ✓ Strategic / Executive Leadership
- ✓ Budget Management
- ✓ Enterprise Infrastructure

KEY ACCOMPLISHMENTS

- Collaborated with key stakeholders to identify challenges and inefficiencies, facilitated work sessions, interviewed SMEs, and created process maps to transform business systems and communication plans for Nusenda Credit Union.
- Established positive, proactive and strategic relationship with New Mexico Health Insurance Exchange as a trusted advisor/service delivery vendor for contact center engagement, project management and financial management systems.
- Transformed Bernalillo County Constituent Contact Center into fully remote operation due to COVID 19 crisis by devising a plan to rout calls to agents' homes within a few days.
- Piloted and overcame logistic challenges for remote service desk to provide Bernalillo constituents unparalleled customer service.
- Advocated for business transformations in customer service environments ranging from healthcare supply chain operations to emergency response and essential government services to push service standards to excellence.

PROFESSIONAL EXPERIENCE

Vice President, Operations • Delta Dental of New Mexico • Albuquerque, NM • 9/2024 - present

Responsible for managing and providing support to enterprise initiatives, including system and staff support for all customers and client groups. Responsible for operational plans and organizing and directing the work of the Operations team that includes customer service, claims administration and customer/client/group enrollment services. Develops and executes department budget and provides significant input and execution into the Company's strategic plan, and member of the senior management team.

Vice President • NFP Health • Albuquerque, NM • 4/2022 – 7/2024

Responsibilities include solving client issues, assigning resources for small & large scale enablement projects, contract budgeting to include invoicing client per agreed upon payment milestones, ensure contract compliance, SLA commitments, finding new ways to deliver NFP products & services to further assist client success. Serve as pivotal liaison and trusted advisor. Entrusted with overseeing and nurturing a portfolio of key client accounts, with the primary objective of fostering enduring relationships, ensuring client satisfaction, and driving the realization of value for assigned clients. Oversight of contact center serving the state of New Mexico.

Director, Contact Center Operations • UnityBPO • Albuquerque, NM • 7/2021 – 4/2022

Responsible for the strategic planning and execution of all Contact Center operations. Core duties include budget responsibility, workforce management, and leadership of processes for the continuous improvement of customer experience. Tactical emphasis is on customer care, quality management, workforce planning, contractual compliance, recruiting, coaching and training. Performance metrics include Service Levels, agent performance, staffing utilization, acceptable turnover, and financial performance.

Business Transformation Manager • Nusenda Credit Union • Albuquerque, NM • 7/2020 – 4/2021

Direct and develop the newly created Business Transformation Department with a team of four direct reports. Partner with leaders to improve processes and the customer and employee experiences. Establish Business Transformation Team guidelines, goals, and KPIs.

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- Drive Continuous Improvement by identifying and implementing process improvement initiatives and best practices.
- Guide high-level projects and process analysis to architect strategy for business-wide improvements, employee engagement, and customer retention efforts.

Bernalillo County • Albuquerque, NM • 12/2012 – 7/2020

Director, Constituent & Support Services (4/2016 – 7/2020)

Reported to Deputy County Manager for General Services and administrated the enterprise inventory management, printing and graphics, and the inbound call center. Created a customer-focused design for constituent support services.

Fostered transition from legacy government departments to progressive lean processes through the Malcolm Baldrige Performance Excellence Framework, earning the Pinon Award for leading the Continuous Improvement & Innovation Cooperative. Centralized service delivery, established KPIs and reporting metrics, and built transparent customer service approach for county government (available through OpenGov.com). Grew contact center staff from three to eight without increasing overhead by persuading leaders to reallocate certain departmental staff to centralized customer service group, which enabled frontline staff to focus on department-specific work instead of fielding customer service emails and phone calls.

Director of Emergency Communications – 911 (10/2014 – 4/2016)

Reported to Deputy County Manager for Public Safety and administered county communications, projects, services, and facilities. Planned future programs, facilities, and services. Coordinated departmental operations with local, state, national groups, and county departments.

Contact Center Manager (12/2012 – 10/2014)

Reported to Solid Waste Director in Public Works Department and managed daily operations, including processing multiple departmental work orders and public service requests. Directed contact center operations, including information and referral services, budget consolidation, and review and improvement of all service desk policies and procedures.

- Centralized contact center planning, projects, SOPs, and KPIs to streamline operations, improve efficiency, and increase customer satisfaction. Planned budgets, conducted staff evaluations, and made technical recommendations for contact center operations.

Cardinal Health • Albuquerque, NM & Sherwood, AR • 1994 – 2011

Senior Business Analyst (3/2009 – 6/2011)

Configured enterprise-wide SAP CRM application and planned and conducted user acceptance testing by writing test scripts and identifying participants. Collaborated with second-tier configuration team to make modifications based on test plans and results.

- Created enterprise-focused communication plan to launch SAP CRM and influenced key stakeholders to ensure smooth transition. Implemented new applications and executed initial application rollout, provided first level support, documented issues, and coordinated mitigation and resolutions.

Senior Business Continuity Specialist (3/2007 – 3/2009)

Identified risk, assessed company response, and authored contingency plans. Managed first responders' team and safety committee.

- Rolled out company's global environmental health and safety program. Analyzed IT initiatives risks and impacts on customer care centers in Sherwood, AR, and Radcliff, KY.

Additional Experience:

Customer Service Supervisor • Sherwood, AR – *Directly supervised and coached 35 pharmaceutical customer service agents in 400 person customer care center, handled escalated calls and complaints, and audited contact center service standards*. ***Telecommunications Administrator*** • Albuquerque, NM – *Served as project manager and developed business plans for local site initiatives. Managed call structure and routing for 150 call center agents and provided technical support for 1K+ employees.* ***Audit Analyst / Dispute Coordinator/ Contracts Administrator*** • Albuquerque, NM – *Resolved contractual disputes for 30+ accounts. Served as liaison between customer, Accounts Receivable and Contract Dept. Implemented and maintained customer pricing contracts.*

EDUCATION

Master of Business Administration
Human Resources Management
College of Santa Fe, Albuquerque, NM

Bachelor of Arts Business Administration
Management (Magna Cum Laude)
College of Santa Fe, Albuquerque, NM

LEAN Practitioner
American Society for Quality

Change Management Specialist (CMS) #24367602
Management & Strategy Institute

LEAN Six Sigma Black Belt #BB1648563640
Veritastech

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Delta Dental PPO Plus Premier™ Summary of Dental Plan Benefits

For Group #N/A

For Proposal Illustration Only – City of Albuquerque

Benefit Period: July 1 through June 30

Deductible: $50 Deductible per person total per Benefit Period limited to a maximum Deductible of $150 per family per Benefit Period with a 3-month carryover provision

Maximum Benefit Amount: $1,500 per person total per Benefit Period

Orthodontic Lifetime Maximum: $1,200 per person total per lifetime

Covered Services	Delta Dental PPO™ Provider	Delta Dental Premier® Provider[1]	Non-Participating Provider[2]
	You Pay	You Pay[1]	You Pay[2]
Diagnostic and Preventive Services			
Diagnostic and Preventive Services – exams, cleanings, and topical fluoride, and space maintainers	No Charge	No Charge	20%
Emergency Palliative Treatment – to temporarily relieve pain	No Charge	No Charge	20%
Sealants – to prevent decay of permanent teeth	No Charge	No Charge	20%
Brush Biopsy – to detect oral cancer	No Charge	No Charge	20%
Radiographs – images	No Charge	No Charge	20%
Periodontal Maintenance – cleanings following periodontal therapy	No Charge	No Charge	20%
Basic Services			
Minor Restorative Services – fillings	15%	15%	15%
Endodontic Services – root canals	15%	15%	15%
Periodontic Services – to treat gum disease	15%	15%	15%
Oral Surgery Services – extractions and dental surgery	15%	15%	15%
Other Basic Services – misc. services	15%	15%	15%
Major Services			
Crown Repair – to individual crowns	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, dentures, and implants	50%	50%	50%
Prosthodontic Services – bridges, dentures, and implants	50%	50%	50%
TMD Treatment – Medically Necessary treatment of Temporomandibular Joint Dysfunction, including diagnostic imaging	50%	50%	50%

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Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit – child and adult	No Age Limit	No Age Limit	No Age Limit

1) Schedule of higher fees applies. Delta Dental Premier Providers are subject to a schedule of higher Maximum Approved Fees than Delta Dental PPO Providers. You may have higher out-of-pocket costs when you visit a Delta Dental Premier Provider than if you visited a Delta Dental PPO Provider. This may be true even if the Coinsurance percentages are the same for these two types of Providers. You may have the lowest out-of-pocket costs when you select a Delta Dental PPO Provider. See the Summary of Dental Plan Benefits for more information on networks and cost sharing.

2) Balance billing applies. Non-Participating Providers may bill you above the Non-Participating Maximum Approved Fees they receive from Delta Dental. You will have the highest out-of-pocket costs when you visit a Non-Participating Provider. This will be true even if the Coinsurance percentages in this column match the percentages for other types of Providers. In addition, Non-Participating Providers have not agreed to Delta Dental's in-network protections for Enrollees. See the Summary of Dental Plan Benefits for more information on networks and cost sharing.

- Oral exams (including evaluations by a specialist) are payable three times per calendar year.
- Routine prophylaxes (cleanings), periodontal maintenance, and scaling in the presence of generalized moderate or severe gingival inflammation are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or topical fluoride treatment. The patient should talk with his or her Provider about treatment.
- Topical fluoride treatments are payable twice per calendar year for people up to age 19. Topical fluoride treatments are payable once per calendar year for people age 19 and older, but only when medically necessary.
- Fixed bilateral space maintainers are payable once per arch per lifetime for people up to age 14.
- Fixed unilateral, removable unilateral, and removable bilateral space maintainers are payable once per quadrant per lifetime for people up to age 14.
- Bitewing images are payable twice per calendar year and a complete series of radiographic images (which include bitewing images) or panoramic radiographic image is payable once in any five-year period.
- Sealants are payable once per tooth per two-year period for permanent molars, excluding coverage where an occlusal restoration has been completed on the tooth, up to age 16. Sealants are payable once per tooth per five-year period for permanent molars, excluding coverage where an occlusal restoration has been completed on the tooth, for people ages 16 and older, but only when medically necessary.
- Composite resin (white) restorations are Covered Services on all teeth.
- Implants and implant-related services are payable once per tooth in any five-year period.
- Medically Necessary TMD is a covered Benefit. Pre-Treatment Estimate is required or the member may be liable for the full cost of the services.

Additional Plan Information

Deductible: Does not apply to Diagnostic and Preventive Services, radiographic images, sealants, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Maximum Benefit Amount: This dental Plan includes Preventive Care Security (PCS); Diagnostic and Preventive Services will not reduce your Maximum Benefit Amount. The Maximum Benefit Amount applies to all services except Diagnostic and Preventive, radiographic images, sealants, emergency palliative treatment, consultations, cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

Orthodontic Lifetime Maximum: Applies to cephalometric radiographic images, photos, diagnostic casts, and orthodontics (including fiberotomy, surgical repositioning, and devices to facilitate tooth eruption).

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Pre-Treatment Estimates: Delta Dental recommends that you ask your Provider for a Pre-Treatment Estimate when more costly procedures are anticipated. A Pre-Treatment Estimate is not a guarantee of coverage. This free report estimates your applicable dental Benefits and out-of-pocket expenses for proposed dental services. Please see the Dental Benefit Handbook for more information. Pre-Treatment Estimates are optional unless specified otherwise in this Summary of Dental Plan Benefits.

Eligibility Provisions

An Eligible Employee is an Employee who satisfies the following: the eligibility definition(s) specified by the Group and accepted by Delta Dental; and the Eligibility Waiting Period specified by the Group and agreed to by Delta Dental. The Eligibility Waiting Period shall not exceed twelve (12) months.

Benefits will cease on the last day of the month in which the Employee is terminated, subject to any additional requirements which may apply.

Special Benefit Provisions

This Plan includes a 3-month deductible carryover provision.

Your Network: Delta Dental PPO Plus Premier

This section describes the types of Providers you may visit under your Plan and how fees and payments will work for different Providers.

Delta Dental PPO Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Lowest
Delta Dental Pays Up To:	Delta Dental PPO Maximum Approved Fees
Provider May Balance Bill You?	No
Description:	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental PPO Maximum Approved Fees. You are also responsible for the full payment for any non-covered services.

Delta Dental Premier Provider	
Participates with Delta Dental?	Yes
Out-of-Pocket Costs for This Plan:	Higher than Delta Dental PPO
Delta Dental Pays Up To:	Delta Dental Premier Maximum Approved Fees
Provider May Balance Bill You?	No
Description:	You will be responsible for any Coinsurance and Deductible (if applicable) for Covered Services up to the Delta Dental Premier Maximum Approved Fees. You are also responsible for the full payment for any non-covered services. Coinsurance amounts may be higher when selecting a Delta Dental Premier Provider.

Non-Participating Provider	
Participates with Delta Dental?	No
Out-of-Pocket Costs for This Plan:	Highest
Delta Dental Pays Up To:	Delta Dental's Non-Participating Maximum Approved Fees
Provider May Balance Bill You?	Yes, up to the Provider's Submitted Amount
Description:	In addition to any Coinsurance, Deductible (if applicable), and fees for non-covered services, you will be responsible for any difference between Delta Dental's Non-Participating Maximum Approved Fees and the Provider's Submitted Amount.

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	Subscribers are responsible for full payment to a Non-Participating Provider. Any payment made by Delta Dental for services received from a Non-Participating Provider may be paid to the Provider or directly to the Subscriber.

Understanding Your Benefits

This Summary of Dental Plan Benefits has been prepared only for proposal presentation purposes.

READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US. Refer to your Dental Benefit Handbook for other important eligibility and Plan provisions. This Summary of Dental Plan Benefits is attached to and is a component of the Dental Benefit Handbook. To the extent that the rules in the Dental Benefit Handbook conflict with the ones stated in this Summary of Dental Plan Benefits, the rules in this Summary of Dental Plan Benefits control.

Call Delta Dental's Customer Service Department at (877) 395-9420, or log into the Member Portal via **www.memberportal.com**, for answers to questions about Benefits and claims.

Contact the New Mexico Office of Superintendent of Insurance (OSI) at any time for assistance with a claim appeal:

Office of Superintendent of Insurance
Phone: 1-855-4-ASK-OSI
www.osi.state.nm.us

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Network Access Analysis

City of Albuquerque

Delta Dental PPO & Delta Dental Premier

July 28, 2025

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Access Analysis: 2 Orthodontists within 15 miles

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Delta Dental PPO

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Access Summary By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee Group
City of Albuquerque

Provider Group
Delta Dental PPO General Dentists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:
2 (Delta Dental PPO General Dentists) providers in 10 miles

[2] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental PPO General Dentists	7,632	98.6	315,941	95,744	45,936	1.6	1.7

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental PPO General Dentists	898	100.0	88	2.0	2.0
	87120	769	Delta Dental PPO General Dentists	769	100.0	35	1.2	1.3
	87114	714	Delta Dental PPO General Dentists	714	100.0	126	1.9	2.1
	87105	661	Delta Dental PPO General Dentists	661	100.0	27	1.4	1.5
Rio Rancho, NM	87124	421	Delta Dental PPO General Dentists	421	100.0	105	1.2	1.2
Albuquerque, NM	87102	412	Delta Dental PPO General Dentists	412	100.0	21	0.8	0.8
Rio Rancho, NM	87144	335	Delta Dental PPO General Dentists	335	100.0	7	3.9	3.9
Albuquerque, NM	87110	324	Delta Dental PPO General Dentists	324	100.0	62	0.6	0.7
	87111	321	Delta Dental PPO General Dentists	321	100.0	54	1.0	1.2
	87107	299	Delta Dental PPO General Dentists	299	100.0	9	1.2	1.3
	87112	295	Delta Dental PPO General Dentists	295	100.0	43	0.9	0.9
Los Lunas, NM	87031	287	Delta Dental PPO General Dentists	287	100.0	64	2.5	2.5
Albuquerque, NM	87123	268	Delta Dental PPO General Dentists	268	100.0	12	1.0	1.0
	87109	251	Delta Dental PPO General Dentists	251	100.0	64	0.9	1.1
	87108	174	Delta Dental PPO General Dentists	174	100.0	17	0.5	0.7
	87106	163	Delta Dental PPO General Dentists	163	100.0	3	0.8	1.1
	87104	129	Delta Dental PPO General Dentists	129	100.0	6	1.0	1.0
	87113	129	Delta Dental PPO General Dentists	129	100.0	10	1.0	1.1
Edgewood, NM	87015	127	Delta Dental PPO General Dentists	127	100.0	14	4.7	4.7
Belen, NM	87002	120	Delta Dental PPO General Dentists	117	97.5	5	1.9	2.5
Bernalillo, NM	87004	83	Delta Dental PPO General Dentists	83	100.0	15	1.3	1.3
Albuquerque, NM	87122	71	Delta Dental PPO General Dentists	71	100.0	9	1.1	1.7
Tijeras, NM	87059	80	Delta Dental PPO General Dentists	63	78.8	3	5.5	5.7
Bosque Farms, NM	87068	55	Delta Dental PPO General Dentists	55	100.0	1	2.2	3.6
Corrales, NM	87048	52	Delta Dental PPO General Dentists	52	100.0	0	2.1	2.4
Peralta, NM	87042	30	Delta Dental PPO General Dentists	30	100.0	1	1.0	3.6
Sandia Park, NM	87047	32	Delta Dental PPO General Dentists	27	84.4	10	3.9	4.0
Cedar Crest, NM	87008	17	Delta Dental PPO General Dentists	17	100.0	1	1.0	2.6
Estancia, NM	87016	16	Delta Dental PPO General Dentists	16	100.0	3	6.5	6.5
Placitas, NM	87043	12	Delta Dental PPO General Dentists	12	100.0	1	2.3	4.7
Santa Fe, NM	87507	9	Delta Dental PPO General Dentists	9	100.0	30	1.3	1.3
Moriarty, NM	87035	20	Delta Dental PPO General Dentists	8	40.0	0	5.9	5.9
Albuquerque, NM	87125	7	Delta Dental PPO General Dentists	7	100.0	0	0.9	0.9
Algodones, NM	87001	12	Delta Dental PPO General Dentists	6	50.0	0	6.1	8.1
Albuquerque, NM	87184	6	Delta Dental PPO General Dentists	6	100.0	0	1.5	1.5

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO General Dentists

Employees With and Without Access

State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	10.1	15.6
New Mexico	Albuquerque	87101	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.9	0.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87102	412	Delta Dental PPO General Dentists / 2 in...	21	With	412	100.0	0.8	0.8
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87103	4	Delta Dental PPO General Dentists / 2 in...	0	With	4	100.0	0.6	0.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87104	129	Delta Dental PPO General Dentists / 2 in...	6	With	129	100.0	1.0	1.0
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87105	661	Delta Dental PPO General Dentists / 2 in...	27	With	661	100.0	1.4	1.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87106	163	Delta Dental PPO General Dentists / 2 in...	3	With	163	100.0	0.8	1.1
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87107	299	Delta Dental PPO General Dentists / 2 in...	9	With	299	100.0	1.2	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87108	174	Delta Dental PPO General Dentists / 2 in...	17	With	174	100.0	0.5	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87109	251	Delta Dental PPO General Dentists / 2 in...	64	With	251	100.0	0.9	1.1
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87110	324	Delta Dental PPO General Dentists / 2 in...	62	With	324	100.0	0.6	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87111	321	Delta Dental PPO General Dentists / 2 in...	54	With	321	100.0	1.0	1.2
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87112	295	Delta Dental PPO General Dentists / 2 in...	43	With	295	100.0	0.9	0.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87113	129	Delta Dental PPO General Dentists / 2 in...	10	With	129	100.0	1.0	1.1
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87114	714	Delta Dental PPO General Dentists / 2 in...	126	With	714	100.0	1.9	2.1
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87116	5	Delta Dental PPO General Dentists / 2 in...	0	With	5	100.0	1.3	1.4
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87119	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	2.3	2.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87120	769	Delta Dental PPO General Dentists / 2 in...	35	With	769	100.0	1.2	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87121	898	Delta Dental PPO General Dentists / 2 in...	88	With	898	100.0	2.0	2.0
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87122	71	Delta Dental PPO General Dentists / 2 in...	9	With	71	100.0	1.1	1.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental PPO General Dentists / 2 in...	12	With	268	100.0	1.0	1.0
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87125	7	Delta Dental PPO General Dentists / 2 in...	0	With	7	100.0	0.9	0.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87154	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	0.7	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87176	3	Delta Dental PPO General Dentists / 2 in...	0	With	3	100.0	0.9	0.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87184	6	Delta Dental PPO General Dentists / 2 in...	0	With	6	100.0	1.5	1.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87187	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.2	0.2
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87191	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.7	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87193	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	0.7	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87194	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.6	0.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87196	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	0.2	0.8
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87199	4	Delta Dental PPO General Dentists / 2 in...	0	With	4	100.0	0.8	0.8
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental PPO General Dentists / 2 in...	0	With	6	50.0	6.1	8.1
				Delta Dental PPO General Dentists / 2 in...		W/o	6	50.0	9.8	14.5
	Belen	87002	120	Delta Dental PPO General Dentists / 2 in...	5	With	117	97.5	1.9	2.5
				Delta Dental PPO General Dentists / 2 in...		W/o	3	2.5	13.8	13.9
	Bernalillo	87004	83	Delta Dental PPO General Dentists / 2 in...	15	With	83	100.0	1.3	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	7	100.0	16.7	17.6
	Bosque Farms	87068	55	Delta Dental PPO General Dentists / 2 in...	1	With	55	100.0	2.2	3.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	21.2	26.0
	Cedar Crest	87008	17	Delta Dental PPO General Dentists / 2 in...	1	With	17	100.0	1.0	2.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Chamisal	87521	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	1.8	2.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Clovis	88101	2	Delta Dental PPO General Dentists / 2 in...	47	With	2	100.0	1.2	1.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	2	100.0	17.9	17.9
	Corrales	87048	52	Delta Dental PPO General Dentists / 2 in...	0	With	52	100.0	2.1	2.4
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental PPO General Dentists / 2 in...	7	With	1	50.0	3.2	3.2
				Delta Dental PPO General Dentists / 2 in...		W/o	1	50.0	12.1	12.1
	Cubero	87014	2	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	2	100.0	18.6	18.6
	Edgewood	87015	127	Delta Dental PPO General Dentists / 2 in...	14	With	127	100.0	4.7	4.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Espanola	87532	3	Delta Dental PPO General Dentists / 2 in...	15	With	3	100.0	2.6	2.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Estancia	87016	16	Delta Dental PPO General Dentists / 2 in...	3	With	16	100.0	6.5	6.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Farmington	87401	1	Delta Dental PPO General Dentists / 2 in...	36	With	1	100.0	0.3	0.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.7	0.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental PPO General Dentists / 2 in...	8	With	4	100.0	1.8	1.8
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Isleta	87022	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	2.1	5.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental PPO General Dentists / 2 in...	0	With	3	60.0	4.7	5.0
				Delta Dental PPO General Dentists / 2 in...		W/o	2	40.0	15.5	16.6
	Jemez Pueblo	87024	5	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	5	100.0	26.1	26.1
	Jemez Springs	87025	4	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	4	100.0	25.8	25.8
	Kirtland AFB	87117	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	1.6	1.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	21.4	21.9
	Laguna	87026	5	Delta Dental PPO General Dentists / 2 in...	1	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	5	100.0	14.1	28.0
	Lamy	87540	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	12.2	12.6
	Las Cruces	88011	1	Delta Dental PPO General Dentists / 2 in...	67	With	1	100.0	1.3	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental PPO General Dentists / 2 in...	11	With	2	100.0	1.2	1.2
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO General Dentists

Employees With and Without Access

State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	7.8	8.4
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Los Alamos	87544	1	Delta Dental PPO General Dentists / 2 in...	4	With	1	100.0	3.5	3.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental PPO General Dentists / 2 in...	64	With	287	100.0	2.5	2.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	12.9	12.9
	Moriarty	87035	20	Delta Dental PPO General Dentists / 2 in...	0	With	8	40.0	5.9	5.9
				Delta Dental PPO General Dentists / 2 in...		W/o	12	60.0	12.3	12.3
	Mountainair	87036	10	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	10	100.0	23.0	23.0
	New Laguna	87038	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	18.6	28.0
	Paguate	87040	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	21.6	26.6
	Pena Blanca	87041	5	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	5	100.0	19.1	19.4
	Peralta	87042	30	Delta Dental PPO General Dentists / 2 in...	1	With	30	100.0	1.0	3.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental PPO General Dentists / 2 in...	1	With	12	100.0	2.3	4.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	2	100.0	27.2	27.2
	Prewitt	87045	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	26.8	26.8
	Pueblo of Acoma	87034	4	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	4	100.0	20.8	20.8
	Rainsville	87736	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	8.8	8.8
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Ribera	87560	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	28.3	28.3
	Rio Rancho	87124	421	Delta Dental PPO General Dentists / 2 in...	105	With	421	100.0	1.2	1.2
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87144	335	Delta Dental PPO General Dentists / 2 in...	7	With	335	100.0	3.9	3.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87174	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	1.0	1.0
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	2	100.0	17.5	17.5

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO General Dentists

Employees With and Without Access

State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Sandia Park	87047	32	Delta Dental PPO General Dentists / 2 in...	10	With	27	84.4	3.9	4.0
				Delta Dental PPO General Dentists / 2 in...		W/o	5	15.6	11.6	11.6
	Santa Fe	87501	4	Delta Dental PPO General Dentists / 2 in...	1	With	4	100.0	1.5	2.6
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87505	5	Delta Dental PPO General Dentists / 2 in...	60	With	5	100.0	0.9	0.9
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87506	2	Delta Dental PPO General Dentists / 2 in...	0	With	2	100.0	3.7	3.7
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87507	9	Delta Dental PPO General Dentists / 2 in...	30	With	9	100.0	1.3	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
		87509	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	0.5	0.5
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental PPO General Dentists / 2 in...	2	With	1	100.0	1.2	1.2
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Santo Domingo P...	87052	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	18.6	22.2
	Silver City	88061	1	Delta Dental PPO General Dentists / 2 in...	6	With	1	100.0	0.3	0.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Socorro	87801	4	Delta Dental PPO General Dentists / 2 in...	4	With	4	100.0	1.1	1.4
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Stanley	87056	4	Delta Dental PPO General Dentists / 2 in...	0	With	1	25.0	9.7	9.7
				Delta Dental PPO General Dentists / 2 in...		W/o	3	75.0	14.3	14.3
	Thoreau	87323	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	26.7	26.7
	Tijeras	87059	80	Delta Dental PPO General Dentists / 2 in...	3	With	63	78.8	5.5	5.7
				Delta Dental PPO General Dentists / 2 in...		W/o	17	21.2	12.1	12.1
	Tome	87060	1	Delta Dental PPO General Dentists / 2 in...	0	With	1	100.0	4.0	4.0
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental PPO General Dentists / 2 in...	27	With	1	100.0	1.4	1.4
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
	Willard	87063	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	19.4	19.4
	Zuni	87327	1	Delta Dental PPO General Dentists / 2 in...	0	With	0	0.0	--	--
				Delta Dental PPO General Dentists / 2 in...		W/o	1	100.0	32.2	32.2
South Carolina	West Columbia	29169	1	Delta Dental PPO General Dentists / 2 in...	41	With	1	100.0	1.1	1.3
				Delta Dental PPO General Dentists / 2 in...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental PPO General Dentists / 2 in...	1,183	With	7,632	98.6	1.6	1.7
				Delta Dental PPO General Dentists / 2 in...		W/o	110	1.4	16.9	18.1

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Access Summary By Zip Code

July 28, 2025

Access Analysis

2 Specialists excluding Orthodontists within 10 miles

Employee Group

City of Albuquerque

Provider Group

Delta Dental PPO Specialists excluding Orthodontists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:

2 (Delta Dental PPO Specialists excluding Orthodontists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

P: Unique providers

L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental PPO Specialists exclu...	7,290	94.2	63,027	16,120	14,243	2.8	3.0

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental PPO Specialists excluding Orthodontists	898	100.0	12	3.7	3.7
	87120	769	Delta Dental PPO Specialists excluding Orthodontists	769	100.0	9	2.1	2.3
	87114	714	Delta Dental PPO Specialists excluding Orthodontists	714	100.0	25	2.5	2.6
	87105	661	Delta Dental PPO Specialists excluding Orthodontists	661	100.0	0	5.3	5.3
Rio Rancho, NM	87124	421	Delta Dental PPO Specialists excluding Orthodontists	421	100.0	23	1.5	2.1
Albuquerque, NM	87102	412	Delta Dental PPO Specialists excluding Orthodontists	412	100.0	0	3.5	3.5
Rio Rancho, NM	87144	335	Delta Dental PPO Specialists excluding Orthodontists	335	100.0	0	4.3	4.6
Albuquerque, NM	87110	324	Delta Dental PPO Specialists excluding Orthodontists	324	100.0	10	1.0	1.3
	87111	321	Delta Dental PPO Specialists excluding Orthodontists	321	100.0	6	1.5	1.5
	87107	299	Delta Dental PPO Specialists excluding Orthodontists	299	100.0	0	3.2	3.3
	87112	295	Delta Dental PPO Specialists excluding Orthodontists	295	100.0	6	1.3	1.3
Los Lunas, NM	87031	287	Delta Dental PPO Specialists excluding Orthodontists	287	100.0	7	2.8	4.6
Albuquerque, NM	87123	268	Delta Dental PPO Specialists excluding Orthodontists	268	100.0	1	1.4	1.8
	87109	251	Delta Dental PPO Specialists excluding Orthodontists	251	100.0	17	1.2	1.5
	87108	174	Delta Dental PPO Specialists excluding Orthodontists	174	100.0	0	1.7	2.7
	87106	163	Delta Dental PPO Specialists excluding Orthodontists	163	100.0	0	2.3	2.3
	87104	129	Delta Dental PPO Specialists excluding Orthodontists	129	100.0	0	3.7	3.7
	87113	129	Delta Dental PPO Specialists excluding Orthodontists	129	100.0	9	1.7	1.7
Bernalillo, NM	87004	83	Delta Dental PPO Specialists excluding Orthodontists	83	100.0	4	1.5	1.5
Albuquerque, NM	87122	71	Delta Dental PPO Specialists excluding Orthodontists	71	100.0	2	2.2	2.2
Bosque Farms, NM	87068	55	Delta Dental PPO Specialists excluding Orthodontists	55	100.0	0	5.1	5.3
Corrales, NM	87048	52	Delta Dental PPO Specialists excluding Orthodontists	52	100.0	0	2.4	3.4
Peralta, NM	87042	30	Delta Dental PPO Specialists excluding Orthodontists	30	100.0	0	3.6	3.6
Belen, NM	87002	120	Delta Dental PPO Specialists excluding Orthodontists	27	22.5	1	4.8	8.5
Cedar Crest, NM	87008	17	Delta Dental PPO Specialists excluding Orthodontists	16	94.1	0	9.0	9.0
Placitas, NM	87043	12	Delta Dental PPO Specialists excluding Orthodontists	12	100.0	0	5.0	5.0
Santa Fe, NM	87507	9	Delta Dental PPO Specialists excluding Orthodontists	9	100.0	13	1.8	1.8
Sandia Park, NM	87047	32	Delta Dental PPO Specialists excluding Orthodontists	8	25.0	0	8.9	8.9
Albuquerque, NM	87125	7	Delta Dental PPO Specialists excluding Orthodontists	7	100.0	0	2.5	2.5
Algodones, NM	87001	12	Delta Dental PPO Specialists excluding Orthodontists	6	50.0	0	8.8	8.8
Albuquerque, NM	87184	6	Delta Dental PPO Specialists excluding Orthodontists	6	100.0	0	1.9	1.9
Tijeras, NM	87059	80	Delta Dental PPO Specialists excluding Orthodontists	5	6.2	0	8.0	8.0
Albuquerque, NM	87116	5	Delta Dental PPO Specialists excluding Orthodontists	5	100.0	0	3.1	3.7
Santa Fe, NM	87505	5	Delta Dental PPO Specialists excluding Orthodontists	5	100.0	6	0.9	1.4
Albuquerque, NM	87103	4	Delta Dental PPO Specialists excluding Orthodontists	4	100.0	0	3.6	3.6

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Specialists excluding Orthodontists

Employees With and Without Access

State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	15.6	23.5
New Mexico	Albuquerque	87101	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	2.5	2.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87102	412	Delta Dental PPO Specialists excluding O...	0	With	412	100.0	3.5	3.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87103	4	Delta Dental PPO Specialists excluding O...	0	With	4	100.0	3.6	3.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87104	129	Delta Dental PPO Specialists excluding O...	0	With	129	100.0	3.7	3.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87105	661	Delta Dental PPO Specialists excluding O...	0	With	661	100.0	5.3	5.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87106	163	Delta Dental PPO Specialists excluding O...	0	With	163	100.0	2.3	2.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87107	299	Delta Dental PPO Specialists excluding O...	0	With	299	100.0	3.2	3.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87108	174	Delta Dental PPO Specialists excluding O...	0	With	174	100.0	1.7	2.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87109	251	Delta Dental PPO Specialists excluding O...	17	With	251	100.0	1.2	1.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87110	324	Delta Dental PPO Specialists excluding O...	10	With	324	100.0	1.0	1.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87111	321	Delta Dental PPO Specialists excluding O...	6	With	321	100.0	1.5	1.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87112	295	Delta Dental PPO Specialists excluding O...	6	With	295	100.0	1.3	1.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87113	129	Delta Dental PPO Specialists excluding O...	9	With	129	100.0	1.7	1.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87114	714	Delta Dental PPO Specialists excluding O...	25	With	714	100.0	2.5	2.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87116	5	Delta Dental PPO Specialists excluding O...	0	With	5	100.0	3.1	3.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87119	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	4.4	4.4
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87120	769	Delta Dental PPO Specialists excluding O...	9	With	769	100.0	2.1	2.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87121	898	Delta Dental PPO Specialists excluding O...	12	With	898	100.0	3.7	3.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87122	71	Delta Dental PPO Specialists excluding O...	2	With	71	100.0	2.2	2.2
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental PPO Specialists excluding O...	1	With	268	100.0	1.4	1.8
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87125	7	Delta Dental PPO Specialists excluding O...	0	With	7	100.0	2.5	2.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87154	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	2.0	2.0
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87176	3	Delta Dental PPO Specialists excluding O...	0	With	3	100.0	1.2	1.2
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87184	6	Delta Dental PPO Specialists excluding O...	0	With	6	100.0	1.9	1.9
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87187	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	2.6	3.1
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87191	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	2.0	2.0
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87193	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	0.7	0.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87194	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	3.9	3.9
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87196	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	2.0	2.0
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87199	4	Delta Dental PPO Specialists excluding O...	0	With	4	100.0	0.8	0.8
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental PPO Specialists excluding O...	0	With	6	50.0	8.8	8.8
				Delta Dental PPO Specialists excluding O...		W/o	6	50.0	15.3	15.3
	Belen	87002	120	Delta Dental PPO Specialists excluding O...	1	With	27	22.5	4.8	8.5
				Delta Dental PPO Specialists excluding O...		W/o	93	77.5	3.7	12.7
	Bernalillo	87004	83	Delta Dental PPO Specialists excluding O...	4	With	83	100.0	1.5	1.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	7	100.0	19.1	27.9
	Bosque Farms	87068	55	Delta Dental PPO Specialists excluding O...	0	With	55	100.0	5.1	5.3
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	26.0	42.0
	Cedar Crest	87008	17	Delta Dental PPO Specialists excluding O...	0	With	16	94.1	9.0	9.0
				Delta Dental PPO Specialists excluding O...		W/o	1	5.9	10.5	10.5
	Chamisal	87521	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	36.3	36.6
	Clovis	88101	2	Delta Dental PPO Specialists excluding O...	2	With	2	100.0	2.9	2.9
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	17.9	17.9
	Corrales	87048	52	Delta Dental PPO Specialists excluding O...	0	With	52	100.0	2.4	3.4
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	52.7	52.7
	Cubero	87014	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	18.6	49.4
	Edgewood	87015	127	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	127	100.0	17.9	17.9
	Espanola	87532	3	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	3	100.0	17.9	17.9
	Estancia	87016	16	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	16	100.0	30.5	30.6
	Farmington	87401	1	Delta Dental PPO Specialists excluding O...	1	With	1	100.0	0.3	5.4
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	1.1	1.1
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental PPO Specialists excluding O...	1	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	4	100.0	1.8	60.7
	Isleta	87022	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	8.7	8.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	5	100.0	9.6	17.1
	Jemez Pueblo	87024	5	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	5	100.0	26.7	26.7
	Jemez Springs	87025	4	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	4	100.0	25.8	25.8
	Kirtland AFB	87117	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	3.7	3.9
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	21.9	24.4
	Laguna	87026	5	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	5	100.0	28.0	31.0
	Lamy	87540	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	12.6	13.6
	Las Cruces	88011	1	Delta Dental PPO Specialists excluding O...	13	With	1	100.0	1.6	1.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	42.0	42.2

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	8.4	38.2
	Los Alamos	87544	1	Delta Dental PPO Specialists excluding O...	2	With	1	100.0	3.5	3.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental PPO Specialists excluding O...	7	With	287	100.0	2.8	4.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	35.0	35.0
	Moriarty	87035	20	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	20	100.0	27.4	27.4
	Mountainair	87036	10	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	10	100.0	30.5	37.2
	New Laguna	87038	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	28.0	38.9
	Paguate	87040	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	26.6	34.8
	Pena Blanca	87041	5	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	5	100.0	20.3	20.3
	Peralta	87042	30	Delta Dental PPO Specialists excluding O...	0	With	30	100.0	3.6	3.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental PPO Specialists excluding O...	0	With	12	100.0	5.0	5.0
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	27.7	27.7
	Prewitt	87045	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	26.8	40.9
	Pueblo of Acoma	87034	4	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	4	100.0	20.8	49.2
	Rainsville	87736	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	48.2	48.2
	Ribera	87560	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	44.2	45.5
	Rio Rancho	87124	421	Delta Dental PPO Specialists excluding O...	23	With	421	100.0	1.5	2.1
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87144	335	Delta Dental PPO Specialists excluding O...	0	With	335	100.0	4.3	4.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87174	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	1.3	1.8
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	2	100.0	18.1	18.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	Average Distance 2
New Mexico	Sandia Park	87047	32	Delta Dental PPO Specialists excluding O...	0	With	8	25.0	8.9	8.9
				Delta Dental PPO Specialists excluding O...		W/o	24	75.0	13.1	13.1
	Santa Fe	87501	4	Delta Dental PPO Specialists excluding O...	0	With	4	100.0	2.6	2.6
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87505	5	Delta Dental PPO Specialists excluding O...	6	With	5	100.0	0.9	1.4
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87506	2	Delta Dental PPO Specialists excluding O...	0	With	2	100.0	3.7	3.7
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87507	9	Delta Dental PPO Specialists excluding O...	13	With	9	100.0	1.8	1.8
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
		87509	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	0.5	0.5
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	93.2	94.0
	Santo Domingo P...	87052	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	24.4	24.4
	Silver City	88061	1	Delta Dental PPO Specialists excluding O...	1	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	1.0	56.7
	Socorro	87801	4	Delta Dental PPO Specialists excluding O...	1	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	4	100.0	1.4	43.7
	Stanley	87056	4	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	4	100.0	26.9	26.9
	Thoreau	87323	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	26.7	39.9
	Tijeras	87059	80	Delta Dental PPO Specialists excluding O...	0	With	5	6.2	8.0	8.0
				Delta Dental PPO Specialists excluding O...		W/o	75	93.8	14.3	14.3
	Tome	87060	1	Delta Dental PPO Specialists excluding O...	0	With	1	100.0	5.0	5.0
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental PPO Specialists excluding O...	4	With	1	100.0	1.4	1.4
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
	Willard	87063	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	41.3	43.7
	Zuni	87327	1	Delta Dental PPO Specialists excluding O...	0	With	0	0.0	--	--
				Delta Dental PPO Specialists excluding O...		W/o	1	100.0	33.1	33.1
South Carolina	West Columbia	29169	1	Delta Dental PPO Specialists excluding O...	18	With	1	100.0	1.1	1.1
				Delta Dental PPO Specialists excluding O...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental PPO Specialists excluding O...	194	With	7,290	94.2	2.8	3.0
				Delta Dental PPO Specialists excluding O...		W/o	452	5.8	16.1	20.0

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Access Summary By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee Group
City of Albuquerque

Provider Group
Delta Dental PPO Orthodontists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:
2 (Delta Dental PPO Orthodontists) providers in 15 miles

[2] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental PPO Orthodontists	7,632	98.6	23,046	5,439	8,425	2.4	3.0

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental PPO Orthodontists	898	100.0	18	2.1	2.5
	87120	769	Delta Dental PPO Orthodontists	769	100.0	5	1.5	1.5
	87114	714	Delta Dental PPO Orthodontists	714	100.0	17	2.5	2.7
	87105	661	Delta Dental PPO Orthodontists	661	100.0	1	2.2	3.2
Rio Rancho, NM	87124	421	Delta Dental PPO Orthodontists	421	100.0	10	1.7	1.7
Albuquerque, NM	87102	412	Delta Dental PPO Orthodontists	412	100.0	1	1.9	3.4
Rio Rancho, NM	87144	335	Delta Dental PPO Orthodontists	335	100.0	2	4.6	6.5
Albuquerque, NM	87110	324	Delta Dental PPO Orthodontists	324	100.0	3	1.1	2.1
	87111	321	Delta Dental PPO Orthodontists	321	100.0	3	1.5	1.6
	87107	299	Delta Dental PPO Orthodontists	299	100.0	0	3.3	3.6
	87112	295	Delta Dental PPO Orthodontists	295	100.0	7	1.3	1.4
Los Lunas, NM	87031	287	Delta Dental PPO Orthodontists	287	100.0	8	2.8	2.8
Albuquerque, NM	87123	268	Delta Dental PPO Orthodontists	268	100.0	2	1.1	1.6
	87109	251	Delta Dental PPO Orthodontists	251	100.0	4	1.3	1.6
	87108	174	Delta Dental PPO Orthodontists	174	100.0	0	1.5	2.0
	87106	163	Delta Dental PPO Orthodontists	163	100.0	0	2.0	2.8
	87104	129	Delta Dental PPO Orthodontists	129	100.0	0	2.5	2.5
	87113	129	Delta Dental PPO Orthodontists	129	100.0	1	1.9	2.8
Edgewood, NM	87015	127	Delta Dental PPO Orthodontists	127	100.0	3	4.9	4.9
Belen, NM	87002	120	Delta Dental PPO Orthodontists	107	89.2	0	11.1	11.1
Bernalillo, NM	87004	83	Delta Dental PPO Orthodontists	83	100.0	1	1.8	9.3
Tijeras, NM	87059	80	Delta Dental PPO Orthodontists	80	100.0	0	10.1	10.1
Albuquerque, NM	87122	71	Delta Dental PPO Orthodontists	71	100.0	8	1.4	1.9
Bosque Farms, NM	87068	55	Delta Dental PPO Orthodontists	55	100.0	0	5.1	5.1
Corrales, NM	87048	52	Delta Dental PPO Orthodontists	52	100.0	0	2.7	2.7
Peralta, NM	87042	30	Delta Dental PPO Orthodontists	30	100.0	0	3.6	3.6
Sandia Park, NM	87047	32	Delta Dental PPO Orthodontists	29	90.6	0	10.8	10.8
Moriarty, NM	87035	20	Delta Dental PPO Orthodontists	19	95.0	0	9.4	9.4
Cedar Crest, NM	87008	17	Delta Dental PPO Orthodontists	17	100.0	0	9.1	9.1
Placitas, NM	87043	12	Delta Dental PPO Orthodontists	12	100.0	0	4.9	10.6
Santa Fe, NM	87507	9	Delta Dental PPO Orthodontists	9	100.0	3	3.6	3.8
Albuquerque, NM	87125	7	Delta Dental PPO Orthodontists	7	100.0	0	2.4	3.2
Algodones, NM	87001	12	Delta Dental PPO Orthodontists	6	50.0	0	8.1	14.1
Albuquerque, NM	87184	6	Delta Dental PPO Orthodontists	6	100.0	0	2.4	3.2
	87116	5	Delta Dental PPO Orthodontists	5	100.0	0	2.0	3.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	122.9	122.9
New Mexico	Albuquerque	87101	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	2.4	3.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87102	412	Delta Dental PPO Orthodontists / 2 in 15...	1	With	412	100.0	1.9	3.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87103	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	4	100.0	1.8	3.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87104	129	Delta Dental PPO Orthodontists / 2 in 15...	0	With	129	100.0	2.5	2.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87105	661	Delta Dental PPO Orthodontists / 2 in 15...	1	With	661	100.0	2.2	3.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87106	163	Delta Dental PPO Orthodontists / 2 in 15...	0	With	163	100.0	2.0	2.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87107	299	Delta Dental PPO Orthodontists / 2 in 15...	0	With	299	100.0	3.3	3.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87108	174	Delta Dental PPO Orthodontists / 2 in 15...	0	With	174	100.0	1.5	2.0
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87109	251	Delta Dental PPO Orthodontists / 2 in 15...	4	With	251	100.0	1.3	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87110	324	Delta Dental PPO Orthodontists / 2 in 15...	3	With	324	100.0	1.1	2.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87111	321	Delta Dental PPO Orthodontists / 2 in 15...	3	With	321	100.0	1.5	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87112	295	Delta Dental PPO Orthodontists / 2 in 15...	7	With	295	100.0	1.3	1.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87113	129	Delta Dental PPO Orthodontists / 2 in 15...	1	With	129	100.0	1.9	2.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87114	714	Delta Dental PPO Orthodontists / 2 in 15...	17	With	714	100.0	2.5	2.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87116	5	Delta Dental PPO Orthodontists / 2 in 15...	0	With	5	100.0	2.0	3.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87119	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	2.3	4.3
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87120	769	Delta Dental PPO Orthodontists / 2 in 15...	5	With	769	100.0	1.5	1.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87121	898	Delta Dental PPO Orthodontists / 2 in 15...	18	With	898	100.0	2.1	2.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87122	71	Delta Dental PPO Orthodontists / 2 in 15...	8	With	71	100.0	1.4	1.9
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental PPO Orthodontists / 2 in 15...	2	With	268	100.0	1.1	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87125	7	Delta Dental PPO Orthodontists / 2 in 15...	0	With	7	100.0	2.4	3.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87154	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	1.6	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87176	3	Delta Dental PPO Orthodontists / 2 in 15...	0	With	3	100.0	1.6	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87184	6	Delta Dental PPO Orthodontists / 2 in 15...	0	With	6	100.0	2.4	3.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87187	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	2.2	2.9
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87191	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	1.6	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87193	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	0.7	0.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87194	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	2.5	2.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87196	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	2.0	2.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87199	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	4	100.0	0.8	0.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental PPO Orthodontists / 2 in 15...	0	With	6	50.0	8.1	14.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	6	50.0	14.7	20.1
	Belen	87002	120	Delta Dental PPO Orthodontists / 2 in 15...	0	With	107	89.2	11.1	11.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	13	10.8	16.7	16.7
	Bernalillo	87004	83	Delta Dental PPO Orthodontists / 2 in 15...	1	With	83	100.0	1.8	9.3
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	7	100.0	27.9	27.9
	Bosque Farms	87068	55	Delta Dental PPO Orthodontists / 2 in 15...	0	With	55	100.0	5.1	5.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	26.0	26.0
	Cedar Crest	87008	17	Delta Dental PPO Orthodontists / 2 in 15...	0	With	17	100.0	9.1	9.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Chamisal	87521	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	20.1	20.1
	Clovis	88101	2	Delta Dental PPO Orthodontists / 2 in 15...	3	With	2	100.0	1.8	1.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	2	100.0	17.9	17.9
	Corrales	87048	52	Delta Dental PPO Orthodontists / 2 in 15...	0	With	52	100.0	2.7	2.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	2	100.0	52.7	52.7
	Cubero	87014	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	2	100.0	18.6	18.6
	Edgewood	87015	127	Delta Dental PPO Orthodontists / 2 in 15...	3	With	127	100.0	4.9	4.9
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Espanola	87532	3	Delta Dental PPO Orthodontists / 2 in 15...	3	With	3	100.0	2.6	2.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Estancia	87016	16	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	6.2	13.0	13.0
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	15	93.8	21.1	21.1
	Farmington	87401	1	Delta Dental PPO Orthodontists / 2 in 15...	5	With	1	100.0	0.3	0.3
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	0.7	1.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental PPO Orthodontists / 2 in 15...	3	With	4	100.0	1.8	1.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Isleta	87022	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	8.7	8.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	20.0	14.4	14.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	4	80.0	16.1	16.1
	Jemez Pueblo	87024	5	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	5	100.0	26.7	26.7
	Jemez Springs	87025	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	4	100.0	25.8	25.8
	Kirtland AFB	87117	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	2.2	3.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	21.9	21.9
	Laguna	87026	5	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	5	100.0	28.0	28.0
	Lamy	87540	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	12.6	12.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Las Cruces	88011	1	Delta Dental PPO Orthodontists / 2 in 15...	9	With	1	100.0	1.6	1.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental PPO Orthodontists / 2 in 15...	4	With	2	100.0	1.9	1.9
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	8.4	8.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Los Alamos	87544	1	Delta Dental PPO Orthodontists / 2 in 15...	4	With	1	100.0	3.5	3.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental PPO Orthodontists / 2 in 15...	8	With	287	100.0	2.8	2.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	18.4	18.4
	Moriarty	87035	20	Delta Dental PPO Orthodontists / 2 in 15...	0	With	19	95.0	9.4	9.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	5.0	15.1	15.1
	Mountainair	87036	10	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	10	100.0	35.9	35.9
	New Laguna	87038	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	28.0	28.0
	Paguate	87040	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	26.6	26.6
	Pena Blanca	87041	5	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	5	100.0	20.8	20.8
	Peralta	87042	30	Delta Dental PPO Orthodontists / 2 in 15...	0	With	30	100.0	3.6	3.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental PPO Orthodontists / 2 in 15...	0	With	12	100.0	4.9	10.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	2	100.0	27.2	28.3
	Prewitt	87045	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	26.8	26.8
	Pueblo of Acoma	87034	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	4	100.0	20.8	20.8
	Rainsville	87736	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	27.7	27.7
	Ribera	87560	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	28.5	28.5
	Rio Rancho	87124	421	Delta Dental PPO Orthodontists / 2 in 15...	10	With	421	100.0	1.7	1.7
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87144	335	Delta Dental PPO Orthodontists / 2 in 15...	2	With	335	100.0	4.6	6.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87174	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	1.0	1.0
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	2	100.0	18.1	18.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental PPO Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	Average Distance 2
New Mexico	Sandia Park	87047	32	Delta Dental PPO Orthodontists / 2 in 15...	0	With	29	90.6	10.8	10.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	3	9.4	16.4	16.4
	Santa Fe	87501	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	4	100.0	2.6	2.6
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87505	5	Delta Dental PPO Orthodontists / 2 in 15...	11	With	5	100.0	1.8	2.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87506	2	Delta Dental PPO Orthodontists / 2 in 15...	0	With	2	100.0	3.7	7.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87507	9	Delta Dental PPO Orthodontists / 2 in 15...	3	With	9	100.0	3.6	3.8
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
		87509	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	0.5	0.5
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	62.9	62.9
	Santo Domingo P...	87052	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	23.9	25.4
	Silver City	88061	1	Delta Dental PPO Orthodontists / 2 in 15...	1	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	2.3	56.6
	Socorro	87801	4	Delta Dental PPO Orthodontists / 2 in 15...	2	With	4	100.0	1.4	1.4
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Stanley	87056	4	Delta Dental PPO Orthodontists / 2 in 15...	0	With	3	75.0	12.2	12.2
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	25.0	16.0	16.0
	Thoreau	87323	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	26.7	26.7
	Tijeras	87059	80	Delta Dental PPO Orthodontists / 2 in 15...	0	With	80	100.0	10.1	10.1
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Tome	87060	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	5.0	5.0
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	67.2	67.3
	Willard	87063	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	34.9	34.9
	Zuni	87327	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	0	0.0	--	--
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	1	100.0	32.2	32.9
South Carolina	West Columbia	29169	1	Delta Dental PPO Orthodontists / 2 in 15...	0	With	1	100.0	4.9	4.9
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental PPO Orthodontists / 2 in 15...	142	With	7,632	98.6	2.4	3.0
				Delta Dental PPO Orthodontists / 2 in 15...		W/o	110	1.4	25.0	25.8

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Delta Dental Premier

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Access Summary By Zip Code

July 28, 2025

Access Analysis

2 General Dentists within 10 miles

Employee Group

City of Albuquerque

Provider Group

Delta Dental Premier General Dentists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:

2 (Delta Dental Premier General Dentists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

P: Unique providers

L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental Premier General De...	7,632	98.6	369,226	126,295	60,355	1.6	1.7

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental Premier General Dentists	898	100.0	88	2.0	2.0
	87120	769	Delta Dental Premier General Dentists	769	100.0	35	1.2	1.3
	87114	714	Delta Dental Premier General Dentists	714	100.0	127	1.9	2.1
	87105	661	Delta Dental Premier General Dentists	661	100.0	27	1.4	1.5
Rio Rancho, NM	87124	421	Delta Dental Premier General Dentists	421	100.0	105	1.2	1.2
Albuquerque, NM	87102	412	Delta Dental Premier General Dentists	412	100.0	22	0.8	0.8
Rio Rancho, NM	87144	335	Delta Dental Premier General Dentists	335	100.0	7	3.9	3.9
Albuquerque, NM	87110	324	Delta Dental Premier General Dentists	324	100.0	64	0.6	0.7
	87111	321	Delta Dental Premier General Dentists	321	100.0	65	1.0	1.2
	87107	299	Delta Dental Premier General Dentists	299	100.0	9	1.2	1.3
	87112	295	Delta Dental Premier General Dentists	295	100.0	43	0.9	0.9
Los Lunas, NM	87031	287	Delta Dental Premier General Dentists	287	100.0	64	2.5	2.5
Albuquerque, NM	87123	268	Delta Dental Premier General Dentists	268	100.0	12	1.0	1.0
	87109	251	Delta Dental Premier General Dentists	251	100.0	69	0.9	1.1
	87108	174	Delta Dental Premier General Dentists	174	100.0	17	0.5	0.7
	87106	163	Delta Dental Premier General Dentists	163	100.0	3	0.8	1.1
	87104	129	Delta Dental Premier General Dentists	129	100.0	6	1.0	1.0
	87113	129	Delta Dental Premier General Dentists	129	100.0	13	1.0	1.0
Edgewood, NM	87015	127	Delta Dental Premier General Dentists	127	100.0	14	4.7	4.7
Belen, NM	87002	120	Delta Dental Premier General Dentists	117	97.5	5	1.9	2.5
Bernalillo, NM	87004	83	Delta Dental Premier General Dentists	83	100.0	15	1.3	1.3
Albuquerque, NM	87122	71	Delta Dental Premier General Dentists	71	100.0	12	1.1	1.6
Tijeras, NM	87059	80	Delta Dental Premier General Dentists	63	78.8	3	5.5	5.7
Bosque Farms, NM	87068	55	Delta Dental Premier General Dentists	55	100.0	1	2.2	3.6
Corrales, NM	87048	52	Delta Dental Premier General Dentists	52	100.0	0	2.1	2.4
Peralta, NM	87042	30	Delta Dental Premier General Dentists	30	100.0	1	1.0	3.6
Sandia Park, NM	87047	32	Delta Dental Premier General Dentists	27	84.4	10	3.9	4.0
Cedar Crest, NM	87008	17	Delta Dental Premier General Dentists	17	100.0	1	1.0	2.6
Estancia, NM	87016	16	Delta Dental Premier General Dentists	16	100.0	3	6.5	6.5
Placitas, NM	87043	12	Delta Dental Premier General Dentists	12	100.0	1	2.3	4.7
Santa Fe, NM	87507	9	Delta Dental Premier General Dentists	9	100.0	31	1.3	1.3
Moriarty, NM	87035	20	Delta Dental Premier General Dentists	8	40.0	0	5.9	5.9
Albuquerque, NM	87125	7	Delta Dental Premier General Dentists	7	100.0	0	0.9	0.9
Algodones, NM	87001	12	Delta Dental Premier General Dentists	6	50.0	0	6.1	8.1
Albuquerque, NM	87184	6	Delta Dental Premier General Dentists	6	100.0	0	1.5	1.5

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	10.1	15.2
New Mexico	Albuquerque	87101	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.9	0.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87102	412	Delta Dental Premier General Dentists /...	22	With	412	100.0	0.8	0.8
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87103	4	Delta Dental Premier General Dentists /...	0	With	4	100.0	0.6	0.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87104	129	Delta Dental Premier General Dentists /...	6	With	129	100.0	1.0	1.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87105	661	Delta Dental Premier General Dentists /...	27	With	661	100.0	1.4	1.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87106	163	Delta Dental Premier General Dentists /...	3	With	163	100.0	0.8	1.1
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87107	299	Delta Dental Premier General Dentists /...	9	With	299	100.0	1.2	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87108	174	Delta Dental Premier General Dentists /...	17	With	174	100.0	0.5	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87109	251	Delta Dental Premier General Dentists /...	69	With	251	100.0	0.9	1.1
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87110	324	Delta Dental Premier General Dentists /...	64	With	324	100.0	0.6	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87111	321	Delta Dental Premier General Dentists /...	65	With	321	100.0	1.0	1.2
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87112	295	Delta Dental Premier General Dentists /...	43	With	295	100.0	0.9	0.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87113	129	Delta Dental Premier General Dentists /...	13	With	129	100.0	1.0	1.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87114	714	Delta Dental Premier General Dentists /...	127	With	714	100.0	1.9	2.1
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87116	5	Delta Dental Premier General Dentists /...	0	With	5	100.0	1.3	1.4
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87119	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	2.3	2.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87120	769	Delta Dental Premier General Dentists /...	35	With	769	100.0	1.2	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87121	898	Delta Dental Premier General Dentists /...	88	With	898	100.0	2.0	2.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87122	71	Delta Dental Premier General Dentists /...	12	With	71	100.0	1.1	1.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental Premier General Dentists /...	12	With	268	100.0	1.0	1.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87125	7	Delta Dental Premier General Dentists /...	0	With	7	100.0	0.9	0.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87154	2	Delta Dental Premier General Dentists /...	0	With	2	100.0	0.6	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87176	3	Delta Dental Premier General Dentists /...	0	With	3	100.0	0.9	0.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87184	6	Delta Dental Premier General Dentists /...	0	With	6	100.0	1.5	1.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87187	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.2	0.2
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87191	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.6	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87193	2	Delta Dental Premier General Dentists /...	0	With	2	100.0	0.7	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87194	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.6	0.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87196	2	Delta Dental Premier General Dentists /...	0	With	2	100.0	0.2	0.8
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87199	4	Delta Dental Premier General Dentists /...	0	With	4	100.0	0.8	0.8
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental Premier General Dentists /...	0	With	6	50.0	6.1	8.1
				Delta Dental Premier General Dentists /...		W/o	6	50.0	9.8	14.5
	Belen	87002	120	Delta Dental Premier General Dentists /...	5	With	117	97.5	1.9	2.5
				Delta Dental Premier General Dentists /...		W/o	3	2.5	13.8	13.9
	Bernalillo	87004	83	Delta Dental Premier General Dentists /...	15	With	83	100.0	1.3	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	7	100.0	16.7	17.6
	Bosque Farms	87068	55	Delta Dental Premier General Dentists /...	1	With	55	100.0	2.2	3.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	26.0	26.0
	Cedar Crest	87008	17	Delta Dental Premier General Dentists /...	1	With	17	100.0	1.0	2.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Chamisal	87521	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	1.8	2.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Clovis	88101	2	Delta Dental Premier General Dentists /...	47	With	2	100.0	1.2	1.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	2	100.0	17.3	17.3
	Corrales	87048	52	Delta Dental Premier General Dentists /...	0	With	52	100.0	2.1	2.4
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental Premier General Dentists /...	7	With	1	50.0	3.2	3.2
				Delta Dental Premier General Dentists /...		W/o	1	50.0	12.1	12.1
	Cubero	87014	2	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	2	100.0	18.6	18.6
	Edgewood	87015	127	Delta Dental Premier General Dentists /...	14	With	127	100.0	4.7	4.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Espanola	87532	3	Delta Dental Premier General Dentists /...	15	With	3	100.0	2.6	2.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Estancia	87016	16	Delta Dental Premier General Dentists /...	3	With	16	100.0	6.5	6.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Farmington	87401	1	Delta Dental Premier General Dentists /...	36	With	1	100.0	0.3	0.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.7	0.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental Premier General Dentists /...	9	With	4	100.0	1.6	1.8
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Isleta	87022	2	Delta Dental Premier General Dentists /...	0	With	2	100.0	2.1	5.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental Premier General Dentists /...	0	With	3	60.0	4.7	5.0
				Delta Dental Premier General Dentists /...		W/o	2	40.0	16.6	16.6
	Jemez Pueblo	87024	5	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	5	100.0	26.1	26.1
	Jemez Springs	87025	4	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	4	100.0	24.7	24.7
	Kirtland AFB	87117	2	Delta Dental Premier General Dentists /...	0	With	2	100.0	1.6	1.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	21.2	21.4
	Laguna	87026	5	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	5	100.0	28.0	28.0
	Lamy	87540	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	12.2	12.6
	Las Cruces	88011	1	Delta Dental Premier General Dentists /...	71	With	1	100.0	1.3	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental Premier General Dentists /...	11	With	2	100.0	1.2	1.2
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	7.8	8.4
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Los Alamos	87544	1	Delta Dental Premier General Dentists /...	10	With	1	100.0	0.4	0.4
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental Premier General Dentists /...	64	With	287	100.0	2.5	2.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	12.9	12.9
	Moriarty	87035	20	Delta Dental Premier General Dentists /...	0	With	8	40.0	5.9	5.9
				Delta Dental Premier General Dentists /...		W/o	12	60.0	12.3	12.3
	Mountainair	87036	10	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	10	100.0	23.0	23.0
	New Laguna	87038	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	28.0	28.0
	Paguate	87040	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	26.6	26.6
	Pena Blanca	87041	5	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	5	100.0	18.7	18.9
	Peralta	87042	30	Delta Dental Premier General Dentists /...	1	With	30	100.0	1.0	3.6
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental Premier General Dentists /...	1	With	12	100.0	2.3	4.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	2	100.0	27.2	27.2
	Prewitt	87045	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	26.5	26.8
	Pueblo of Acoma	87034	4	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	4	100.0	20.8	20.8
	Rainsville	87736	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	8.8	8.8
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Ribera	87560	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	28.3	28.3
	Rio Rancho	87124	421	Delta Dental Premier General Dentists /...	105	With	421	100.0	1.2	1.2
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87144	335	Delta Dental Premier General Dentists /...	7	With	335	100.0	3.9	3.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87174	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	1.0	1.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	2	100.0	17.5	17.5

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 General Dentists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier General Dentists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Sandia Park	87047	32	Delta Dental Premier General Dentists /...	10	With	27	84.4	3.9	4.0
				Delta Dental Premier General Dentists /...		W/o	5	15.6	11.6	11.6
	Santa Fe	87501	4	Delta Dental Premier General Dentists /...	2	With	4	100.0	1.5	1.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87505	5	Delta Dental Premier General Dentists /...	67	With	5	100.0	0.8	0.9
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87506	2	Delta Dental Premier General Dentists /...	1	With	2	100.0	3.7	3.7
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87507	9	Delta Dental Premier General Dentists /...	31	With	9	100.0	1.3	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
		87509	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	0.5	0.5
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental Premier General Dentists /...	2	With	1	100.0	1.2	1.2
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Santo Domingo P...	87052	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	18.6	20.6
	Silver City	88061	1	Delta Dental Premier General Dentists /...	7	With	1	100.0	0.2	0.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Socorro	87801	4	Delta Dental Premier General Dentists /...	5	With	4	100.0	1.0	1.3
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Stanley	87056	4	Delta Dental Premier General Dentists /...	0	With	1	25.0	9.7	9.7
				Delta Dental Premier General Dentists /...		W/o	3	75.0	14.3	14.3
	Thoreau	87323	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	26.5	26.7
	Tijeras	87059	80	Delta Dental Premier General Dentists /...	3	With	63	78.8	5.5	5.7
				Delta Dental Premier General Dentists /...		W/o	17	21.2	12.1	12.1
	Tome	87060	1	Delta Dental Premier General Dentists /...	0	With	1	100.0	4.0	4.0
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental Premier General Dentists /...	27	With	1	100.0	1.4	1.4
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
	Willard	87063	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	19.4	19.4
	Zuni	87327	1	Delta Dental Premier General Dentists /...	0	With	0	0.0	--	--
				Delta Dental Premier General Dentists /...		W/o	1	100.0	32.2	32.2
South Carolina	West Columbia	29169	1	Delta Dental Premier General Dentists /...	52	With	1	100.0	1.1	1.1
				Delta Dental Premier General Dentists /...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental Premier General Dentists /...	1,242	With	7,632	98.6	1.6	1.7
				Delta Dental Premier General Dentists /...		W/o	110	1.4	17.6	18.0

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Access Summary By Zip Code

July 28, 2025

Access Analysis

2 Specialists excluding Orthodontists within 10 miles

Employee Group

City of Albuquerque

Provider Group

Delta Dental Premier Specialists excluding Orthodontists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:

2 (Delta Dental Premier Specialists excluding Orthodontists) providers in 10 miles

[2] Provider counts represent:

#: Provider access points

P: Unique providers

L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental Premier Specialists e...	7,290	94.2	73,351	19,912	16,933	2.8	3.0

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental Premier Specialists excluding Orthodon...	898	100.0	12	3.7	3.7
	87120	769	Delta Dental Premier Specialists excluding Orthodon...	769	100.0	9	2.1	2.3
	87114	714	Delta Dental Premier Specialists excluding Orthodon...	714	100.0	26	2.5	2.6
	87105	661	Delta Dental Premier Specialists excluding Orthodon...	661	100.0	0	5.3	5.3
Rio Rancho, NM	87124	421	Delta Dental Premier Specialists excluding Orthodon...	421	100.0	23	1.5	2.1
Albuquerque, NM	87102	412	Delta Dental Premier Specialists excluding Orthodon...	412	100.0	0	3.5	3.5
Rio Rancho, NM	87144	335	Delta Dental Premier Specialists excluding Orthodon...	335	100.0	0	4.3	4.6
Albuquerque, NM	87110	324	Delta Dental Premier Specialists excluding Orthodon...	324	100.0	10	1.0	1.2
	87111	321	Delta Dental Premier Specialists excluding Orthodon...	321	100.0	12	1.4	1.4
	87107	299	Delta Dental Premier Specialists excluding Orthodon...	299	100.0	0	3.2	3.3
	87112	295	Delta Dental Premier Specialists excluding Orthodon...	295	100.0	6	1.3	1.3
Los Lunas, NM	87031	287	Delta Dental Premier Specialists excluding Orthodon...	287	100.0	7	2.8	4.6
Albuquerque, NM	87123	268	Delta Dental Premier Specialists excluding Orthodon...	268	100.0	1	1.4	1.8
	87109	251	Delta Dental Premier Specialists excluding Orthodon...	251	100.0	24	1.2	1.2
	87108	174	Delta Dental Premier Specialists excluding Orthodon...	174	100.0	0	1.7	2.7
	87106	163	Delta Dental Premier Specialists excluding Orthodon...	163	100.0	0	2.3	2.3
	87104	129	Delta Dental Premier Specialists excluding Orthodon...	129	100.0	0	3.7	3.7
	87113	129	Delta Dental Premier Specialists excluding Orthodon...	129	100.0	9	1.7	1.7
Bernalillo, NM	87004	83	Delta Dental Premier Specialists excluding Orthodon...	83	100.0	4	1.5	1.5
Albuquerque, NM	87122	71	Delta Dental Premier Specialists excluding Orthodon...	71	100.0	2	2.2	2.2
Bosque Farms, NM	87068	55	Delta Dental Premier Specialists excluding Orthodon...	55	100.0	0	5.1	5.3
Corrales, NM	87048	52	Delta Dental Premier Specialists excluding Orthodon...	52	100.0	0	2.4	3.4
Peralta, NM	87042	30	Delta Dental Premier Specialists excluding Orthodon...	30	100.0	0	3.6	3.6
Belen, NM	87002	120	Delta Dental Premier Specialists excluding Orthodon...	27	22.5	1	4.8	8.5
Cedar Crest, NM	87008	17	Delta Dental Premier Specialists excluding Orthodon...	16	94.1	0	9.0	9.0
Placitas, NM	87043	12	Delta Dental Premier Specialists excluding Orthodon...	12	100.0	0	5.0	5.0
Santa Fe, NM	87507	9	Delta Dental Premier Specialists excluding Orthodon...	9	100.0	13	1.4	1.4
Sandia Park, NM	87047	32	Delta Dental Premier Specialists excluding Orthodon...	8	25.0	0	8.9	8.9
Albuquerque, NM	87125	7	Delta Dental Premier Specialists excluding Orthodon...	7	100.0	0	2.5	2.5
Algodones, NM	87001	12	Delta Dental Premier Specialists excluding Orthodon...	6	50.0	0	8.8	8.8
Albuquerque, NM	87184	6	Delta Dental Premier Specialists excluding Orthodon...	6	100.0	0	1.9	1.9
Tijeras, NM	87059	80	Delta Dental Premier Specialists excluding Orthodon...	5	6.2	0	8.0	8.0
Albuquerque, NM	87116	5	Delta Dental Premier Specialists excluding Orthodon...	5	100.0	0	3.1	3.7
Santa Fe, NM	87505	5	Delta Dental Premier Specialists excluding Orthodon...	5	100.0	10	0.9	1.2
Albuquerque, NM	87103	4	Delta Dental Premier Specialists excluding Orthodon...	4	100.0	0	3.6	3.6

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	15.6	23.5
New Mexico	Albuquerque	87101	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	2.5	2.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87102	412	Delta Dental Premier Specialists excludin...	0	With	412	100.0	3.5	3.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87103	4	Delta Dental Premier Specialists excludin...	0	With	4	100.0	3.6	3.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87104	129	Delta Dental Premier Specialists excludin...	0	With	129	100.0	3.7	3.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87105	661	Delta Dental Premier Specialists excludin...	0	With	661	100.0	5.3	5.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87106	163	Delta Dental Premier Specialists excludin...	0	With	163	100.0	2.3	2.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87107	299	Delta Dental Premier Specialists excludin...	0	With	299	100.0	3.2	3.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87108	174	Delta Dental Premier Specialists excludin...	0	With	174	100.0	1.7	2.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87109	251	Delta Dental Premier Specialists excludin...	24	With	251	100.0	1.2	1.2
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87110	324	Delta Dental Premier Specialists excludin...	10	With	324	100.0	1.0	1.2
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87111	321	Delta Dental Premier Specialists excludin...	12	With	321	100.0	1.4	1.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87112	295	Delta Dental Premier Specialists excludin...	6	With	295	100.0	1.3	1.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87113	129	Delta Dental Premier Specialists excludin...	9	With	129	100.0	1.7	1.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87114	714	Delta Dental Premier Specialists excludin...	26	With	714	100.0	2.5	2.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87116	5	Delta Dental Premier Specialists excludin...	0	With	5	100.0	3.1	3.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87119	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	4.4	4.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87120	769	Delta Dental Premier Specialists excludin...	9	With	769	100.0	2.1	2.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87121	898	Delta Dental Premier Specialists excludin...	12	With	898	100.0	3.7	3.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87122	71	Delta Dental Premier Specialists excludin...	2	With	71	100.0	2.2	2.2
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental Premier Specialists excludin...	1	With	268	100.0	1.4	1.8
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87125	7	Delta Dental Premier Specialists excludin...	0	With	7	100.0	2.5	2.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87154	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	1.6	1.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87176	3	Delta Dental Premier Specialists excludin...	0	With	3	100.0	1.2	1.2
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87184	6	Delta Dental Premier Specialists excludin...	0	With	6	100.0	1.9	1.9
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87187	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	2.6	3.1
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87191	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	1.6	1.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87193	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	0.7	0.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87194	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	3.9	3.9
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87196	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	2.0	2.0
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87199	4	Delta Dental Premier Specialists excludin...	0	With	4	100.0	0.8	0.8
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental Premier Specialists excludin...	0	With	6	50.0	8.8	8.8
				Delta Dental Premier Specialists excludin...		W/o	6	50.0	15.3	15.3
	Belen	87002	120	Delta Dental Premier Specialists excludin...	1	With	27	22.5	4.8	8.5
				Delta Dental Premier Specialists excludin...		W/o	93	77.5	3.7	12.7
	Bernalillo	87004	83	Delta Dental Premier Specialists excludin...	4	With	83	100.0	1.5	1.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	7	100.0	19.1	27.9
	Bosque Farms	87068	55	Delta Dental Premier Specialists excludin...	0	With	55	100.0	5.1	5.3
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	26.0	42.0
	Cedar Crest	87008	17	Delta Dental Premier Specialists excludin...	0	With	16	94.1	9.0	9.0
				Delta Dental Premier Specialists excludin...		W/o	1	5.9	10.5	10.5
	Chamisal	87521	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	36.3	36.6
	Clovis	88101	2	Delta Dental Premier Specialists excludin...	2	With	2	100.0	2.9	2.9
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	17.9	17.9
	Corrales	87048	52	Delta Dental Premier Specialists excludin...	0	With	52	100.0	2.4	3.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	52.7	52.7
	Cubero	87014	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	18.6	49.4
	Edgewood	87015	127	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	127	100.0	17.9	17.9
	Espanola	87532	3	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	3	100.0	17.9	17.9
	Estancia	87016	16	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	16	100.0	30.5	30.6
	Farmington	87401	1	Delta Dental Premier Specialists excludin...	1	With	1	100.0	0.3	5.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	1.1	1.1
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental Premier Specialists excludin...	1	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	4	100.0	1.8	60.7
	Isleta	87022	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	8.7	8.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	5	100.0	9.6	17.1
	Jemez Pueblo	87024	5	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	5	100.0	26.7	26.7
	Jemez Springs	87025	4	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	4	100.0	25.8	25.8
	Kirtland AFB	87117	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	3.7	3.9
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	21.9	24.4
	Laguna	87026	5	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	5	100.0	28.0	31.0
	Lamy	87540	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	9.8	12.6
	Las Cruces	88011	1	Delta Dental Premier Specialists excludin...	15	With	1	100.0	1.6	1.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	40.0	42.0

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	8.4	38.2
	Los Alamos	87544	1	Delta Dental Premier Specialists excludin...	3	With	1	100.0	3.5	3.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental Premier Specialists excludin...	7	With	287	100.0	2.8	4.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	35.0	35.0
	Moriarty	87035	20	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	20	100.0	27.4	27.4
	Mountainair	87036	10	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	10	100.0	30.5	37.2
	New Laguna	87038	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	28.0	38.9
	Paguate	87040	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	26.6	34.8
	Pena Blanca	87041	5	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	5	100.0	20.3	20.3
	Peralta	87042	30	Delta Dental Premier Specialists excludin...	0	With	30	100.0	3.6	3.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental Premier Specialists excludin...	0	With	12	100.0	5.0	5.0
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	27.7	27.7
	Prewitt	87045	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	26.8	40.9
	Pueblo of Acoma	87034	4	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	4	100.0	20.8	49.2
	Rainsville	87736	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	48.2	48.2
	Ribera	87560	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	41.7	44.2
	Rio Rancho	87124	421	Delta Dental Premier Specialists excludin...	23	With	421	100.0	1.5	2.1
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87144	335	Delta Dental Premier Specialists excludin...	0	With	335	100.0	4.3	4.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87174	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	1.3	1.8
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	2	100.0	18.1	18.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Specialists excluding Orthodontists within 10 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Specialists excluding Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	Average Distance 2
New Mexico	Sandia Park	87047	32	Delta Dental Premier Specialists excludin...	0	With	8	25.0	8.9	8.9
				Delta Dental Premier Specialists excludin...		W/o	24	75.0	13.1	13.1
	Santa Fe	87501	4	Delta Dental Premier Specialists excludin...	1	With	4	100.0	2.6	2.6
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87505	5	Delta Dental Premier Specialists excludin...	10	With	5	100.0	0.9	1.2
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87506	2	Delta Dental Premier Specialists excludin...	0	With	2	100.0	3.7	3.7
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87507	9	Delta Dental Premier Specialists excludin...	13	With	9	100.0	1.4	1.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
		87509	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	0.5	0.5
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	90.9	93.2
	Santo Domingo P...	87052	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	24.4	24.4
	Silver City	88061	1	Delta Dental Premier Specialists excludin...	1	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	1.0	56.7
	Socorro	87801	4	Delta Dental Premier Specialists excludin...	1	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	4	100.0	1.4	43.7
	Stanley	87056	4	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	4	100.0	26.9	26.9
	Thoreau	87323	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	26.7	39.9
	Tijeras	87059	80	Delta Dental Premier Specialists excludin...	0	With	5	6.2	8.0	8.0
				Delta Dental Premier Specialists excludin...		W/o	75	93.8	14.3	14.3
	Tome	87060	1	Delta Dental Premier Specialists excludin...	0	With	1	100.0	5.0	5.0
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental Premier Specialists excludin...	4	With	1	100.0	1.4	1.4
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
	Willard	87063	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	41.3	43.7
	Zuni	87327	1	Delta Dental Premier Specialists excludin...	0	With	0	0.0	--	--
				Delta Dental Premier Specialists excludin...		W/o	1	100.0	33.1	33.1
South Carolina	West Columbia	29169	1	Delta Dental Premier Specialists excludin...	24	With	1	100.0	1.1	1.1
				Delta Dental Premier Specialists excludin...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental Premier Specialists excludin...	222	With	7,290	94.2	2.8	3.0
				Delta Dental Premier Specialists excludin...		W/o	452	5.8	16.1	20.0

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Access Summary By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee Group
City of Albuquerque

Provider Group
Delta Dental Premier Orthodontists

[1] The Access Standard is defined as (City of Albuquerque) employees accessing:
2 (Delta Dental Premier Orthodontists) providers in 15 miles

[2] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Employees With Access

Employee		Provider	With Access[1]		Counts[2]			Average Distance	
Group	#	Group	#	%	#	P	L	1	2
City of Albuquerque	7,742	Delta Dental Premier Orthodontists	7,632	98.6	26,948	6,803	10,285	2.4	3.0

Key Geographic Areas

City	Zip Code	Employee	Provider	With Access[1]		Counts[2]	Average Distance	
		#	Group	#	%	#	1	2
Albuquerque, NM	87121	898	Delta Dental Premier Orthodontists	898	100.0	18	2.1	2.5
	87120	769	Delta Dental Premier Orthodontists	769	100.0	5	1.5	1.5
	87114	714	Delta Dental Premier Orthodontists	714	100.0	22	2.4	2.6
	87105	661	Delta Dental Premier Orthodontists	661	100.0	1	2.2	3.2
Rio Rancho, NM	87124	421	Delta Dental Premier Orthodontists	421	100.0	10	1.7	1.7
Albuquerque, NM	87102	412	Delta Dental Premier Orthodontists	412	100.0	1	1.9	3.4
Rio Rancho, NM	87144	335	Delta Dental Premier Orthodontists	335	100.0	2	4.6	6.5
Albuquerque, NM	87110	324	Delta Dental Premier Orthodontists	324	100.0	3	1.1	2.1
	87111	321	Delta Dental Premier Orthodontists	321	100.0	9	1.5	1.5
	87107	299	Delta Dental Premier Orthodontists	299	100.0	0	3.3	3.6
	87112	295	Delta Dental Premier Orthodontists	295	100.0	7	1.3	1.4
Los Lunas, NM	87031	287	Delta Dental Premier Orthodontists	287	100.0	10	2.8	2.8
Albuquerque, NM	87123	268	Delta Dental Premier Orthodontists	268	100.0	2	1.1	1.6
	87109	251	Delta Dental Premier Orthodontists	251	100.0	6	1.3	1.6
	87108	174	Delta Dental Premier Orthodontists	174	100.0	0	1.5	2.0
	87106	163	Delta Dental Premier Orthodontists	163	100.0	0	2.0	2.8
	87104	129	Delta Dental Premier Orthodontists	129	100.0	0	2.5	2.5
	87113	129	Delta Dental Premier Orthodontists	129	100.0	2	1.3	2.2
Edgewood, NM	87015	127	Delta Dental Premier Orthodontists	127	100.0	3	4.9	4.9
Belen, NM	87002	120	Delta Dental Premier Orthodontists	107	89.2	0	11.1	11.1
Bernalillo, NM	87004	83	Delta Dental Premier Orthodontists	83	100.0	1	1.8	9.3
Tijeras, NM	87059	80	Delta Dental Premier Orthodontists	80	100.0	0	10.1	10.1
Albuquerque, NM	87122	71	Delta Dental Premier Orthodontists	71	100.0	9	1.4	1.9
Bosque Farms, NM	87068	55	Delta Dental Premier Orthodontists	55	100.0	0	5.1	5.1
Corrales, NM	87048	52	Delta Dental Premier Orthodontists	52	100.0	0	2.7	2.7
Peralta, NM	87042	30	Delta Dental Premier Orthodontists	30	100.0	0	3.6	3.6
Sandia Park, NM	87047	32	Delta Dental Premier Orthodontists	29	90.6	0	10.8	10.8
Moriarty, NM	87035	20	Delta Dental Premier Orthodontists	19	95.0	0	9.4	9.4
Cedar Crest, NM	87008	17	Delta Dental Premier Orthodontists	17	100.0	0	9.1	9.1
Placitas, NM	87043	12	Delta Dental Premier Orthodontists	12	100.0	0	4.9	10.6
Santa Fe, NM	87507	9	Delta Dental Premier Orthodontists	9	100.0	3	3.6	3.8
Albuquerque, NM	87125	7	Delta Dental Premier Orthodontists	7	100.0	0	2.4	3.2
Algodones, NM	87001	12	Delta Dental Premier Orthodontists	6	50.0	0	8.1	14.1
Albuquerque, NM	87184	6	Delta Dental Premier Orthodontists	6	100.0	0	1.9	2.4
	87116	5	Delta Dental Premier Orthodontists	5	100.0	0	2.0	3.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
Montana	Lakeside	59922	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	35.3	82.7
New Mexico	Albuquerque	87101	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	2.4	3.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87102	412	Delta Dental Premier Orthodontists / 2 i...	1	With	412	100.0	1.9	3.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87103	4	Delta Dental Premier Orthodontists / 2 i...	0	With	4	100.0	1.8	3.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87104	129	Delta Dental Premier Orthodontists / 2 i...	0	With	129	100.0	2.5	2.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87105	661	Delta Dental Premier Orthodontists / 2 i...	1	With	661	100.0	2.2	3.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87106	163	Delta Dental Premier Orthodontists / 2 i...	0	With	163	100.0	2.0	2.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87107	299	Delta Dental Premier Orthodontists / 2 i...	0	With	299	100.0	3.3	3.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87108	174	Delta Dental Premier Orthodontists / 2 i...	0	With	174	100.0	1.5	2.0
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87109	251	Delta Dental Premier Orthodontists / 2 i...	6	With	251	100.0	1.3	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87110	324	Delta Dental Premier Orthodontists / 2 i...	3	With	324	100.0	1.1	2.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87111	321	Delta Dental Premier Orthodontists / 2 i...	9	With	321	100.0	1.5	1.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87112	295	Delta Dental Premier Orthodontists / 2 i...	7	With	295	100.0	1.3	1.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87113	129	Delta Dental Premier Orthodontists / 2 i...	2	With	129	100.0	1.3	2.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87114	714	Delta Dental Premier Orthodontists / 2 i...	22	With	714	100.0	2.4	2.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87116	5	Delta Dental Premier Orthodontists / 2 i...	0	With	5	100.0	2.0	3.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87119	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	2.3	4.3
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87120	769	Delta Dental Premier Orthodontists / 2 i...	5	With	769	100.0	1.5	1.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87121	898	Delta Dental Premier Orthodontists / 2 i...	18	With	898	100.0	2.1	2.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87122	71	Delta Dental Premier Orthodontists / 2 i...	9	With	71	100.0	1.4	1.9
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Albuquerque	87123	268	Delta Dental Premier Orthodontists / 2 i...	2	With	268	100.0	1.1	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87125	7	Delta Dental Premier Orthodontists / 2 i...	0	With	7	100.0	2.4	3.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87154	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	1.6	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87176	3	Delta Dental Premier Orthodontists / 2 i...	0	With	3	100.0	1.6	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87184	6	Delta Dental Premier Orthodontists / 2 i...	0	With	6	100.0	1.9	2.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87187	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	2.2	2.9
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87191	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	1.6	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87193	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	0.7	0.7
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87194	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	2.5	2.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87196	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	2.0	2.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87199	4	Delta Dental Premier Orthodontists / 2 i...	0	With	4	100.0	0.8	0.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Algodones	87001	12	Delta Dental Premier Orthodontists / 2 i...	0	With	6	50.0	8.1	14.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	6	50.0	14.7	20.1
	Belen	87002	120	Delta Dental Premier Orthodontists / 2 i...	0	With	107	89.2	11.1	11.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	13	10.8	16.7	16.7
	Bernalillo	87004	83	Delta Dental Premier Orthodontists / 2 i...	1	With	83	100.0	1.8	9.3
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Bosque	87006	7	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	7	100.0	27.9	27.9
	Bosque Farms	87068	55	Delta Dental Premier Orthodontists / 2 i...	0	With	55	100.0	5.1	5.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Casa Blanca	87007	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	26.0	26.0
	Cedar Crest	87008	17	Delta Dental Premier Orthodontists / 2 i...	0	With	17	100.0	9.1	9.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Chamisal	87521	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	20.1	20.1
	Clovis	88101	2	Delta Dental Premier Orthodontists / 2 i...	3	With	2	100.0	1.8	1.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--

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Continued on next page...

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Cochiti Lake	87083	2	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	2	100.0	17.9	17.9
	Corrales	87048	52	Delta Dental Premier Orthodontists / 2 i...	0	With	52	100.0	2.7	2.7
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Cuba	87013	2	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	2	100.0	52.7	52.7
	Cubero	87014	2	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	2	100.0	18.6	18.6
	Edgewood	87015	127	Delta Dental Premier Orthodontists / 2 i...	3	With	127	100.0	4.9	4.9
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Espanola	87532	3	Delta Dental Premier Orthodontists / 2 i...	3	With	3	100.0	2.6	2.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Estancia	87016	16	Delta Dental Premier Orthodontists / 2 i...	0	With	1	6.2	13.0	13.0
				Delta Dental Premier Orthodontists / 2 i...		W/o	15	93.8	21.1	21.1
	Farmington	87401	1	Delta Dental Premier Orthodontists / 2 i...	6	With	1	100.0	0.3	0.3
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Gallup	87305	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	0.7	0.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Grants	87020	4	Delta Dental Premier Orthodontists / 2 i...	6	With	4	100.0	1.8	1.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Isleta	87022	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	8.7	8.7
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Jarales	87023	5	Delta Dental Premier Orthodontists / 2 i...	0	With	1	20.0	14.4	14.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	4	80.0	16.1	16.1
	Jemez Pueblo	87024	5	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	5	100.0	26.7	26.7
	Jemez Springs	87025	4	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	4	100.0	25.8	25.8
	Kirtland AFB	87117	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	2.2	3.7
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	La Joya	87028	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	21.9	21.9
	Laguna	87026	5	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	5	100.0	28.0	28.0
	Lamy	87540	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	12.6	12.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Las Cruces	88011	1	Delta Dental Premier Orthodontists / 2 i...	9	With	1	100.0	1.6	1.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Las Vegas	87701	2	Delta Dental Premier Orthodontists / 2 i...	4	With	2	100.0	1.9	1.9
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Orthodontists

Employees With and Without Access

State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	2
New Mexico	Lemitar	87823	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	8.4	8.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Los Alamos	87544	1	Delta Dental Premier Orthodontists / 2 i...	4	With	1	100.0	3.5	3.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Los Lunas	87031	287	Delta Dental Premier Orthodontists / 2 i...	10	With	287	100.0	2.8	2.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	McIntosh	87032	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	18.4	18.4
	Moriarty	87035	20	Delta Dental Premier Orthodontists / 2 i...	0	With	19	95.0	9.4	9.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	5.0	15.1	15.1
	Mountainair	87036	10	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	10	100.0	35.9	35.9
	New Laguna	87038	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	28.0	28.0
	Paguate	87040	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	26.6	26.6
	Pena Blanca	87041	5	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	5	100.0	20.8	20.8
	Peralta	87042	30	Delta Dental Premier Orthodontists / 2 i...	0	With	30	100.0	3.6	3.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Placitas	87043	12	Delta Dental Premier Orthodontists / 2 i...	0	With	12	100.0	4.9	10.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Ponderosa	87044	2	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	2	100.0	27.2	28.3
	Prewitt	87045	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	26.8	26.8
	Pueblo of Acoma	87034	4	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	4	100.0	20.8	20.8
	Rainsville	87736	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	27.7	27.7
	Ribera	87560	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	28.5	28.5
	Rio Rancho	87124	421	Delta Dental Premier Orthodontists / 2 i...	10	With	421	100.0	1.7	1.7
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87144	335	Delta Dental Premier Orthodontists / 2 i...	2	With	335	100.0	4.6	6.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87174	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	1.0	1.0
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	San Ysidro	87053	2	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	2	100.0	18.1	18.1

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Access Detail By Zip Code

July 28, 2025

Access Analysis
2 Orthodontists within 15 miles

Employee / Provider Groups
City of Albuquerque
Delta Dental Premier Orthodontists

Employees With and Without Access										
State Name	City	Zip Code	Employee #	Provider Group / Access Standard	Counts #	Access Results	#	%	Average Distance 1	Average Distance 2
New Mexico	Sandia Park	87047	32	Delta Dental Premier Orthodontists / 2 i...	0	With	29	90.6	10.8	10.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	3	9.4	16.4	16.4
	Santa Fe	87501	4	Delta Dental Premier Orthodontists / 2 i...	0	With	4	100.0	2.6	2.6
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87505	5	Delta Dental Premier Orthodontists / 2 i...	11	With	5	100.0	1.8	2.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87506	2	Delta Dental Premier Orthodontists / 2 i...	0	With	2	100.0	3.7	7.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87507	9	Delta Dental Premier Orthodontists / 2 i...	3	With	9	100.0	3.6	3.8
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
		87509	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	0.5	0.5
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Santa Rosa	88435	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	62.9	62.9
	Santo Domingo P...	87052	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	23.9	25.4
	Silver City	88061	1	Delta Dental Premier Orthodontists / 2 i...	1	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	2.3	56.6
	Socorro	87801	4	Delta Dental Premier Orthodontists / 2 i...	2	With	4	100.0	1.4	1.4
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Stanley	87056	4	Delta Dental Premier Orthodontists / 2 i...	0	With	3	75.0	12.2	12.2
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	25.0	16.0	16.0
	Thoreau	87323	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	26.7	26.7
	Tijeras	87059	80	Delta Dental Premier Orthodontists / 2 i...	0	With	80	100.0	10.1	10.1
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Tome	87060	1	Delta Dental Premier Orthodontists / 2 i...	0	With	1	100.0	5.0	5.0
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
	Truth or Conseq...	87901	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	67.2	67.3
	Willard	87063	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	34.9	34.9
	Zuni	87327	1	Delta Dental Premier Orthodontists / 2 i...	0	With	0	0.0	--	--
				Delta Dental Premier Orthodontists / 2 i...		W/o	1	100.0	32.2	32.8
South Carolina	West Columbia	29169	1	Delta Dental Premier Orthodontists / 2 i...	1	With	1	100.0	2.2	4.9
				Delta Dental Premier Orthodontists / 2 i...		W/o	0	0.0	--	--
Grand Totals			7,742	Delta Dental Premier Orthodontists / 2 i...	164	With	7,632	98.6	2.4	3.0
				Delta Dental Premier Orthodontists / 2 i...		W/o	110	1.4	24.2	25.5

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Demographics and financials: Totals by client, subclient & month.

For the period 01-Oct-2023 to 31-Oct-2023

Client Name

GROUP NUMBER	SUB GROUP	MONTH	SUBSCRIBERS	SPOUSES	DEPENDENTS	EMPLOYEE ONLY	EMPLOYEE SPOUSE	EMPLOYEE SPOUSE CHILDREN	EMPLOYEE CHILD	EMPLOYEE CHILDREN	NUMBER OF CLAIMS	PAID CLAIMS
XXXX	0001	10/31/2023	1,622	463	670	1,042	197	266	73	44	305	$35,381.15
XXXX	0002	10/31/2023	6,059	2,815	4,265	2,591	1,100	1,715	369	284	1,913	$292,445.27
XXXX	1999	10/31/2023	3	0	0	3	0	0	0	0	1	$104.00
XXXX	2999	10/31/2023	34	12	10	22	6	6	0	0	9	$1,665.35

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DELTA DENTAL®

How is treatment distributed by network? The big picture.

Claims paid between 01-Jul-2023 and 30-Sep-2023
Client Name

Category	% of Total	Category Total	# Treat.	Delta Dental PPO	# Treat.	Delta Dental Premier	# Treat.	Out of Network	# Treat.
Exams and Cleanings	37.15%	$430,106.53	9,626	$376,651.17	8,647	$51,140.36	903	$2,315.00	76
X-rays	14.67%	$169,889.33	5,482	$148,207.23	4,905	$20,606.85	524	$1,075.25	53
Sealants	0.70%	$8,153.22	289	$7,565.22	275	$588.00	14	$0.00	0
Fillings	8.53%	$98,710.16	1,312	$90,632.42	1,220	$7,828.04	83	$249.70	9
Crowns	11.38%	$131,731.84	578	$115,157.44	515	$15,914.30	58	$660.10	5
Root Canals	4.32%	$50,014.83	125	$29,924.23	90	$20,090.60	35	$0.00	0
Gum Disease	2.50%	$28,886.28	431	$23,413.88	389	$5,156.70	34	$315.70	8
Gum Disease Cleaning	1.46%	$16,855.95	354	$13,418.05	296	$3,402.70	56	$35.20	2
Extractions	4.15%	$48,044.65	502	$34,628.27	416	$13,192.07	81	$224.31	5
Oral Surgery Other Than Extractions	0.18%	$2,062.10	61	$1,429.50	45	$632.60	15	$0.00	1
Dentures	1.37%	$15,834.65	42	$12,708.80	37	$2,842.00	4	$283.85	1
Bridges	1.47%	$17,003.50	58	$15,723.50	52	$1,003.00	3	$277.00	3
Implants	4.01%	$46,373.99	128	$34,517.81	100	$10,893.62	22	$962.50	6
Denture Repair	0.14%	$1,662.50	19	$886.20	14	$776.30	5	$0.00	0
Braces	6.55%	$75,818.56	1,104	$48,998.23	721	$23,842.55	335	$2,977.78	48
Other Services	1.43%	$16,554.21	453	$9,888.94	357	$6,132.92	90	$532.35	6
Total	**100.00%**	**$1,157,702.24**	**20,564**	**$963,750.89**	**18,079**	**$184,042.61**	**2,262**	**$9,908.74**	**223**

For more information, contact your Delta Dental of New Mexico Sales or Service Representative
Date report was run 09-Nov-2023 for report period ending 31-Oct-2023

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DELTA DENTAL®

How are treatments and costs distributed by member?

Claims paid between 01-Jul-2023 and 30-Sep-2023
Client Name

Category	% of Total	Category Total	# Treat.	Subscriber	# Treat.	Spouse	# Treat.	Other	# Treat.
Exams and Cleanings	37.15%	$430,106.53	9,626	$196,520.68	4,076	$75,740.98	1,655	$157,844.87	3,895
X-rays	14.67%	$169,889.33	5,482	$83,070.75	2,610	$33,726.83	1,099	$53,091.75	1,773
Sealants	0.70%	$8,153.22	289	$0.00	2	$0.00	0	$8,153.22	287
Fillings	8.53%	$98,710.16	1,312	$52,212.33	674	$15,903.25	201	$30,594.58	437
Crowns	11.38%	$131,731.84	578	$87,365.20	365	$36,570.92	153	$7,795.72	60
Root Canals	4.32%	$50,014.83	125	$29,782.30	64	$13,904.23	29	$6,328.30	32
Gum Disease	2.50%	$28,886.28	431	$18,687.52	276	$7,381.36	124	$2,817.40	31
Gum Disease Cleaning	1.46%	$16,855.95	354	$11,420.58	240	$5,077.17	109	$358.20	5
Extractions	4.15%	$48,044.65	502	$12,112.88	181	$5,037.50	92	$30,894.27	229
Oral Surgery Other Than Extractions	0.18%	$2,062.10	61	$232.50	29	$0.00	14	$1,829.60	18
Dentures	1.37%	$15,834.65	42	$9,414.15	24	$6,420.50	17	$0.00	1
Bridges	1.47%	$17,003.50	58	$12,407.50	40	$4,596.00	18	$0.00	0
Implants	4.01%	$46,373.93	128	$31,066.21	89	$14,509.22	38	$798.50	1
Denture Repair	0.14%	$1,662.50	19	$1,423.10	15	$154.70	3	$84.70	1
Braces	6.55%	$75,818.56	1,104	$9,968.92	154	$4,016.13	78	$61,833.51	872
Other Services	1.43%	$16,554.21	453	$2,750.17	125	$1,568.00	40	$12,236.04	288
Total	**100.00%**	**$1,157,702.24**	**20,564**	**$558,434.79**	**8,964**	**$224,606.79**	**3,670**	**$374,660.66**	**7,930**

For more information, contact your Delta Dental of New Mexico Sales or Service Representative
Date report was run 09-Nov-2023 for report period ending 31-Oct-2023

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COMPANY, Inc.

Group 1800

Dental Action Report

Jane Smith
Account Manager
Jane.smith@deltadental.com

18,499 Members were continuously enrolled
Q1 2022 - Q4 2022

National Benchmark

Your Oral Health Score:
69/100
92nd Percentile
National benchmark data comes from Healthentic's database of over 50 million members from all 50 states

Peer Comparison

Your peers are 118 groups similar to your own, nationwide:

- Hospitals
- 2500+ members

DELTA DENTAL

Healthentic

Healthy



Peers 39%
21% above peers

These members had preventive care only

Moderate



Peers 17%
18% above peers

These members primarily had preventive care and treatment

Serious



Peers 12%
8% above peers

These members had emergency care only or extensive care

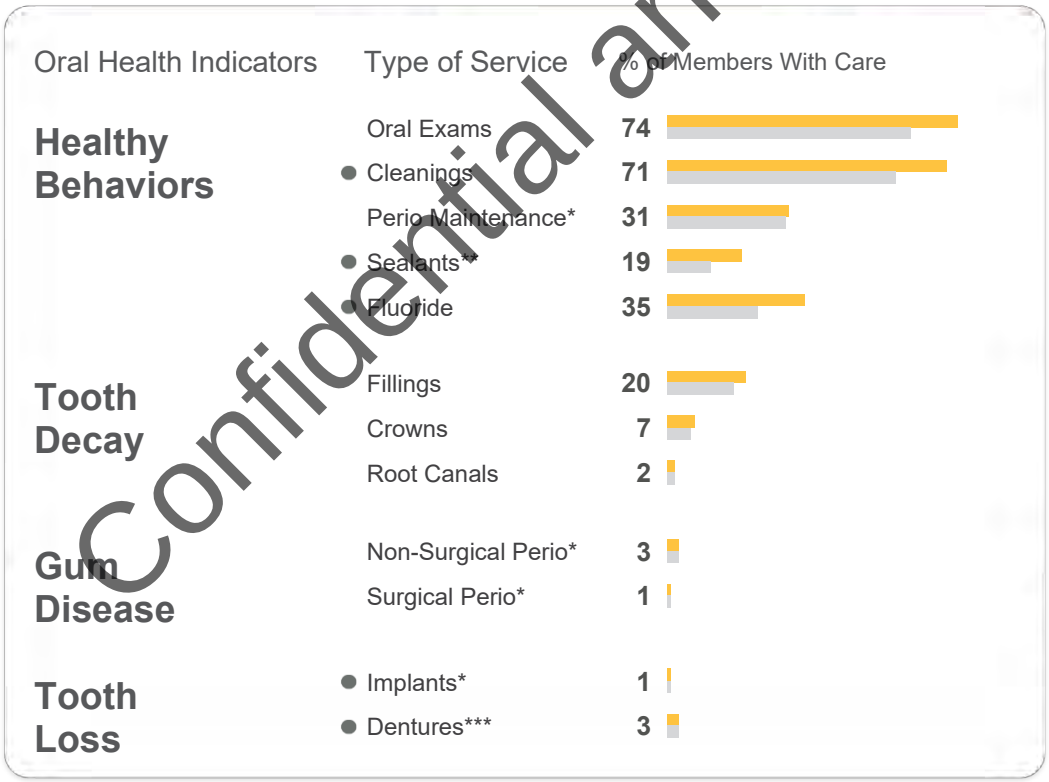
No Visit

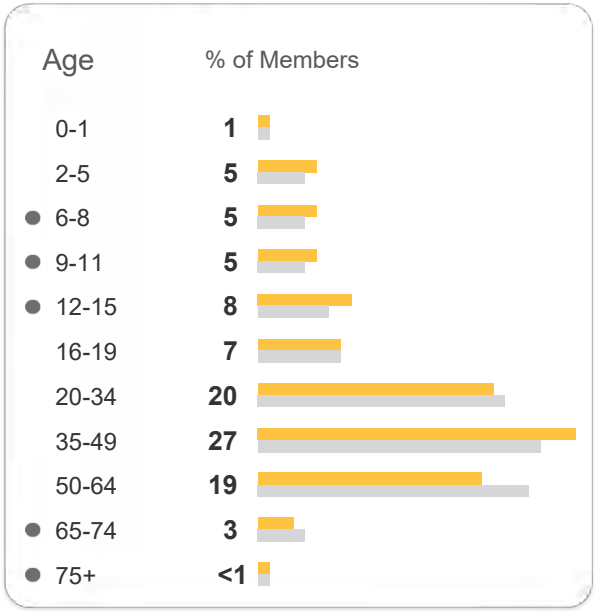


Peers 31%
32% below peers

These members had no dental claims

Oral Health Indicators





Your Group Peers
Indicates ≥ 20% above or below peers
*Age 20+ **Age 6-19 ***Age 50+

Confidential and Proprietary

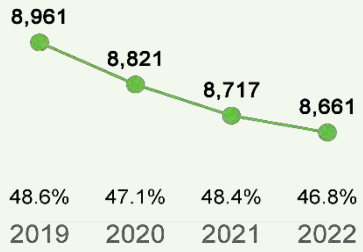
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Oral Health Changes

One year reporting period ending Q4 2022

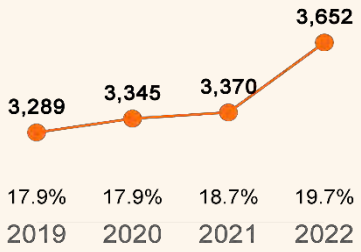
Healthy 47%

8,661 Members



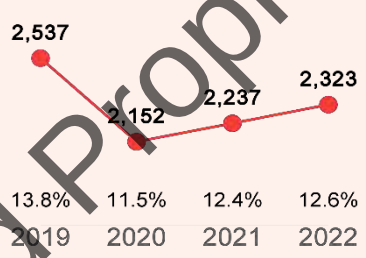
Moderate 20%

3,652 Members



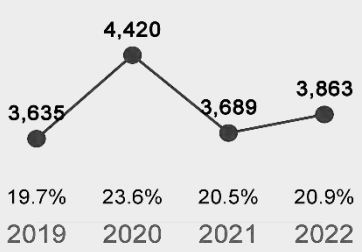
Serious 13%

2,323 Members



No Visit 21%

3,863 Members



Confidential and Proprietary

Changes in the No Visit Category

Positive

521 previously *No Visit* saw a dentist and are *Healthy*

311 previously *No Visit* saw a dentist and are *Moderate*

Concerning

509 previously *Healthy* have not seen a dentist.

368 previously *No Visit* saw a dentist and are Serious.

983 *No Visit* are new enrollees.

Negative

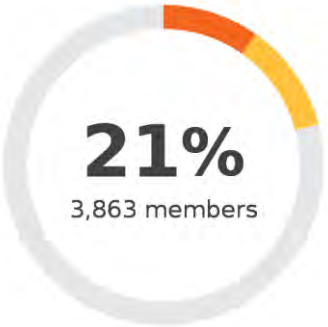
1,807 *No Visit* for two years in a row

288 previously *Serious* have not seen a dentist

276 previously *Moderate* have not seen a dentist

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

No Visit Members

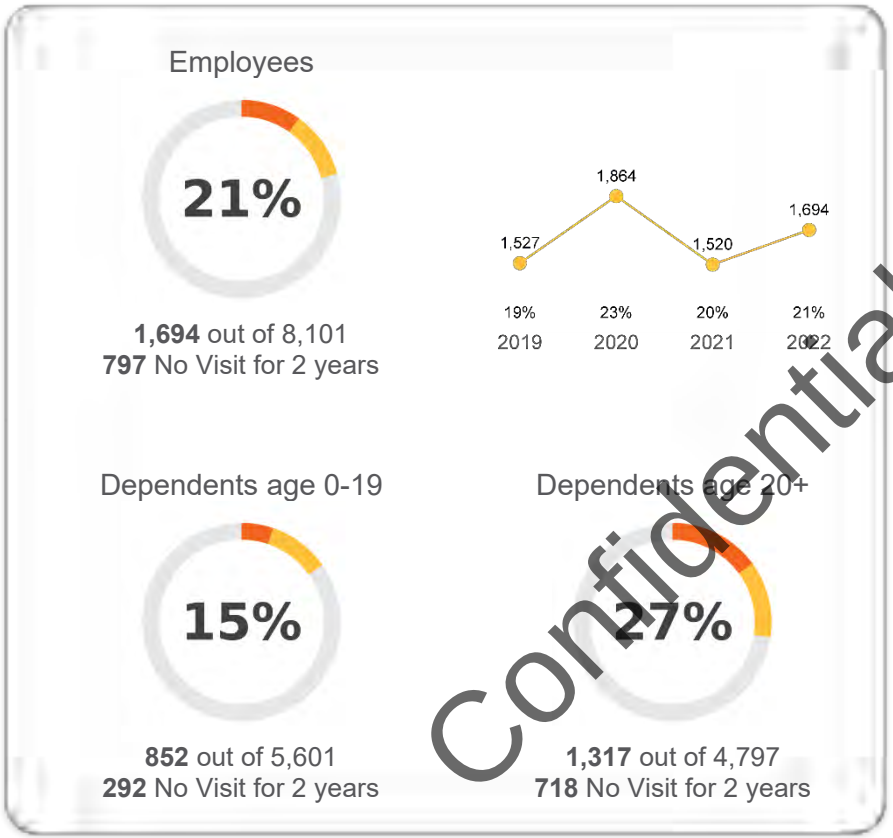


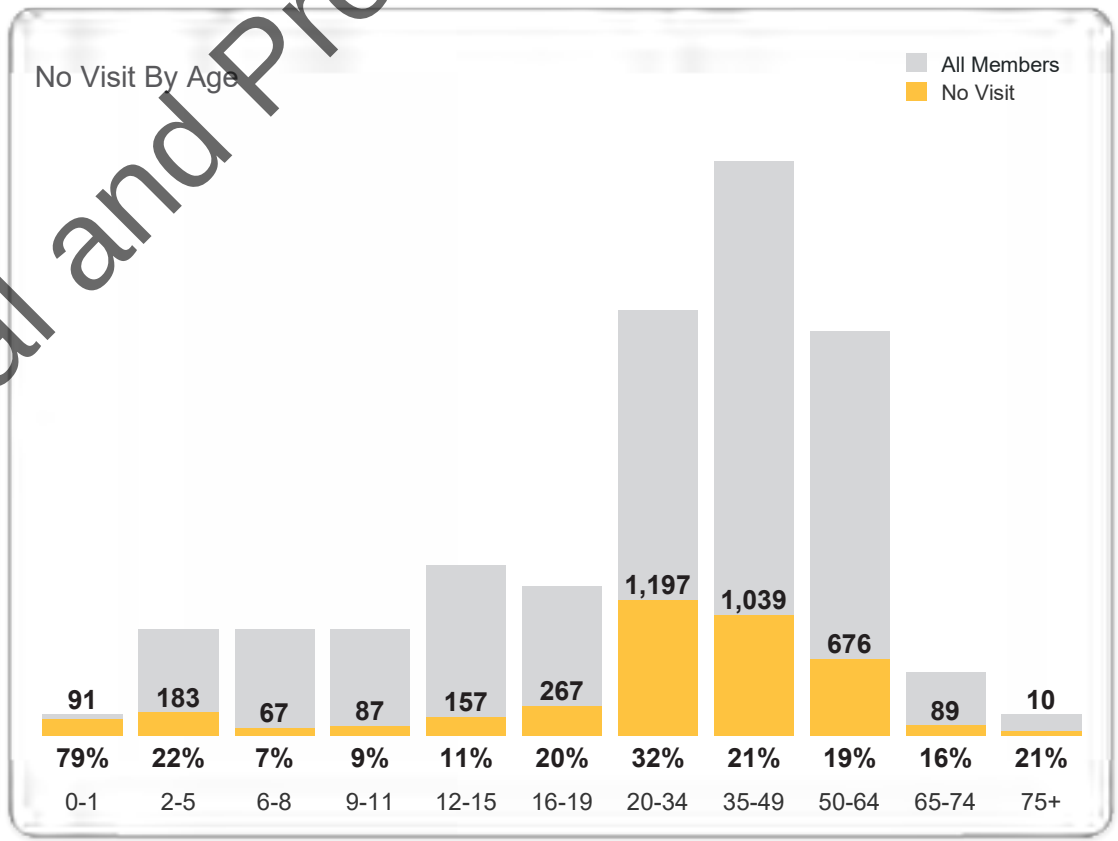
1,807 members have not seen a dentist for two years and may be at increased risk

- **797** are employees
- **1,515** are adults
- **292** are children









Confidential and Proprietary

Note: Age-specific metrics do not include members of an unknown age

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The Cost of No Visits

It is estimated that over $45 billion is lost in productivity each year due to untreated dental disease[1]. In addition, members who delay care also tend to require more expensive treatment for oral health problems when they finally return to the dentist. The five-year analysis below compares members with routine visits to members who did not see a dentist until this year.
Source: (1) https://www.cdc.gov/chronicdisease/programs-impact/pop/oral-disease.htm

How Much Do No Visits Cost?

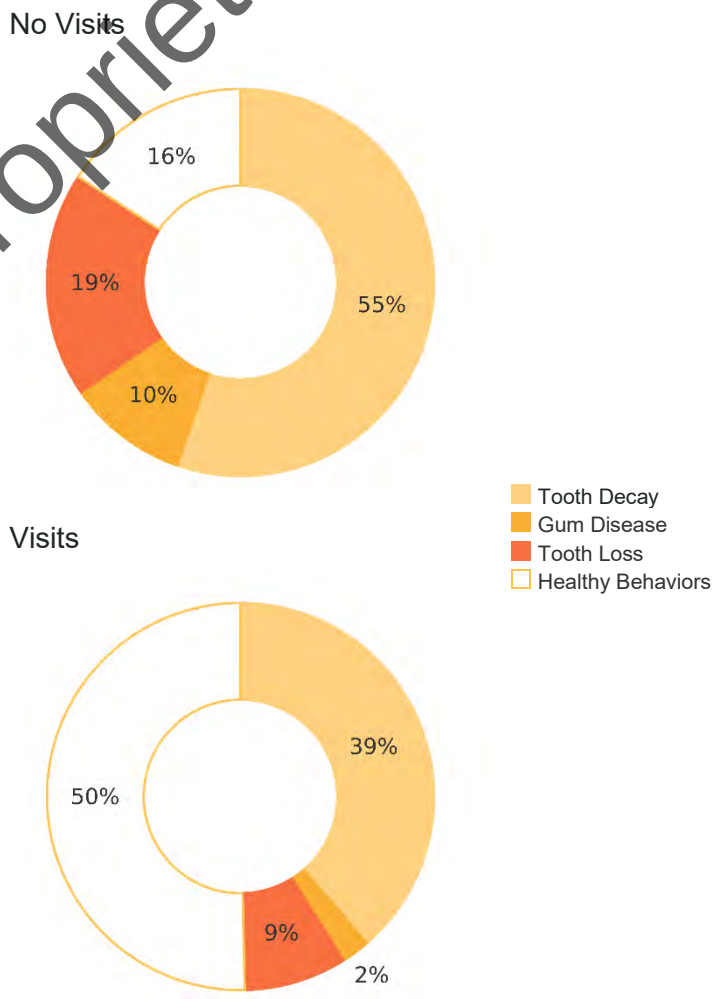
Compared to members with routine visits, the cost of previous No Visit members in the current year often increases with each additional year of no visit.

The graph below shows the average cost per member in the current year after 1 or more years of visits or no visits.



What Types of Procedures Are Driving Costs?

Distribution of procedure costs in the current year after 4 years of no visits or visits



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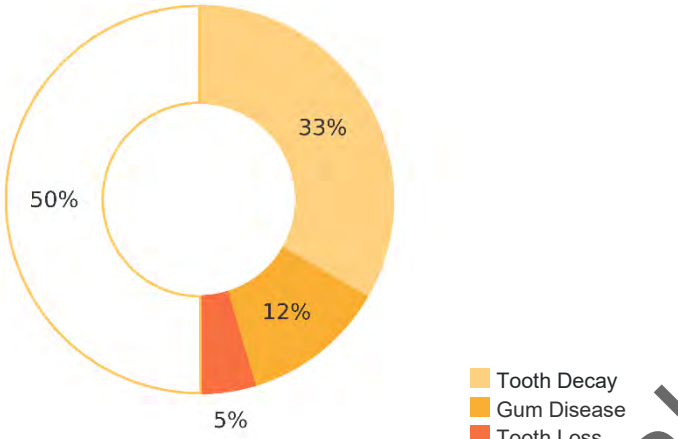
The Cost of No Visits

Previous No Visit members tend to require more extensive treatment for oral health issues in the current year compared to members with routine visits. The Centers for Disease Control and Prevention says this can lead to lost productivity and hours at work. The five-year analysis below compares members with routine visits to members who did not see a dentist until this year.

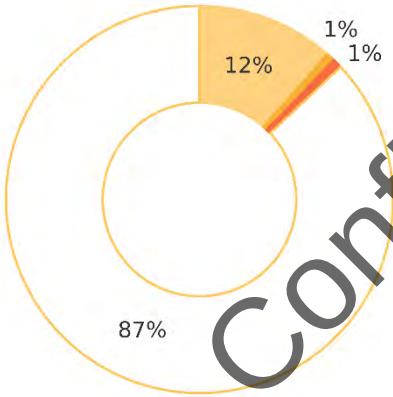
What Type of Care Do They Need?

Distribution of procedure counts in the current year after 4 years of no visits or visits

No Visits



Visits



What Are Their Oral Health Outcomes?

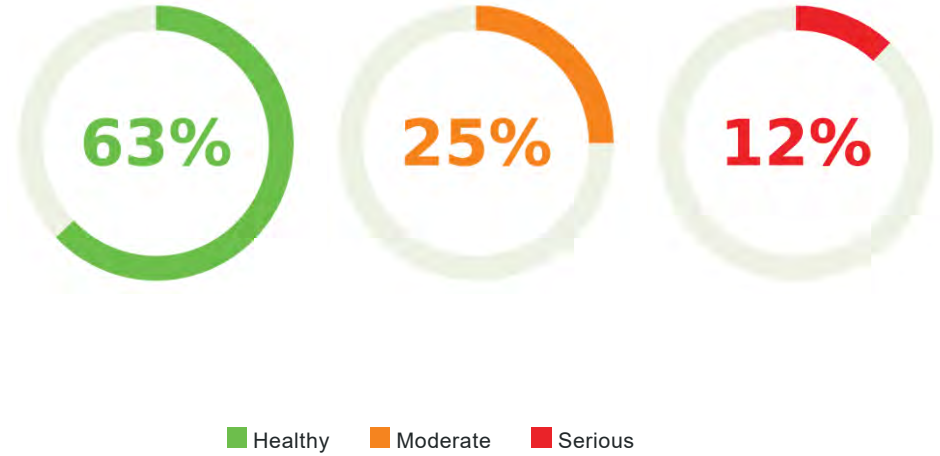
Delaying care may increase the risk of oral health problems that have been linked to whole health concerns such as diabetes, heart disease, and Alzheimer's disease.

Distribution of members in the current year after 4 years of no visits or visits

No Visits



Visits



Confidential and Proprietary

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The Case For Prevention

Do Healthy Behaviors Reduce Overall Costs?

For most organizations, members who get preventive care tend to have better oral health and cost less than people who don't get preventive care. The members included below regularly see a dentist (at least once a year for the last two years). This compares costs for those who received preventive care with those who did not.

Oral Exams

Total Cost Per Member with Oral Exams

These members had at least one exam in the previous reporting period



Total Cost Per Member with No Oral Exams

These members had no exams in the previous reporting period



2022 Benchmark: National Data **$347 Less**

Sealants

Restorative Cost Per Member Aged 6-19 with Sealant Visits

These members had at least one sealant visit and one restorative visit in the previous reporting period



Restorative Cost Per Member Aged 6-19 with No Sealant Visits

These members had no sealant visits but at least one restorative visit in the previous reporting period



2022 Benchmark: National Data **$82 Less**

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Healthy Behaviors

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.

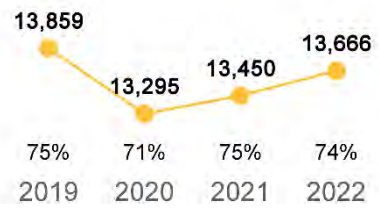
Oral Exams

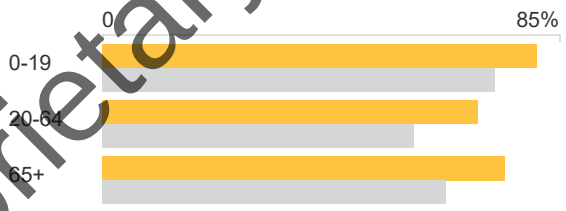
All Ages

74%

had oral exams

13,666 of 18,499 members | 18% above peers





Routine check-ups help dentists catch early signs of tooth decay and gum disease before they become serious conditions.

Cleanings

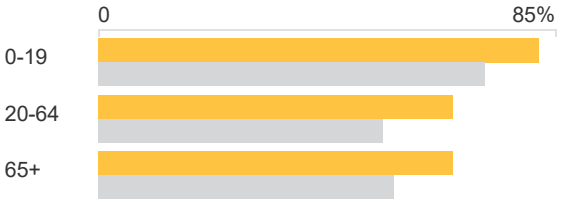
All Ages

71%

had cleanings

13,121 of 18,499 members | 23% above peers





Professional cleanings help remove tartar and other build-up that a toothbrush can't reach.

Perio Maintenance

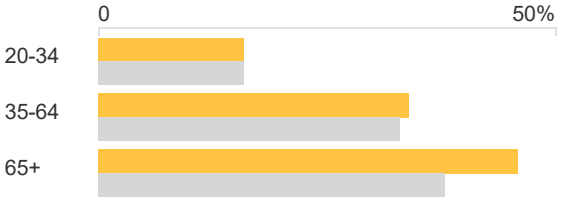
Age 20+ with Previous Perio Treatment

31%

had maintenance

300 of 955 members | 3% above peers





Periodontitis, or advanced gum disease, can lead to tooth loss without proper routine maintenance.

● Indicates ≥20% above or below peers

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Healthy Behaviors

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.

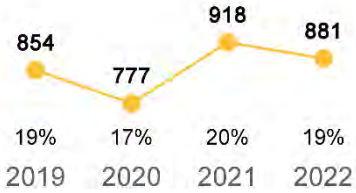
Sealants (Children)

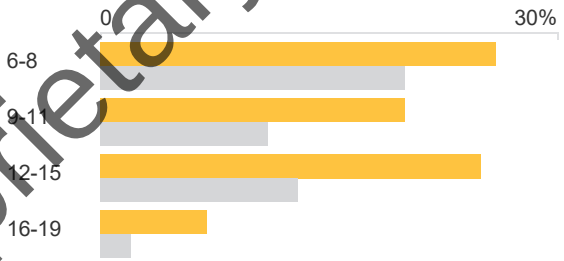
Age 6-19

19%

had sealants

881 of 4,650 members | 76% above peers





Sealants save time and money by avoiding fillings, crowns and caps to fix decayed teeth.

Fluoride (Children)

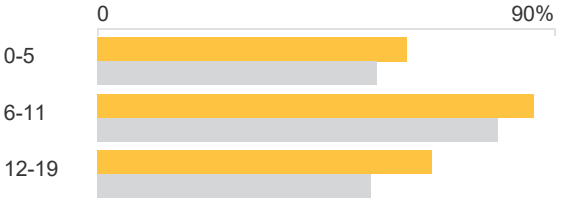
Age 0-19

72%

had fluoride

4,036 of 5,603 members | 17% above peers





Dentists may use topical fluoride to help prevent tooth decay.

Fluoride (Adults)

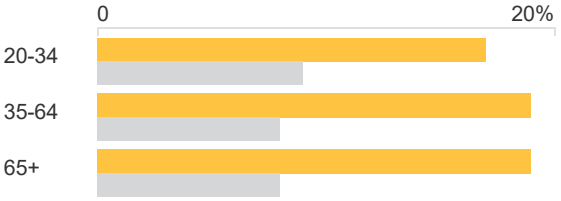
Age 20+

19%

had fluoride

2,408 of 12,896 members | 126% above peers





Dentists may use topical fluoride to help prevent tooth decay.

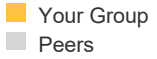
● Indicates ≥20% above or below peers

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Tooth Decay

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.



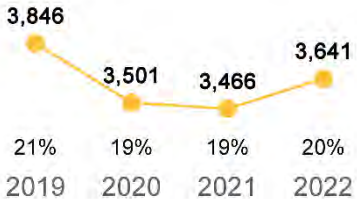
Fillings

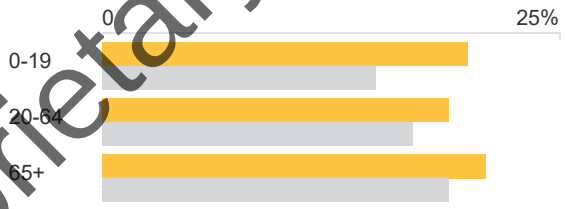
All Ages

20%

had fillings

3,641 of 18,499 members | 19% above peers





Fillings replace lost tooth structure with a suitable restorative material such as amalgam or composite.

Crowns

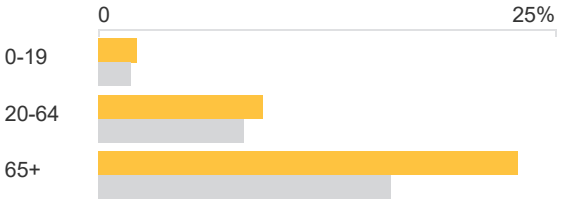
All Ages

7%

had crowns

1,349 of 18,499 members | 13% above peers





Crowns replace the visible portion of a tooth's surface. They are often used to replace broken down fillings or repair fractured teeth.

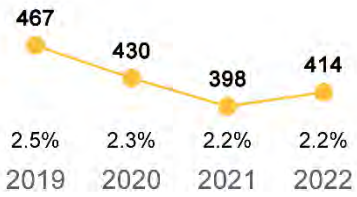
Root Canals

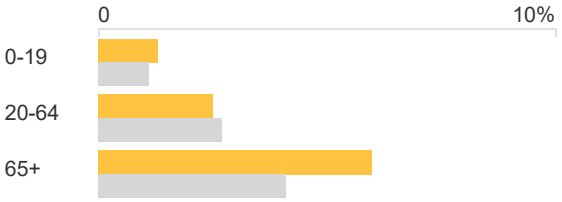
All Ages

2.2%

had root canals

414 of 18,499 members | 5% below peers





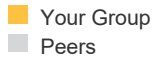
This procedure involves removing a tooth's pulp or nerve from the canal inside the root, and replacing it with an inert filling material.

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Tooth Loss

Risk of tooth loss increases with age. Tooth loss may also result from untreated gum disease.



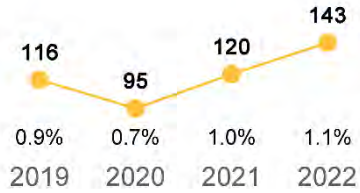
Implants

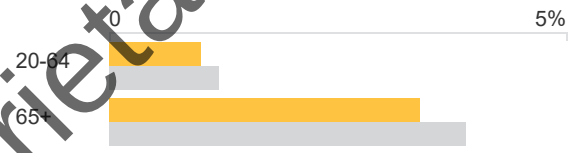
Age 20+

1.1%

had implants

143 of 12,896 members | 22% below peers





Implants are an alternative to bridges and dentures for replacing lost teeth. People with implants still need routine care to maintain good oral health.

Dentures

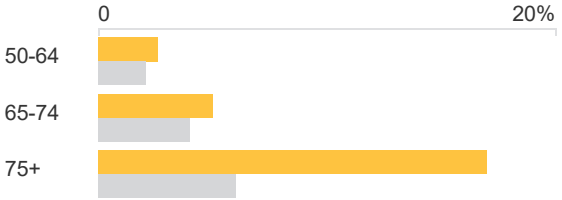
Age 50+

3.1%

had dentures

129 of 4,186 members | 21% above peers





Members with dentures still need routine care to maintain good oral health.

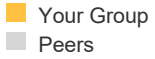
● Indicates ≥20% above or below peers

Confidential and Proprietary

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Gum Disease

Risk of gum disease increases with age and can lead to tooth loss if not treated.



Non-Surgical Perio Treatment

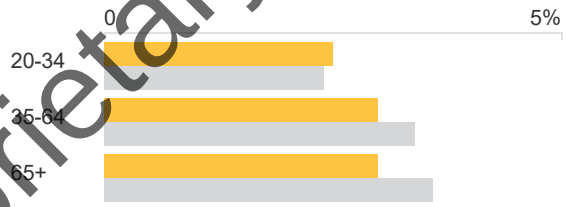
Age 20+

2.9%

had non-surgical treatment

368 of 12,896 members | 9% below peers





Hard deposits on root surfaces and under gums are removed to promote healing and reduce the depth of the periodontal pocket.

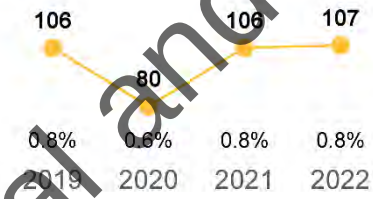
Surgical Perio Treatment

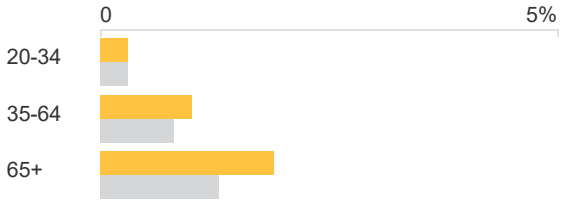
Age 20+

0.8%

had surgical treatment

107 of 12,896 members | 15% above peers





Severe gum disease requires surgical treatment of the diseased teeth and their supporting structures.

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No Follow-up

Restorative Members Without a Follow-up Visit

16%

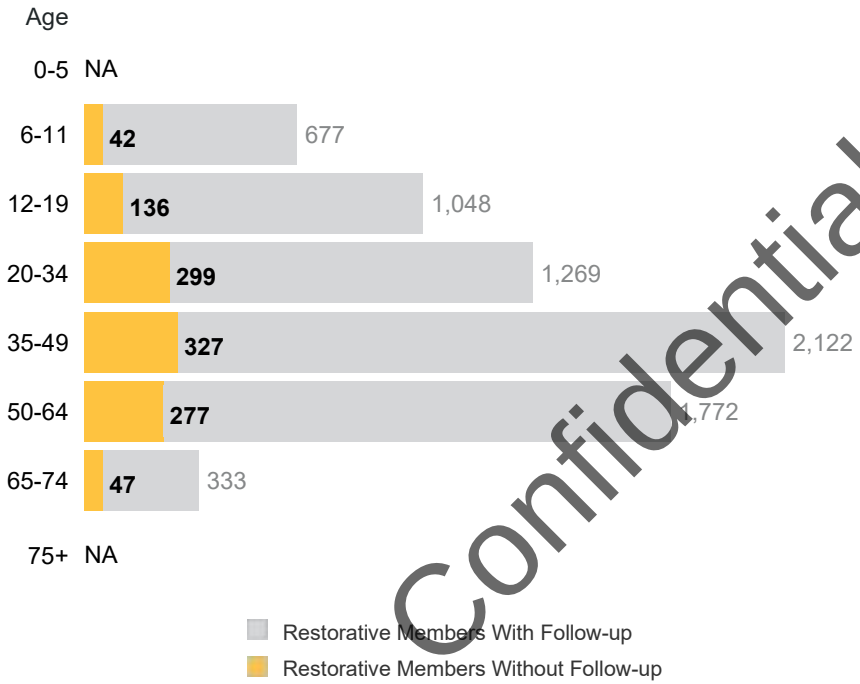
had at least one restorative visit in the previous 3 years, and no follow-up in the most recent year.



2022 Benchmark: National Data **24%**

1,135 Members Had Restorative Treatment and No Follow-up Visit

Data may be hidden for confidentiality if an age group has fewer than 4 no follow-up members.



Perio Members Without a Follow-up Visit

25%

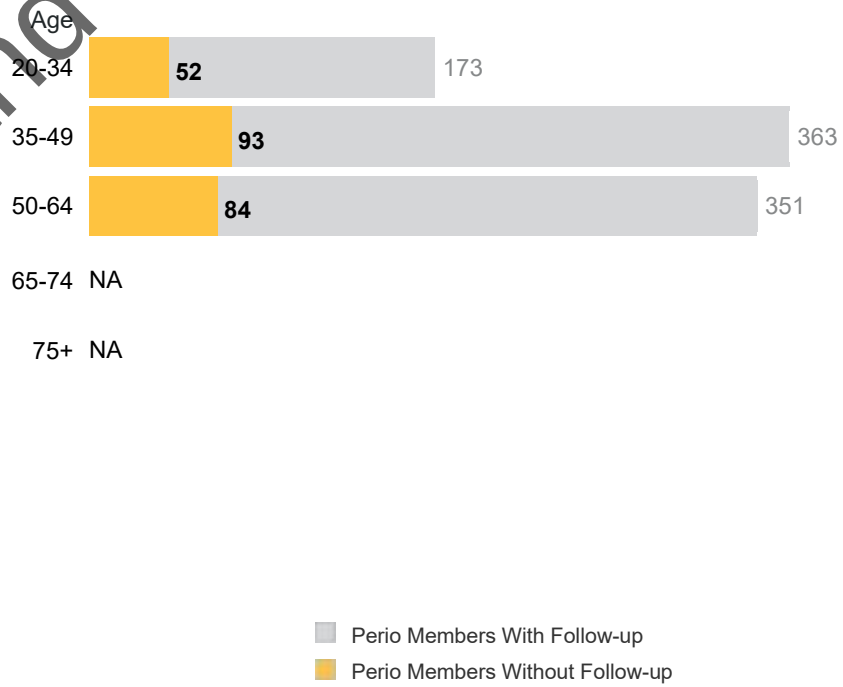
age 20+ had at least one perio visit in the previous 4 years, and no follow-up visit in the most recent year.



2022 Benchmark: National Data **33%**

243 Members Had Perio Treatment and No Follow-up Visit

Data may be hidden for confidentiality if an age group has fewer than 4 no follow-up members.



Data may be hidden for confidentiality if an age group has fewer than 4 members.

Confidential and Proprietary

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Understanding Whole Health Risks

Gum Disease and its Links to Medical Conditions

Periodontal (gum) diseases primarily result from infections and inflammation of the gums and bone that surround and support the teeth. In its early stage, gingivitis, gums can become swollen and bleed. In its more serious form, periodontitis, the gums can pull away from the tooth, bone can be lost, and the teeth may loosen or fall out. Gum disease and tooth decay are the two biggest threats to dental health. **Nearly 50% of all adults aged 30 or older have signs of gum disease**[1].

Members should be educated about the complex interplay between bacterial infection and the body's immune response to infection. Studies have linked oral health infections with diabetes, heart disease, stroke, and premature, low-weight births[2]. Severe/progressive periodontitis is also associated with cancer, Alzheimer's disease, and dozens of other serious diseases[3].

Diabetes

Adults 45 years or older with poorly controlled diabetes were **2.9 times more likely to have gum disease** than those without diabetes[4]. The likelihood was 4.6 times higher among smokers with poorly controlled diabetes[4]. Oral manifestations of uncontrolled diabetes can include xerostomia, burning sensation in the mouth (which may possibly be related to neuropathy), impaired/delayed wound healing, increased incidence and severity of infections, secondary infection with candidiasis; parotid salivary gland enlargement; gingivitis and/or periodontitis[5].

Other Chronic Diseases

Having a chronic disease, such as arthritis, heart disease, stroke, emphysema, hepatitis C, or a liver condition, or being obese may increase an individual's **risk of having missing teeth and poor oral health**[6]. Patients with weakened immune systems, such as those infected with HIV and other medical conditions (organ transplants) and who use some medications (e.g., steroids) are at higher risk for oral problems[6].

Pregnancy

The medical and dental communities concur that maintaining **periodontal health is an important part of a healthy pregnancy**. Clinical recommendations released by the AAP and the EFP state that non-surgical periodontal therapy is safe for pregnant women and can result in improved periodontal health[7].

Cancer, Tobacco Use, and e-Cigarettes

Head and neck radiation and chemotherapy can cause mouth problems that range from dry mouth to life-threatening infections. Patients should **see a dentist about one month before beginning cancer treatment** to make sure their mouth is healthy[8].

In addition to the risk of developing lung cancer, smokers have **twice the risk of developing gum disease** compared to non-smokers[9]. More than half of severe gum disease cases in the United States may result from cigarette smoking[10]. **Smoking has also been linked to tooth loss**. Male smokers are up to 3.6 times more likely to lose their teeth than non-smokers; female smokers were found to be 2.5 times more likely[9].

New studies highlight how **e-cigarettes alter oral health and may be contributing to gum disease**. The latest research finds that e-cigarette users have a unique oral microbiome that is less healthy than nonsmokers but potentially healthier than cigarette smokers, and measures worsening gum disease over time[11].

Confidential and Proprietary

Sources:

1. https://www.cdc.gov/oralhealth/conditions/periodontal-disease.html
2. https://www.nidcr.nih.gov/research/data-statistics/surgeon-general
3. https://pubmed.ncbi.nlm.nih.gov/32844419/
4. http://www.diabetesincontrol.com/wp-content/uploads/PDF/ndep_diabetes_facts_2011.pdf
5. https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/diabetes
6. https://www.cdc.gov/oralhealth/basics/adult-oral-health/index.html
7. https://www.sciencedaily.com/releases/2013/08/130828092310.htm
8. https://www.nidcr.nih.gov/health-info/cancer-treatments
9. https://periodontalhealthcenter.com/blog/covid-smoking-and-gum-disease-18536/
10. https://pubmed.ncbi.nlm.nih.gov/10872955/
11. https://www.sciencedaily.com/releases/2022/02/220222151907.htm

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Definitions

How are the four oral health categories defined?

Healthy - Received routine, preventive dental care, did not have periodontal disease, and required no further treatment.

Moderate - Received routine, preventive dental care, but had minor oral health conditions that were taken care of. Members with periodontal maintenance visits are in this category.

Serious - Had claims for either severe periodontal procedures or major restorative work like crowns and root canals. Often, Serious members had not received routine preventative care.

No Visit - Had no dental claims submitted of any kind for the given reporting period.

How many lives and which states have contributed to the Healthentic data pool?

We have a national database that contains more than 50 million lives total, and more than 24 million lives during the most recent year. Data represents claims from across all 50 states and includes some of the biggest corporations in the world.

What is a member?

Members are unique individuals who have been continuously enrolled for the 12-month reporting period. The report measures the number of people who have received any service, as well as people who received no service during that time. The report counts each person once for each service received. If they received the same service multiple times, they still count as just one person in the measure.

Why is 20% higher to 20% lower considered typical when comparing against peers?

20% higher to 20% lower than peers highlights pronounced differences for evaluation.

What does the Oral Health Score mean?

The Oral Health Score reflects changes in population oral health when viewed over time. The number of members in each of the four oral health categories determines the annual score. Generally, healthier populations have higher scores.

How are restorative No Follow-up members identified?

The measure looks for people who had fillings, crowns, or root canals sometime in the prior 3 years. Once they are flagged, we see if they have gone back to the dentist for a routine check-up in the current year. If they have not gone back for a routine check-up in the current year, they are counted as No Follow-up.

How are periodontal No Follow-up members identified?

The measure looks for people who had periodontal treatment sometime in the prior 4 years. Once they are flagged, we see if they have gone back to the dentist for a periodontal maintenance visit or a cleaning in the current year. If they have not gone back for a maintenance visit or a cleaning in the current year, they are counted as No Follow-up.

How do you define adults and children?

An adult is any member age 20 or older, and a child is any member age 19 or younger.

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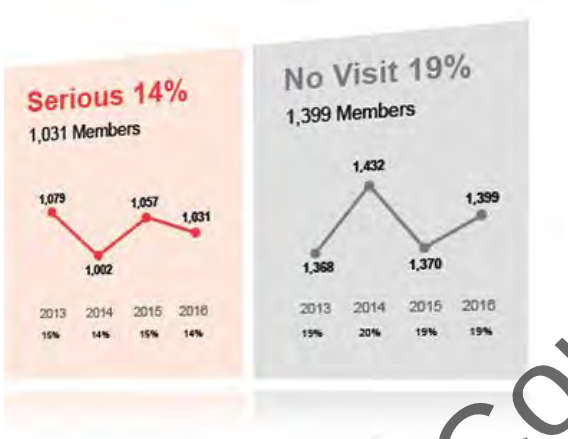
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Dental Action Report (DAR) Guide To Outreach

This Action Guide suggests ways to increase the oral health of your members.

Use your Dental Action Report (DAR) to focus on the right goals for improvement.

Take advantage of these insights and make a difference!



1. Delta Dental works with you to determine the best actions to effectively educate your plan participants. Consider focused activities to address those members most at risk.

Oral Health Communications

- Email oral health information
- Publish articles in the company newsletter addressing specific oral health topics
- Hang flyers and posters in public places
- Host lunch and learn sessions

Plan Design Changes

- Adjust coinsurance levels
- Change age and frequency limitations
- Add oral health preventive care activities to wellness program

Targeted Campaigns

- Communicate specific messages to at-risk people
- Send information directly to households through direct mail or email campaigns

2. Identify which risk groups you want to take action on. The four areas below are a great place to start.

- Perio Members With 1 Year *No Follow-up*
- Children With 1 Year *No Visit*
- *Serious* Members That Became *No Visit*
- Adults With 2 Years *No Visit*

3. Delta Dental helps you launch the program, and the DAR measures the results.

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Recommended Outreach Groups

Perio Members With 1 Year *No Follow-up*

Periodontal/gum disease is strongly linked to overall health; properly managed gum disease leads to better outcomes for key medical conditions and ultimately reduces costs and enhances productivity. *Outreach to these members to reinforce compliance with periodontal treatment follow-up requirements.*

Children With 1 Year *No Visit*

Proper childhood oral health leads to better oral health throughout adulthood. Tooth decay is the most common chronic disease among school age children, and is totally preventable. Good oral health in childhood reduces costs, improves attendance at school and avoids parent loss of time. *Outreach to the parents of these children to remind them to get their children in for their dental preventive visits, including applying sealants and fluoride.*

Serious* Members That Became *No Visit

Catching tooth decay and gum disease issues earlier avoids extensive treatment, thereby reducing costs and improving productivity. Maintaining good oral health contributes to good overall health throughout adulthood. These members had extensive care last year, but have not gone back to the dentist this year. *Outreach to these members to encourage them to get back to the dentist, keep up with dental preventive care, and avoid future major problems.*

Adults With 2 Years *No Visit*

Help avert emergency care that is expensive for these members. Increasing awareness of the need to get preventive oral health care may lead to better awareness of the need for preventive medical care, too. *Outreach to these members to educate them about the importance of a preventive dental check-up.*

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Other Outreach Groups

1 Year *No Visit* - Adults & Children, Employees and Dependents
Everyone should take advantage of visiting the dentist each year to upkeep their overall oral wellness and prevent future costly treatments. *Outreach to the entire population or choose specific segments to focus on.*

2 Year *No Visit*- Adults & Children, Employees and Dependents
Improve the oral health of people who have not sought any dental care for 2 years and may have an increased risk of expensive emergency care. Encourage them to see a dentist before major problems develop. *Outreach to the entire population or choose specific segments to focus on.*

***Serious* Members in Current Period**
Tooth decay and extensive restorative treatments are often indications that patients may be putting off prevention until it is too late. *Outreach to these members to make sure they get the appropriate follow-up care after their serious treatment.*

New Enrollees Who Were *No Visit* in Current Period
People who are new to your insurance coverage might not know they can use their dental coverage, might not know how to pick a dentist, or how preventive care is covered. *Outreach to these members to make sure they start using their dental coverage.*

***No Visit* Members Who Moved to *Serious* in Current Period**
Avoiding going to the dentist often leads to significant procedures in the future. This group had major work after not visiting the dentist in the past. *Outreach to these members to make sure they get the appropriate follow-up care after their serious treatment.*

Perio Non-Surgical Treatment in Current Period
Gum disease is never cured, only controlled. Patients with gum disease especially need to follow up with cleanings and periodontal maintenance in order to keep the disease at bay. *Outreach to these members to make sure they keep up with maintenance for their periodontal disease.*

Perio Surgical Treatment in Current Period
These patients had extensive surgical treatment and needed intensive treatment. *Outreach to these critical care members to make sure they get the follow-up care they need and then help them improve to a maintenance-only level of care.*

Children (age 19 or less) with Root Canal Treatment in Current Period
Root canal therapy in children represents extensive decay that is not typical for this population. *Outreach to these patients to ensure further extensive decay is detected and treated before the need for such serious treatment arises.*

Restorative No Follow-up
Once tooth decay has occurred, there is an increased risk of future problems. It's important to keep up with regular check-ups to be sure additional problems don't develop. *Outreach to these members to remind them of the importance of keeping up with their preventive care to avoid additional problems.*

Adults with Bridges/Dentures in Current Period
These people have recently dealt with tooth loss. This is primarily caused by gum disease. Any patient needing tooth replacement treatment needs continued follow-up to be sure their oral health is maintained. *Outreach to these members to educate them about the importance of good follow-up care to avoid any additional tooth loss.*

Children (age 19 or less) with Restorative Treatment in Current Period
Tooth decay in children is largely preventable, but remains the most common chronic disease of children. *Outreach to the parents of these children to remind them to get their children in for their dental preventive visits, including applying sealants and fluoride, and prevent any further tooth decay.*

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City of Albuquerque

Group 2517 | 14,078 Members | Q3 2023 - Q2 2024

Healthy

38%
5,333 members

Peers 40%

These members had preventive care only

Moderate

15%
2,182 members

Peers 18%

These members primarily had preventive care and treatment

Serious

12%
1,667 members

Peers 12%

These members had emergency care only or extensive care

No Visit

35%
4,896 members

Peers 28%

These members had no dental claims

Your Oral Health Score

60

49th Percentile

Your national benchmark comparison comes from Healthentic's database of over 60 million members from all 50 states

Dental Action Report

Keith Witt
Account Manager
kwitt2@deltadentalnm.com

DELTA DENTAL

Healthentic

Members with care	% of Members
Routine care	61
Continuity of care	48
Ongoing Care for Perio	49
Fluoride	23
Sealants for children	10
Previously No Visit returned	29

Oral health opportunities	
Employees No Visit	39
New enrollees No Visit	51
No Visit two years in a row	21
Restorative treatment	18
Perio treatment for adults	7
No follow-up	26

Age	% of Members
0-5	5
6-19	22
20-34	24
35-49	29
50-64	18
65-74	3
75+	<1

Your Group
Peers

Your Peer Comparison

95 groups in Executive, Legislative, and Other General Government Support, nationwide

2500+ members

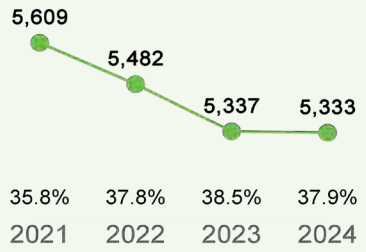
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Oral Health Changes

One year reporting period ending Q2 2024.

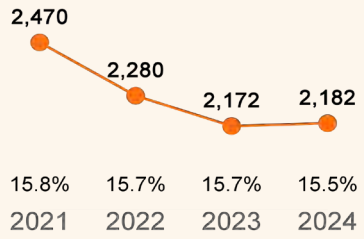
Healthy 38%

5,333 Members



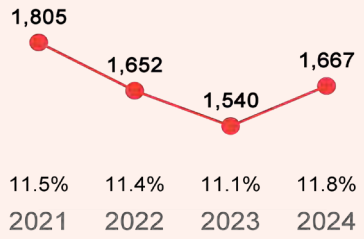
Moderate 15%

2,182 Members



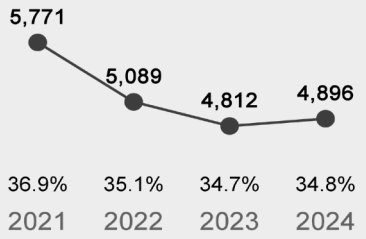
Serious 12%

1,667 Members



No Visit 35%

4,896 Members



Changes in the No Visit Category

Positive

485 previously *No Visit* saw a dentist and are *Healthy*

324 previously *No Visit* saw a dentist and are *Moderate*

Concerning

448 previously *Healthy* have not seen a dentist.

437 previously *No Visit* saw a dentist and are Serious.

875 *No Visit* are new enrollees.

Negative

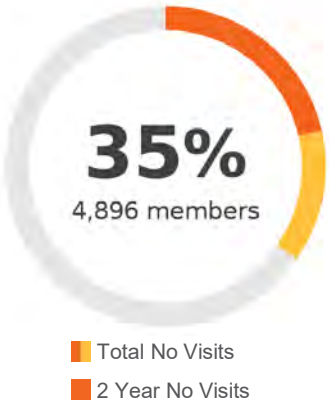
3,012 *No Visit* for two years in a row

275 previously *Serious* have not seen a dentist

286 previously *Moderate* have not seen a dentist

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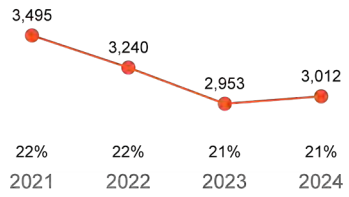
No Visit Members



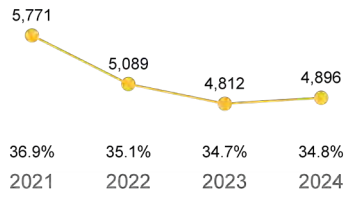
3,012 members have not seen a dentist for two years and may be at increased risk

- **1,538** are employees
- **2,570** are adults
- **442** are children

2 Year No Visits



Total No Visits

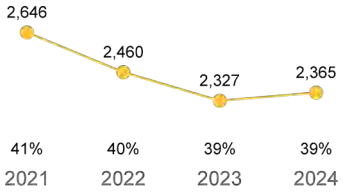


Peers **28%** | National Data **34%**

Employees



2,365 out of 6,125
1,538 No Visit for 2 years



Dependents age 0-19



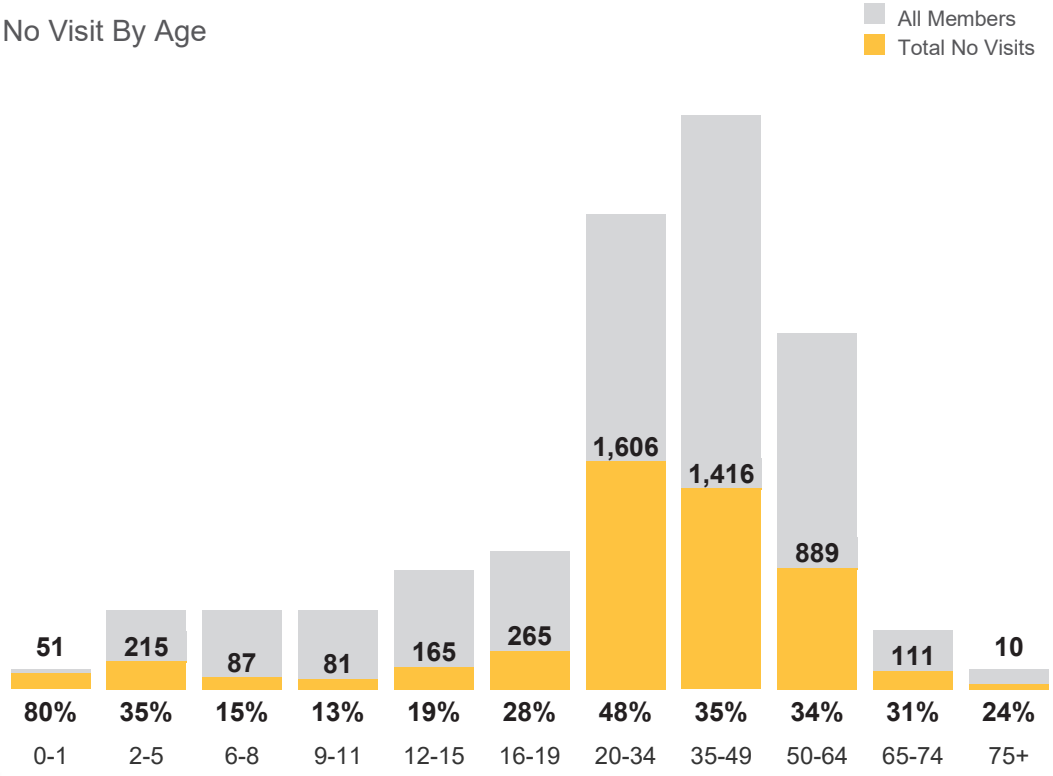
862 out of 3,705
441 No Visit for 2 years

Dependents age 20+



1,669 out of 4,248
1,033 No Visit for 2 years

No Visit By Age



Note: Age-specific metrics do not include members of an unknown age. Data may be hidden for confidentiality if a measure has fewer than 4 No Visit people.

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The Cost of No Visits

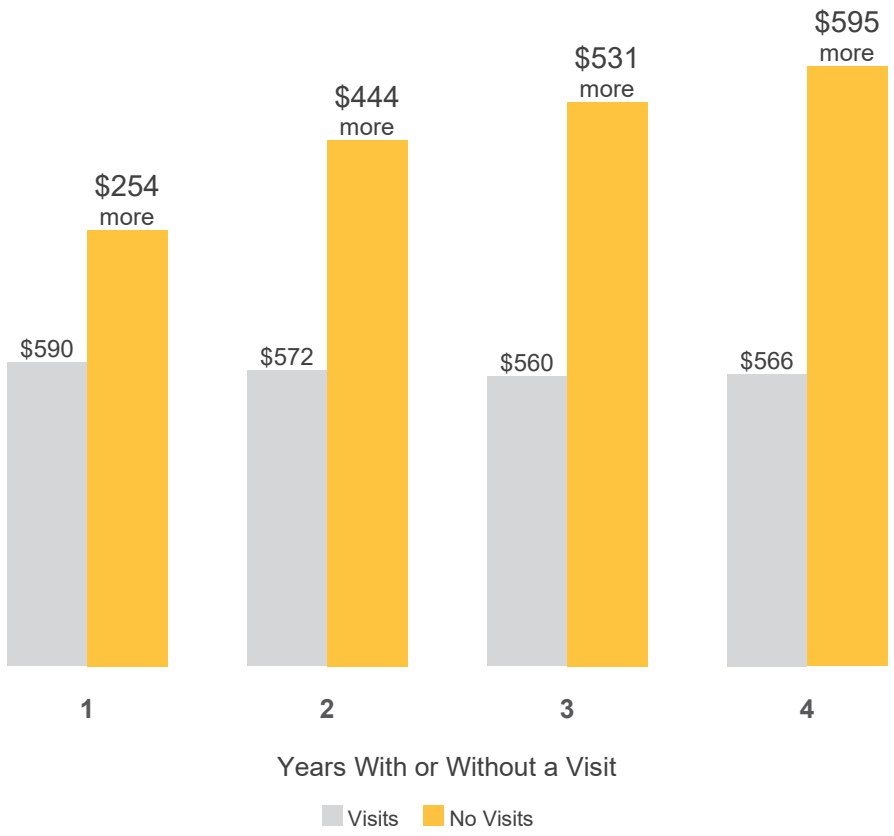
It is estimated that over $45 billion is lost in productivity each year due to untreated dental disease[1]. In addition, members who delay care also tend to require more expensive treatment for oral health problems when they finally return to the dentist. The five-year analysis below compares members with routine visits to members who did not see a dentist until this year.

Source: (1) https://www.cdc.gov/oral-health/prevention/index.html

How Much Do No Visits Cost?

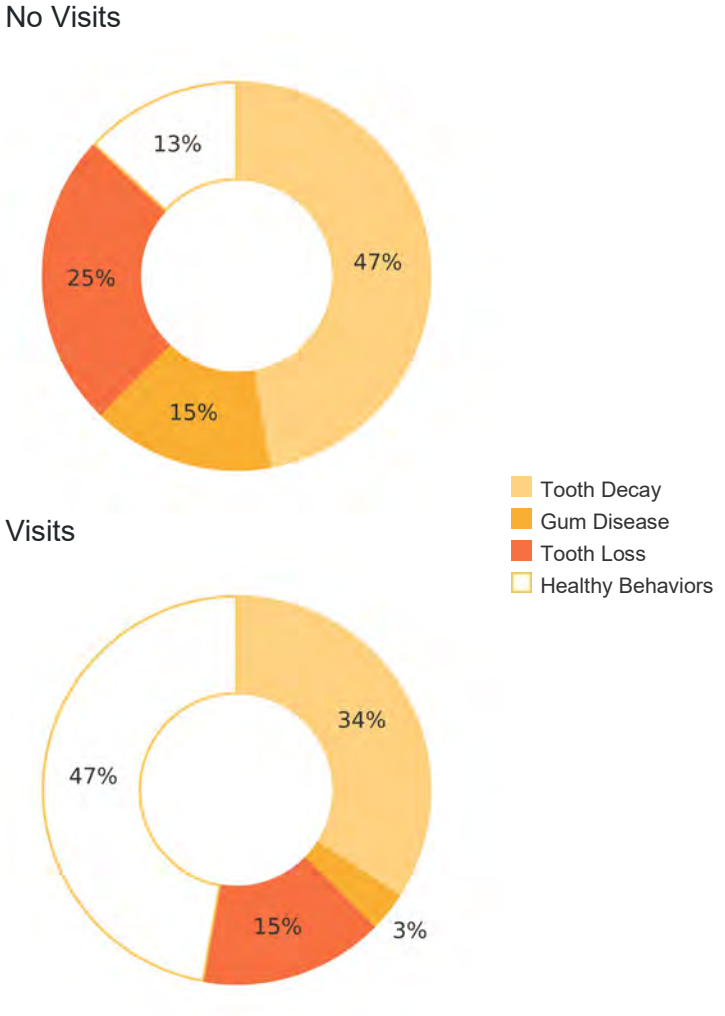
Compared to members with routine visits, the cost of previous No Visit members in the current year often increases with each additional year of no visit.

The graph below shows the average cost per member in the current year after 1 or more years of visits or no visits.



What Types of Procedures Are Driving Costs?

Distribution of procedure costs in the current year after 4 years of no visits or visits



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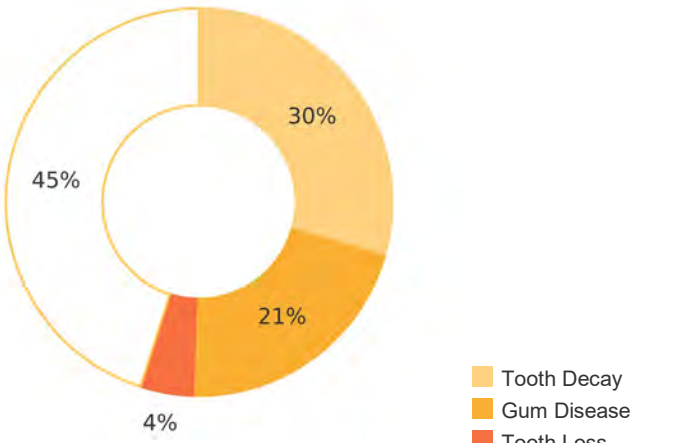
The Cost of No Visits

Previous No Visit members tend to require more extensive treatment for oral health issues in the current year compared to members with routine visits. The Centers for Disease Control and Prevention says this can lead to lost productivity and hours at work. The five-year analysis below compares members with routine visits to members who did not see a dentist until this year.

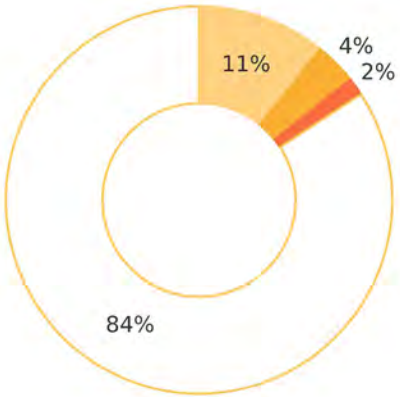
What Type of Care Do They Need?

Distribution of procedure counts in the current year after 4 years of no visits or visits

No Visits



Visits



What Are Their Oral Health Outcomes?

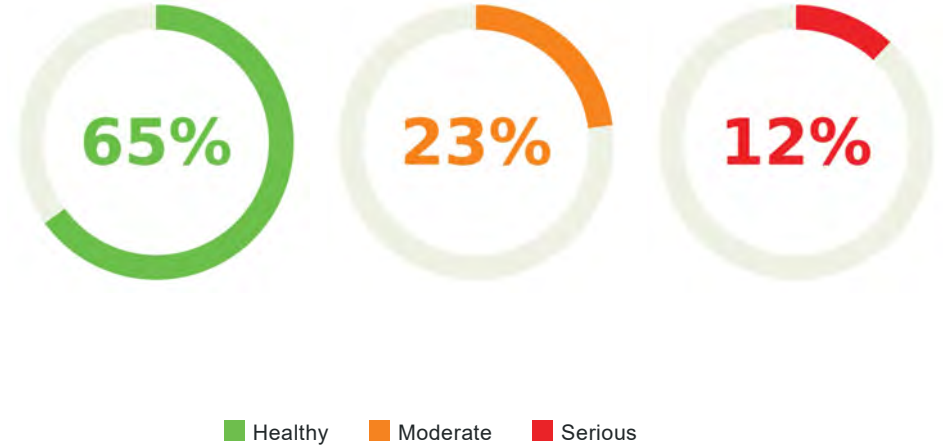
Delaying care may increase the risk of oral health problems that have been linked to whole health concerns such as diabetes, heart disease, and Alzheimer's disease.

Distribution of members in the current year after 4 years of no visits or visits

No Visits



Visits



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The Case For Prevention

Do Healthy Behaviors Reduce Overall Costs?

For most organizations, members who get preventive care tend to have better oral health and cost less than people who don't get preventive care. The members included below regularly see a dentist (at least once a year for the last two years). This compares costs for those who received preventive care with those who did not.

Oral Exams

Total Cost Per Member with Oral Exams

These members had at least one exam in the previous reporting period

$571

Total Cost Per Member with No Oral Exams

These members had no exams in the previous reporting period

$791

$220 Less

2024 Benchmark: National Data **$380 Less**

Sealants

Restorative Cost Per Member Aged 6-19 with Sealant Visits

These members had at least one sealant visit and one restorative visit in the previous reporting period

$65

Restorative Cost Per Member Aged 6-19 with No Sealant Visits

These members had no sealant visits but at least one restorative visit in the previous reporting period

$137

$72 Less

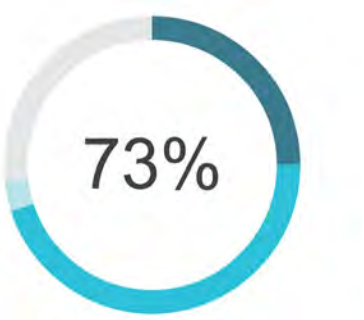
2024 Benchmark: National Data **$78 Less**

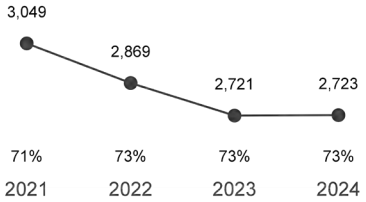
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Preventive Care Summary - Children

Child Routine Care

2,723 of 3,708 children had at least one routine visit



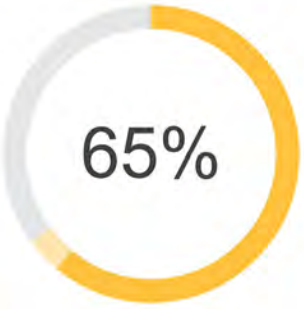


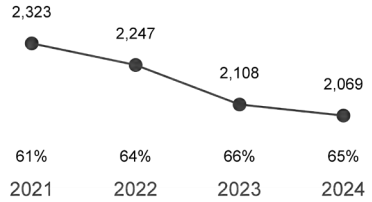
Peers 77% | National Data 74%

25% had one | 45% had two | 3.3% had three or more

Child Continuity of Care

2,069 of 3,208 children had a routine exam two years in a row





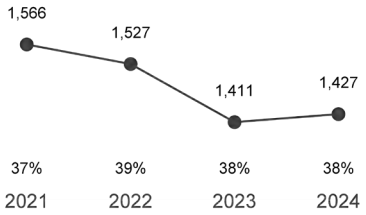
Peers 69% | National Data 65%

61% visited the same practice both years | 3.9% changed practices

Children with Fluoride

1,427 of 3,708 children had at least two fluoride applications





Peers 36% | National Data 31%

38% had two | 0.4% had three or more

Evidence-Based Recommendations

Routine Care: Tooth decay is the most common chronic disease of childhood. Poor oral health can have a detrimental effect on children's quality of life, their performance at school, and their success later in life.[1] Children should see a dentist every six months to prevent and treat oral disease.[2]

Fluoride for Children: To help reduce the risk of tooth decay, topical fluoride should be applied to children every three to six months based on risk for dental caries.[3]

Continuity of Care: Continuity of care is an important part of any health plan and dental health is no exception.[4] Children who have a dental home and receive ongoing care from the same source are more likely to receive individualized preventive and routine oral health care to help reduce the risk of preventable oral disease.[5]

1. https://www.cdc.gov/school-health-conditions/chronic/oral-health.html
2. https://www.aapd.org/resources/parent/faq/
3. https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary
4. https://www.mouthhealthy.org/dental-care-concerns/questions-about-going-to-the-dentist
5. https://www.aapd.org/globalassets/media/policies_guidelines/p_dentalhome.pdf

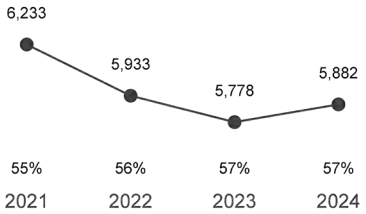
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Preventive Care Summary - Adults

Adult Routine Care

5,882 of 10,370 adults had at least one routine visit



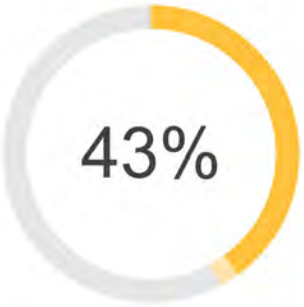


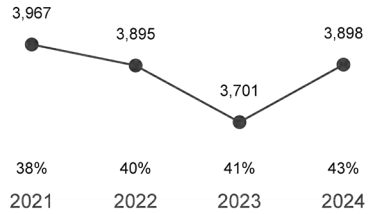
Peers 65% | National Data 59%

21% had one | 32% had two | 4.5% had three or more

Adult Continuity of Care

3,898 of 9,146 adults had a routine exam two years in a row



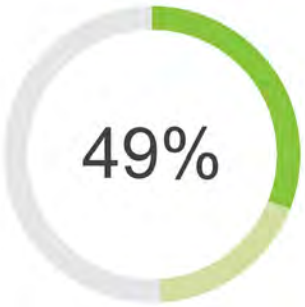


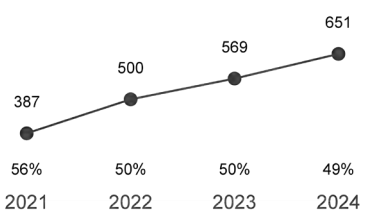
Peers 55% | National Data 49%

40% visited the same practice both years | 2.2% changed practices

Ongoing Care for Perio

651 of 1,319 perio members had at least two follow-up visits





Peers 60% | National Data 55%

31% had two visits | 18% had three or more

Evidence-Based Recommendations

Routine Care: Adults should see a dentist at least once a year to prevent and treat oral disease.[1,2] Providers may recommend more frequent visits for patients with certain conditions like periodontitis or diabetes.[3,4,5]

Ongoing Care for Perio: For patients with periodontitis, a periodontal maintenance program following active periodontal therapy can effectively reduce tooth loss and recurrence of disease.[6]

Continuity of Care: Continuity of care is an important part of any health plan and dental health is no exception. Maintaining regular dental visits can help spot dental health problems early on when treatment is likely to be simpler and more affordable, and can help prevent many problems from developing in the first place.[1]

1. https://www.mouthhealthy.org/dental-care-concerns/questions-about-going-to-the-dentist
2. https://www.cdc.gov/oral-health/prevention/oral-health-tips-for-adults.html
3. https://www.cdc.gov/oral-health/about/gum-periodontal-disease.html
4. https://www.cdc.gov/diabetes/treatment/your-diabetes-care-schedule.html
5. https://diabetes.org/health-wellness/keeping-your-mouth-healthy
6. https://pubmed.ncbi.nlm.nih.gov/23647520/

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Healthy Behaviors

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.

Your Group
Peers

Oral Exams

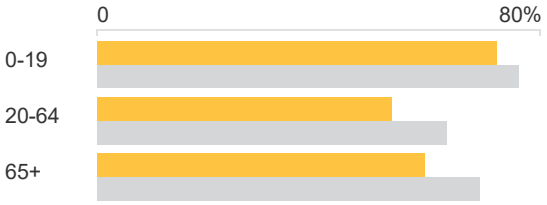
All Ages

58%

had oral exams

8,181 of 14,078 members | 12% below peers





Routine check-ups help dentists catch early signs of tooth decay and gum disease before they become serious conditions.

Cleanings

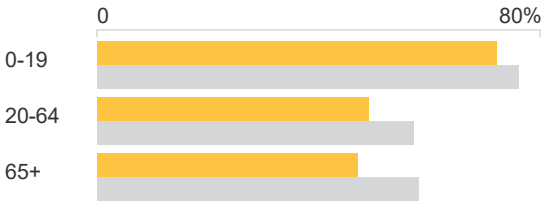
All Ages

55%

had cleanings

7,765 of 14,078 members | 10% below peers





Professional cleanings help remove tartar and other build-up that a toothbrush can't reach.

● Perio Maintenance

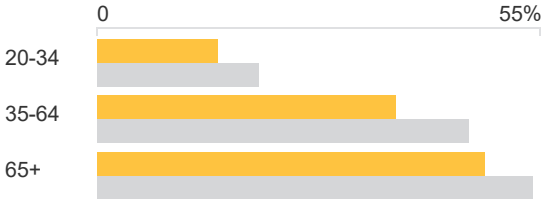
Age 20+ with Previous Perio Treatment

35%

had maintenance

458 of 1,319 members | 23% below peers





Periodontitis, or advanced gum disease, can lead to tooth loss without proper routine maintenance.

● Indicates ≥20% above or below peers

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Healthy Behaviors

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.

Your Group
Peers

Sealants (Children)

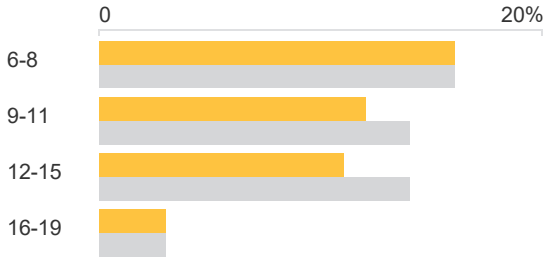
Age 6-19

10%

had sealants

298 of 3,031 members | 10% below peers





Sealants save time and money by avoiding fillings, crowns and caps to fix decayed teeth.

Fluoride (Children)

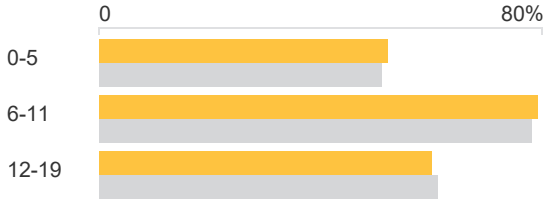
Age 0-19

65%

had fluoride

2,403 of 3,708 members | <1% below peers





Dentists may use topical fluoride to help prevent tooth decay.

Fluoride (Adults)

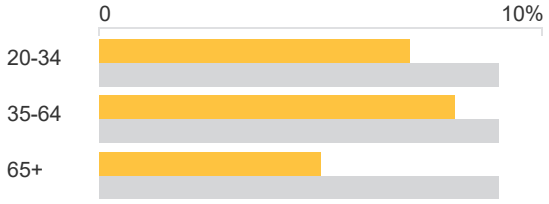
Age 20+

7%

had fluoride

772 of 10,370 members | 20% below peers





Dentists may use topical fluoride to help prevent tooth decay.

● Indicates ≥20% above or below peers

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Tooth Decay

Preventive procedures help reduce the development of tooth decay, tooth loss, and gum disease.

Your Group
Peers

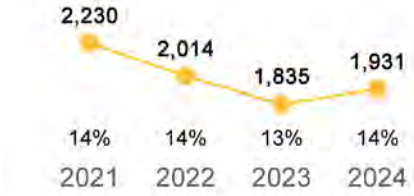
Fillings

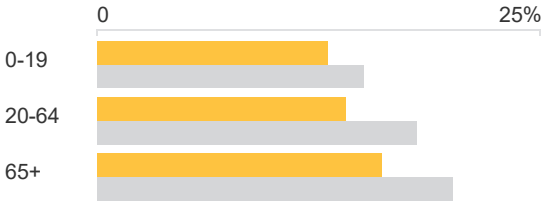
All Ages

14%

had fillings

1,931 of 14,078 members | 22% below peers





Fillings replace lost tooth structure with a suitable restorative material such as amalgam or composite.

Crowns

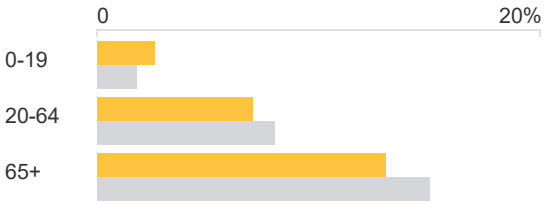
All Ages

6%

had crowns

794 of 14,078 members | 22% below peers





Crowns replace the visible portion of a tooth's surface. They are often used to replace broken down fillings or repair fractured teeth.

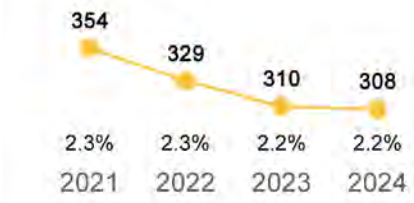
Root Canals

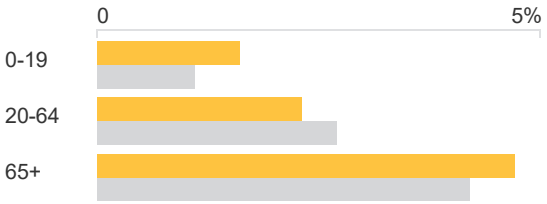
All Ages

2.2%

had root canals

308 of 14,078 members | 11% below peers





This procedure involves removing a tooth's pulp or nerve from the canal inside the root, and replacing it with an inert filling material.

● Indicates ≥20% above or below peers

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Tooth Loss

Risk of tooth loss increases with age. Tooth loss may also result from untreated gum disease.

Your Group
Peers

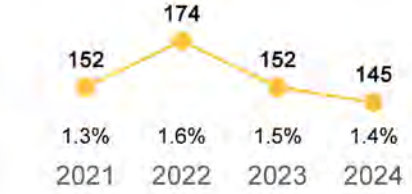
Implants

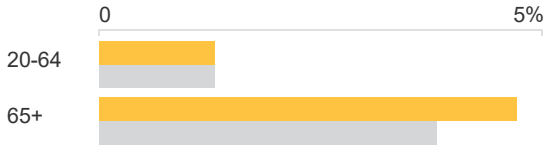
Age 20+

1.4%

had implants

145 of 10,370 members | 13% below peers





Implants are an alternative to bridges and dentures for replacing lost teeth. People with implants still need routine care to maintain good oral health.

Dentures

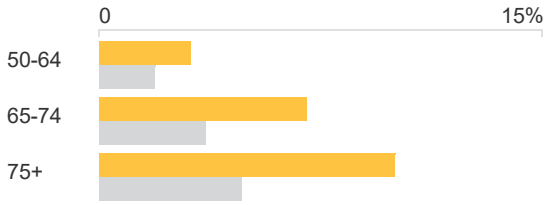
Age 50+

3.6%

had dentures

108 of 2,991 members | 34% above peers





Members with dentures still need routine care to maintain good oral health.

● Indicates ≥20% above or below peers

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Gum Disease

Risk of gum disease increases with age and can lead to tooth loss if not treated.

Your Group
Peers

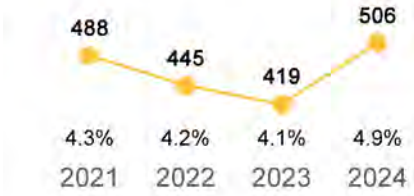
Non-Surgical Perio Treatment

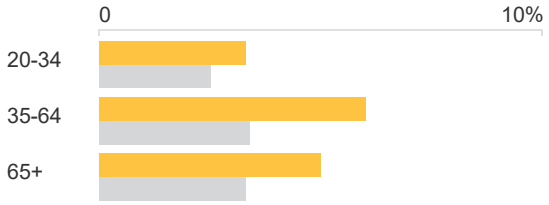
Age 20+

4.9%

had non-surgical treatment

506 of 10,370 members | 56% above peers





Hard deposits on root surfaces and under gums are removed to promote healing and reduce the depth of the periodontal pocket.

Surgical Perio Treatment

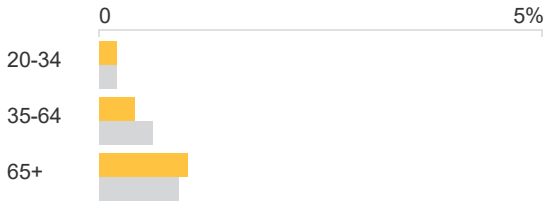
Age 20+

0.4%

had surgical treatment

38 of 10,370 members | 34% below peers





Severe gum disease requires surgical treatment of the diseased teeth and their supporting structures.

● Indicates ≥20% above or below peers

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No Follow-up

Restorative Members Without a Follow-up Visit

24%

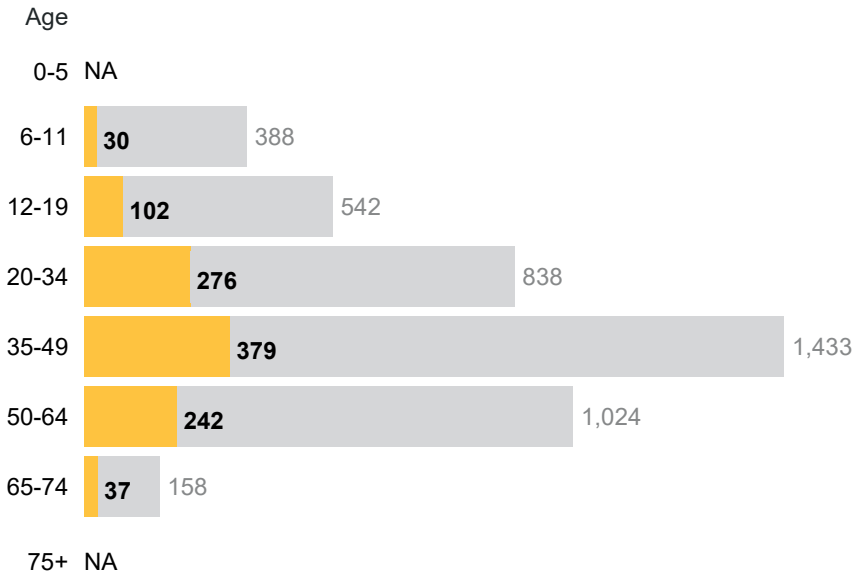
had at least one restorative visit in the previous 3 years, and no follow-up in the most recent year.



2024 Benchmark: National Data **21%**

1,073 Members Had Restorative Treatment and No Follow-up Visit

Data may be hidden for confidentiality if an age group has fewer than 4 no follow-up members.

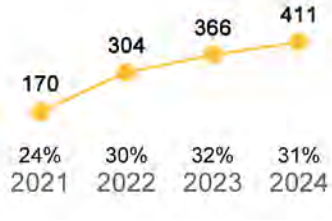


Restorative Members With Follow-up
Restorative Members Without Follow-up

Perio Members Without a Follow-up Visit

31%

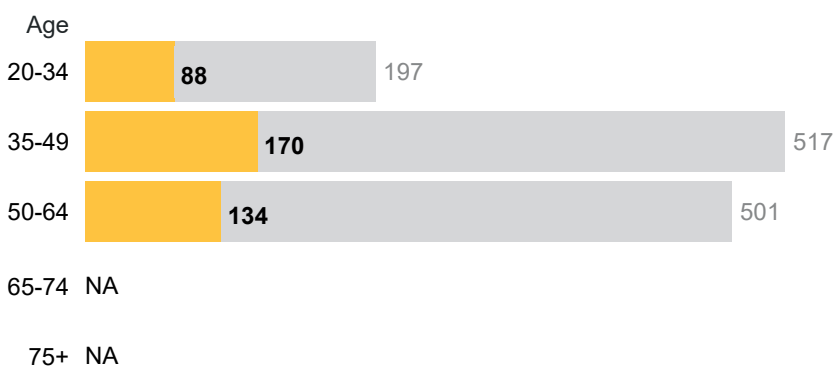
age 20+ had at least one perio visit in the previous 4 years, and no follow-up visit in the most recent year.



2024 Benchmark: National Data **27%**

411 Members Had Perio Treatment and No Follow-up Visit

Data may be hidden for confidentiality if an age group has fewer than 4 no follow-up members.



Perio Members With Follow-up
Perio Members Without Follow-up

Data may be hidden for confidentiality if an age group has fewer than 4 members.

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Understanding Whole Health Risks

Gum Disease and its Links to Medical Conditions

Periodontal (gum) diseases primarily result from infections and inflammation of the gums and bone that surround and support the teeth. In its early stage, gingivitis, gums can become swollen and bleed. In its more serious form, periodontitis, the gums can pull away from the tooth, bone can be lost, and the teeth may loosen or fall out. Gum disease and tooth decay are the two biggest threats to dental health. **Nearly 50% of all adults aged 30 or older have signs of gum disease**[1].

Members should be educated about the complex interplay between bacterial infection and the body's immune response to infection. Studies have pointed to possible links between chronic oral health infections and diabetes, heart and lung diseases, stroke, and low-birth-weight, premature births[2]. Severe/progressive periodontitis is also associated with cancer, Alzheimer's disease, and dozens of other serious diseases[3].

Diabetes

Adults 45 years or older with poorly controlled diabetes were **2.9 times more likely to have gum disease** than those without diabetes[4]. The likelihood was 4.6 times higher among smokers with poorly controlled diabetes[4]. Oral manifestations of uncontrolled diabetes can include: xerostomia; burning sensation in the mouth; impaired/delayed wound healing; increased incidence and severity of infections; secondary infection with candidiasis; parotid salivary gland enlargement; gingivitis; and/or periodontitis[5].

Other Chronic Diseases

People with chronic conditions are more likely to have untreated dental disease, which can result in tooth loss. Certain chronic conditions are associated with severe tooth loss, which can diminish quality of life and interfere with eating healthy foods. A recent study found **severe tooth loss was 50% higher** among older adults with rheumatoid arthritis, asthma, diabetes, emphysema, heart disease, liver condition, or stroke than among adults without these chronic conditions[6].

Pregnancy

The medical and dental communities concur that maintaining **periodontal health is an important part of a healthy pregnancy**. Clinical recommendations released by the AAP and the EFP state that non-surgical periodontal therapy is safe for pregnant women and can result in improved periodontal health[7].

Cancer, Tobacco Use, and e-Cigarettes

Head and neck radiation and chemotherapy can cause mouth problems that range from dry mouth to life-threatening infections. Patients should **see a dentist about one month before beginning cancer treatment** to make sure their mouth is healthy[8].

In addition to the risk of developing lung cancer, smokers have **twice the risk of developing gum disease** compared to non-smokers[9]. More than half of severe gum disease cases in the United States may result from cigarette smoking[10]. **Smoking has also been linked to tooth loss**. Male smokers are up to 3.6 times more likely to lose their teeth than non-smokers; female smokers were found to be 2.5 times more likely[9].

New studies highlight how **e-cigarettes alter oral health and may be contributing to gum disease**. The latest research finds that e-cigarette users have a unique oral microbiome that is less healthy than nonsmokers but potentially healthier than cigarette smokers, and measures worsening gum disease over time[11].

Sources:

1. https://www.cdc.gov/oral-health/data-research/facts-stats/fast-facts-gum-disease.html
2. https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf
3. https://pubmed.ncbi.nlm.nih.gov/32844419/
4. http://www.diabetesincontrol.com/wp-content/uploads/PDF/ndep_diabetes_facts_2011.pdf
5. https://www.ada.org/resources/ada-library/oral-health-topics/diabetes
6. https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6921a1-h.pdf
7. https://www.sciencedaily.com/releases/2013/08/130828092310.htm
8. https://www.nidcr.nih.gov/health-info/cancer-treatments
9. https://periodontalhealthcenter.com/blog/covid-smoking-and-gum-disease-18536/
10. https://pubmed.ncbi.nlm.nih.gov/10872955/
11. https://www.sciencedaily.com/releases/2022/02/220222151907.htm

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Definitions

Oral Health Categories

- **Healthy** - Received routine dental care and no treatment, no indicators of periodontal disease
- **Moderate** - Received routine care and minor treatment, or has indicators of periodontal disease
- **Serious** - Received treatment and no routine care, or had routine care in addition to severe periodontal procedures or major restorative work
- **No Visit** - Had no dental claims of any kind

Oral Health Score

This is a weighted average of the number of members in the four Oral Health Categories, expressed as a number over 100. Generally, healthier populations have higher scores. The percentile shows how your score compares to all employers in the Healthentic database.

Key Metrics

- **Routine Care** - Percent of all members who had a routine exam or preventive care
- **Continuity of Care** - Percent of all members who had a routine exam two years in a row
- **Ongoing Care for Perio** - Percent of perio members who received ongoing care
- **Fluoride** - Percent of all members who had a fluoride
- **Sealants for Children** - Percent of children ages 6-19 who had a sealant placed in the current year
- **Previous No Visit Returned** - Percent of No Visit members from the prior year who had a visit in the current year
- **Employees No Visit** - Percent of employees who did not have a visit in the current year
- **New Enrollees No Visit** - Percent of new enrollees who did not have a visit in the current year
- **No Visit Two Years in a Row** - Percent of all members who had no visit two years in a row
- **Restorative Treatment** - Percent of all members who had restorative treatment in the current year
- **Perio Treatment for Adults** - Percent of adults age 20 and older who had perio treatment in the current year
- **No Follow-up** - Percent of members with prior restorative care or perio who did not receive appropriate follow-up care

How do you define children and adults?

Children are any members age 19 or younger. Adults are any members age 20 and older.

Why is some data hidden or not available?

Data may be hidden for privacy if fewer than 4 members are included in a measure. Certain measures require historical data and will not be available if historical data is not available for the group.

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Dental Action Report (DAR) Guide To Outreach

This Action Guide suggests ways to increase the oral health of your members.

Use your Dental Action Report (DAR) to focus on the right goals for improvement.

Take advantage of these insights and make a difference!



1. Delta Dental works with you to determine the best actions to effectively educate your plan participants. Consider focused activities to address those members most at risk.

Oral Health Communications

- Email oral health information
- Publish articles in the company newsletter addressing specific oral health topics
- Hang flyers and posters in public places
- Host lunch and learn sessions

Plan Design Changes

- Adjust coinsurance levels
- Change age and frequency limitations
- Add oral health preventive care activities to wellness program

Targeted Campaigns

- Communicate specific messages to at-risk people
- Send information directly to households through direct mail or email campaigns

2. Identify which risk groups you want to take action on. The four areas below are a great place to start.

- Perio Members With 1 Year *No Follow-up*
- Children With 1 Year *No Visit*
- *Serious* Members That Became *No Visit*
- Adults With 2 Years *No Visit*

3. Delta Dental helps you launch the program, and the DAR measures the results.

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Recommended Outreach Groups

Perio Members With 1 Year *No Follow-up*

Periodontal/gum disease is strongly linked to overall health; properly managed gum disease leads to better outcomes for key medical conditions and ultimately reduces costs and enhances productivity. *Outreach to these members to reinforce compliance with periodontal treatment follow-up requirements.*

Children With 1 Year *No Visit*

Proper childhood oral health leads to better oral health throughout adulthood. Tooth decay is the most common chronic disease among school age children, and is totally preventable. Good oral health in childhood reduces costs, improves attendance at school and avoids parent loss of time. *Outreach to the parents of these children to remind them to get their children in for their dental preventive visits, including applying sealants and fluoride.*

Serious* Members That Became *No Visit

Catching tooth decay and gum disease issues earlier avoids extensive treatment, thereby reducing costs and improving productivity. Maintaining good oral health contributes to good overall health throughout adulthood. These members had extensive care last year, but have not gone back to the dentist this year. *Outreach to these members to encourage them to get back to the dentist, keep up with dental preventive care, and avoid future major problems.*

Adults With 2 Years *No Visit*

Help avert emergency care that is expensive for these members. Increasing awareness of the need to get preventive oral health care may lead to better awareness of the need for preventive medical care, too. *Outreach to these members to educate them about the importance of a preventive dental check-up.*

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Other Outreach Groups

1 Year *No Visit* - Adults & Children, Employees and Dependents
Everyone should take advantage of visiting the dentist each year to upkeep their overall oral wellness and prevent future costly treatments. *Outreach to the entire population or choose specific segments to focus on.*

2 Year *No Visit*- Adults & Children, Employees and Dependents
Improve the oral health of people who have not sought any dental care for 2 years and may have an increased risk of expensive emergency care. Encourage them to see a dentist before major problems develop. *Outreach to the entire population or choose specific segments to focus on.*

***Serious* Members in Current Period**
Tooth decay and extensive restorative treatments are often indications that patients may be putting off prevention until it is too late. *Outreach to these members to make sure they get the appropriate follow-up care after their serious treatment.*

New Enrollees Who Were *No Visit* in Current Period
People who are new to your insurance coverage might not know they can use their dental coverage, might not know how to pick a dentist, or how preventive care is covered. *Outreach to these members to make sure they start using their dental coverage.*

***No Visit* Members Who Moved to *Serious* in Current Period**
Avoiding going to the dentist often leads to significant procedures in the future. This group had major work after not visiting the dentist in the past. *Outreach to these members to make sure they get the appropriate follow-up care after their serious treatment.*

Perio Non-Surgical Treatment in Current Period
Gum disease is never cured, only controlled. Patients with gum disease especially need to follow up with cleanings and periodontal maintenance in order to keep the disease at bay. *Outreach to these members to make sure they keep up with maintenance for their periodontal disease.*

Perio Surgical Treatment in Current Period
These patients had extensive surgical treatment and needed intensive treatment. *Outreach to these critical care members to make sure they get the follow-up care they need and then help them improve to a maintenance-only level of care.*

Children (age 19 or less) with Root Canal Treatment in Current Period
Root canal therapy in children represents extensive decay that is not typical for this population. *Outreach to these patients to ensure further extensive decay is detected and treated before the need for such serious treatment arises.*

Restorative No Follow-up
Once tooth decay has occurred, there is an increased risk of future problems. It's important to keep up with regular check-ups to be sure additional problems don't develop. *Outreach to these members to remind them of the importance of keeping up with their preventive care to avoid additional problems.*

Adults with Bridges/Dentures in Current Period
These people have recently dealt with tooth loss. This is primarily caused by gum disease. Any patient needing tooth replacement treatment needs continued follow-up to be sure their oral health is maintained. *Outreach to these members to educate them about the importance of good follow-up care to avoid any additional tooth loss.*

Children (age 19 or less) with Restorative Treatment in Current Period
Tooth decay in children is largely preventable, but remains the most common chronic disease of children. *Outreach to the parents of these children to remind them to get their children in for their dental preventive visits, including applying sealants and fluoride, and prevent any further tooth decay.*

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Preventive Care Security (PCS)

What is Preventive Care Security (PCS)?

Your dental plan includes the Preventive Care Security option. PCS is an oral health benefit enhancement from Delta Dental of New Mexico. With PCS, the benefits paid for Diagnostic and Preventive (D&P) Services never reduce the Annual Maximum Benefit Amount. This feature encourages preventive care, which results in improved oral health, while making sure full-plan benefits are always available when other types of services are needed.

Did you know that every dollar you spend on preventive care, such as brushing and cleaning, may help save you money later in additional costly dental procedures?

It's true, keeping your teeth and gums healthy by seeing your dentist regularly can help you avoid more serious oral health problems and more extensive and expensive treatment. For every dollar spent on prevention an estimated four dollars is saved in future treatment. With better preventive dental care, early detection, and treatment, savings in the U.S. alone could be $4 billion annually.

Preventive Care Security:

- ☑ Allows you to take advantage of D&P services even in benefit years when other types of services are anticipated
- ☑ Does not penalize you for using D&P benefits by leaving you with less of a Maximum Benefit Amount
- ☑ Makes it easier to visit the dentist at least once a year, which can help you identify problems early and reduce the extent of restorative care needed
- ☑ Eliminates the confusion that sometimes occurs when benefits paid at 100% are applied to your Annual Maximum Benefit Amount
- ☑ Promotes wellness and encourages better oral health behaviors

Questions on PCS?

Call us today at (505) 855-7111
or toll-free (877) 395-9420

Dental policies have exclusions and limitations. For costs and coverage details, contact your insurance provider or Delta Dental Plan of New Mexico toll free at [1-877-395-9420] or by email at [customerservice@deltadentalnm.com]

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Delta Dental of New Mexico

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Evidence Based Dentistry (EBD)

Delta Dental's **Evidence-based Dentistry (EBD)** plan benefit provides enhanced dental coverage for enrollees with certain high-risk medical conditions that have oral health implications. Research has shown that increased frequency of cleanings can greatly impact oral health and sometimes even play an important role in managing conditions, such as[1]:

- Diabetes & Periodontal Disease
- Heart disease & defects
- Cancer
- Renal failure or dialysis
- Pregnancy & Periodontal Disease
- Head & neck radiation
- Rheumatoid arthritis
- Suppressed immune systems
  (due to chemotherapy/radiation, HIV positive, organ transplant or stem cell/bone marrow transplant)

The improved benefits include coverage of up to four teeth cleanings (routine cleanings or periodontal maintenance cleanings) per calendar year, as opposed to the typical two. Additional cleanings are benefits at the coinsurance level specified on your Summary of Dental Plan Benefits. For people undergoing head & neck radiation, fluoride applications by your dentist are also covered twice per calendar year. **The cost of the additional cleanings & flouride treatments are not applied to your annual maximum.**

What should I do if I have one of the conditions listed?

Talk with your dentist and physician about if and when treatment is right for you. **The timing of treatment is important when serious medical conditions exist.**

[1]Not all high-risk medical conditions listed here. Please check your plan documentation for specific plan benefits, limitations, and additional information.

[2]Dental policies have exclusions and limitations. For costs and coverage details, contact your insurance provider or Delta Dental Plan of New Mexico toll free at [1-877-395-9420] or by email at [customerservice@deltadentalnm.com]

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DELTA DENTAL®

Delta Dental Virtual Visits

delivered by TeleDentistry.com



Covering You 24/7

Dental emergencies don't always happen between the hours of eight to five. That's why Delta Dental of New Mexico members have access to 24/7 dental care whenever and wherever they are.[1,2,3]

Use Delta Dental Virtual Visits delivered by TeleDentistry.com when your dentist is not available and you're:

- having an after-hour dental issue.
- traveling and need dental assistance.
- facing a dental emergency but don't have a regular dentist to call.

Delta Dental Virtual Visits are considered covered in-network services.[1,2] In addition to your consult, a TeleDentistry.com dentist can write a prescription,[3] and refer an in-network dentist if you don't have one.

Learn more at DeltaDentalNM.com/Virtual-Visits

[1] Delta Dental Virtual Visits are only available to Delta Dental of New Mexico members whose plans include coverage for oral exams.
[2] This service supplements your current plan coverage and should be used after business hours, holidays and weekends, or when your regular dentist is unavailable. A virtual visit delivered by TeleDentistry.com is counted as a problem-focused examination (D0140) under your plan and does not count as one of your regular preventive oral exams.
[3] The TeleDentistry.com dentist cannot prescribe controlled substances or write international prescriptions. E-prescriptions are not available internationally.

How Do Delta Dental Virtual Visits Work?

Sign into the Delta Dental Virtual Visits patient portal or call 866.302.0905.

Fill out your e-documents.

Take photos of the problem area if necessary.

Begin your dental consultation.

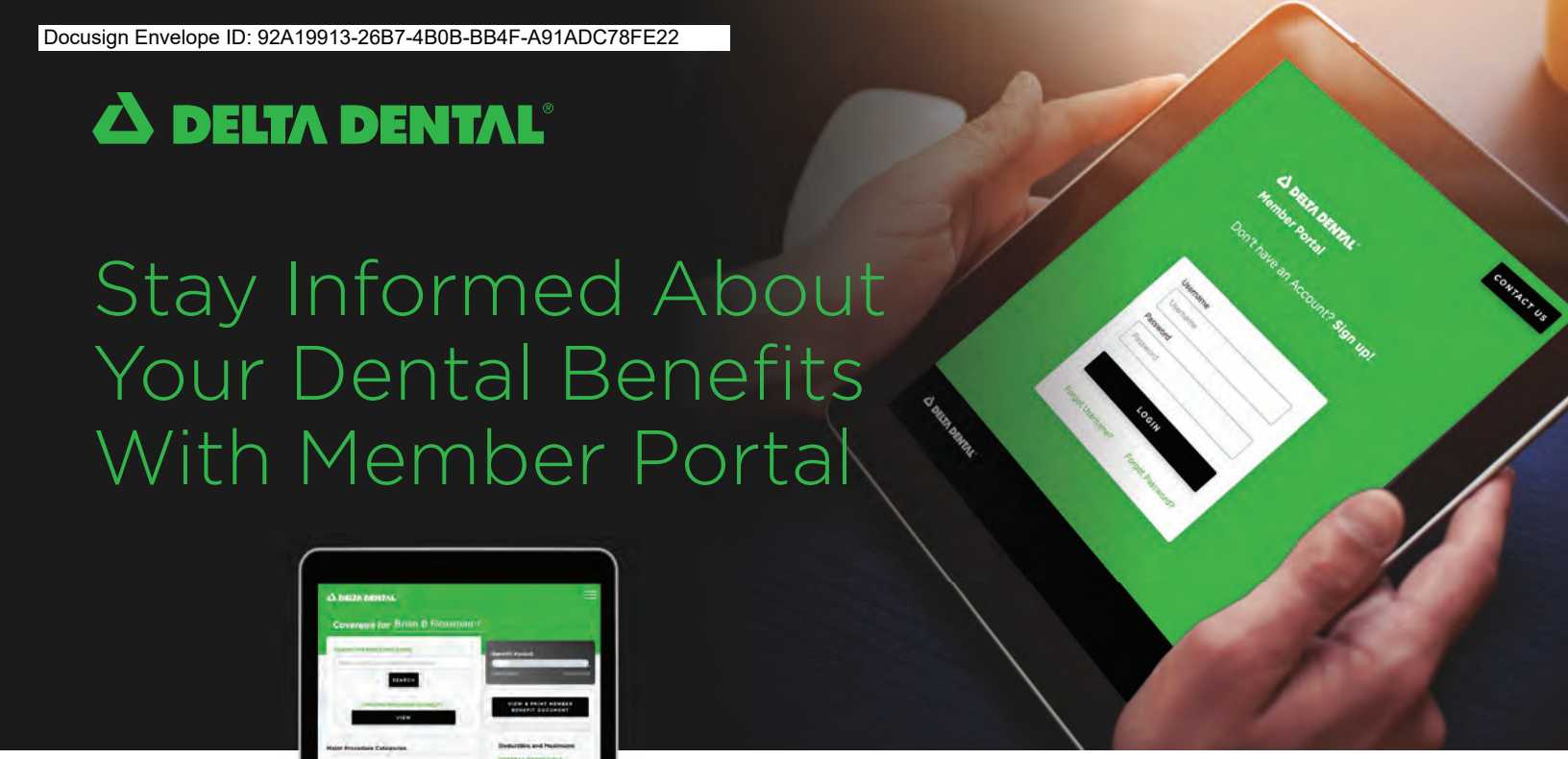
Delta Dental Plan of New Mexico, Inc. dba Delta Dental of New Mexico.

2023-002-DDNM-MKT

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DELTA DENTAL®

Stay Informed About Your Dental Benefits With Member Portal





Member Portal gives you 24/7 access to important information about your dental benefits.

With Member Portal, you can:

- See which members are covered on your plan, now and in the future
- Find an in-network dentist
- See common procedures
- Access an online ID card
- View the status of all claims and toggle between different family member claims
- View and print Explanation of Benefits (EOBs)

NOTE: Member Portal has replaced Consumer Toolkit.

Get started today

Visit www.memberportal.com

Log in using your existing Consumer Toolkit® credentials

OR

If you do not have existing credentials, click "Sign up"

Complete the required fields and follow the on-screen instructions to register as a new user

NOTE: You will need the subscriber's ID (the person whose name is on the benefit package). The member ID is an assigned number unique to the subscriber. In many cases, the member ID is the same as the subscriber's Social Security number.

Questions? Call Toolkit Support at 866-356-0301

Privacy of your online benefit information is assured through highly secure encryption technology.

DeltaDentalNM.com

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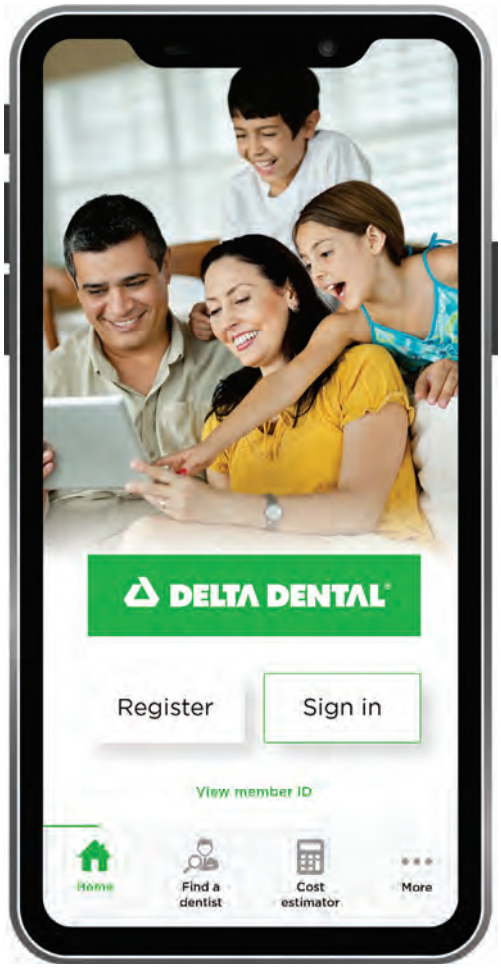
DELTA DENTAL®



Delta Dental Mobile App

Manage your oral health anytime, anywhere

Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device.



Getting started

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App. Or, scan the QR code below. You will need an internet connection in order to download and use most features of our free app.

Logging in to view benefits

Delta Dental members can sign in using the username and password they use to sign in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App.

SCAN TO DOWNLOAD
DELTA DENTAL MOBILE APP

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Delta Dental Mobile App features

Sign in to access the full range of tools and resources



Mobile ID card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.



Find a dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.



Dental Care Cost Estimator

Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.



Save your preferred dentist for quick access

Save your favorite dentists using the Delta Dental Mobile App for quick access to contact information making it easy to schedule your routine cleaning.

Secure access to your benefits

You must sign in each time you access the secure portion of the mobile app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

Please note information displayed may vary based on your particular coverage. For more information on your coverage, contact your Delta Dental company. "Delta Dental" refers to the national network of 39 independent Delta Dental companies that provide dental benefits and is a registered trademark of Delta Dental Plans Association.

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DELTA DENTAL®

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Your Member Feedback Report

DELTA DENTAL

Making every members' experiences exceptional.

At Delta Dental, our goal is to provide you with valuable insights as we strive to ensure members are satisfied with their dental plan and the care they receive from in-network dentists. We deploy the CAHPS® Dental Plan Survey to better understand members' health care journeys. This valuable, ongoing feedback is essential to our commitment to providing members with exceptional experiences. Their direct responses may also help you manage your dental benefits to best meet their needs.

Prepared for: 87111-1601

January 2016 - March 2025



8.4/10

Your members' overall rating of **their dental benefit plan**



8.4/10

Your members' overall rating of **finding a dentist easily**



9.5/10

Your members' overall rating of **their dental care**

Percentage of your members indicating that **their dental benefit plan** always or usually:

84%

covered the services **they expected**

88%

covered the services **they needed**

Percentage of your members indicating that they **would recommend** their dental benefit plan:

94%

would recommend

Please note 3,770 members enrolled in your dental benefits plan were surveyed during the time period indicated, while "n" represents the total number of your members who responded to each individual question, and as such, may vary based on completion rates.

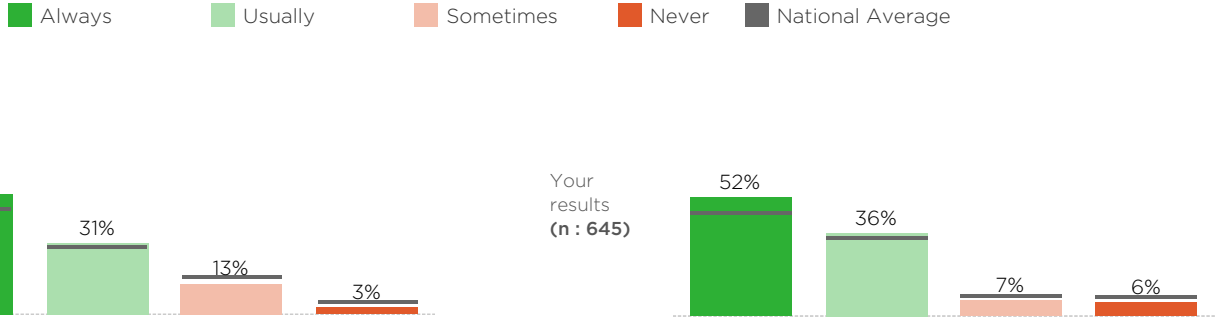
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Your Member Feedback Report

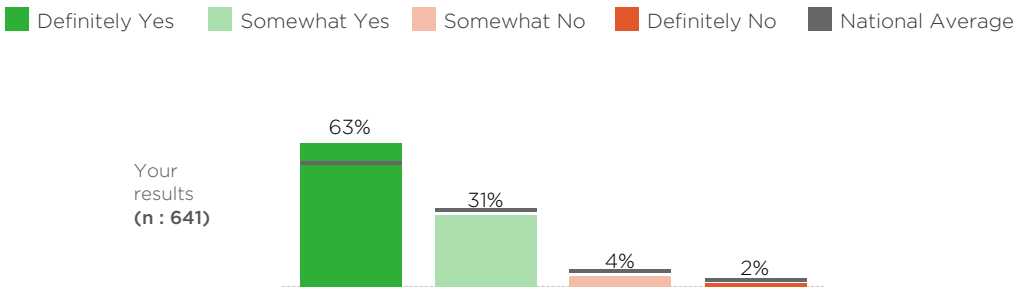
Dental Benefits Coverage

A great benefits package can help your business attract and retain top talent. Providing the right benefits requires understanding of how members rate their dental plan in meeting their coverage expectations and oral health needs, as well as delivering value.



Coverage as expected
In the last 12 months, how often did your Delta Dental benefit plan cover all of the services you thought were covered?

Coverage as needed
In the last 12 months, did your Delta Dental benefit plan cover what you and your family needed to get done?



Coverage worth recommending
Would you recommend the Delta Dental plan to people who want to join?

Delta Dental of New Mexico

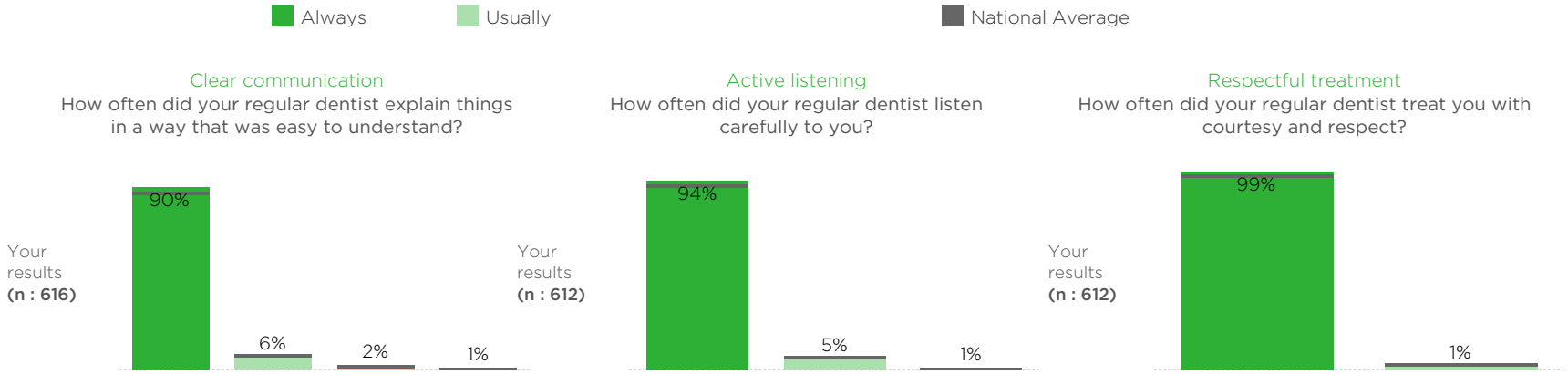
Delta Dental national average is based on all members surveyed across the national network of 39 independent Delta Dental companies. Please note 3,770 members enrolled in your dental benefits plan were surveyed during the time period indicated, while "n" represents the total number of your members who responded to each individual question, and as such, may vary based on completion rates.

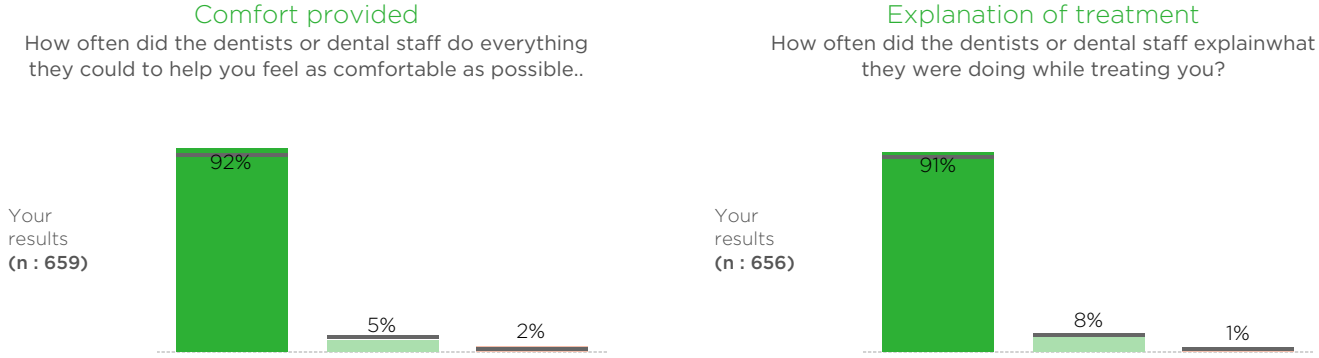
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Your Member Feedback Report

Dental Care

Understanding members' dental care experiences during their dental visits gives you confidence in the care they receive. The feedback regarding their interactions with Delta Dental network dentists empowers us to continue to advance patient-centered care on behalf of your members.





Delta Dental of New Mexico

Delta Dental national average is based on all members surveyed across the national network of 39 independent Delta Dental companies. Please note 3,770 members enrolled in your dental benefits plan were surveyed during the time period indicated, while "n" represents the total number of your members who responded to each individual question, and as such, may vary based on completion rates.

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AGREEMENT

THIS AGREEMENT is made and entered into as of the date of the last signature below, by and between the City of Albuquerque, New Mexico, a municipal corporation ("City"), and _____, _____ ("Contractor").

RECITALS

WHEREAS, the City issued a Request For Proposals for the _____ Department, RFP-_____, titled "_____", which is Exhibit A to this Agreement; and

WHEREAS, the Contractor submitted its Proposal, dated _____, in response to P_____, which Proposal is Exhibit B to this Agreement; and

WHEREAS, the City desires to engage the Contractor to render certain services in connection therewith, and the Contractor is willing to provide such services.

NOW, THEREFORE, in consideration of the premises and mutual obligations herein, the parties hereto do mutually agree as follows:

1. Scope of Services. The Contractor shall perform the following services ("Services") in a satisfactory and proper manner, as determined by the City:

Provide [Insert brief description of services in lowercase lettering], in accordance with Exhibit A as supplemented by Exhibit B. To the extent the Exhibits conflict with this Agreement, the terms of this Agreement shall govern.

2. Time of Performance. Services of the Contractor shall commence upon execution of Agreement, and shall be undertaken and completed in such sequence as to assure their expeditious completion in light of the purposes of this Agreement; provided, however, that in any event, all of the Services required hereunder shall be completed _____.

[Should be revised to fit the procurement.]

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3. Compensation and Method of Payment.

[Should be revised to fit the procurement.]

A. Compensation. For performing the Services specified in Section 1 hereof, the City agrees to pay the Contractor up to the amount of _____, which amount includes any applicable gross receipts taxes and which amount shall constitute full and complete compensation for the Contractor's Services under this Agreement, including all expenditures made and expenses incurred by the Contractor in performing the Services.

B. Method of Payment. Such amount shall be payable at the rate of _____ and No/100 Dollars ($_____) per hour, which rate includes any applicable gross receipt taxes. Payments shall be made to the Contractor monthly for completed Services upon receipt by the City of properly documented requisitions for payment as determined by the budgetary and fiscal guidelines of the City and on the condition that the Contractor has accomplished the Services to the satisfaction of the City.

C. Appropriations. Notwithstanding any other provision in this Agreement, the terms of this Agreement are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the City Council, or if the City Council un-appropriates or deauthorizes funds during a fiscal year, this Agreement may be terminated upon thirty (30) days' written notice given by the City to all other parties to this Agreement. Such event shall not constitute an event of default. All payment obligations of the City and all of its interest in this Agreement will cease upon the date of termination. The City's decision as to whether sufficient appropriations are available shall be accepted by all parties and shall be final.

D. Responsibility to Monitor Contract. Contractor shall be responsible for ensuring that the Contractor does not bill for Services in an amount that exceeds the total contract amount. With each invoice submitted to the City, the Contractor shall include a ledger report that identifies the total amount the Contractor has billed for Services under this Agreement and any Supplements to this Agreement. If at any time the Contractor determines that payment for Services may or will exceed the total amount provided in this Agreement and any Supplements to this Agreement, the Contractor shall notify the City in writing, as soon as possible after making that determination. If the Contractor's billing exceeds the amount of this Agreement and any Supplements, the City may stop or delay payment, or the Services may be ceased or delayed at the City's request.

4. Independent Contractor. Neither the Contractor nor its employees are considered to be employees of the City of Albuquerque for any purpose whatsoever. The Contractor is considered as an independent contractor at all times in the performance of the Services described in Section 1. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers' Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

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5. Personnel.

A. The Contractor represents that it has, or will secure at its own expense, all personnel required in performing all of the Services required under this Agreement. Such personnel shall not be employees of or have any contractual relationships with the City.

B. All the Services required hereunder will be performed by the Contractor or under its supervision and all personnel engaged in the work shall be fully qualified and shall be authorized or permitted under state and local law to perform such Services.

C. None of the work or the Services covered by this Agreement shall be subcontracted without the prior written approval of the City. Any work or Services subcontracted hereunder shall be specified by written contract or Agreement and shall be subject to each provision of this Agreement.

6. Indemnity. The Contractor agrees to defend, indemnify, and hold harmless the City and its officials, agents, and employees from and against any and all claims, actions, suits, or proceedings of any kind brought against said parties because of any injury or damage received or sustained by any person, persons, or property, which injury is arising out of or resulting from the Services performed by the Contractor under this Agreement or by reason of any asserted act or omission, neglect, or misconduct of the Contractor or Contractor's agents, or employees or any subcontractor or its agents or employees. The indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Agreement.

7. Insurance. The Contractor shall procure and maintain at its expense until final payment by the City for Services covered by this Agreement, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by it or its agents. Before commencing the Services and upon the renewal of all coverages, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days' written notice be given to the Risk Manager, Department of Finance and Administrative Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than professional liability or workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided. Kinds and amounts of insurance required are as follows:

A. Commercial General Liability Insurance. A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$2,000,000	Per Occurrence
$2,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury

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$ 5,000 Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor, and contractual liability coverage shall specifically insure the hold harmless provisions of this Agreement.

B. Automobile Liability Insurance. An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

C. Workers' Compensation Insurance. Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensations Act of the State of New Mexico.

D. Increased Limits. If, during the term of this Agreement, the City requires the Contractor to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Contractor's compensation will be made.

8. Discrimination Prohibited. In performing the Services required hereunder, the Contractor shall not discriminate against any person on the basis of race, color, religion, gender, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap, or disability as defined in the Americans With Disabilities Act of 1990, as now enacted or hereafter amended.

9. ADA Compliance. In performing the Services required hereunder, the Contractor agrees to meet all the requirements of the Americans With Disabilities Act of 1990, and all applicable rules and regulations (the 'ADA'), which are imposed directly on the Contractor or which would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify and hold harmless the City, its officials, agents and employees from and against any and all claims, actions, suits or proceedings of any kind brought against said parties as a result of any acts or omissions of the Contractor or its agents in violation of the ADA.

10. Conflict of Interest. No officer, agent or employee of the City will participate in any decision relating to this Agreement which affects that person's financial interest, the financial interest of his or her spouse or minor child or the financial interest of any business in which he or she has a direct or indirect financial interest.

11. Interest of Contractor. The Contractor agrees that it presently does not have, and shall acquire no direct or indirect interest which conflicts in any manner or degree with the performance of the terms of this Agreement. The Contractor will not employ any person who has any such conflict of interest to assist the Contractor in performing the Services.

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12. No Collusion. The Contractor represents that this Agreement is entered into by the Contractor without collusion on the part of the Contractor with any person or firm, without fraud and in good faith. The Contractor also represents that no gratuities, in the form of entertainment, gifts or otherwise, were, or during the term of this Agreement, will be offered or given by the Contractor or any agent or representative of the Contractor to any officer or employee of the City with a view towards securing this Agreement or for securing more favorable treatment with respect to making any determinations with respect to performing this Agreement.

13. Debarment, Suspension, Ineligibility and Exclusion Compliance. The Contractor certifies that it has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Contractor agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor, the Contractor will notify the City immediately.

14. Reports and Information. At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Agreement. Unless otherwise authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to this Agreement until the final product is submitted to the City.

15. Open Meetings Requirements. Any nonprofit organization in the City which receives funds appropriated by the City, or which has as a member of its governing body an elected official, or appointed administrative official, as a representative of the City, is subject to the requirements of § 2-5-1 et seq., R.O.A. 1994, Public Interest Organizations. The Contractor agrees to comply with all such requirements, if applicable.

16. Public Records. The parties acknowledge that the City is a government entity subject to the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq., NMSA 1978). Notwithstanding any other provision of this Agreement, the City shall not be responsible to Contractor for any disclosure of Confidential Information pursuant to that Act or pursuant to the City's public records act laws, rules, regulations, instructions or any other legal requirement.

17. Establishment and Maintenance of Records. Records shall be maintained by the Contractor in accordance with applicable law and requirements prescribed by the City with respect to all matters covered by this Agreement. Except as otherwise authorized by the City, such records shall be maintained for a period of three (3) years after receipt of final payment under this Agreement.

18. Audits and Inspections. At any time during normal business hours and as often as the City may deem necessary, there shall be made available to the City for examination all of the Contractor's records with respect to all matters covered by this Agreement. The Contractor shall permit the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment and other data relating to all matters covered by this Agreement. The Contractor

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understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. and Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 9 of the Albuquerque City Charter.

19. Ownership, Publication, Reproduction and Use of Material. No material produced in whole or in part under this Agreement shall be subject to copyright in the United States or in any other country. The City shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Agreement.

20. Compliance With Laws. In performing the Services required hereunder, the Contractor shall comply with all applicable laws, ordinances, and codes of the federal, state and local governments.

21. Changes. The City may, from time to time, request changes in the Services to be performed hereunder. Such changes, including any increase or decrease in the amount of the Contractor's compensation, which are mutually agreed upon by and between the City and the Contractor, shall be incorporated in written amendments to this Agreement.

22. Assignability. The Contractor shall not assign any interest in this Agreement and shall not transfer any interest in this Agreement (whether by assignment or novation), without the prior written consent of the City thereto.

23. Termination for Cause. If, through any cause, the Contractor shall fail to fulfill in a timely and proper manner its obligations under this Agreement or if the Contractor shall violate any of the covenants, agreements, or stipulations of this Agreement, the City shall thereupon have the right to terminate this Agreement by giving written notice to the Contractor of such termination and specifying the effective date thereof at least five (5) days before the effective date of such termination. In such event, all finished or unfinished documents, data, maps, studies, surveys, drawings, models, photographs and reports prepared by the Contractor under this Agreement shall, at the option of the City, become its property, and the Contractor shall be entitled to receive just and equitable compensation for any work satisfactorily completed hereunder.

Notwithstanding the above, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Agreement by the Contractor, and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

24. Termination for Convenience of City. The City may terminate this Agreement at any time by giving at least fifteen (15) days' notice in writing to the Contractor. If the Contractor is terminated by the City as provided herein, the Contractor will be paid an amount which bears the same ratio to the total compensation as the Services actually performed bear to the total Services of the Contractor covered by this Agreement, less payments of compensation previously made. If this Agreement is terminated due to the fault of the Contractor, the preceding Section hereof relative to termination shall apply.

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25. Construction and Severability. If any part of this Agreement is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Agreement so long as the remainder of the Agreement is reasonably capable of completion.

26. Enforcement. The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Agreement.

27. Entire Agreement. This Agreement contains the entire agreement of the parties and supersedes any and all other agreements or understandings, oral or written, whether previous to the execution hereof or contemporaneous herewith.

28. Applicable Law and Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Mexico, and the laws, rules and regulations of the City of Albuquerque. The venue for actions arising out of this Agreement is Bernalillo County, New Mexico.

29. Force Majeure. The City shall not be liable for failure to perform its obligations under this Agreement due to causes beyond the control and without the fault or negligence of the City which would render such performance impossible or hazardous. Such causes include, but are not restricted to, acts of God or the public enemy, acts of State or Federal governments, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of subcontractors due to any of the above (hereinafter "Force Majeure Event"). If a Force Majeure Event causes any failure to perform, the City shall promptly inform the Contractor in writing of such event, indicating the expected duration thereof and the period for which suspension in performance is requested. The parties shall consult with each other in good faith with respect to modification of this Agreement to reflect such suspension or other changes (if any) desired by the City as a result thereof. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this Agreement.

30. Electronic Signatures. The parties agree that this Agreement may be electronically signed and that the electronic signatures appearing on this Agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

31. Approval Required. This Agreement shall not become binding upon the City until approved by the highest approval authority of the City required under this Agreement.

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IN WITNESS WHEREOF, the City and the Contractor have executed this Agreement as of the last date written below.

CITY OF ALBUQUERQUE

Approved By:

_____
Chief Administrative Officer

Date: _____

_____, Director

Department _____

Date: _____

_____, Chief Procurement Officer

Department _____

Date: _____

CONTRACTOR:

By: _____

Title: _____

Date: _____

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RENAHEA-04 JDEHAAN

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/17/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Joshua DeHaan
Acrisure Great Lakes Partners Insurance Services, LLC 223 West Grand River Ave #1 Howell, MI 48843	PHONE (A/C, No, Ext): (248) 375-4640 FAX (A/C, No): E-MAIL ADDRESS: jdehaan@acrisure.com

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Delta Dental Plan of New Mexico Inc. 100 Sun Avenue NE, Suite 400 Albuquerque, NM 87109	INSURER A : Massachusetts Bay Insurance Company	22306
	INSURER B : Allmerica Financial Benefit Insurance Company	41840
	INSURER C : The Hanover Insurance Company	22292
	INSURER D : The Continental Insurance Company	35289
	INSURER E : Great American Insurance Company	16691
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT X LOC OTHER:			ZDIH285795-05	6/15/2025	6/15/2026	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG EMPLOYEE BENEFI	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ Included $ 2,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS HIRED AUTOS ONLY NON-OWNED AUTOS ONLY			AWIH275653-05	6/15/2025	6/15/2026	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
C	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 0			UHIH285802-06	6/15/2025	6/15/2026	EACH OCCURRENCE AGGREGATE	$ 25,000,000 $ 25,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		WMIH275617-06	6/15/2025	6/15/2026	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
D	Excess over $25 mil			6081264133	6/15/2025	6/15/2026	Aggregate	25,000,000
E	Computer Crime			FS 0240881 15 00	6/15/2025	6/15/2026	Single Loss Limit	10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

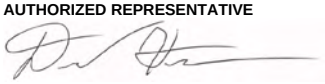
CERTIFICATE HOLDER

Delta Dental Plan of New Mexico Inc.
100 Sun Avenue NE, Suite 400
Albuquerque, NM 87109

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 7/14/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER M3 Insurance Solutions, Inc. 828 John Nolen Drive Madison WI 53713	**CONTACT NAME:** **PHONE (A/C, No, Ext):** 800-272-2443 **FAX (A/C, No):** 608-273-1725 **E-MAIL ADDRESS:** info@m3ins.com **PRODUCER CUSTOMER ID #:** DELTDEN-05
INSURED Delta Dental New Mexico, Inc. 4100 Okemos Rd Okemos MI 48864	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** Lloyds of London **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** 2358429 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	☐ POLICY ☐ PRO-JECT ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	☐ SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	☐ HIRED AUTOS							$
	☐ NON-OWNED AUTOS							$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DEDUCTIBLE							$
	☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Cyber/Technology E&O			FM2400101	7/15/2025	7/15/2026	Limit Retention	60,000,000 250,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

$25M of Technology E&O is not separate to, but part of the overall $60M aggregate limit

Renaissance Health Service Corporation is an additional named insured in regards to the Cyber Liability coverage reflected.

CERTIFICATE HOLDER

Proof of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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City of Albuquerque
DENTAL PPO COST PROPOSAL FORM
Appendix H

This form must be completed in its entirety. Please do not alter, add or delete rows. Multi-year rates and rate caps will be considered more favorably. Failure to complete this form in its entirety may deem your submission as non-responsive.

REQUESTED AND/OR PROPOSED PLAN DESIGN RATES					
Dental PPO Cost Form		Current Plan Design			
		7/1/2024 - 6/30/2025	7/1/2025 - 6/30/2026	7/1/2026 - 6/30/2027	7/1/2027- 6/30/2028
Enrollment Assumptions					
Employee Only		2,865	2,865	2,865	2,865
Employee + Spouse		1,208	1,208	1,208	1,208
Employee + Child(ren)		808	808	808	808
Employee + Family		2,043	2,043	2,043	2,043
Total		6,924	6,924	6,924	6,924
Monthly Fully Insured Premium Rates	*Rate Tiers*				
Employee Only	1.00	$34.28	$34.28	$35.66	$37.08
Employee + Spouse	2.02	$69.32	$69.32	$72.10	$74.98
Employee + Child(ren)	2.22	$76.16	$76.16	$79.20	$82.37
Employee + Family	3.01	$103.08	$103.08	$107.21	$111.49
Total Monthly Premium		$454,080	$454,080	$472,286	$491,139
Total Annual Premium		$5,448,966	$5,448,966	$5,667,436	$5,893,669
Are there any additional costs not included in your rates? If so, please identify.		NO	NO	NO	NO
Rate Guarantees					
Rate Guaranteed?		YES	YES	YES	YES
Implementation/Communication/Tech Credits					
Indicate if any credits are included in your proposal.		NO	NO	NO	NO
Participation					
Minimum Participation Requirements		60.0%	60.0%	60.0%	60.0%

Comments
Listed 4% rates for years 3 & 4 but DDNM is providing a not-to-exceed 4% in years 3 & 4

Authorized Signature		
Authorized Name		Louis Volk III
Vendor Name		Delta Dental Plan of New Mexico
Date		8/19/2025
Contact Phone Number		505-225-4291

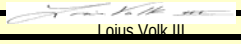
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City of Albuquerque
SELF FUNDED DENTAL ADMINISTRATION
Appendix H

This form must be completed in its entirety. Please do not alter, add or delete rows. Multi-year rates and rate caps will be considered more favorably. Failure to complete this form in its entirety may deem your submission as non-responsive.

REQUESTED AND/OR PROPOSED PLAN DESIGN RATES					
Dental PPO Cost Form		Current Plan Design			
		7/1/2024 - 6/30/2025	7/1/2025 - 6/30/2026	7/1/2026 - 6/30/2027	7/1/2027- 6/30/2028
Enrollment Assumptions					
Employee Only		2,865	2,865	2,865	2,865
Employee + Spouse		1,208	1,208	1,208	1,208
Employee + Child(ren)		808	808	808	808
Employee + Family		2,043	2,043	2,043	2,043
Total		6,924	6,924	6,924	6,924
Monthly Self Insured Administration (PEPM)		$3.85	$3.85	$4.00	$4.15
Total Annual Self Insured Administative Cost		$319,888.80	$319,888.80	$332,352.00	$344,815.20
Are there any additional costs not included in your rates? If so, please identify.		NO	NO	NO	NO
Rate Guarantees					
Rate Guaranteed?		YES	YES	YES	YES
Implementation/Communication/Tech Credits					
Indicate if any credits are included in your proposal.		NO	NO	NO	NO
Participation					
Minimum Participation Requirements		60.0%	60.0%	60.0%	60.0%

Comments
Equivalency factors available upon request. DDNM will assist in the development and adjustment of equivalency factors.

Authorized Signature		
Authorized Name		Lojus Volk III
Vendor Name		Delta Dental Plan of New Mexico
Date		8/19/2025
Contact Phone Number		505-225-429[illegible]

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City of Albuquerque
COST PROPOSAL - PERFORMANCE GUARANTEES
Appendix H

For the following categories, provide the performance standard you are willing to offer, the financial penalty (maximum dollar amount or % of administrative fees) you will agree to pay if the standard is not met, and the method of measuring the penalty.

PERFORMANCE GUARANTEES	VENDOR RESPONSE
1. **Vendor attendance at the Client meetings** Attendance by vendor representatives when requested at meetings scheduled by the Client during the contract period and implementation phase.	DDNM agrees with the following revisions: Attendance by vendor representative when requested with advanced notice and as negotiated in the final Contract. No Penalty - not a metric to be tracked
2. **Vendor call (or e-mail) return timeliness** The Client or designated consultant's calls (or e-mails) to vendor are returned within 48 business hours.	DDNM agrees with the following revisions: The Client or designated consultant's calls (or emails) to Account Manager are returned within 2 business days. Penalty:$500 per applicable quarter
3. **Processing monthly eligibility updates** All updates to eligibility or enrollment records will be made within 3 business days after the information is received by the vendor.	DDNM agrees with the following revisions: All electronic eligibility or Benefit Manger Toolkit access updates to eligibility or enrollment records will be made within 3 business days after the information is received by the Vendor. Penalty: $500 per applicable quarter
4. **Telephone call availability & answering speed** 90% of all calls are answered within 30 seconds, and telephone service is available between 8:00 am and 4:30 pm MST on business days.	DDNM agrees 90% of all calls to Delta Dental's Member Services will be 30 seconds or less. Penalty: $750 per applicable quarter.
5. **Telephone call on-hold (in-queue) time** An average of less than 2 minute(s) on hold before a **human being** answers.	Agreed with the understanding that the call has left the IVR system. We offer self-service options through our IVR system that allows members the ability to verify eligibility, detailed benefit overview, and verification if they are eligible for cleaning, exam or x-rays. $500 per quarter missed PG
6. **Telephone Abandonment Rate** An abandonment rate of less than 3% is maintained during standard business hours.	Agreed $750 per quarter missed PG
7. **Claims Processing Accuracy** 99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the vendor must reimburse the Client for all overpayments that are not recovered from the recipient within 60 days after the overpayment is discovered. The Client will assign its right to any recover such overpayments to the vendor.	Agreed Penalty: $750 per applicable quarter
8. **Turnaround Time on Claims Payments** 97% of all claims received will be completely processed (paid, denied, or pended for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 calendar days of receipt.	DDNM agrees with the following revisions: 97 percent of all dental claims within ten business days. 100% of clean claims will be processed within 30 calendar days of receipt. Penalty:$750 per applicable quarter
9. **Timeliness of Claim Reports** Each report the vendor will supply the Client will be provided within a mutually agreed upon timeframe.	DDNM agrees with the following revisions: Vendor will supply the Client with the standard reporting package within 45 business days after the end of the reporting period. Penalty: $1,000 per applicable quarter
10. **Claims Coding** 99% of all claims will be coded with no errors.	DDNM does not agree to this metric. Providers are responsible for the coding of claims based on the services performed. Instead, DDNM is agreeing to the revised metric for Claims Processing Accuracy. See #7.
11. **Implementation** Successful implementation as defined by key milestones. Include measurable milestones in your proposal.	DDNM agrees to a $1,500 penalty based upon mutually agreed upon milestones and deliverables.
12. **Data Exchange** Receive and transmit data with vendors based on a frequency defined by the business needs of the Client.	TBD based upon City of Albuquerque requirements and mutually agreed upon project scope

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Renaissance Health Service Corporation and Affiliates

Consolidated Financial Report
with Additional Information
December 31, 2024

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Renaissance Health Service Corporation and Affiliates

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Plante & Moran, PLLC
Suite 600
8181 E. Tufts Avenue
Denver, CO 80237
Tel: 303.740.9400
Fax: 303.740.9009
plantemoran.com

Independent Auditor's Report

To the Audit, Finance, and Risk
Management Committee
Renaissance Health Service Corporation and
Affiliates

Opinion

We have audited the consolidated financial statements of Renaissance Health Service Corporation and Affiliates (the "Enterprise"), which comprise the consolidated statement of financial position as of December 31, 2024 and 2023 and the related consolidated statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Enterprise as of December 31, 2024 and 2023 and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audits of the Consolidated Financial Statements* section of our report. We are required to be independent of the Enterprise and to meet our ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Enterprise's ability to continue as a going concern within one year after the date that the consolidated financial statements are issued or available to be issued.

Auditor’s Responsibilities for the Audits of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore, is not a guarantee that audits conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

PRAXITY
Empowering Business Globally

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To the Audit, Finance, and Risk
Management Committee
Renaissance Health Service Corporation and
Affiliates

In performing audits in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audits.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audits in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Enterprise's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Enterprise's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audits, significant audit findings, and certain internal control-related matters that we identified during the audits.

Plante & Moran, PLLC

June 12, 2025

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Renaissance Health Service Corporation and Affiliates

Consolidated Statement of Financial Position

December 31, 2024 and 2023
(000s omitted)

	2024	2023
Assets		
Current Assets		
Cash and cash equivalents	$ 235,809	$ 267,092
Investments (Notes 6 and 8)	1,336,950	1,217,427
Accounts receivable - Net (Note 9)	158,210	145,443
Reinsurance receivable	56,340	53,001
Prepaid expenses and other current assets	40,478	49,274
Total current assets	1,827,787	1,732,237
Property and Equipment - Net (Note 10)	171,860	174,222
Goodwill and Intangible Assets - Net (Note 11)	32,555	34,168
Pension Asset (Note 14)	89,713	51,635
Notes Receivable (Note 6)	1,043	5,305
Other Investments (Notes 6 and 8)	110,108	81,691
Other Assets (Note 8)	103,123	95,578
Total assets	**$ 2,336,189**	**$ 2,174,836**
Liabilities and Net Assets		
Current Liabilities		
Accounts payable	$ 29,494	$ 36,269
Unpaid claims and other reserves (Notes 12 and 13)	98,711	98,833
Risk-sharing payables (Note 16)	-	2,619
Premiums received in advance and customer deposits	58,752	60,640
Reinsurance payable	46,315	40,335
Current portion of lease liabilities (Note 19)	3,083	3,789
Accrued and other current liabilities	108,066	100,722
Total current liabilities	344,421	343,207
Other Postretirement Obligations (Note 14)	1,689	1,757
Other Long-term Liabilities (Note 19)	83,961	73,951
Total liabilities	430,071	418,915
Net Assets - Without donor restrictions		
Contributed capital	29,189	29,189
Capital contributed by dentists	115	115
Noncontrolling interest	6,382	(683)
Unassigned reserves	1,870,432	1,727,300
Total net assets	1,906,118	1,755,921
Total liabilities and net assets	**$ 2,336,189**	**$ 2,174,836**

See notes to consolidated financial statements.

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Renaissance Health Service Corporation and Affiliates

Consolidated Statement of Activities and Changes in Net Assets

Years Ended December 31, 2024 and 2023
(000s omitted)

	2024	2023
Revenue		
Premiums and administrative fees:		
Premiums earned (Note 13)	$ 2,587,526	$ 2,451,948
Administrative fees	164,448	158,427
Total premiums and administrative fees	2,751,974	2,610,375
Investment income - Net (Note 7)	78,702	41,146
Other income	15,328	8,645
Third-party administrator fees	58,845	60,427
Service revenue	9,736	25,152
Total premiums earned and other revenue	2,914,585	2,745,745
Expenses		
Claims expenses (Notes 12 and 13)	2,193,845	2,049,780
Operating and other expenses	697,886	700,019
Total expenses	2,891,731	2,749,799
Operating Income (Loss)	22,854	(4,054)
Nonoperating Income		
Unrealized gain on securities	76,549	107,909
Pension-related changes other than service cost (Note 14)	41,156	15,645
Other nonoperating income	9,638	2,648
Total nonoperating income	127,343	126,202
Consolidated Changes in Net Assets without Donor Restrictions	150,197	122,148
Net Assets - Without donor restrictions - Beginning of year	1,755,921	1,633,773
Net Assets - Without donor restrictions - End of year	**$ 1,906,118**	**$ 1,755,921**

See notes to consolidated financial statements.

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Renaissance Health Service Corporation and Affiliates

Consolidated Statement of Cash Flows

Years Ended December 31, 2024 and 2023
(000s omitted)

	2024	2023
Cash Flows from Operating Activities		
Consolidated changes in net assets without donor restrictions	$ 150,197	$ 122,148
Adjustments to reconcile consolidated changes in net assets without donor restrictions to net cash from operating activities:		
Depreciation and amortization	30,625	32,001
Loss (gain) on disposal of property and equipment	93	(109)
Loss (gain) incurred on other investments	1,560	(1,921)
Net amortization of investment premiums and discounts	3,223	3,334
Realized and unrealized gain on investments	(99,154)	(103,035)
Noncash lease expense	3,538	3,785
Gain on sale of Dewpoint, LLC	(1,600)	-
Changes in operating assets and liabilities that (used) provided cash:		
Accounts receivable	(15,321)	(21,382)
Reinsurance receivable	(3,339)	(3,269)
Prepaid expenses and other current assets	5,837	2,072
Other assets	(9,499)	(7,129)
Accounts payable	(7,472)	(5,387)
Unpaid claims and other reserves	(122)	11,723
Risk-sharing payables	(2,619)	(8,250)
Premiums received in advance and customer deposits	(1,888)	3,240
Reinsurance payable	5,980	4,473
Accrued and other current liabilities	6,772	7,294
Pension and postretirement obligations	(38,146)	(18,352)
Other long-term liabilities	7,682	5,651
Lease liabilities	(3,379)	(3,728)
Net cash provided by operating activities	32,968	23,159
Cash Flows from Investing Activities		
Purchase and development of property and equipment	(22,710)	(18,598)
Proceeds from disposition of property and equipment	48	505
Purchases of investment securities	(483,735)	(681,199)
Proceeds from sales and maturities of investment securities	460,483	676,770
Investments in nonmarketable equity securities and other	(26,520)	(16,589)
Investments in notes receivable	(1,403)	(3,758)
Proceeds from and repayment of notes receivable	1,766	1,026
Cash paid for intangible assets	-	(1,926)
Proceeds from sale of Dewpoint, LLC	12,678	-
Net cash paid for purchase of Dent-Well, LLC	(4,858)	-
Net cash used in investing activities	(64,251)	(43,769)
Net Change in Cash and Cash Equivalents	(31,283)	(20,610)
Cash and Cash Equivalents - Beginning of year	267,092	287,702
Cash and Cash Equivalents - End of year	**$ 235,809**	**$ 267,092**
Significant Noncash Transactions		
Conversion of note receivable to other investments	$ 4,772	$ 4,771
Right-of-use assets obtained in exchange for new lease liabilities	5,465	3,840
Noncontrolling interest resulting from acquisition	7,200	-

See notes to consolidated financial statements.

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Note 1 - Nature of Business

Renaissance Health Service Corporation and Affiliates (the "Enterprise") is a Michigan nonprofit corporation and is one of the largest dental plan administrators in the United States. Its affiliates, located in Michigan, Ohio, Indiana, Kentucky, New Mexico, New York, Tennessee, North Carolina, Arkansas, and Utah, offer dental plans that are provided on both an insurance basis and under administrative services contracts. Certain affiliates are member companies of the Delta Dental Plans Association, a nationwide system of independently operated dental health service plans that have a key feature of offering subscribers access to the national provider networks under the DeltaUSA program and access to the local provider networks maintained by the Enterprise. Subsidiaries of the Enterprise also offer life, vision, and disability coverage to customers throughout the United States.

Several affiliates provide other services to customers, including third-party administrative services, claims processing, information technology, and investment management services. In addition, the Enterprise, with its philanthropic arms, the Delta Dental Foundation; Renaissance Family Foundation, Inc.; Delta Dental of Kentucky Foundation, Inc.; and Delta Dental of Arkansas Foundation, Inc., is organized and committed to making a positive impact on the quality of life, placing a special emphasis on dental health, in the communities in which the Enterprise operates.

Note 2 - Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America and include the accounts of Renaissance Health Service Corporation (RHSC) and its affiliates. All significant intercompany balances and transactions have been eliminated.

Use of Estimates

The preparation of consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The Enterprise considers the accounting estimates for unpaid claims and other reserves, pension and postretirement obligations, and impairment considerations related to investments at cost critical in the preparation of the consolidated financial statements. The Enterprise uses information available at the time the estimates are made; however, these estimates could change materially if different information or assumptions were used. Additionally, these estimates may not ultimately reflect the actual amounts of the final transactions that occur. It is reasonably possible that these estimates will change in the near term.

Fair Value of Financial Instruments

The estimated fair values of investments are described in Note 8. Financial instruments also consist of cash equivalents, accounts receivable, and accounts payable, whose carrying value approximates fair value due to the short-term nature.

Cash and Cash Equivalents

The Enterprise considers its cash and cash equivalents to include only cash on hand, demand deposits, and investments with an original maturity of three months or less when purchased.

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Note 2 - Significant Accounting Policies (Continued)

Investments

Debt and equity securities are reported at fair value within current assets, with unrealized gains and losses reported in nonoperating income. Certain investments in direct equity securities and equity equivalents of privately held, early-stage portfolio companies are not traded on a public market. These securities are recorded at fair value, as determined by the managing member, using the framework of fair value measurements and are included in other investments in the consolidated financial statements.

The Enterprise has investments in private entities in which the Enterprise is not able to exert significant influence. These investments do not have a readily determinable fair value. Investments in these entities are carried at net asset value or at cost, evaluated for impairment, and adjusted for any observable changes in price. No impairment losses on these investments were recognized and there were no observable price changes for the years ended December 31, 2024 and 2023.

Investments in entities in which the Enterprise is able to exert significant influence and investments in limited partnerships in which the Enterprise has more than a minor interest are carried using the equity method. The Enterprise records its initial investment and adjusts the value based on its proportionate share of earnings. Dividends received are included in income except for those dividends received in excess of the Enterprise's proportionate share of accumulated earnings, which are applied as a reduction of the cost of the investment. Impairment losses due to a decline in the value of the investment that are other than temporary are recognized when incurred. No impairment losses on these investments were recognized for the years ended December 31, 2024 and 2024.

Realized capital gains and losses are determined on a specific identification basis and are included in investment income. Premiums and discounts are amortized or accreted over the life of the related debt security as an adjustment to yield. Dividend and interest income is recognized when earned.

The Enterprise's investments are exposed to various risks, such as market risk, credit, and overall market volatility. Due to the level of risk associated with certain securities, it is at least reasonably possible that changes in the value of securities will occur in the near term and that such changes could materially affect the amounts reported in the consolidated financial statements.

Receivables

Premiums receivable consist of unsecured customer obligations and are stated at invoice cost. If an invoice remains unpaid, insurance benefits are terminated retroactively to the month through which amounts due were paid. Accounts receivable related to administrative service contracts are the unpaid balance of administrative fees charged and unreimbursed paid claims. Other accounts receivable are stated at invoice amounts based on contract amounts.

An allowance for credit losses is established for amounts expected to be uncollectible over the contractual life of the receivables. The Enterprise collectively evaluates receivables to determine the allowance for credit losses based on receivables at year end. The Enterprise calculates the allowance using an expected loss model that considers the Enterprise’s actual historical loss rates adjusted for current economic conditions. Uncollectible amounts are written off against the allowance for credit losses in the period they are determined to be uncollectible. Recoveries of amounts previously written off are recognized when received.

Property and Equipment

Property and equipment are recorded at cost. Depreciation is computed using the straight-line method over the estimated useful lives of the assets. The costs of leasehold improvements are amortized over the expected term of the related lease. Costs of maintenance and repairs are charged to expense when incurred.

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Note 2 - Significant Accounting Policies (Continued)

The Enterprise capitalizes significant costs incurred in the acquisition or development of software for internal use, including the costs of software, materials, consultants, and payroll and payroll-related costs for employees incurred in developing internal-use computer software, once project feasibility is determined. Costs incurred prior to project feasibility and costs not qualifying for capitalization are charged to expense when incurred.

Property and equipment held for sale are recorded at the lower of cost or fair value. Property and equipment held for sale are not depreciated once classified as held for sale.

Goodwill

The recorded amounts of goodwill from business combinations are based on management's best estimates of the fair values of assets acquired and liabilities assumed at the date of acquisition.

The Enterprise elected to apply the private company accounting alternative for goodwill developed by the Private Company Council. Under the accounting alternative, goodwill is amortized on a straight-line basis over a 10-year period. Additionally, goodwill is assessed for potential impairment if events occur or circumstances change that indicate the fair value of the Enterprise may be less than its carrying value. The Enterprise elected to test goodwill for impairment at the reporting-unit level. In addition, under the accounting alternative, certain intangible assets are no longer recognized separately from goodwill.

During the years ended December 31, 2024 and 2023, no impairment charges were recognized. It is reasonably possible that management's estimates of the carrying amount of goodwill will change in the near term.

Intangible Assets

Acquired intangible assets subject to amortization are stated at cost and are amortized using the straight-line method over the estimated useful lives of the assets, ranging from 3 to 15 years. Intangible assets that are subject to amortization are reviewed for potential impairment whenever events or circumstances indicate that carrying amounts may not be recoverable. Assets not subject to amortization are tested for impairment at least annually.

No impairment charges were recognized during the years ended December 31, 2024 and 2023.

Unpaid Claims and Other Reserves

The reported liability for unpaid claims reserves is composed of two components: a liability for known claims that are unpaid as of the consolidated statement of financial position date and a liability for claims incurred but not reported (IBNR).

The liability for unpaid claims IBNR is determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet *Actuarial Standards of Practice*.

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Note 2 - Significant Accounting Policies (Continued)

Claims IBNR are based primarily on past experience, including claims payment patterns, enrollment data, historical utilization of services, emerging cost trends, seasonality, and other relevant information and are determined by actuarial calculations. Dental cost trends are primarily impacted by service utilization and unit costs that are affected by changes in the level and mix of benefits offered, in addition to the impact of copays and deductibles, changes in provider practices, and changes in consumer demographics. Under this process, historical paid claims data is formatted into claim triangles, which compare claim incurred dates to the dates of claim payments. This information is analyzed to create completion factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims. Vision claims IBNR are not significant to the consolidated financial statements.

Liabilities for unallocated claim adjustment expenses are calculated based on the estimated administrative cost per claim multiplied by the estimated number of claims included in the unpaid claims reserves.

Life and disability reserves are developed by actuarial methods and are intended to provide, in the aggregate, reserves that are greater than or equal to the minimum or guaranteed policy cash values or the amounts required by law. The life reserve is calculated based on completion factors applied to expected claims by month. The expected claims are derived by applying an expected loss ratio to gross earned premiums. The disability reserve is based on the historical payout pattern by days since incurred date. Expected claims are based on the average claim paid multiplied by the historical continuance factor for the number of days of benefit remaining, summed over the number of remaining weeks in the benefit period. Management utilizes an in-house actuary to assist in its evaluation of reserve estimates.

Although considerable variability is inherent in such estimates, management believes the recorded liability for unpaid claims and other reserves is adequate. The estimates are continually reviewed and adjusted as necessary as experience develops or new information becomes known. Such adjustments are reflected in current operations. There were no significant changes in estimate methodologies or assumptions during 2024 or 2023.

Revenue Recognition - Insurance Premiums

The Enterprise has insurance contracts recognized in accordance with Accounting Standards Codification (ASC) 944, *Financial Services - Insurance*. Dental and vision insurance premiums are recognized as earned over the terms of the contracts. Life premiums are recognized as income over the premium paying period of the related policies. Premiums received in advance represent payments received prior to the effective date of the policy. Expenses incurred in connection with acquiring new insurance business, including acquisition costs such as sales commissions, are charged to operations over the related policy period.

The Enterprise estimates accrued retrospective premium adjustments for policies where the premium varies based on loss experience and specific contract terms. The Enterprise records the accrued retrospective premiums as earned by adjusting written premiums. Return premiums are recorded as liabilities within risk-sharing payables, and additional premiums are recorded as assets. While management believes these estimates are accurate, it is reasonably possible that a change in estimate will occur in the near term as a result of actual loss experience differing from projected loss experience.

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Note 2 - Significant Accounting Policies (Continued)

Revenue Recognition - Administrative Fees

Administrative services only (ASO) and administrative services contracts in place with customers provide access to a network of dental providers and claim processing services and do not contain insurance risk. As a result, ASO and administrative services contracts are not accounted for as insurance contracts. Under these agreements, the Enterprise remits approved claim payments directly to providers and is reimbursed directly from customers. The Enterprise reflects claim payment activity as an agent and charges an administrative fee for these services.

The collective services provided under these contracts represent a single performance obligation, as no individual service provided is separately identifiable. Administrative service fee revenue is recognized over time using the output method, given customers simultaneously receive and consume the benefits provided. These fees are recognized monthly on a per member, per month basis. Under the typical payment terms, customers remit administrative fees on a monthly basis. The Enterprise recognizes a receivable as claim payments are made to providers. Administrative services contract claim reimbursements are remitted by customers on either a monthly or weekly basis. ASO claim payments are paid directly from the accounts of the customer.

For the years ended December 31, 2024 and 2023, the Enterprise had contract assets related to various credits granted to customers that are recognized over the life of the contract. Contract assets are recorded within prepaid expenses and other current assets and other noncurrent assets in the consolidated statement of financial position. There were no contract liabilities as of December 31, 2024 and 2023.

The Enterprise elected to use the practical expedient to recognize incremental costs of obtaining administrative services contracts and ASO contracts, as the amortization period of the assets the Enterprise otherwise would have recognized would have been one year or less. As such, these costs, which include commissions, are charged to operations as incurred. Commission expense for insurance, ASO, and administrative services contracts totaled $99,189 and $98,269 in 2024 and 2023, respectively.

Revenue Recognition - Service Revenue

Service revenue is related to The 4100 Group, Inc. and Subsidiaries (T4G) operations. T4G is engaged in the business of software and hardware information technology solutions and services, as well as providing investment management and financial portfolio consulting services. Revenue is recognized when control of the promised goods or services is transferred to customers in an amount that reflects the consideration to which T4G expects to be entitled in exchange for those goods or services. T4G's contracts are typically performed over time. Customers obtain the benefits of such services as the services are performed. Therefore, T4G satisfies its performance obligations as services are rendered.

Sales-based taxes are excluded from revenue. Information technology services are invoiced monthly as work is performed. Investment management services are based on assets under management and invoiced in arrears and recognized evenly over the period of service. Additional information on T4G's revenue recognition policies can be found in its separately issued financial statements. There were no contract liabilities as of December 31, 2024 and 2023.

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Note 2 - Significant Accounting Policies (Continued)

Revenue Recognition - Third-party Administrator Fees

Renaissance Life and Health Insurance Company of America (Renaissance America), a Renaissance Holding Company (RHC) subsidiary; Dentist Direct, LLC, an RHC subsidiary; and Delta Dental Plan of Michigan, Inc. (DDPMI) provide third-party administrator (TPA) services for affiliated and unaffiliated insurance carriers. These services consist primarily of claims processing and insurance administration services. Contracts are grouped under the portfolio approach, given contracts in each area have similar characteristics, and no individual contracts are material. TPA services provided to affiliates are eliminated.

The collective services provided under these contracts represent a single performance obligation, as no individual service provided is separately identifiable. Amounts are recognized over time, given customers simultaneously receive and consume the benefits provided. Administration services are recognized on a per member per month basis, per subscriber per month basis, or per claim basis. Under the typical payment terms, customers remit TPA fees on a monthly basis.

As of December 31, 2024 and 2023, the Enterprise had no recognized contract assets or liabilities related to TPA fees.

Reinsurance

The Enterprise utilizes reinsurance agreements primarily to facilitate the acquisition or disposition of certain insurance contracts. Ceded reinsurance agreements permit the Enterprise to recover a portion of losses from reinsurers although they do not discharge the primary liability as direct insurer of the risks reinsured. Failure of reinsurers to indemnify the Enterprise could result in losses; however, management does not expect charges for unrecoverable reinsurance to have a material effect on the results of operations or financial position. Ceded reinsurance premiums are recognized on the same basis as the premiums are earned on the underlying insurance contracts. Assumed reinsurance premiums are earned as reported by the ceding company in accordance with the reinsurance contracts. Premiums earned and losses incurred are reflected in the accompanying consolidated financial statements, net of related reinsurance. Amounts due to the ceding company are included within reinsurance receivable and reinsurance payable.

Leases

The Enterprise has operating leases for office space. The Enterprise recognizes expense for operating leases on a straight-line basis over the lease term. The Enterprise made a policy election not to separate lease and nonlease components for office space. Therefore, all payments are included in the calculation of the right-of-use asset and lease liability.

The Enterprise elected to use the risk-free rate as the discount rate for calculating the right-of-use asset and lease liability in place of the incremental borrowing rate for office space leases.

Accrued and Other Current Liabilities

The Enterprise records accrued and other current liabilities for short-term obligations that have been incurred and are outstanding at year end. Included in accrued and other current liabilities at December 31, 2024 and 2023 is $52,838 and $54,085, respectively, of liabilities incurred related to payroll obligations.

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Note 2 - Significant Accounting Policies (Continued)

Pension, Postretirement, and Other Deferred Compensation Liabilities

The Enterprise sponsors deferred compensation plans in accordance with Sections 457(b) and 457(f) of the Internal Revenue Code (the "Deferred Compensation Plans") for various affiliates. The various affiliates' boards of directors determine the 457(b) plan participation, which is currently directors and officers of the affiliates within the Enterprise. The 457(f) plans are nonqualified plans established to retain senior officers. Participants in the Deferred Compensation Plans are determined by the boards of directors and require a vesting period. The liability for compensation deferred under both types of plan is recorded in other long-term liabilities, and the assets held by the plans are recorded at fair value in other assets. Pension and other postretirement benefits are recognized as earned over the participants service period.

Income Taxes

RHSC and specific affiliates are exempt from federal income taxes under the provisions of Section 501(c)(4) or Section 501(c)(3) of the Internal Revenue Code. However, RHSC and these specific affiliates are required to pay taxes on unrelated business income. For-profit affiliates are subject to both federal and state income taxes.

A current tax liability or asset is recognized for the estimated taxes payable or refundable on tax returns for the year. Deferred tax liabilities or assets are recognized for the estimated future tax effects of temporary differences between financial reporting and tax accounting. As of December 31, 2024 and 2023, the Enterprise has $1,518 and $3,099, respectively, of net deferred tax assets recorded within other assets in the consolidated statement of financial position. A valuation allowance is recognized if, based on the weight of available evidence, it is more likely than not that some portion or all of the deferred tax assets will not be realized. A valuation allowance of $16,048 and $7,672 was recorded at December 31, 2024 and 2023, respectively. As of December 31, 2024 and 2023, the Enterprise's unrecognized tax benefits were not significant. There were no significant penalties or interest recognized during the year or accrued at year end.

Operating Measure

The Enterprise’s operating income includes all operating revenue and expenses that are an integral part of its programs and supporting activities and other nonoperating funds to support current operating activities. Operating income excludes unrealized gains and losses on securities, income or loss from other investments, and pension-related changes other than net periodic pension costs related to service costs.

Methods Used for Allocation of Expenses from Management and General Activities

Expenses related to program services and management and general are reported on a functional basis in Note 17. Program-related costs represent expenses incurred to support program activities, including the provision of insurance services to customers, claims processing services, information technology consulting and services, investment management services, and the mission to support and improve oral health. Costs directly attributable to a specific function are reported in those functional areas. Costs that benefit more than one area, where a direct relationship does not exist, are allocated based on time and resources estimated to be used in each area. Although methods of allocation used are considered appropriate, other methods could be used that would produce different amounts.

Subsequent Events

The consolidated financial statements and related disclosures include evaluation of events up through and including June 12, 2025, which is the date the consolidated financial statements were available to be issued.

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Note 3 - Corporate Transactions

Dent-Well, LLC Acquisition

On July 19, 2024, T4G acquired 6,554 Class A units of Dent-Well, LLC (Dent-Well) for an ownership percentage of 64.2 percent. The primary reason for the acquisition was to expand the services offered by the T4G and its affiliates.

The following table summarizes the fair value of the consideration transferred as part of the acquisition of Dent-Well:

Cash	$	4,800
Assumed liabilities		(85)
Fair value of total consideration transferred	$	4,715

The fair value of the 6,554 shares issued as part of the consideration transferred for Dent-Well was determined on the basis of an independent valuation of the T4G's common shares prior to the acquisition.

The following table summarizes the acquisition-date fair values of the assets acquired and liabilities assumed:

Financial assets	$	3,340
Property, plant, and equipment		2,434
Financial liabilities		(1,058)
Total identifiable net assets		4,716
Noncontrolling interest in Dent-Well		(7,200)
Goodwill		7,199
Total	$	4,715

The fair value of the noncontrolling interest in Dent-Well was determined on the basis of an independent valuation, which used the multiperiod excess earnings method based on T4G's projections. This fair value measurement is based on significant inputs that are not observable in the market. Key assumptions include a weighted-average cost of capital discount rate of 18.5 percent and a long-term growth rate of 3.5 percent.

Acquisition-related costs, which include legal, accounting, and valuation fees, were not significant and have been expensed.

Sale of Dewpoint, LLC

The 4100 Group, Inc. sold a component of its business, Dewpoint, LLC, on June 3, 2024 for $12,000,000 to an unrelated party. This resulted in a gain of approximately $1,600,000 during the year ended December 31, 2024. The disposal of Dewpoint, LLC represents a strategic shift of The 4100 Group, Inc., as it represents the only activity in this market segment (technology services) and is considered to be a discontinued operation. The effects of discontinued operations on the Enterprise’s financial statements were not considered to be significant; however, The 4100 Group, Inc.'s separate financial statements reflect the presentation of discontinued operations.

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Note 3 - Corporate Transactions (Continued)

Activity in 2024 for Dewpoint, LLC prior to the sale was not significant. Dewpoint, LLC's major classes of assets and liabilities as of December 31, 2023 were as follows:

Assets:	
Cash and cash equivalents	$ 5,241
Investments	7,182
Accounts receivable - Net - Other	6,435
Other current assets	542
Property and equipment - Net	220
Right-of-use operating lease assets	1,634
Goodwill - Net	4,337
Intangible assets - Net	2,110
Total assets	$ 27,701
Liabilities:	
Accounts payable	$ 2,107
Accrued liabilities	296
Other liabilities	43
Short-term lease obligations	472
Long-term lease obligations	1,318
Total liabilities	$ 4,236

Note 4 - Custodial Credit Risk of Bank Deposits

Custodial credit risk is the risk that, in the event of a bank failure, the Enterprise's deposits may not be returned to it. The Enterprise's policy related to custodial credit risk of bank deposits is to maintain all deposits in a high-quality institution. The Enterprise maintains balances in its deposit accounts to adequately cover current operating and claims payment expenses and, as a result, generally requires balances that exceed the Federal Deposit Insurance Corporation (FDIC) insurance limits of $250,000 at December 31, 2024. The Enterprise believes that, due to the dollar amounts of cash deposits and the limits of FDIC insurance, it is sometimes impractical to insure all deposits.

Note 5 - Liquidity and Availability of Resources

The Enterprise's financial assets available for general expenditures are as follows at December 31:

	2024	2023
Cash and cash equivalents	$ 235,809	$ 267,092
Accounts receivable	158,210	145,443
Investments	1,331,228	1,211,838
Total	$ 1,725,247	$ 1,624,373

Financial assets totaling less than $5,800 and $5,600 for the years ended December 31, 2024 and 2023, respectively, are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the consolidated statement of financial position date. Accounts receivable are subject to implied time restrictions but are expected to be collected within one year.

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Note 5 - Liquidity and Availability of Resources (Continued)

The Enterprise has a goal to maintain financial assets, which consist of cash, cash equivalents, and investments, on hand to meet 30 days of normal operating expenses, which are, on average, $493,683 and $459,717 at December 31, 2024 and 2023, respectively. The Enterprise has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due. In addition, the Enterprise invests cash in excess of daily requirements in various investments. The Enterprise also realizes there could be unanticipated liquidity needs.

Note 6 - Investments

The details of the Enterprise's investments in equity and debt securities at December 31, 2024 and 2023 are as follows:

	2024			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities:				
Common and preferred stocks	$ 161,285	$ 71,099	$ (5,908)	$ 226,476
Mutual funds and ETFs	495,676	114,549	(10,186)	600,039
Debt securities:				
U.S. government and agencies securities	177,486	52	(12,762)	164,776
Certificates of deposit	2,952	-	-	2,952
Municipal debt securities	29,785	11	(6,441)	23,355
Corporate debt securities	167,314	2,022	(6,307)	163,029
Mortgage-backed securities	162,355	3,993	(10,025)	156,323
Total	$ 1,196,853	$ 191,726	$ (51,629)	$ 1,336,950

	2023			
	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Equity securities:				
Common and preferred stocks	$ 153,235	$ 47,304	$ (3,727)	$ 196,812
Mutual funds and ETFs	482,844	63,677	(18,643)	527,878
Debt securities:				
U.S. government and agencies securities	137,167	660	(8,561)	129,266
Certificates of deposit	4,022	-	-	4,022
Municipal debt securities	29,188	18	(5,958)	23,248
Corporate debt securities	195,793	3,030	(7,676)	191,147
Mortgage-backed securities	149,098	5,008	(9,052)	145,054
Total	$ 1,151,347	$ 119,697	$ (53,617)	$ 1,217,427

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Note 6 - Investments (Continued)

The amortized cost and fair value of debt securities by contractual maturity at December 31, 2024 are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
Due in one year or less	$ 18,329	$ 18,137
Due in one through five years	162,800	161,677
Due after five years through ten years	77,669	75,196
Due after ten years	118,739	99,102
Mortgage-backed securities	162,355	156,323
Total	$ 539,892	$ 510,435

Other Investments

The Enterprise's investments in various nonmarketable equity securities and privately held companies are as follows:

	2024	2023
Equity securities and equity equivalents of privately held, early-stage portfolio companies - Unobservable fair value	$ 11,865	$ -
NAPA EA/MEDX, LLC - Carried at cost	30,000	30,000
Other equity and securities in privately held companies - Carried at cost	41,686	40,987
Other equity and securities in privately held companies - Carried at net asset value	13,441	-
Equity method investments	13,116	10,704
Total	$ 110,108	$ 81,691

All of the Company's investments carried at net asset value include several venture capital and investment funds that invest in U.S. and foreign-based companies. These investments generally cannot be redeemed. Distributions from each fund will be received only as the underlying investments of the funds are liquidated, which is estimated to occur over the next 6 to 9 years. The Enterprise has unfunded future commitments to such funds totaling $1,784 as of December 31, 2024.

Notes Receivable

The Enterprise also holds investments in convertible notes in privately held companies totaling $3,266 and $9,961 as of December 31, 2024 and 2023, respectively. These notes charge an interest rate between 6.00 and 10.00 percent, with principal due at various dates through 2026. These investments are included in other assets and notes receivable on the consolidated statement of financial position. The Enterprise assessed the risk of credit loss on the notes receivable and deemed it to be insignificant to the consolidated financial statements.

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Note 7 - Investment Income

Investment income is composed of the following for the years ended December 31, 2024 and 2023:

	2024	2023
Interest income	$ 36,258	$ 33,349
Amortization and accretion - Net	(2,472)	(3,612)
Dividend income	18,203	17,537
Realized gain (loss) on sale of investments	27,450	(4,873)
Gain (loss) on other assets - Other	131	(633)
Gross investment income	79,570	41,768
Investment expenses	(868)	(622)
Total investment income	$ 78,702	$ 41,146

Note 8 - Fair Value Measurements

Accounting standards require certain assets and liabilities be reported at fair value in the consolidated financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the inputs and valuation techniques used to measure fair value.

Fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the Enterprise has the ability to access.

Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets and other inputs, such as interest rates and yield curves, that are observable at commonly quoted intervals.

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

In instances where inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Enterprise’s assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

The total investment portfolio contains certain investments in privately held companies carried at cost, equity method investments, and certificates of deposit totaling $87,754 and $81,691 at December 31, 2024 and 2023, respectively, which are excluded from the following tables. Investments carried at net asset value totaling $13,441 and $0 at December 31, 2024 and 2023, respectively, have also been excluded from the following tables.

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Note 8 - Fair Value Measurements (Continued)

The following tables present information about the Enterprise's assets measured at fair value on a recurring basis at December 31, 2024 and 2023 and the valuation techniques used by the Enterprise to determine those fair values:

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2024			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2024
Equity securities:				
Common and preferred stocks	$ 226,476	$ -	$ 11,865	$ 238,341
Mutual funds - Large cap	351,625	-	-	351,625
Mutual funds - International	3,708	-	-	3,708
Mutual funds - Small/Mid cap	72,621	-	-	72,621
Bond ETFs - Investment grade	61,711	-	-	61,711
Mutual funds - High yield	1,088	-	-	1,088
Mutual funds - Other	109,286	-	-	109,286
Debt securities:				
U.S. government and agencies securities	-	164,776	-	164,776
Municipal debt securities	-	23,355	-	23,355
Corporate debt securities	-	163,029	-	163,029
Mortgage-backed securities	-	156,323	-	156,323
Other assets in deferred compensation plans - Mutual funds	50,934	3,380	-	54,314
Total	$ 877,449	$ 510,863	$ 11,865	1,400,177
Investments measured at NAV				13,441
Total assets				$ 1,413,618

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Note 8 - Fair Value Measurements (Continued)

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2023			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2023
Equity securities:				
Common and preferred stocks	$ 196,812	$ -	$ -	$ 196,812
Mutual funds - Large cap	325,468	-	-	325,468
Mutual funds - International	7,837	-	-	7,837
Mutual funds - Small/Mid cap	41,533	-	-	41,533
Bond ETFs - Investment grade	52,778	-	-	52,778
Mutual funds - High yield	1,082	-	-	1,082
Mutual funds - Other	99,180	-	-	99,180
Debt securities:				
U.S. government and agencies securities	-	129,266	-	129,266
Municipal debt securities	-	23,248	-	23,248
Corporate debt securities	-	191,147	-	191,147
Mortgage-backed securities	-	145,054	-	145,054
Other assets in deferred compensation plans - Mutual funds	43,865	2,864	-	46,729
Total	$ 768,555	$ 491,579	$ -	1,260,134

The following summarizes the valuation methodology used in determining fair value measurements of the significant classes of the Enterprise's assets measured at fair value on a recurring basis:

Level 1 Measurements

Equity securities and other assets - The fair value of these investments is based upon the unadjusted quoted prices for the identical security in active markets that the Enterprise can access.

Level 2 Measurements

Debt securities and other assets - The primary inputs to the valuation include quoted prices for identical or similar assets in markets that are not active, contractual cash flows, benchmark yields, prepayment speeds, collateral performance, and credit spreads.

Level 3 Measurements

Preferred stocks - The fair value of these investments is based primarily on unadjusted inputs that have been internally developed by management, including third-party transactions.

Level 3 investment purchases totaling $11,865 were made during 2024.

There were no transfers into or out of Level 3 investments during 2024 and 2023.

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Note 9 - Accounts Receivable

Components of accounts receivable for the years ended December 31, 2024 and 2023 are as follows:

	2024	2023
Premiums receivable	$ 40,789	$ 27,244
Administrative service contracts	99,164	93,141
Other accounts receivable	20,405	25,561
Less allowance for credit losses	2,148	503
Total accounts receivable - Net	$ 158,210	$ 145,443

Activity in the allowance for credit losses during the years ended December 31, 2024 and 2023 was not significant to the financial statements.

Note 10 - Property and Equipment

Property and equipment are summarized as follows:

	2024	2023	Depreciable Life - Years
Land and improvements	$ 15,944	$ 15,944	10-15
Buildings and improvements	139,034	135,594	7-40
Capitalized software - Internally developed	54,489	46,965	1-7
Capitalized software - Purchased	46,074	37,795	1-7
Equipment and furniture	111,857	120,297	5-10
Leasehold improvements	7,661	8,975	5-20
Construction in progress	11,109	14,568	-
Total cost	386,168	380,138	
Accumulated depreciation and amortization	214,308	205,916	
Net property and equipment	$ 171,860	$ 174,222	

Depreciation and amortization expense for 2024 and 2023 was $27,145 and $27,268, respectively. Construction in progress primarily represents costs of capitalized software and building renovations. There are no significant commitments related to these projects at December 31, 2024.

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Note 11 - Goodwill and Acquired Intangible Assets

Goodwill and intangible assets of the Enterprise at December 31, 2024 and 2023 are summarized as follows:

	2024		2023	
	Gross Amount	Accumulated Amortization	Gross Amount	Accumulated Amortization
Subject to amortization:				
Customer lists	$ 12,148	$ (4,470)	$ 22,247	$ (12,602)
Intellectual property	3,409	(2,126)	3,409	(1,770)
Licenses	1,599	(1,599)	1,599	(1,599)
Noncompete agreement	376	(348)	2,976	(2,941)
Goodwill	25,777	(6,072)	23,658	(5,770)
Trade name	230	(230)	230	(230)
Total subject to amortization	43,539	(14,845)	54,119	(24,912)
Indefinite lived:				
Licenses	2,821	-	2,821	-
Trade name	1,040	-	2,140	-
Total indefinite lived	3,861	-	4,961	-
Total	$ 47,400	$ (14,845)	$ 59,080	$ (24,912)

Amortization expense for goodwill and intangible assets totaled $3,480 and $4,733 for the years ended December 31, 2024 and 2023, respectively.

Estimated amortization expense for the years ending December 31 is as follows:

Years Ending	Amount
2025	$ 3,896
2026	3,896
2027	3,827
2028	3,617
2029	3,611
Thereafter	9,847
Total	$ 28,694

As discussed in Note 2, the Enterprise has elected to apply the private company accounting alternative for accounting of goodwill. The changes in the carrying amount of goodwill are as follows:

	2024	2023
Balance - January 1	$ 17,888	$ 20,183
Current year activity:		
Additions	7,199	65
Goodwill reduction related to sale of Dewpoint, LLC	(4,337)	-
Amortization expense	(2,161)	(2,360)
Other	1,116	-
Net current year activity	1,817	(2,295)
Balance - December 31	$ 19,705	$ 17,888

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Note 12 - Unpaid Claims and Other Reserves

The following summarizes activity in the liability for unpaid claims reserves related to dental and vision contracts for the years ended December 31, 2024 and 2023:

	2024	2023
Gross liability as of January 1	$ 83,163	$ 70,710
Incurred (recovered) related to:		
Current year	2,173,395	2,039,658
Prior years	(4,476)	(8,124)
Total incurred	2,168,919	2,031,534
Paid related to:		
Current year	2,097,803	1,951,247
Prior years	73,642	67,834
Total paid	2,171,445	2,019,081
Gross liability as of December 31	$ 80,637	$ 83,163

Renaissance Life and Health Insurance Company of America and Renaissance Life and Health Insurance Company of New York (Renaissance New York), affiliates of RHSC, also write and assume life and disability contracts. Total direct and assumed life and disability claims incurred during 2024 and 2023 were $24,926 and $18,246, respectively. Total direct and assumed life and disability reserves as of December 31, 2024 and 2023 were $18,074 and $15,670, respectively.

As a result of changes to incurred claims expenses attributable to insured events of prior years, the provision for claims changed during 2024 and 2023. Estimates are adjusted as changes in these factors occur, and such adjustments are reported in the period of determination.

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Note 12 - Unpaid Claims and Other Reserves (Continued)

The following is information about incurred and paid claims development as of December 31, 2024 and 2023, as well as incurred but not reported and cumulative reported claims by loss year. The information related to incurred and paid claims development for the year ended December 31, 2023 is presented as supplemental information.

Dental

	Incurred Claims Expenses for the Years Ended December 31		As of December 31, 2024	
Claim Year	2023	2024	Total IBNR Reserves	Cumulative Number of Reported Claims
2023	$ 2,018,159	$ 2,013,868	$ 662	11,535
2024		2,141,975	72,643	12,064
Total		$ 4,155,843		

	Cumulative Paid Claims for the Years Ended December 31	
Claim Year	2023	2024
2023	$ 1,931,720	$ 2,012,830
2024		2,068,436
Total		$ 4,081,266
Total liability for unpaid claims reserves - Net of reinsurance		$ 74,577

Life and Disability

	Incurred Life and Disability Claims for the Years Ended December 31		As of December 31, 2024	
Claim Year	2023	2024	Total IBNR and Bulk Reserves	Cumulative Number of Reported Claims
2023	$ 21,426	$ 23,229	$ 4,489	12
2024		26,335	9,889	11
Total		$ 49,564		

	Cumulative Paid Life and Disability Claims for the Years Ended December 31	
Claim Year	2023	2024
2023	$ 12,928	$ 18,740
2024		16,446
Total		$ 35,186
Total liability for life and disability reserves - Net of reinsurance		$ 14,378

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Note 12 - Unpaid Claims and Other Reserves (Continued)

There is no single or common claim frequency metric used in the health care industry. The Enterprise believes a relevant metric is the total number of dental and life and disability claims paid on behalf of participants receiving health care insurance during the year. This metric will generally be consistent and comparable over time.

The reconciliation of the net incurred and paid claim development tables to the liability for claims and other reserves in the accompanying consolidated statement of financial position is as follows:

Liability for unpaid claims and other reserves - Net of reinsurance:		
Dental	$	74,577
Life and disability		14,378
Other life and disability		3,697
Vision		1,963
Contract reserves		2,341
Other		590
Subtotal		97,546
Unallocated claim adjustment expenses		1,165
Total liability for unpaid claims and other reserves	$	98,711

Note 13 - Reinsurance

Renaissance America participates in a reinsurance ceded agreement with Mutual of Omaha. Under the terms of the reinsurance agreement, Renaissance America cedes a percentage of earned premiums and claims incurred pertaining to the life insurance line of business. The agreement is continuous until terminated by either party pursuant to the agreement.

Renaissance America and Renaissance New York entered into a reinsurance agreement with RGA Insurance Company (RGA) in July 2020, and the contract has been renewed on an annual basis as of July 1, 2024 and 2023. Under the terms of this agreement, losses in excess of retention related to direct life, health, and accident insurance business are ceded to RGA. Ceded losses are limited on a per occurrence basis.

Renaissance America participates in two quota share reinsurance agreement with Solstice Health Insurance Company (Solstice) and Axis Insurance Company (Axis). Under the terms of this agreement, dental and vision premiums and losses administered by a given third-party administrator are ceded to Solstice and Axis. The agreement is continuous until terminated by either party pursuant to the agreement.

At December 31, 2024 and 2023, the Enterprise participates in seven assumed reinsurance agreements with unrelated entities in which the Enterprise assumes a risk-sharing percentage of specific contract premiums earned and claims incurred.

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Note 13 - Reinsurance (Continued)

The following is a summary of the effects of reinsurance on the Enterprise's consolidated financial statements as of December 31, 2024 and 2023:

	2024	2023
Premiums earned:		
Direct	$ 2,371,819	$ 2,250,776
Assumed	223,503	209,250
Ceded	(7,229)	(8,078)
Net premiums earned	$ 2,588,093	$ 2,451,948
Claims expenses:		
Direct	$ 1,996,500	$ 1,872,050
Assumed	202,290	181,680
Ceded	(4,945)	(3,950)
Net claims expenses	$ 2,193,845	$ 2,049,780
Unpaid claims and other reserves:		
Direct	$ 89,010	$ 87,905
Assumed	11,980	12,424
Ceded	(2,279)	(1,496)
Net unpaid claims and other reserves	$ 98,711	$ 98,833

Note 14 - Pension and Other Postretirement Benefit Plans

The Enterprise offers defined contribution plans to all full-time employees. The Enterprise also offers certain executive employees and members of the board of directors deferred and supplemental compensation plans. As of December 31, 2024 and 2023, the Enterprise has established a liability of approximately $54,400 and $46,800, respectively, for the deferred and supplemental compensation plans included within other long-term liabilities on the consolidated statement of financial position.

The Enterprise has two noncontributory defined benefit pension plans. The Enterprise also has one underfunded postretirement benefit plan that benefits certain employees. Collectively, the pension and postretirement plans are referred to as the "Plans."

Generally, the Enterprise's funding policy is to contribute annually, at a minimum, the amount the pension fund actuary has recommended, which amortizes past service liability over 10 years and which is in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974 (ERISA). The Plans' assets include cash and cash equivalents, debt securities, and equity securities.

Obligations and Funded Status

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Projected benefit obligation	$ 359,915	$ 376,018	$ 1,689	$ 1,757
Fair value of plan assets	449,628	427,653	-	-
Overfunded (underfunded) status	$ 89,713	$ 51,635	$ (1,689)	$ (1,757)

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Note 14 - Pension and Other Postretirement Benefit Plans (Continued)

Amounts recognized in the consolidated statement of financial position consist of the following:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Noncurrent assets	$ 89,713	$ 51,635	$ -	$ -
Noncurrent liabilities	-	-	(1,689)	(1,757)
Funded status	$ 89,713	$ 51,635	$ (1,689)	$ (1,757)

The Enterprise has two overfunded pension plans as of December 31, 2024 and 2023. As of December 31, 2024 and 2023, the Enterprise's fair value of plan assets exceeded the accumulated benefit obligation for both plans.

The accumulated benefit obligation for all defined benefit pension plans was $331,862 and $344,736 at December 31, 2024 and 2023, respectively.

The following cumulative amounts have been recognized in net assets without donor restrictions and will be reclassified to operating expenses in future periods through net periodic benefit cost:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Net (loss) gain	$ (43,971)	$ (72,644)	$ 3,730	$ 4,035
Prior service cost	4,214	4,660	-	-
Total recognized in net assets without donor restrictions	$ (39,757)	$ (67,984)	$ 3,730	$ 4,035

The estimated net loss and prior service credit for the defined benefit pension plans that will be amortized from net assets into net periodic benefit cost over the next fiscal year are $339 and $(446), respectively.

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Note 14 - Pension and Other Postretirement Benefit Plans (Continued)

Components of net periodic benefit cost and other changes in plan assets and benefit obligations for the Plans are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Net Periodic Benefit Cost				
Service cost	$ 13,174	$ 12,469	$ -	$ -
Interest cost	20,281	19,524	96	100
Expected return on plan assets	(35,059)	(30,941)	-	-
Amortization of prior service credit	(446)	(446)	-	-
Amortization of actuarial loss (gain)	2,199	3,916	(305)	(303)
Net periodic benefit cost (credit)	149	4,522	(209)	(203)
Other Changes in Plan Assets and Benefit Obligations				
Net (gain) loss amortized during the year	(2,199)	(3,916)	305	303
Net gain arising during the year	(26,474)	(4,328)	-	-
Prior service credit amortized during the year	446	446	-	-
Total other changes in plan assets and benefit obligations	(28,227)	(7,798)	305	303
Total (increase) decrease in net assets related to plans	$ (28,078)	$ (3,276)	$ 96	$ 100

The service costs disclosed above were included as a component of operating and other expenses on the consolidated statement of activities and changes in net assets. The other components of net periodic benefit cost have been included in pension-related changes other than service cost on the consolidated statement of activities and changes in net assets. See summary of amounts included in pension-related changes other than service cost in the following table:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Interest cost	$ 20,281	$ 19,524	$ 96	$ 100
Expected return on plan assets	(35,059)	(30,941)	-	-
Net gain arising during the year	(26,474)	(4,328)	-	-
Total pension-related changes other than service cost	$ (41,252)	$ (15,745)	$ 96	$ 100

During 2021, one of the noncontributory defined benefit plans adopted a plan amendment to allow active participants to elect to take a lump-sum distribution upon termination of employment. This amendment resulted in lump-sum distributions of $5,020 and $982 during 2024 and 2023, respectively.

Actuarial gains during 2024 related to changes in the discount rate and lump-sum interest rates. Actuarial losses during 2023 related to changes in the demographic experience and changes in the discount rate.

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Note 14 - Pension and Other Postretirement Benefit Plans (Continued)

Assumptions used to determine benefit obligations at December 31 are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Discount rate	6.10%-6.11%	5.54%	5.75%	5.75%
Rate of compensation increase	4.05%	4.16%		

Assumptions used to determine net periodic benefit cost for the years ended December 31 are as follows:

	Pension Benefits		Other Postretirement Benefits	
	2024	2023	2024	2023
Discount rate	5.54%	5.70-5.71%	3.40%	3.40%
Expected long-term return on plan assets	8.00-8.25%	8.00-8.25%		
Rate of compensation increase	4.16%	3.75%		

The overall expected rate of return on plan assets represents a weighted-average composite rate based on the historical rates of returns of the respective asset classes adjusted for anticipated market movements.

Pension Plan Assets

The target allocation of plan assets is 5-65 percent equity securities, 30-70 percent debt securities, and 0-10 percent cash and cash equivalents.

The Enterprise's defined benefit plans are guided by a comprehensive investment policy statement (IPS), which prescribes the investment philosophy, valuation-based asset allocation policy, long-term investment goals, investment restrictions, and management procedures used to manage assets in a prudent and consistent manner. The Enterprise implements a diversified portfolio strategy through a mix of traditional and alternative asset classes using individual securities, exchange-traded funds (ETFs), mutual funds, and private funds.

A consulting group reviews forecasts of future obligations and associated actuarial assumptions at least annually to ensure adequate funding levels are being met by each plan. Using these forecasts and expected long-term return objectives, it has been determined that the aim of each plan is long-term growth of principal and income while providing for the preservation of capital within reasonable and prudent levels of risk.

Achieving this objective over the long term requires a commitment to an appropriate valuation-based asset allocation policy that balances risk and return. This approach to asset allocation analyzes the long-term performance characteristics of various asset classes to create a diverse portfolio while also analyzing the price of those asset classes to determine fundamental relative value. The Enterprise attempts to minimize investment risk through diversification and prudent investment decisions. It is recognized that risk and liquidity posture is, in large part, a function of asset class mix. The performance characteristics of various asset classes are reviewed at least annually, focusing on balancing the risks and rewards of market behavior. Based on these characteristics, the valuation-based allocation ranges (measured by market value) were constructed for the Plans.

This allocation takes into account the changing dynamics of the capital markets and forecasts of expected returns of each asset class over long periods of time, typically greater than five years. This length of time should be sufficient to allow asset class characteristics to emerge. Tactical adjustments are made to the asset mix within the prescribed ranges to exploit market inefficiencies in relative value among the asset classes.

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Note 14 - Pension and Other Postretirement Benefit Plans (Continued)

Management of the Plans' assets will also make asset allocation decisions based on returns and risks relative to the Plans' liability, an approach commonly referred to as liability-driven investing (LDI). This allocation is designed to achieve the long-term investment objective of the Plans at an acceptable level of risk using an LDI approach. This approach does not preclude taking risk; rather, it reframes risk from absolute-basis investing (total-return investing) to liability-driven investing.

LDI's investment objective is to attempt to maintain the Plans' ERISA funded status as fully funded. The Plans' accounting funded status, defined as the ratio of the projected benefit obligation (PBO) to the market value of assets (MVA) is measured and recorded annually by the Plans' actuary. Quarterly estimates of the accounting funded status will be measured by using the Plans' liability duration, change in bond yields and estimated service cost accruals, and actual benefit disbursements.

The Plans' funding ratio (how plan assets change relative to the plan liabilities) is the key measure of success. Both the level of the funding ratio and the stability of the funding ratio are important. Investments will be managed in a prudent manner so as to minimize the change in funded status and volatility of plan expenses balanced against total return of plan assets.

The corporate investment committee formally reviews investment performance, policy allocation, and oversight of transactions quarterly. The Plans must adhere to the guidelines as defined in all applicable laws, rules, and regulations. Additional restrictions are explicitly stated in the IPS for each asset class.

The following tables present information about the pension plan assets measured at fair value on a recurring basis at December 31, 2024 and 2023 and the valuation techniques used by the Enterprise to determine those values.

The total investment portfolio of $449,628 and $427,653 at December 31, 2024 and 2023, respectively, contains cash equivalents and accrued interest of $2,464 and $12,207, respectively, which are depository accounts and are not subject to the fair value measurement disclosure contained in the following tables. The fair values of the Enterprise's pension plan assets at December 31, 2024 and 2023 by major asset classes are as follows:

	Fair Value Measurements at December 31, 2024			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Asset Classes				
Equity securities:				
Mutual funds - Large cap	$ 134,885	$ -	$ -	$ 134,885
Mutual funds - International	62,536	-	-	62,536
Mutual funds - Small/Mid cap	50,479	-	-	50,479
Mutual funds - Other	13,278	-	-	13,278
Debt securities:				
U.S. government and agency securities	-	48,968	-	48,968
Corporate debt securities	-	137,018	-	137,018
Total	$ 261,178	$ 185,986	$ -	$ 447,164

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Note 14 - Pension and Other Postretirement Benefit Plans (Continued)

	Fair Value Measurements at December 31, 2023			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Asset Classes				
Equity securities:				
Mutual funds - Large cap	$ 124,379	$ -	$ -	$ 124,379
Mutual funds - International	57,746	-	-	57,746
Mutual funds - Small/Mid cap	33,559	-	-	33,559
Mutual funds - Other	16,395	-	-	16,395
Debt securities:				
U.S. government and agency securities	-	46,608	-	46,608
Corporate debt securities	-	136,759	-	136,759
Total	$ 232,079	$ 183,367	$ -	$ 415,446

The following summarizes the valuation methodology used in determining fair value measurements of the significant classes of the Plans' financial instruments:

Level 1 Measurements

Equity securities - The fair value of these stocks is based upon the unadjusted quoted prices for the identical security in active markets that the Enterprise can access.

Level 2 Measurements

Debt securities - The primary inputs to the valuation include quoted prices for identical or similar assets in markets that are not active, contractual cash flows, benchmark yields, and credit spreads.

Cash Flow

Contributions

The Enterprise expects to contribute approximately $149 to its other postretirement benefit plan in 2025. The Enterprise does not expect to contribute to its pension plans in 2025.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Years Ending	Pension Benefits	Other Postretirement Benefits
2025	$ 21,789	$ 149
2026	23,297	151
2027	23,261	144
2028	24,933	144
2029	26,202	144
Thereafter	142,948	694

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Note 15 - Regulatory Requirements

The Enterprise's insurance subsidiaries are subject to certain risk-based capital (RBC) requirements specified by the National Association of Insurance Commissioners (NAIC). Under these requirements, the amount of capital and surplus maintained by those subsidiaries is to be determined based on regulatory requirements and various risk factors. At December 31, 2024 and 2023, the insurance subsidiaries met the RBC requirements.

Note 16 - Retrospectively Rated Contracts and Contracts Subject to Redetermination

Medical Loss Ratio

Delta Dental Plan of Arkansas, Inc. (DDPAR) is required to refund premiums related to the State of Arkansas Medicaid contract to the extent that medical loss ratios fall short of the percentages specified by the contracts in force. The amount of premiums written by DDPAR as of December 31, 2024 and 2023 that are subject to these retrospective rating features is $59,067 and $75,163, respectively. As of December 31, 2023, DDPAR estimated that $2,619 will be paid out under the contract terms, which is included in risk-sharing payables. This amount was settled with the State in 2024. There is no amount estimated as due as of December 31, 2024

DDPMI is required to refund premiums to the State of Michigan to the extent that medical loss ratios fall short of the percentages specified by the Healthy Kids Dental contract. The final determination of payment will be computed based on actual claims incurred through September 30, 2024 and 2025 for contract years 2023 - 2024 and 2024 - 2025, respectively. The Enterprise recorded no liabilities at December 31, 2024 and 2023.

Note 17 - Functional Expenses

The Enterprise provides various services to its members. Expenses related to providing these services are as follows for the years ended December 31:

	2024		
	Program Services - Insurance Operations	Program Services - Other Operations	Management and General
Claims and claim adjustment expenses	$ 2,193,845	$ -	$ -
Salaries, benefits, and taxes	111,964	39,219	112,430
Contract labor	17,490	11,645	10,869
Commissions	-	-	99,800
Premium taxes and fees	28	-	20,129
Purchased computer services	13,567	7,933	16,541
Professional services	10,392	2,056	12,750
Processing fees	30,674	-	878
Postage and freight	11,602	2,001	1,290
Advertising and promotional fees	77	-	16,541
Depreciation and amortization	4,381	6,400	17,831
Contributions and charitable activities	402	15,454	1,450
Other	26,927	400	74,765
Total	$ 2,421,349	$ 85,108	$ 385,274

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Note 17 - Functional Expenses (Continued)

	2023		
	Program Services - Insurance Operations	Program Services - Other Operations	Management and General
Claims and claim adjustment expenses	$ 2,049,780	$ -	$ -
Salaries, benefits, and taxes	111,114	62,567	110,826
Contract labor	10,608	12,418	8,277
Commissions	-	-	98,390
Premium taxes and fees	27	-	20,441
Purchased computer services	13,029	8,446	15,030
Professional services	8,664	2,184	11,712
Processing fees	27,704	-	844
Postage and freight	9,981	1,969	1,142
Advertising and promotional fees	86	-	14,761
Depreciation and amortization	4,654	6,292	18,851
Contributions and charitable activities	384	18,792	1,042
Other	25,597	465	73,722
Total	$ 2,261,628	$ 113,133	$ 375,038

Note 18 - Contingencies

Beginning on October 11, 2019, multiple putative class action antitrust lawsuits were filed against Delta Dental Plans Association (DDPA), DeltaUSA, and the 39 Delta Dental Member Companies, including the Enterprise and its affiliates (collectively, the “Delta Dental Defendants”). These lawsuits were consolidated in the U.S. District Court for the Northern District of Illinois. The plaintiffs in these lawsuits, a collection of different dental providers, allege that numerous DDPA rules and practices violate the Sherman Antitrust Act and seek damages on behalf of a putative class of dental providers that provided dental goods or services within the United States to Delta Dental subscribers from 2014 through the present. The Delta Dental Defendants have denied all substantive allegations in the complaint. No trial date has been set. At this point, it is too early in the proceedings to determine the outcome of the matter or the range or amount of any potential loss.

Note 19 - Leases

The Enterprise is obligated under operating leases primarily for office space, expiring at various dates through October 2040. The right-of-use asset and related lease liability have been calculated using discount rates ranging from 1.0 percent to 5.4 percent. The leases require the Enterprise to pay taxes, insurance, utilities, and maintenance costs. Total rent expense under these leases was approximately $4,200 and $4,000 for 2024 and 2023, respectively. Long-term obligations under leases are included in other long-term liabilities on the consolidated statement of financial position.

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Note 19 - Leases (Continued)

Future minimum annual commitments under these operating leases are as follows:

Years Ending December 31	Amount
2025	$ 3,882
2026	3,776
2027	3,543
2028	3,493
2029	3,455
Thereafter	16,371
Total	34,520
Less amount representing interest	5,442
Present value of net minimum lease payments	29,078
Less current obligations	3,083
Long-term obligations under leases	$ 25,995

Expenses recognized under these leases for the years ended December 31, 2024 and 2023 consist of the following:

	2024	2023
Operating lease cost	$ 4,048	$ 3,667
Short-term lease cost	676	523
Total lease cost	$ 4,724	$ 4,190
Weighted-average remaining lease term (years) - Operating leases	10.27	12.22
Weighted-average discount rate - Operating leases	2.99	2.67

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Additional Information

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Plante & Moran, PLLC
Suite 600
8181 E. Tufts Avenue
Denver, CO 80237
Tel: 303.740.9400
Fax: 303.740.9009
plantemoran.com

Independent Auditor's Report on Additional Information

To the Audit, Finance, and Risk
Management Committee
Renaissance Health Service Corporation and
Affiliates

We have audited the consolidated financial statements of Renaissance Health Service Corporation and Affiliates as of and for the year ended December 31, 2024 and have issued our report thereon dated June 12, 2025, which contained an unmodified opinion on those consolidated financial statements. Our audit was performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying consolidating statements of financial position and activities and changes in net assets are presented for the purpose of additional analysis rather than to present the financial position and results of operations of the individual companies and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from, and relates directly to, the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Plante & Moran, PLLC

June 12, 2025

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Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Financial Position

December 31, 2024
(000s omitted)

	Renaissance Health Service Corporation	Delta Dental Plan of Michigan, Inc. and Subsidiary	Delta Dental Plan of Ohio, Inc.	Delta Dental Plan of Indiana, Inc.	Delta Dental of Tennessee and Subsidiaries	Delta Dental of Kentucky, Inc. and Subsidiaries	Delta Dental Plan of New Mexico, Inc.	Delta Dental of North Carolina
Assets								
Current Assets								
Cash and cash equivalents	$ 4,379	$ 79,129	$ 6,642	$ 7,239	$ 10,371	$ 9,208	$ 10,101	$ 1,461
Investments	20,784	293,782	297,063	120,256	73,444	85,439	65,895	28,429
Accounts receivable - Net	-	66,766	24,007	6,518	9,694	14,380	3,470	12,729
Reinsurance receivable	-	51,192	-	-	-	-	-	-
Intercompany receivable	50	11,092	10	-	30	-	-	-
Prepaid expenses and other current assets	6	21,416	1,792	414	3,225	2,054	519	510
Total current assets	25,219	523,377	329,514	134,427	96,764	111,081	79,985	43,129
Property and Equipment - Net	118	100,971	244	-	4,454	17,909	567	1,085
Goodwill and Intangible Assets - Net	-	-	-	-	-	1,283	-	-
Pension Asset	-	89,713	-	-	-	-	-	-
Notes Receivable	-	-	-	-	-	-	-	-
Other Investments	-	-	-	-	-	-	-	-
Other Assets	71,049	272,455	41,422	10,581	18,389	12,032	11,033	4,904
Total assets	**$ 96,386**	**$ 986,516**	**$ 371,180**	**$ 145,008**	**$ 119,607**	**$ 142,305**	**$ 91,585**	**$ 49,118**

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Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Financial Position (Continued)

December 31, 2024
(000s omitted)

	Delta Dental Plan of Arkansas, Inc. and Subsidiaries	Renaissance Holding Company and Certain Subsidiaries	Renaissance Life and Health Insurance Company of America (RHC Subsidiary)	Renaissance Life and Health Insurance Company of New York (RHC Subsidiary)	Delta Dental Foundation	The 4100 Group, Inc. and Subsidiaries	Eliminating Entries	Total
Assets								
Current Assets								
Cash and cash equivalents	$ 34,454	$ 29,095	$ 22,365	$ 4,960	$ 2,558	$ 13,847	$ -	$ 235,809
Investments	98,594	12,419	60,293	8,267	136,301	35,984	-	1,336,950
Accounts receivable - Net	9,527	-	4,800	2,459	-	3,860	-	158,210
Reinsurance receivable	-	-	5,148	-	-	-	-	56,340
Intercompany receivable	8	1	856	368	-	1,333	(13,748)	-
Prepaid expenses and other current assets	1,202	33	4,325	34	351	4,596	1	40,478
Total current assets	143,785	41,548	97,787	16,088	139,210	59,620	(13,747)	1,827,787
Property and Equipment - Net	21,173	-	22,797	-	-	2,542	-	171,860
Goodwill and Intangible Assets - Net	-	9,875	2,423	398	-	18,576	-	32,555
Pension Asset	-	-	-	-	-	-	-	89,713
Notes Receivable	539	-	-	-	-	504	-	1,043
Other Investments	8,037	41,865	-	-	-	60,206	-	110,108
Other Assets	31,131	87,352	6,742	-	-	1,281	(465,248)	103,123
Total assets	**$ 204,665**	**$ 180,640**	**$ 129,749**	**$ 16,486**	**$ 139,210**	**$ 142,729**	**$ (478,995)**	**$ 2,336,189**

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Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Financial Position (Continued)

December 31, 2024
(000s omitted)

	Renaissance Health Service Corporation	Delta Dental Plan of Michigan, Inc. and Subsidiary	Delta Dental Plan of Ohio, Inc.	Delta Dental Plan of Indiana, Inc.	Delta Dental of Tennessee and Subsidiaries	Delta Dental of Kentucky, Inc. and Subsidiaries	Delta Dental Plan of New Mexico, Inc.	Delta Dental of North Carolina
Liabilities and Net Assets								
Current Liabilities								
Accounts payable	$ 4	$ 11,929	$ 347	$ 354	$ 4,059	$ 1,189	$ 128	$ 954
Unpaid claims and other reserves	-	31,033	9,075	3,580	8,703	8,505	1,438	4,288
Premiums received in advance and customer deposits	-	23,727	7,604	3,424	3,144	2,668	775	2,489
Reinsurance payable	-	46,247	-	-	-	-	-	-
Current portion of lease liabilities	-	430	218	97	81	154	192	144
Intercompany payable	42	686	4,219	1,412	699	628	1,122	2,153
Accrued and other current liabilities	125	49,201	11,266	2,991	6,091	6,899	1,896	5,651
Total current liabilities	171	163,253	32,729	11,858	22,777	20,043	5,551	15,679
Other Postretirement Obligations	-	1,689	-	-	-	-	-	-
Other Long-term Liabilities	-	56,873	1,139	206	2,600	1,959	3,922	4,834
Total liabilities	171	221,815	33,868	12,064	25,377	22,002	9,473	20,513
Net Assets - Without donor restrictions								
Contributed capital	30	5,122	9,593	14,547	-	-	-	-
Capital contributed by dentists	-	-	115	-	-	-	-	-
Noncontrolling interest	-	-	-	-	-	-	-	-
Unassigned reserves	96,185	759,579	327,604	118,397	94,230	120,303	82,112	28,605
Total net assets	96,215	764,701	337,312	132,944	94,230	120,303	82,112	28,605
Total liabilities and net assets	**$ 96,386**	**$ 986,516**	**$ 371,180**	**$ 145,008**	**$ 119,607**	**$ 142,305**	**$ 91,585**	**$ 49,118**

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Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Financial Position (Continued)

December 31, 2024
(000s omitted)

	Delta Dental Plan of Arkansas, Inc. and Subsidiaries	Renaissance Holding Company and Certain Subsidiaries	Renaissance Life and Health Insurance Company of America (RHC Subsidiary)	Renaissance Life and Health Insurance Company of New York (RHC Subsidiary)	Delta Dental Foundation	The 4100 Group, Inc. and Subsidiaries	Eliminating Entries	Total
Liabilities and Net Assets								
Current Liabilities								
Accounts payable	$ 6,311	$ 540	$ 2,282	$ 11	$ 25	$ 1,396	$ (35)	$ 29,494
Unpaid claims and other reserves	6,430	-	22,943	2,716	-	-	-	98,711
Premiums received in advance and customer deposits	5,130	-	8,904	887	-	-	-	58,752
Reinsurance payable	-	-	56	12	-	-	-	46,315
Current portion of lease liabilities	-	-	1,485	-	-	282	-	3,083
Intercompany payable	1,073	448	711	24	269	227	(13,713)	-
Accrued and other current liabilities	7,123	-	10,858	623	2,171	3,171	-	108,066
Total current liabilities	26,067	988	47,239	4,273	2,465	5,076	(13,748)	344,421
Other Postretirement Obligations	-	-	-	-	-	-	-	1,689
Other Long-term Liabilities	3,380	-	7,343	28	316	1,361	-	83,961
Total liabilities	29,447	988	54,582	4,301	2,781	6,437	(13,748)	430,071
Net Assets - Without donor restrictions								
Contributed capital	-	132,773	33,572	6,369	5	139,936	(312,758)	29,189
Capital contributed by dentists	-	-	-	-	-	-	-	115
Noncontrolling interest	-	-	-	-	-	6,381	1	6,382
Unassigned reserves	175,218	46,879	41,595	5,816	136,424	(10,025)	(152,490)	1,870,432
Total net assets	175,218	179,652	75,167	12,185	136,429	136,292	(465,247)	1,906,118
Total liabilities and net assets	**$ 204,665**	**$ 180,640**	**$ 129,749**	**$ 16,486**	**$ 139,210**	**$ 142,729**	**$ (478,995)**	**$ 2,336,189**

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Activities and Changes in Net Assets

Year Ended December 31, 2024
(000s omitted)

	Renaissance Health Service Corporation	Delta Dental Plan of Michigan, Inc. and Subsidiary	Delta Dental Plan of Ohio, Inc.	Delta Dental Plan of Indiana, Inc.	Delta Dental of Tennessee and Subsidiaries	Delta Dental of Kentucky, Inc. and Subsidiaries	Delta Dental Plan of New Mexico, Inc.	Delta Dental of North Carolina
Revenue								
Premiums and administrative fees:								
Premiums earned	$ -	$ 996,335	$ 379,062	$ 155,730	$ 244,338	$ 189,627	$ 66,043	$ 156,469
Administrative fees	-	67,823	30,818	11,408	13,926	4,697	4,994	13,898
Total premiums and administrative fees	-	1,064,158	409,880	167,138	258,264	194,324	71,037	170,367
Investment income (expense) - Net	1,216	18,302	15,302	6,739	3,170	2,729	3,306	1,822
Contributions from affiliates	-	-	-	-	-	-	-	-
Other income	-	417	6	2	76	7,873	15	32
Third-party administrator fees	-	89,201	-	-	-	-	-	-
Service revenue	-	-	-	-	-	-	-	-
Total premiums earned and other revenue	1,216	1,172,078	425,188	173,879	261,510	204,926	74,358	172,221
Expenses								
Claims expenses	-	887,142	340,549	137,524	206,753	148,207	53,655	131,770
Operating and other expenses	268	276,986	70,155	30,571	46,923	52,133	15,976	38,827
Contributions to affiliates	-	1,500	500	500	-	-	-	175
Total expenses	268	1,165,628	411,204	168,595	253,676	200,340	69,631	170,772
Operating Income (Expense)	948	6,450	13,984	5,284	7,834	4,586	4,727	1,449
Nonoperating Income (Expense)								
Unrealized gain (loss) on securities	1,971	17,251	16,540	7,606	1,365	6,063	2,132	693
Pension-related changes other than service cost	-	41,156	-	-	-	-	-	-
Other nonoperating (loss) income	-	(10,587)	(2,050)	(567)	(868)	(575)	(393)	-
Total nonoperating income	1,971	47,820	14,490	7,039	497	5,488	1,739	693
Consolidated Changes in Net Assets without Donor Restrictions	**$ 2,919**	**$ 54,270**	**$ 28,474**	**$ 12,323**	**$ 8,331**	**$ 10,074**	**$ 6,466**	**$ 2,142**

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Renaissance Health Service Corporation and Affiliates

Consolidating Statement of Activities and Changes in Net Assets (Continued)

Year Ended December 31, 2024
(000s omitted)

	Delta Dental Plan of Arkansas, Inc. and Subsidiaries	Renaissance Holding Company and Certain Subsidiaries	Renaissance Life and Health Insurance Company of America (RHC Subsidiary)	Renaissance Life and Health Insurance Company of New York (RHC Subsidiary)	Delta Dental Foundation	The 4100 Group, Inc. and Subsidiaries	Eliminating Entries	Total
Revenue								
Premiums and administrative fees:								
Premiums earned	$ 211,933	$ -	$ 173,743	$ 14,322	$ -	$ -	$ (76)	$ 2,587,526
Administrative fees	17,363	-	56	-	-	-	(535)	164,448
Total premiums and administrative fees	229,296	-	173,799	14,322	-	-	(611)	2,751,974
Investment income (expense) - Net	4,483	(5,840)	3,360	456	7,527	3,025	13,105	78,702
Contributions from affiliates	-	-	-	-	2,675	-	(2,675)	-
Other income	519	239	670	1	2	5,552	(76)	15,328
Third-party administrator fees	-	1,632	15,770	-	-	-	(47,758)	58,845
Service revenue	-	-	-	-	-	14,875	(5,139)	9,736
Total premiums earned and other revenue	234,298	(3,969)	193,599	14,779	10,204	23,452	(43,154)	2,914,585
Expenses								
Claims expenses	160,802	-	118,232	9,211	-	-	-	2,193,845
Operating and other expenses	79,971	6,159	83,835	5,066	7,243	32,218	(48,445)	697,886
Contributions to affiliates	-	-	-	-	-	-	(2,675)	-
Total expenses	240,773	6,159	202,067	14,277	7,243	32,218	(51,120)	2,891,731
Operating Income (Expense)	(6,475)	(10,128)	(8,468)	502	2,961	(8,766)	7,966	22,854
Nonoperating Income (Expense)								
Unrealized gain (loss) on securities	8,370	(247)	142	194	10,586	34	3,849	76,549
Pension-related changes other than service cost	-	-	-	-	-	-	-	41,156
Other nonoperating (loss) income	(1,419)	342	-	-	-	6,055	19,699	9,637
Total nonoperating income	6,951	95	142	194	10,586	6,089	23,548	127,342
Consolidated Changes in Net Assets without Donor Restrictions	**$ 476**	**$ (10,033)**	**$ (8,326)**	**$ 696**	**$ 13,547**	**$ (2,677)**	**$ 31,514**	**$ 150,196**

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Questionnaire Instructions to Offerors:

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING***.**

- Provide answers to the questionnaires in MS Word format.
- Provide an answer to each question even if the answer is "not applicable" or "unknown."
- Answer the question as directly as possible.
  - If the questions asks "How many…" provide a number.
  - If the question asks "Do you…" indicate Yes or No **first**, followed by your additional narrative explanation.
- Lengthy responses may be truncated when displayed. Be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 250 words in length so that the response contains the most important points you want displayed. Responses longer than the 250 words will be truncated in review.
- Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments.
- Offeror will be held accountable for accuracy/validity of all answers.
- Remember, RFP responses will become part of the contract between the awarded Offeror and The City of Albuquerque.
- Any references to "Client" in the questionnaire refer the The City of Albuquerque. Other abbreviations include CITY for the City of Albuquerque.

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MINIMUM CONTRACTUAL REQUIREMENTS

ALL OFFERORS

Indicate "Yes" or "No" as to your organization's ability to meet the minimum requirements. **Failure to complete this form and include it with your response may result in elimination from consideration**.

A "Yes" response shall result in the provision being adopted in the final contract. No deviations will be accepted for "YES" answers in this section.

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
1. Proposal, Interview, and Best and Final Responses Become Part of Contract: Do you agree that your written response to this RFP, written information provided as part of an interview and written responses provided during a Best and Final negotiation become part of the contract between your organization and The City of Albuquerque?	X	
2. Agree that your proposal and pricing are **not** contingent on acceptance of other coverages or services outside the scope of this RFP.	X	
3. Are each of the coverage lines included in your response free-standing and not contingent upon the CITY selecting the entire package of services being offered?	X	
4. Effective Date of Offer: Proposal terms are guaranteed for at least 180 days from the proposal due date.	X	
5. You agree that the Contract has a length of four (4) years.	X	
6. Variance Provision: Any provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote must be clearly noted in the financial section of the questionnaire.	X	
7. Any changes in **financial strength** rating agencies (downgrades or upgrades) shall be disclosed to the City of Albuquerque within 30 days of the effective date of the award.	X	
8. Proper Licensure: Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for The City of Albuquerque?	X	
9. Prior Notice of Major Operational Changes: Do you agree to provide no less than 30 day notice to the City of Albuquerque for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign countries that will impact The City of Albuquerque?	X	
10. Subcontracting: Unless otherwise explained in this RFP, do you agree that you will disclose all subcontractor arrangements.	X	
11. HIPAA Compliance: OFFEROR attests to meeting all applicable HIPAA EDI, Privacy, Security, and HITECH requirements and agrees to hold the City of Albuquerque harmless for breaches that are the result of OFFEROR actions.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
12. The successful OFFEROR's proposal must contain provisions reserving these rights to City of Albuquerque: **No-Loss, No-Gain:** Current participants in any of City of Albuquerque's sponsored PPO dental will be provided coverage on a "no-loss, no-gain" basis.	X	
13. Eligibility Rules and Uncertain Claimant Eligibility Situations: The OFFEROR agrees to the specified eligibility rules established by City of Albuquerque. The OFFEROR(s) must communicate directly with City of Albuquerque regarding any uncertain claimant eligibility situations before notifying the claimant of ineligibility.	X	
14. No Member Communication Without Client Consent: The OFFEROR will not automatically enroll City of Albuquerque in any programs that involve any type of communication with members, without express written consent from City of Albuquerque.	X	
15. Rights to Claims Data: Selling of the City of Albuquerque's data to outside entities must be disclosed and approved in writing in advance by the City of Albuquerque.	X	
16. Right to Audit: City of Albuquerque reserves the right to review and audit the PPO dental files and financial accounting data to assure that claims subject to each proposed coverage are evaluated in accordance with the plan provisions. Additionally, the OFFEROR agrees to allow for no less than one claim audit per year at no cost to City of Albuquerque using the auditor of City of Albuquerque's choice (so long as the auditor is not a competitor or involved in any legal proceedings with the OFFEROR). The OFFEROR will cooperate with any outside auditor the City of Albuquerque selects to perform the audit. This provision shall survive the termination of the agreement between the parties for a period of two (2) years.	X	
17. Maintenance, Ownership, and Transfer of Records: a) The OFFEROR will be required to maintain all pertinent records for seven years. b) The OFFEROR will be charged with the safekeeping of plan experience information; and c) In the event of contract termination, and related to contract termination, the OFFEROR will be required to cooperate with City of Albuquerque, or their representative, in the prompt, accurate, and orderly transfer of City of Albuquerque's plan experience, claims and utilization information to City of Albuquerque or its designated succeeding dental carrier at **no added fee**.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
18. Renewal Notification: The OFFEROR must provide any rate changes in writing with full justification **by January 1 of the Calendar year for a July 1 effective date in that Calendar Year. (For example, January 1, 2026 is the deadline for rate actions effective July 1, 2026)**. Additionally, the OFFEROR must provide the following with each renewal package: a. Any contract language changes requested b. Specific justification of rate/fee changes, including the Rate Development/Underwriting Worksheet. c. Current enrollment by rate class d. Additional options for consideration e. All underwriting caveats f. Any proposed plan design or benefit changes	X	
19. Assignment or Transfer of Rights: Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of City of Albuquerque?	X	
20. Scope of Services: Are you able to provide the services outlined in the Scope of Services?	X	
21. Commissions: The City contracts with McGriff, a Marsh McLennan Agency as the City's benefits consultant. The City does not seek to add another consultant or general agent through this RFP. a) Proposal submitted must be net of commissions. Confirm.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
If you answered “No” to any of the questions above, please provide an explanation below:		
Requirement No.	**Explanation**	

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate	
	Month and Year of Rating	
1. Indicate your firm's most recent ratings by all of the following agencies:	**Rating**	**Date**
A.M. Best	A- (Excellent)	February/2025
Standard and Poor's (S&P)	N/A	
Fitch	N/A	
Moody's	N/A	
Weiss	N/A	
2. Organization background:		
a. Organization's name.	Delta Dental Plan of New Mexico, Inc.	
b. Corporate headquarters address.	100 Sun Avenue NE, Suite 400 Albuquerque, NM 87109	
c. City & State that will service the City's account.	Albuquerque, NM	
d. Does your firm have a local office?	Yes	
e. Date your firm became operational.	May 6, 1971	
f. Date your firm became operational for the services requested in this RFP.(Specify dental and/or vision separately.)	May 6, 1971	
g. Ownership of your firm.	100%	
3. Is your company "affiliated" with another company? If so, describe the "affiliate relationship." "Affiliated" means owned by another company, owned by a common controlling shareholder or interest, or inter-tied by contract so as to be under the dominion or influence of another.	DDNM is a local, independent nonprofit 501(c)(4) organization with local autonomy. We are a member of The Delta Dental Plans Association, one of America's largest and most experienced dental benefits systems. Members of the Delta Dental Plans Association provide combined coverage to more than 80 million Americans and operate two of the nation's largest networks of participating dentists. DDNM leverages national resources while delivering local expertise. Our independence and nonprofit structure allow us to reinvest in our mission, support underserved communities, and respond directly to New Mexico's evolving needs.	

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
4. If your firm is not a corporation, please advise who each of the partners, proprietors or other owners are and whether they have interest in any dental services provider firms.	Delta Dental of New Mexico is incorporated as a 501(c)(4).
5. Is your firm involved in any current litigation against or from the Client? If yes, please describe.	No

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
6. Have you been involved in litigation within the last five years arising out of your performance in the administration of a Group Dental or Vision plan? Exclude routine matters involving participants that do not reflect on your performance under the contract with your Client. If the answer is yes, explain fully.	No
7. a. Has your organization **acquired, been acquired by, or merged with** another organization in the past 24 months?	No
b. Is your firm **anticipating restructuring or reorganizing** in the next two years? (Include any major staff relocations or office closings.)	No
c. What is your plan for continuance of principles in the event of a reorganization or restructuring?	N/A
8. Do you understand that you are prohibited from using the IIHI for any purpose other than as required by law and further agree to promptly destroy such data if you are NOT the successful bidder?	Yes
9. Do you agree to attend the Annual Open Enrollment meeting at the City's desired location (up to 10 meetings over the course of 3 weeks) at no additional cost?	Yes
10. Implementation: a. What is the minimum implementation lead-time needed to initiate the proposed services?	The implementation process will be initiated 120 days prior to the effective date with a kick-off call. This allows time for systems configurations and testing, as well as custom material development and design (if needed). These materials will be submitted to OSI (if needed) 90 days prior to the effective date. Communication materials will be developed 60 days prior to the effective date. Open enrollment will take place according to the City of Albuquerque's schedule. Welcome packets with ID cards will be mailed upon entry of eligibility into DDNM's system. Delta Dental's expertise allows flexibility in the implementation timeline based on the City's needs. Please see the attached implementation plan.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
b. List any transition issues the City should consider.	DDNM is well prepared to implement the City's benefits on a timely basis as the former incumbent for over 20 years. We will leverage the expertise of our team to provide a smooth transition. The quoted provider networks will allow for minimal disruption and enhanced access.
c. List any specific administrative procedures or information your firm will need from the City in order to implement your services?	DDNM will require updates to any historical information or procedures we have on file based on any changes that have occurred over the last 2 years.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
11. If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the:	
a. Master Policy?	Within 30 days notice of award and confirmation of benefit design.
b. Certificate booklet?	Within 30 days notice of award and confirmation of benefit design.
c. ID Cards	Within 3 business days.
12. Complete the following information about the individual who will be assigned as the OVERALL ACCOUNT MANAGER for the City:	
Name & Title:	Anthony Moya, Senior Account Manager
City/State:	Albuquerque, NM
Length of Time in Current Position:	20+ years industry experience, (1+ years with DDNM)
13. Complete the following information about the individual from your organization who will be assigned as the PRIMARY DAY TO DAY CONTACT for the City:	
Name & Title:	Anthony Moya, Senior Account Manager
City/State:	Albuquerque, NM
Length of Time in Current Position:	20+ years industry experience, (1+ years with DDNM)
14. The master contract is to reflect the elimination of the actively-at-work restrictions or deferred effective date for employees and dependents eligible on the effective date of the contract. This provision however, does not remove the liability of the prior carrier for expenses incurred with respect to the extension of benefits provisions of their contract. Indicate your agreement to this stipulation.	Yes, Delta Dental of New Mexico agrees to this stipulation. City of Albuquerque determines eligibility criteria and DDNM administers in accordance with those requirements.
15. Identify any services under any subsequent contract that may be awarded as part of this RFP that are currently or planned to be performed outside the borders of the United States.	None-DDNM does not utilize offshore services for any business functions.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
16. Do you agree to provide the City a clear path (representative phone number or email, etc.) for employees to register complaints?	Yes, DDNM's local customer service team is available by phone or email.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
17. All sample forms and communication materials should be provided for approval to the City in advance of distribution (ID cards, claim forms, enrollment forms, booklets, brochures, flyers, mailers, etc.). Do you agree to this requirement?	Yes, with the understanding that materials may be subject to regulatory approval.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
1. Will there be a designated team of customer service representatives for the City?	Yes
2. Will you provide a toll-free customer service number for claim and benefit inquiries?	Yes
3. Are questions regarding provider billing, benefits, or member grievances covered by the same phone number? If not, please explain.	Yes
4. What hours and days are live customer service representatives available (indicate using NM time)?	8:00am – 4:30pm MST Monday through Friday
5. Are your customer service representatives located in the continental US?	Yes, all customer service representatives are located in Albuquerque, NM.
6. What alternative services do you provide? (i.e., Assistance for the hearing impaired, 24-hour toll-free automated benefits and eligibility, bilingual option, customer service accessible via the internet, etc.).	Delta Dental offers bilingual representatives who provide assistance in both English and Spanish. Additionally, telephonic interpretation services for over 250 languages are available through Language Line. We also provide American Sign Language (ASL) interpretation as a benefit for providers treating patients with hearing challenges, at no additional cost to the provider. The Integrated Voice Response (IVR) is available 24/7 to assist with eligibility, coverage and out-of-pocket expense questions. Members have access to the Member Portal 24/7 for benefit, coverage, and oral wellness information. TeleDentistry is available 24/7 for members to access care after hours.
7. Please provide the following statistics for 2023 and 2024: Average speed to answer: ___% within 30 seconds Busy rate: ___ seconds Abandonment Rate : ___%	2023: Average speed to answer: 91% within 30 seconds Busy rate: 99% Abandonment rate: 1.4% 2024: Average speed to answer: 93% within 30 seconds Busy rate: 89% Abandonment rate: 1.0%

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
8. Will the City have online access to address additions, terminations, and status changes?	Yes, via the DDNM's Benefit Manager Toolkit.
9. Are plan participants able to access a web portal for:	
a. Status of claims	Yes
b. Benefit brochure	Yes
c. ID cards	Yes
d. Cost estimator of common services	Yes
e. Cost of services by a specific provider	Yes, as part of the Pre-Treatment estimate submission typically initiated by the provider.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
f. Network Provider Quality	DDNM is exploring partnerships with an industry leading vendor to assess dental provider quality.
g. Deductible/benefit maximum accumulator	Yes
10. Can the City and their designated Consultant access eligibility and reporting through a secure website?	Yes, eligibility is available through the BMT portal.
11. What kind of reports can the City and/or their designated Consultant retrieve online?	COA will have access to billing invoices, subscriber listings, member information and eligibility records through the Benefit Manager Toolkit. Plan cost and utilization reporting will automatically be sent to COA by the Account Management Team by the desired due date. If the City or consultant request online availability of financial and utilization reporting, DDNM will create a secure Sharepoint site to retrieve this information.
12. What other kinds of information can the City obtain through your website?	The DDNM website at www.deltadentalnm.com provides a variety of tools and resources for our members. Members can manage their accounts, find a dentist, check benefits and claims, get estimated cost ranges for common dental procedures, access plan information, and access virtual dental consultations for emergencies or after-hours needs.
13. Please provide a temporary login/password so the Client can evaluate your tools. (If Available)	Benefit Manager Toolkit (BMT) is a live eligibility system. Due to HIPAA requirements, we are unable to grant temporary access. We can provide demo videos for BMT and Member Portal to highlight the functionality of each. Many other tools are available to view on our website at deltadentalnm.com.
14. What methods does your organization use to measure customer satisfaction?	DDNM participates in an independent CAHPS Dental Survey. It is an anonymous questionnaire about adult patient's oral healthcare experiences, including their dental plan and the care received from their dental office.
15. Provide a copy of your most recent customer satisfaction survey statistics.	Please see attached CAHPS DDNM Member Feedback Report
16. How do your providers recognize a patient as a participant in your program – voucher, ID card, electronic connection to your eligibility database, etc.? Please explain.	Providers can verify eligibility electronically through DDNM's Dental Office Toolkit, by member ID cards (not required) or unique identifier.

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DENTAL NETWORK	OFFEROR RESPONSE
1. Do you contract with individual dentists, dental group facilities, or both?	Yes, DDNM contracts with both individual dentists and group dental practices and facilities.
2. Do you wholly own and operate the network you are proposing for the City?	Yes, DDNM owns and operates our PPO + Premier network. We do not lease provider networks from other dental insurance carriers or allow other dental insurance carriers to lease our proprietary networks.
3. Indicate the marketing name of the network you are proposing.	Delta Dental PPO + Premier
4. Provide the number of network providers that terminated in the City's service area during the past 12 months:	
a. By your organization	4
b. By the provider	34 (includes relocations, retirements and deaths)
5. What changes do you anticipate to your network over the next two years?	Over the next two years, it is anticipated that the network will experience enhancements such as increased educational initiatives, improved communication channels, the formation of advisory groups to identify key provider priorities, utilization of claims reports for predicting terminations, more personal visits, and ongoing efforts to retain and recruit providers.
6. Please provide Geo Access reports using the following access standards: For the census provided, provide a GeoAccess report to determine the following (6,900 employees must be used in each determination): Reports should reflect city, state, zip code, and number of **unique** dental providers by zip, number of employees with desired access (as defined below) for each category AND **locations (Zip Code and County) where access standards are not met** including the number of employees without desired access.	
a. **General Dentists:** Access criteria: 2 providers within 10 miles of home zip code	Please see the attached GeoAccess report.
b. **Specialists (excluding orthodontists):** Access criteria: 2 providers within 10 miles of home zip code	

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DENTAL NETWORK	OFFEROR RESPONSE
c. **Orthodontists:** Access criteria: 2 providers within 15 miles of home zip code	
7. How does your organization measure the quality of care provided by the providers in your network?	We base our provider quality on claims utilization, and internal Plan Action Report (PAR). The PAR report identifies outliers by comparing submitted claims vs peers in the network. This triggers outreach by our Provider Relations Team for education and resolution. The CAHPS survey asks consumers and patients about their experiences with health care. The survey standardizes this information to ensure safe, quality, and coordinated care. CAHPS covers topics that are important to consumers. It also focuses on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.
8. How many complaints per 1,000 visits do you receive on your network providers?	Of the more than 352,000 visits year to date by DDNM members, there were 57 complaints or 0.1617 complaints per 1000 visits.
9. Do any network providers include night or weekend hours?	Yes
10. Do network providers pay a membership fee to your organization?	No, DDNM does not require a membership fee for providers to be contracted into our network.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
1. Are you able to match the requested PPO Dental plan (Current & Alternates)	Yes, DDNM confirms we are able to match the requested PPO Dental plan.
2. a. Does your proposed plan include any exclusions or limitations that are more restrictive than the current plan?	No
b. Does your proposed plan include any services that are paid in a different benefit class than the existing plan design?	Yes, stainless steel fillings are covered in Basic Services rather than Major Services.
c. Does your proposal include any pre-existing condition limitations?	No
d. If yes to 'a', 'b', or 'c' above, identify any differences in the Deviations Exhibit A. Do not merely refer the reader to your proposal but specifically detail in the exhibit.	DDNM's proposed plan meets all required benefits plus includes the following enhancements (Preventive Care Security, Evidence Based Dentistry, Teledentistry).
3. Describe any exclusions or limitations on your orthodontia benefits.	Delta Dental of New Mexico does not cover or reimburse home-based or self-applied orthodontic treatments. Orthodontic treatment must occur under the supervision of a Dental Provider.
4. Describe how treatment in progress (at initial takeover) will be covered. 5. How will orthodontic claims be adjudicated? 6. What portion of claim expenses will be honored?	4. DDNM works closely with our contracted providers to eliminate any continuity of care issues for our members. Treatment plans are reviewed for appropriateness and determination of the correct benefit coverage level under the Delta Dental of New Mexico plan. Delta Dental applies coverage as outlined in the benefit booklet for all services that have been rendered after the effective date of the policy contingent on the benefit coverage level and maximums in force. 5. The dentist will submit a copy of the original treatment case to Delta Dental. Claims payments are pro-rated based on the effective date of the patient and number of remaining treatment months. Benefits will commence with the first treatment month following the patient's effective date and are paid on a quarterly basis. 6. Claims payments are pro-rated based on the effective date of the patient and number of remaining treatment months.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
7. Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment. 8. What services (i.e., root canal, crowns, etc.) are covered and for what amounts?	All services rendered prior to the termination of eligibility date will be covered. Any services received after the termination date will not be covered due to ineligibility.
9. Describe any missing tooth limits your plan may have for new participants.	DDNM's plan does not include a missing tooth exclusion.
10. Describe how you would handle a late entrant.	A member is eligible for coverage at Open Enrollment or due to a Qualifying Event.
11. Are implants covered under the dental plan?	Yes, implant coverage is provided under DDNM's plan.
12. How does your plan handle a resin composite filling on teeth that traditionally would be treated with an amalgam?	DDNM's plan covers composite fillings on all teeth.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
13. If benefits under the City's plan are exhausted or not covered, can members take advantage of your negotiated pricing? If not, please explain.	If a member's benefits are exhausted, they can still take advantage of DDNM's negotiated pricing as long as the service is performed by an in-network provider. Per New Mexico law, non-covered services cannot have discounted pricing.
14. How will your plan pay benefits for students who reside outside of the state?	Delta Dental members have seamless access to the nation's largest network of providers with no additional steps required to access in-network care.
15. Describe how your pretreatment review system operates and the current turnaround time.	Pre-treatment estimates follow the same review guidelines as any claim. Utilization Review makes coverage determinations, controls costs, and monitors quality of care. In 2025 year to date, DDNM's claims turnaround time is 99.82% in 10 calendar days.
16. What additional benefits do you offer to pregnant women?	DDNM's Evidence-based Dentistry (EBD) is a program that can offer additional dental benefits for pregnant women who are at a higher risk to develop chronic periodontal disease. This can lead to an infection that affects their health and may affect the health of their baby. Therefore, DDNM covers up to 2 additional cleanings (total of 4 cleanings per calendar year) during the pregnancy to prevent this from occurring. The EBD program is part of DDNM's commitment to improve oral health and recognize the correlation between oral health and overall health.
17. Does your plan allow nitrous oxide analgesia? If so, please indicate any additional costs.	No, nitrous oxide analgesia is not a covered benefit.
18. What types of sedatives do you cover and what are the coverage limitations?	IV sedation and general anesthesia are covered benefits when administered by a licensed provider in conjunction with specified surgical procedures, subject to clinical review and when medically necessary.
19. Do you cover temporary fillings?	Temporary fillings are included in the overall cost of a permanent filling.
20. Up to what age do you cover fluoride treatments and how often?	Topical fluoride treatments are payable twice per calendar year for people up to age 19. Topical fluoride treatments are payable once per calendar year for people age 19 and older, when medical necessary.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
21. Up to what age do you cover sealants and how often?	Sealants are payable once per tooth per two-year period for permanent molars, excluding coverage where an occlusal restoration has been completed on the tooth, up to age 16. Sealants are payable once per tooth per five-year period for permanent molars, excluding coverage where an occlusal restoration has been completed on the tooth, for people ages 16 and older, when medically necessary.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
1. From what location would this policyholder's claims be processed?	All DDNM claims are processed locally in Albuquerque, NM
2. What is your company's claims processing turn-around time for dental claims not involving coordination of benefits?	DDNM's claims processing turn-around time is 0.34 days which outperforms industry standards and leads to a stable provider network.
3. Does your claim system have any protections against fraud by: a. Providers	a. DDNM's claim system and policies detect fraud-waste-abuse while optimizing Member's dental benefits, assuring medical necessity and appropriateness. InFocus represents DDNM's ability to detect billing and treatment patterns through data analytics and continuous audit in coordination with DDNM's claim system. InFocus detects potential billing and treatment abuse patterns, allowing DDNM to evaluate these patterns using factors from data mining, integrated reporting and visualization to evaluate the provider's practice in relation to a particular peer group. DDNM may place a provider on focused review or initiate an investigation into a provider's treatment and billing practices. DDNM requires providers to complete fraud-waste-abuse, compliance, and cultural competency training.
a. Members	Our systems are developed with integrated fraud, waste, and abuse detection to identify aberrant patterns that would indicate fraud by members.
b. Employees	Our systems are developed with integrated fraud, waste, and abuse detection to identify aberrant patterns that would indicate fraud by employees.
4. Does your claim system have any protections against unbundling and/or upgrading claims? If so, describe in detail.	DDNM's claims system uses member care history crosschecks that enforce processing policies to prevent duplicate claims. The system automatically re-bundles services that are commonly unbundled. Any questionable service combinations route for review.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
5. a. What cost containment/management programs are available to City of Albuquerque (i.e., precertification, utilization review, etc.)?	Delta Dental utilizes Dental Maximum Approved Fees instead of U&C reimbursement strategy. Fees are evaluated on a fee-by-fee basis every year to manage the network, and fee increases while preventing “across the board” increases that can occur in the absence of efficient network management. It facilitates in-network utilization, decreasing costs for clients. Delta Dental leverages state of the art Claims and Utilization Review processes to validate medical necessity, control costs, ensure accurate billing and coding and continuous data analytic auditing of claims to verify charges and services and detect fraud, waste and abuse.
b. Are these programs included in your quoted premium or are they an additional cost? If an additional cost, list the cost for each individual program.	There is no additional cost for these programs.
6. a. How are network claims processed?	Network claims can be submitted via paper, electronically through a clearing house, or by utilizing our Dental Office Toolkit. DDNM's state-of-the-art claims processing system verifies eligibility, patient history and plan benefits with over 93% of claims being auto adjudicated.
b. Are any authorization forms necessary or ID cards required?	No authorization forms or ID cards are required.
c. Do members pay up-front and submit claims for reimbursement or are members responsible for only plan copays, deductibles and coinsurance?	Only non-participating providers may require up-front payments in full. Participating providers may request any applicable copayment, deductible or non-covered services at the time of service.
e. Are there any time limits for submitting claims?	Claims must be submitted within 12 months from the date of service.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
7. How are non-network claims processed?	Non-Provider network claims are processed utilizing the same guidelines as in-network claims. They can be submitted electronically or by paper from the provider or the member. Our plan is intentionally designed to reimburse out-of-network claims at lower levels to ensure the integrity and value of our Provider Network. This enables COA to realize the full value of DDNM's network in assuring cost-containment, membership access to affordable and quality care, and improved oral health outcomes.
b. How do you determine Usual, Customary, and Reasonable (UCR) for non-network dental benefits (e.g., own data, percentile of HIAA data, relative value scale, Fair Health)?	DDNM utilizes internally developed, proprietary fee schedules based on regional determinants instead of UCR. Upon careful assessment of local market data, DDNM determines appropriate fee levels for both participating and non-participating providers in every region of the state. This approach enables Delta Dental of New Mexico to conduct a comprehensive, comparative analysis against national benchmark data, ensuring that each fee is evaluated at the code level for appropriateness. Fees are reviewed annually. When necessary, fees are adjusted to maintain fairness, competitiveness, and alignment with industry standards.
8. Does your plan use maximum allowable cost for limiting non-network allowances?	DDNM utilizes an internally developed, proprietary Maximum Allowed Fee schedule to limit non-network allowances.
9. What UCR level have you used for non-network claims?	DDNM utilizes internally developed, proprietary fee schedules based on regional determinants instead of UCR. Upon careful assessment of local market data, DDNM determines appropriate fee levels for both participating and non-participating providers in every region of the state. This approach enables Delta Dental of New Mexico to conduct a comprehensive, comparative analysis against national benchmark data, ensuring that each fee is evaluated at the code level for appropriateness. Fees are reviewed annually. When necessary, fees are adjusted to maintain fairness, competitiveness, and alignment with industry standards.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
10. Explain how maximum allowable charges are determined geographically:	DDNM does not utilize regional based fee schedules. Fee schedules are determined by provider type, not geographic location. DDNM utilizes internally developed, proprietary fee schedules based on regional determinants instead of UCR. Upon careful assessment of local market data, DDNM determines appropriate fee levels for both participating and non-participating providers in every region of the state. This approach enables Delta Dental of New Mexico to conduct a comprehensive, comparative analysis against national benchmark data, ensuring that each fee is evaluated at the code level for appropriateness. Fees are reviewed annually. When necessary, fees are adjusted to maintain fairness, competitiveness, and alignment with industry standards.
11. a. By the location of the employer, or the provider of dental services? Other? Please explain. b. How are specific areas delineated *(e.g.,* 5 digit zip, 3 digit zip, county)? c.How often is data updated?	DDNM does not utilize regional based fee schedules. Fee schedules are determined by provider type, not geographic location. DDNM utilizes internally developed, proprietary fee schedules based on regional determinants instead of UCR. Upon careful assessment of local market data, DDNM determines appropriate fee levels for both participating and non-participating providers in every region of the state. This approach enables Delta Dental of New Mexico to conduct a comprehensive, comparative analysis against national benchmark data, ensuring that each fee is evaluated at the code level for appropriateness. Fees are reviewed annually. When necessary, fees are adjusted to maintain fairness, competitiveness, and alignment with industry standards.
12. What steps are taken if the maximum allowable charge is un-coded?	DDNM's claims system uses member care history crosschecks that enforce processing policies to prevent duplicate claims. The system automatically re-bundles services that are commonly unbundled. Any questionable service combinations route for review.
13. How are the client and plan participants supported in their resistance to charges in excess of the maximum allowable charge?	When a participating provider is utilized, the provider contractually cannot bill more than the agreed upon allowable charge.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
14. How can a claimant find out what the maximum allowable charge is for a particular procedure in advance of having the procedure performed?	Members are encouraged to request a pre-treatment estimate from DDNM prior to having a procedure performed. Members can also access the cost estimator tool on deltadentalnm.com for an estimate of the member responsibility.
15. With respect to dental surgery, do you ever reimburse assistant surgeons? 16. What is the basis for such a determination 17. How is the allowance for the assistant surgeon, if any, calculated?	15. DDNM contracts directly with licensed dental providers. We don't contract with additional support staff. Any compensation will be the responsibility of the dental practice. 16. N/A 17. Surgeon expenses are included in and are submitted as one charge for the procedure.
18. When you are COB secondary payor, do you use your UCR profiles or those of the primary carrier to determine your level of reimbursement?	DDNM considers either the contracted provider fee allowance or the non-contracted provider maximum allowed fee for consideration not to exceed the plan benefits and/or the member liability.

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DENTAL PPO PLAN UNDERWRITING	OFFEROR RESPONSE
1. What experience period will be used for the first renewal (e.g., first 6 months)? What period will be used in subsequent renewals?	DDNM is offering a multi-year rate guarantee. The first renewal outside of the guarantee will be based on the most recent 12 months' experience.
2. How much would the group have to change in size before the credibility percentages above would vary by more than 10 percent?	10%
3. What credibility do you anticipate assigning to the Client's experience at:	
First Renewal?	100%
Subsequent?	100%
4. How will projected incurred claims be estimated?	DDNM uses the most recent 12 months of paid claims experience, then applies a specific reserve based on historical data utilization and trends forward into the renewal period.
5. a. Do you agree to use client specific lag to determine paid to incurred adjustments for renewal calculations?	Yes
b. If no, describe how you adjust paid claims to incurred claims? What standard reserve factor would you use?	
6. Is retention calculated as a percentage of claims, a percentage of premium, or a per capita basis?	For fully insured or risk clients, the retention percentage is a percent of total premium. For self-funded clients the retention percentage is a component of the administrative fee.
7. What were your historic 2023 and 2024 DPPO trends and anticipated 2025 trends for your proposed plan in the greater Albuquerque metropolitan area?	
a. 2023	3.21%
b. 2024	0.25%
c. Anticipated 2025	3.0%
FINANCIAL	
1. Please list all provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote.	Funding type, plan design, frequency limitations and initial enrollment assumption is greater than 60% participation. Subsequent enrollment changes of +/- 10%.

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DENTAL BILLING PROCESS	OFFEROR RESPONSE
1. When is premium due and when is it considered delinquent?	Premiums are due the 6th of the following month since the COA is eligible for a 30-day premium grace period for municipalities. Premiums are delinquent 15 days from the due date.
2. How do you handle reconciliation of billing and enrollment issues?	Billing and enrollment issues are reconciled on an ongoing basis. Enrollment error reports are provided after each eligibility file has been processed. Issues should be reported to DDNM's Group Administration Department within a 90-day period.
3. How often would you audit the City of Albuquerque for eligibility discrepancies?	DDNM recommends the City of Albuquerque review the subscriber listing on a quarterly basis. A full eligibility report can be requested as needed, which would include all member enrollment information. Utilizing an electronic eligibility file feed reduces eligibility issues, but a quarterly audit is still recommended. Member eligibility can also be viewed and updated online through Benefit Manager Toolkit (BMT).
4. The City of Albuquerque would prefer at a minimum current month plus 60 days for retroactive terminations. What is your timeframe allowed for retroactive terminations? Is this negotiable?	Retro terminations are allowed up to 90 days from DDNM's current billing period in progress.

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REPORTING						
1. Based on the attached required structure, do you agree to provide the following reports as identified in the table below? Please indicate if your report is available online to City of Albuquerque (and/or their consulting firm). Please include sample reports.						
REPORTING – ALL OFFERORS						
Coverage Line	**Month**	**Quarter**	**Annual**	**OFFEROR Response (Y or N)**	**Online Access (Y or N)**	**Excel (Y or N)**
Dental						
Enrollment (subscriber/member) by coverage tier and active/cobra.	X			Y	Y	Y
Premiums paid	X			Y	Y	Y
Claims paid by Status (active/cobra) and in-network vs out of network	X			Y	N	N
Utilization report		X		Y	N	N
Lag report			X	Y	N	Y
Ad Hoc Reporting Capabilities						
Ability for the City to generate Ad Hoc Reports	Determined by the City			N	N	N

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DEVIATIONS

Offeror Name: **Delta Dental Plan of New Mexico**

Signature: 

Date: **August 18, 2025**

Deviations	
Reference in RFP	**Deviation**
Terms and Conditions Review	**3.C. Appropriations** Would the City be amenable to adding the following provision: "If the City proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Contract or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment." **19. Compliance With Laws** Consider the proposed language acknowledging HIPAA compliance. **22. Termination for Cause** Would the City be amenable to language that provides Contractor with the ability to remediate or cure a material breach within 30 days of being notified by the City? Proposed language for 23 would be: "The City shall give Contractor at least thirty (30) days prior to the intended date of

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Deviations	
	termination, which notice shall: (i) identify all Contractor's material breaches of this Agreement upon which the termination was based and (ii) state what the Contractor must do to cure such material breaches within the thirty (30) day notice period to the satisfaction of the CIty which shall not unreasonably be withheld." **24. Termination for Convenience of City** City may consider a longer notice period, such as 30 days or 45 days to accommodate a transition and assure dental care continuity for enrolled Subscribers and dependents. **25. Force Majeure** The Force Majeure provision should apply to the Contractor as well who is providing professional services to the City of Albuquerque. As such, a deletion could be made to strike “The City shall not. . .” and insert “Neither Party shall be . . . “. Alternatively, the proposed Subsection B could be added to discuss the Contractor’s protections in the event of a Force Majeure Event.
Part 1 – Instructions to Offerors: 1.5.5	None
Part 1 – Instructions to Offerors: 1.5.9, 1.5.10	None
Part 1 – Instructions to Offerors: 1.23.1	None
Part 1 – Instructions to Offerors: 1.23.2	None
Part 1 – Instructions to Offerors: 1.23.3.1	None
Part 1 – Instructions to Offerors: 1.23.4, 1.23.5	None

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TAXATION & REVENUE
NEW MEXICO

Michelle Lujan Grisham
Governor

Stephanie Schardin Clarke
Cabinet Secretary

DELTA DENTAL PLAN OF NM
100 SUN AVE NE STE 400
ALBUQUERQUE, NM 87109-4677

March 22, 2024
NM Business Tax ID:
01-790370-00-0
Letter ID: L1850142320

Resident Preference Certification Renewal

Our records indicate that your Resident Preference Certificate (L1874336176) will expire 30 days from the date of this letter.

If you would like to renew your certificate for another three years, please complete and mail this renewal request and the $35 fee within fifteen (15) days of receipt of this letter to the address below. The Taxation & Revenue Department will process your renewal request within 30 days of receipt and will mail the updated certification.

For any questions, please call (505) 827-0951.

Taxation and Revenue Department
P.O. Box 5374
Santa Fe, NM 87502-5374

General Information		
Name of Licensed Contractor	Doing Business As (DBA) if applicable DELTA DENTAL PLAN OF NM	
Mailing Address - City, State, Zip Code 100 SUN AVE NE STE 400 ALBUQUERQUE NM 87109-4677		
Physical Address - City, State, Zip Code		
Name of Business Owner or Officer	Phone Number of Business Owner or Officer	Email of Business Owner or Officer
Name of Business Contact	Phone Number of Business Contact	Email of Business Contact
NM Business Tax ID Number: 01790370000GRT	Contractor License Number	FEIN/SSN **-***4562
VIN of Vehicle Registered by Contractor with NM	Name of Vehicle Owner	

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STATE OF NEW MEXICO

TAXATION AND REVENUE DEPARTMENT

RESIDENT BUSINESS CERTIFICATE

Issued to: **DELTA DENTAL PLAN OF NEW MEXICO**

DBA: **DELTA DENTAL PLAN OF NM**
100 SUN AVE NE STE 400
ALBUQUERQUE, NM 87109-4677

Expires: **14-May-2027**

Certificate Number:

L0729858416

Stephanie Schardin Clarke
Cabinet Secretary

THIS CERTIFICATE IS NOT TRANSFERABLE

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BlueCross BlueShield of New Mexico



Cover Letter & Executive Summary

CITY OF ALBUQUERQUE

August 20, 2025



Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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August 20, 2025

Cassaundra Gomez, Senior Buyer
Department of Finance and Administrative Services, Purchasing Division
City of Albuquerque
P.O. Box 1293
Albuquerque, NM 87103

RE: RFP – 2025-710-HRM-CG, Fully Insured & Self-Funding Group Dental Insurance

Dear Ms. Gomez:

On behalf of Blue Cross and Blue Shield of New Mexico, we are pleased to present our response to the City of Albuquerque's (the City) request for proposal for fully insured and self-funded dental insurance with an effective date of July 1, 2026. The following are the highlights of our proposed dental offering:

- **Rate Guarantee:** A 36-month rate guarantee for either fully insured or self-funded.
- **Dental Performance Guarantees**: $20,000 at risk for fully insured and 20% of administrative fees at risk for self-funded, illustrating our commitment to delivering excellence. As of May 2025, we have met and exceeded all performance guarantees currently in place.
- **Network Access**: We have a superior network access with over 151,000 unique dental network providers in all 50 states. Currently 86.4% of the City's dental claims are paid in-network, which is higher than our book of business average of 81%.
- **Complete Integration:** Our integrated benefits make administration easy with one bill, a single technology platform, shared data, and combined reporting. The same, familiar account management team will continue to support the City, using their experience and expertise to provide consultative guidance and strategies to maximize plan performance.

Our broad network, skilled account management, and emphasis on wellness and prevention, combined with our dedicated expertise in providing dental benefits, positions us as the best carrier in the marketplace. We appreciate our existing partnership and are committed to delivering flexible solutions that provide value for the City's employees and their families.

We welcome any questions regarding this proposal. Please reach out to Amanda Romero, account executive, at 505-900-4021or amanda_romero@bcbsnm.com or Lisa Smith, dental account executive, at 815-791-6121or lasmith@bcbsil.com.

Sincerely,

Marlene Baca
Vice President of Sales

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The Best of New Mexico Working Together

The organizations that come together to form the City of Albuquerque each play an integral role in ensuring New Mexico citizens of all ages enjoy all the state has to offer. BCBSNM has served New Mexicans for over 80 years. We understand the importance of providing a comprehensive dental benefit program while forming a partnership that is beneficial for the City, its members, and your benefits administrators.

As part of our large group division, BCBSNM is the health plan provider for 22 public entities in New Mexico, offering us a deep understanding of the needs of employers like the City. Through our proven service models, streamlined administrative capabilities, integrated wellness program, and our ever-expanding dental network, we are well-positioned to manage complex plan designs, offering a long-term dental solution.

Serving the City of Albuquerque

We are an active part of the City and the greater New Mexico community. Our 2,000+ New Mexico-based employees are dedicated to making a positive difference in the lives of our members and the communities where they live, work, and play.

We participate in community investments that focus on underserved/underinsured New Mexicans and those that offer outcome-based solutions. Some of our community investments in the Albuquerque area include:

- $1.6 million+ in funding provided in 2024 and 2025 to community organizations serving Albuquerque.
- 6,400 hours volunteered by our New Mexico employees, valued at $214,000, at local non-profits.
- 150+ events visited by the BCBSNM Care Van, which provides a mobile health clinic bringing health screenings and immunizations to children and adults who are uninsured or underinsured.

We have included a copy of our 2024 BCBSNM Corporate Social Responsibility Report Highlights in the Exhibits section of our proposal.

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Providing Access to Competitive and Extensive Dental Networks

We differentiate ourselves by offering a single-tier network with deep discounts on all providers. We pass along the *entire* discount to members with no hidden fees or shared savings. Members can easily find a provider and know they are getting the deepest discount possible.

Broad access combined with our PPO network awareness campaigns results in higher in-network utilization, generating greater savings. Our persistent focus on network discounts has resulted in 49.4% savings for the City.

With BlueCare Dental, the City and its employees currently have access to one of the largest dental networks in New Mexico with over 1,200 unique dental providers. This broad access, combined with our PPO network awareness campaigns, results in higher in-network utilization and greater savings.

We continually recruit providers, focusing our efforts on providers with high utilization rates among our membership, along with providers our members recommend. **In the past year, we have contracted with 27 new providers used by the City's employees, with another 4 applications currently under review.**

Network Savings

Our dental networks delivered the following for the City:

88.2% in network utilization

41.3% average discount

50,122 in-network procedures

$5,375,940 in overall savings

Claims data processed 7/1/24 – 5/31/25

Out of Network Results

7549 procedures out of network

$525,971 total balanced billed

$69.67 average balanced billed per procedure

Claims data processed 7/1/24 -5/31/25

Integrated Solutions Improving Access and Outcomes

We understand oral health plays a critical role in overall health. Our enhanced **Workplace Dental** solution brings dental care directly to your worksite through a network of contracted providers—available to business units with 250+ employees. Notably, **80%** of Workplace Dental users had not seen a dentist in more than two years. Workplace Dental, offered through our partner Jet Dental, is available at no additional cost.

We also offer **24/7 teledentistry**, including emergency dental assistance, to help members avoid unnecessary ER visits by connecting to our provider network.

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Innovative Wellness Outreach and Support

Through **BlueCare Dental Connection**, we offer one of the industry's most comprehensive wellness programs. Members with certain medical conditions—such as diabetes, heart disease, or pregnancy—automatically receive additional dental benefits, such as extra cleanings and periodontal services, without needing to self-report or enroll.

This evidence-based approach leverages medical and dental claims to identify at-risk members, drive engagement through proactive outreach, and close care gaps.

BlueCare Dental Connection includes access to the **Dental Wellness Center**, an online source of consumer-driven tools allowing members to:

- Find educational information about dental topics, treatments, and procedures.
- Ask questions through "Ask A Dentist."
- Locate in-network dentists or specialists with Provider Finder.
- Research information with the dental dictionary.
- Determine approximate dental fees in the marketplace with Dental Cost Advisor.

When members need additional help, they can reach out to a **U.S.-based, dental-only customer service** and claims unit for answers.

BlueCare Dental Connection Outreach

Members with the following conditions who visited their dentist within 12 months after outreach:

- Cardiovascular disease: **16.5%**.
- Diabetes: **16%**.
- New mothers: **15.4%**.
- Pre-natal: **35.3%.**
- Sealants (ages 5-7): **14.8%.**
- Periodontal disease**: 38.5%.**

Our Commitment to the City of Albuquerque

We are committed to helping the City achieve its goals by developing flexible, customized benefit solutions and working side-by-side with the City to optimize performance of those benefits. We are confident we can continue to provide the City with the best plans at cost-effective rates.

For questions and supplemental information about our commitment and capabilities, please contact:

Amanda Romero, Account Executive
Phone: 505-900-4021
Email: amanda_romero@bcbsnm.com

Lisa Smith, Dental Account Executive
Phone: 815-791-6121
Email: lasmith@bcbsil.com

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BlueCross BlueShield
of New Mexico



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2.1 Technical Proposal Format, Section One

2.1.1 Offeror Identification: State name and address of your organization or office and nature of organization (individual, partnership or corporation, private or public, profit or non-profit). Subcontractors, if any, must be identified in a similar manner. Include name, email address and telephone number of person(s) in your organization authorized to execute the contract resulting from this RFP. Submit a statement of compliance with all laws stated herein. Submit a statement of agreement to the Required Contract Terms; state exceptions as directed in Section
1.11. Show receipt of Addenda if applicable. Provide a statement or show ability to carry the insurance specified.

Organization

Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a mutual legal reserve company, and an independent licensee of the Blue Cross and Blue Shield Association. HCSC is the largest non-investor-owned insurer in the nation and the third-largest overall, serving more than 26 million members. HCSC also operates Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Oklahoma and Blue Cross and Blue Shield of Montana. The BCBSNM corporate headquarters is located at 5701 Balloon Fiesta Parkway NE, Albuquerque, New Mexico 87113.

Subcontractors

We use Dental Network of America, LLC as our dental administrator for core services. Dental Network of America may coordinate services with various vendors for many of the products and services we offer to our members, employer groups, and providers but Dental Network of America remains responsible for the administration of those core services.

Core services include claim determinations, network management, utilization reviews, payment integrity, appeal determinations, and customer service involving any direct contact with members. Customer service means a call center staffed to answer members' claims, benefit, and network questions. Core services do not include work necessary to support the infrastructure for these functions, such as phone systems, computer, software, facilities, database or information management, quality services, or security services. Core services also do not include backroom operations, which are activities that do not involve direct contact with covered members.

As of August 2025, we partner with the following vendors specific to this proposal offering:

Vendor	Headquarters	Description
Dental Network of America, subsidiary of Health Care Corporation (HCSC)	701 East 22nd Street Lombard, IL 60148	Dental administration
Fiserv Solutions, Inc.	255 Fiserv Drive, Brookfield, WI 53045	Member Cards Manufacturer

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MedeAnalytics, Inc.	501 W President George Bush Hwy Suite 250, Richardson, TX 75080	Client Reporting
R.R. Donnelley & Sons Company	35 West Wacker Drive, Chicago, IL 60601	Print enrollment materials

Authorized Representative

The BCBSNM representative authorized to execute the agreement is Marlene Baca, vice president of sales and account management. Marlene can be reached at 505-816-4408 or Marlene_Baca@bcbsnm.com.

Account Executive, Amanda Romero, will continue to be your day-to-day contact for the City of Albuquerque. Amanda can be reached via email at amanda_romero@bcbsnm.com, or by phone at 505-900-4021.

Compliance with all Laws

We comply with all state and federal laws applicable to services under our administrative services agreement. Our state and federal government relations teams monitor new laws and regulations that impact our services. We work in close collaboration between these teams, legal, compliance, and operational teams when implementing operational changes. In addition, we adhere to our internal Code of Conduct. We also have a robust Ethics and Compliance program with annual training for employees on matters such as privacy; information security; and fraud, waste, and abuse.

Contract Terms

Refer to the Terms and Conditions documents included in the Technical Proposal section of our proposal for details.

Receipt of Addenda

Addendum 1 has been acknowledged in Bonfire.

Statement of Ability to Carry Insurance Specified

We have reviewed the insurance section (1.23) of the RFP. HCSC procures and maintains the insurance policies specified in this section. For compliance purposes, some of the language may need to be modified in order to meet OSI and carrier requirements. Comments are listed below. Any changes would be subject to discussion, and agreed-upon terms would be included in the ASA.

Regarding: 1.23.1 General Conditions – Certificates of insurance are issued in compliance with Department of Insurance rules using ACORD forms. Special language for Notice of Cancellation is not allowed as worded. More common on a policy for construction work. Our insurance policies are confidential and proprietary. Policies in whole or in part are not released to third parties. Additional insured status and primary positioning on the Commercial General Liability policy do not appear to be applicable to this engagement. During the contract phase, we can discuss this further and work out the appropriate terms that are suitable for this type of

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engagement. Please refer to the attached certificates of insurance included in the Exhibits section of this proposal.

Regarding: 1.23.2 Approval of Insurance: We assume responsibility for our subcontractors. Subcontractors may have different insurance requirements based on the type of service they are performing.

Regarding: 1.23.3.1 Commercial General Liability Insurance: Our commercial general liability policy includes contractual liability coverage; however, it cannot be tied to the Hold Harmless provisions as worded. The Hold Harmless provisions should be separate from the insurance provisions.

Regarding: 1.23.4 Increased Limits – During the life of the contract, HCSC will consider an increase in limits. Any agreed-to changes or increases must be added to the Services Agreement by way of a signed addendum. A discussion is always welcomed.

Regarding: 1.23.5 Additional Insurance - During the life of the contract, HCSC will consider additional forms of insurance. Any agreed to changes or increases must be added to the Services Agreement by way of a signed addendum. A discussion is always welcomed.

2.1.2 Experience:

2.1.2.1 Current Experience. State relevant experience of the company and person(s) who will be actively engaged in the proposed project, including experience of subcontractors. Submit resumes for the individuals who will be performing the services for the City.

Blue Cross and Blue Shield of New Mexico is one of the largest commercial health insurers in New Mexico, with more than 620,000 New Mexicans carrying a Blue Cross and Blue Shield card. Since 1940, we have been committed to promoting the health and wellness of our members and communities through accessible, cost-effective quality health care.

As a division of Health Care Service Corporation, we are among the nation’s strongest health insurers—providing members a high level of confidence and security. We offer individuals, families, employer groups and seniors a full range of health plans with flexible benefit designs and access to one of the largest networks of hospitals and physicians in the state.

We are a technologically innovative, efficient, and responsive health insurance company. We offer Blue Access for Members, which provides secure online access to benefits summaries, claim status, provider information and valuable health tips for group health plan members and their dependents.

We have a significant presence throughout the state and are committed to fulfilling our corporate citizenship responsibilities to the communities we serve. Each of our more than 2,000 employees practice the highest standards of business ethics and integrity. We are dedicated to being part of the solution for more affordable and accessible health care in New Mexico, leading to healthy members and communities.

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Experience of Subcontractors

This response is considered confidential. Please refer to the Legally Confidential folder for details.

Key BCBSNM Staff Serving the City

This response is considered confidential. Please refer to the Legally Confidential folder for details.

2.1.2.2 Past Experience. Describe a minimum of three (3) projects of similar scope and size, which are now complete; state for whom the work was performed, year completed, and a letter of reference for each regarding the work. References must be for work performed in the past three to five (3 to 5) years. DO NOT use City employees or any City elected officials as a reference. The City will not contact and will not assign any evaluation points for references from City employees or elected officials. State relevant experience with other municipalities or government entities.

Our expertise with the public sector includes insuring or administering benefits for hundreds of counties, cities, school districts, colleges, and universities. We have provided references, all of which have completed a survey which measures our level of service and helps us assess our performance beginning at implementation We solicit feedback at, during, and after the experience and apply the results to drive enhancements.

Refer to the references document provided under the Technical Proposal section for details.

2.1.2.3 The minimum information that must be provided about each reference is:

1. **Name of the individual or company the services were provided for**
2. **Address of individual or company**
3. **Name of contact person**
4. **Telephone number of contact person**
5. **Type of services provided and dates services were provided**

   Refer to the references document provided under the Technical Proposal section for details.

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2.1.3 Client Management Team Qualifications: Submit resumes of key proposed professional staff members who will be performing services under the contract awarded under this RFP. Experience narratives shall be attached that describe the specific relevant experience of the staff members in relation to the role that the member will perform for the contract resulting from this solicitation. The narrative(s) must include the name of the individual(s) proposed and should include a thorough description of the education, knowledge, and relevant experience, as well as certifications or other professional credentials that clearly show how they are qualified to provide the required services to the City.

Refer to the account team biographies included with this proposal for details.

2.1.4 Management Summary: Describe individual staff and subcontractor's responsibilities with lines of authority and interface with the City of Albuquerque staff. Describe resources to be drawn from in order to complete tasks.

Account Executive Amanda Romero, who has extensive experience with large group clients, will continue to be the lead BCBSNM liaison with the City. Amanda's resume has been included in the Exhibits section of this proposal. Amanda will have decision-making authority and will be supported by the local sales and account management team; the directors of subscriber services, which includes membership, claims, and customer service; the network service director; the health care management division medical director; and the health services director.

The BCBSNM senior management team will bring all corporate resources to support the ongoing servicing of the City's account and members. As a locally managed—and locally focused—company with extensive national resources, we can bring to the City a quality of service that no other health care plan can provide. We are committed at the highest level of the organization to bring the City exceptional service and customer satisfaction.

For subcontractors, we remain fully responsible and liable for the performance of any such services to be performed by us but delegated to other entities.

2.1.5 Organizational Strength:

2.1.5.1 Submit a statement of relevant corporate qualifications, strengths, and experience, including similar experience of subcontractors. The documentation must thoroughly describe how the Offeror has supplied expertise for similar contracts and work related to dental services.

For information regarding BCBSNM's corporate qualifications, strengths, experience, and vendors, please see our responses to questions 2.1.1, 2.1.2.1, and 2.1.2.2.

2.1.5.2 Provide a copy of the company's most recent audited financial report labeled Appendix G.

Refer to the Appendix G 2024 HCSC Audited Financial Report included with this proposal.

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2.1.5.3 Proposed Approach to Tasks: Discuss fully your proposed approach to each of the tasks described in Part 3, Scope of Services.

Noted. Refer to the Scope of Services document included with this proposal for details.

2.1.6 Proposed Plan Design: Discuss fully your proposed plan design.

As the incumbent carrier, we are matching your current dental plan design. Refer to the benefit highlight sheet included with this proposal for details.

2.1.7 Implementation Plan: Discuss fully your proposed approach to the services described in Part 3, Scope of Services to fulfill all requirements of the Scope of Services. Offerors shall provide with their proposals a detailed implementation plan assuming a July 1, 2026, effective date or Alternate January 1, 2026 effective date.

Not applicable as we are the incumbent carrier on your dental plan.

2.1.8 Proposed Plan design: Provide information demonstrating that your plan design has the size and service capability with management systems and procedures capable of providing benefits to a major employer of the magnitude encompassed by the City and its Participating Entities. Offerors must demonstrate a fully insured and/or self- funded plan that matches or exceeds the current plan design.

As the incumbent carrier, we are matching your current dental plan design.

Our proposal focuses on performing dental plan claims administration for the City. As the incumbent carrier on your dental benefit plan, we can affirm that we have experience in administering dental services as requested in both size and design.

We implemented the BlueCare Dental PPO program in 2002. We have provided dental benefits to New Mexico employers since 1977.

With decades of experience providing claims administration, customer service, account billing, eligibility setup and maintenance, and provider compensation for our clients' dental plans, we are confident we can successfully continue to perform the requested services and meet or exceed the City's expectations.

2.1.9 Utilization Management: Show your demonstrated commitment to providing consistent, valuable and timely utilization information, which must comply with data requirements and reporting frequency as defined in Part 3, Scope of Services, of this RFP. The City wishes to identify cost drivers within its program and develop action plans to increase awareness or engagement in activities that demonstrate a reduction in healthcare costs

Noted. Refer to the Scope of Services document included with this proposal for details

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2.1.10 Wellness programs: **Provide detailed information about your wellness programs.**

Through medical and dental integration, one of the strongest differentiators of our dental offering is a unique wellness program that recognizes the financial and clinical value of prevention, as well as the holistic interdependence of dental health and overall health. The BlueCare Dental Connection program allows us to create a customized plan for total member health and wellness—at no additional cost to you.

Through BlueCare Dental Connection, we contact dental members with a higher risk for tooth decay and periodontal disease. The goal is to promote good oral health in relation to overall health, based on research showing a link between periodontal disease and other health problems, such as heart disease, stroke, diabetes, and premature birth. Since the beginning of our dental wellness program in 2008, we have reached out to over two million people at all stages of life and created positive oral health outcomes through prevention and member education.

Our unique wellness program takes a proactive approach to preventing dental disease and associated costly medical problems. The percentages below reflect members who visited their dentist within 12 months after outreach:

- Cardiovascular disease: 16.5%.
- Diabetes: 16%.
- New mothers: 15.4%.
- Pre-natal: 35.3%.
- Sealants (ages five through seven): 14.8%.
- Periodontal disease: 38.5%.

BlueCare Dental Connection includes The Dental Wellness Center, a source of consumer-driven tools available online 24/7. Members can find educational information on subjects including pediatric care, cosmetic dentistry, prevention, and dental treatments. The Dental Wellness Center also allows members to:

- Ask dentists questions through Ask a Dentist.
- Locate an in-network dentist or specialist with Provider Finder.
- Research information with the Dental Dictionary.
- Determine approximate dental fees in the marketplace with the Dental Cost Advisor.
- View animations about various dental topics, treatments, and procedures.

We also promote preventive care through benefit design and ongoing education for network providers. Members traditionally receive preventive services at a 100% benefit, which encourages regular checkups to avoid more serious conditions and costs. All network offices provide instruction and care in best oral health practices, supported by plan-sponsored continuing education seminars, professional services field representatives, and contractual obligations for each office to use a formal patient recall system.

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2.1.11 Broad Provider Network: Provide detailed information regarding the maintenance and the composition of a broad provider network to include but not limited to the following:

a. Outline with specificity how plan members will be provided with comparable or superior geographic access (See Appendix B and F.)

As the current dental insurance provider, we ensure members will continue to receive comparable or superior access through our extensive nationwide provider network.

b. Describe how the Offeror's provider network will result in minimum disruption to current plan member services (See Appendix B and F.)

Based on the data provided, 88.2% of utilized providers are in the BCBSNM network, resulting in minimal disruption to members to continue seeing their current dentist. To further expand access for your members, we are able to implement custom recruitment plans around your membership in areas that lack access. We focus on non-network providers that have high utilization and gap areas where network access can be further bolstered.

2.1.12 Network Composition and Access: Provide comprehensive information on their provider networks. This information shall indicate where provider networks are directly contracted and where they are leased from another entity. Do not provide hard copy provider directories Provide the website address where such directories can be viewed. Where requested, geo-access and disruption analysis shall be included (refer to RFP Appendix F.) Further, the details on the management and operation of the network shall be included. Information on the expected provider and network membership shall be provided.

Provider Networks

Our network is made up of a combination of our proprietary network and strategic leased networks, which allows us to create the largest network with the best overall gross discount nationally.

We are industry leaders in expanded PPO network solutions, with over 10 years of experience successfully managing partnerships with other national and regional dental PPOs.

While we focus on organically growing our network, our customers and members see advantages in having an expanded network solution where they receive greater access to network providers and discounts. This provides increased savings and satisfaction for our customers and members. Members would not receive any disruption to their experience, as the network is seamlessly branded to help mitigate member confusion.

As part of our leasing arrangement with our network partners, we access provider fee schedules from these leased networks and seamlessly integrate them into our claims adjudication system. We internally manage these network relationships and all the provider data and fee schedules needed to discount in-network claims. Our system assures that the best discount is used when processing in-network claims.

We are committed to continuously investing in the growth of our priority network and are focused on investing in resources to grow the depth of our dental network overall, providing additional access and savings. We continually monitor our leased networks according to contract requirements and evaluate new network opportunities as they arise.

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There are no additional costs passed on to our customers or members to access providers with leasing partnerships (such as no shared savings, cost containment, or other fees).

Provider Directories

Members can locate a dentist through our online Provider Finder, at www.bcbsnm.com.

Management and Operation of Network

This response is considered confidential. Please refer to the Legally Confidential folder for details

Provider and Network Membership

This response is considered confidential. Please refer to the Legally Confidential folder for details.

2.1.13 Questionnaire: Complete Questionnaire, Appendix B. Any response of "No" to Minimum Contractual Requirements shall result in lower scoring. Your response to the Deviations may result in lower scoring

Noted.

2.1.14 Technical Workbook: Complete Technical Workbook, Appendix F. Any response of "No" to Minimum Contractual Requirements shall result in lower scoring. Your response to Deviations may result in lower scoring.

Noted.

2.2 Cost Proposal Format, Section Two

2.2.1 Total Cost: Submit your Cost Proposal (Appendix A) separately from your Technical Proposal (upload Appendix A in the City's eProcurement system). **Failure to submit your cost separately from your Technical Proposal shall result in your proposal being deemed non-responsive.**

Noted. Appendix H Cost Proposal has been completed and provided under the Appendix H Cost Proposal section of this proposal.

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SCOPE OF SERVICES

The successful Offeror shall provide the following Services:

3.1 The successful Offeror shall maintain all provider records, contracts, terms and conditions, and maintain a recordkeeping system for the administration of the City's dental plan.

BCBSNM acknowledges and confirms.

3.2 The successful Offeror shall align incentives and a business model that drives value for the City and its members.

BCBSNM acknowledges and confirms.

3.3 The successful Offeror shall provide comprehensive account management and designated customer service representatives including resources and personnel as necessary to support the City's broader health care strategy.

BCBSNM acknowledges and confirms.

3.4 The successful Offeror's account management shall attend all enrollment meetings, entity meetings, and health fairs.

BCBSNM acknowledges.

Our tailored enrollment assistance offers your employees the necessary information for making informed health benefit decisions. A designated enrollment specialist will answer any questions from employees. This assistance demonstrates our commitment to ensuring we fully educate our clients and members on their benefits.

Typical enrollment assistance includes:

- **Formal employee enrollment meetings:** Your designated enrollment specialist presents the plan benefits and enrollment procedures and distributes enrollment literature in a formal employee meeting. After the presentation, the enrollment specialist will answer employee questions. The availability of the enrollment specialist for a meeting depends on the number of employees and the location: 75 at each location for existing clients; 50 at each location for new clients.
- **Informal onsite enrollment assistance:** Your enrollment specialist is available onsite to answer questions and distribute enrollment literature more informally. As with the formal meeting, the enrollment specialist's availability for a meeting depends on the number of employees and the location: 75 at each location for existing clients; 50 at each location for new clients.
- **Virtual meetings:** The enrollment specialist can also support client meetings through webinars and conference calls.

We require a minimum lead time of seven days for onsite enrollment meeting assistance. There is no additional cost for this service.

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3.5 The successful Offeror shall provide effective coordination and integration with the City's other external vendor partners.

We are willing to work with third-party vendors if federal and state regulations, as well as corporate policies, allow the type and scope of coordination. Before we can commit to specific third-party working relationships, we require further discussions about integrating with the requested vendors.

3.6 The successful Offeror shall comply with the detailed process measurement model/performance guarantees that will evaluate the successful Offeror's performance and hold it accountable for certain guaranteed standards.

Confirmed. Refer to the performance guarantees exhibit included with this proposal for details.

3.7 The successful Offeror shall prepare summary plan descriptions, and any other employee notices required by State or Federal Law; and shall provide recommendations and advice on the City's benefit plan design.

BCBSNM acknowledges and confirms.

3.8 The successful Offeror shall assist in preparation of publishing of City's benefit booklet and pay a pro rata share of the benefit booklet.

We offer various communication materials to inform members about their dental benefits. We distribute printed enrollment guides and benefit highlight summaries during annual enrollment meetings and fairs. Using Blue Access for Members, we email members who elect to receive news and updates.

3.9 The successful Offeror shall provide best in class enrollee focus with staff that are determined to get any issues resolved in a timely manner.

BCBSNM acknowledges and confirms.

3.10 The successful Offeror shall adjudicate and pay claims according to the City's benefit plan design including the application of benefit determinations and other cost saving value-based measures.

BCBSNM acknowledges and confirms.

We systematically process claims that auto-adjudicate to ensure the appropriate treatment level and compliance with current standard coding practices. Under the alternate benefit provision, we select complex or high-cost claims—or other claims that do not auto-adjudicate—for individual consideration and route them through the utilization review process. Additionally, we suspend any claims the examiner or technician cannot complete and send them for professional review.

We use a team of dental consultants to conduct professional reviews according to established utilization management guidelines. During a professional review, we suspend all the provider's claims for further review if the consultant determines a provider is engaging in potentially misleading, subjective, or aberrant coding practices. For 2024, our professional review process saved nearly $16 million.

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3.11 The successful Offeror shall provide a customer service call center, online member access website, and other support services for members.

BCBSNM acknowledges and confirms.

3.11.1 The successful Offeror shall ensure that members at a minimum are able to access a member portal which houses plan information on plan design, claims payment and year to date deductible and out of pocket maximum levels, locate a provider, and lookup basic educational materials via provider's secured website.

Through our website, www.bcbsnm.com, we offer convenient self-service options for members and engage potential members, group administrators, providers, and insurance brokers.

Blue Access for Members and Online Health Information

The secure Blue Access for Members portion of our website allows members to access their personal membership and claims information. They can complete the following tasks:

- Check the status of a claim (updated in real time, Monday through Friday).
- View 18 months of claim history.
- View deductible and remaining annual benefit status.
- View and download explanations of benefits (EOBs).
- Request discontinuation of paper EOBs.
- Sign up to receive email notification when claims are filed.
- Confirm covered dependents.
- Order replacement ID cards and print a temporary ID card.
- Send an email inquiry to customer service.

Members can also access dental product information, review frequently asked questions, locate a provider, download a claim form, and nominate a provider to include in our network.

Blue Access for Members is available 24/7 (with help desk representatives available to assist with technical questions from 6 a.m. to 6 p.m. Mountain time Monday to Saturday, excluding major U.S. holidays).

The Dental Wellness Center

We also offer a unique, proactive wellness campaign called BlueCare Dental Connection. This outreach program targets at-risk members and educates them about their dental health to prevent more serious and costly health conditions. BlueCare Dental Connection includes member access to The Dental Wellness Center, a source of consumer-driven tools available online 24/7. Members can find educational information on subjects such as pediatric care, cosmetic dentistry, prevention, and dental treatments. Through the Dental Wellness Center, members can also:

- Ask dentists questions through Ask a Dentist.
- Locate an in-network dentist or specialist with Provider Finder.

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- Research information with the Dental Dictionary.
- Determine approximate dental fees in the marketplace with the Dental Cost Advisor.
- View animations from various dental topics with our Treatment and Procedure Animations.

Provider Finder

Members can locate a dentist through our online Provider Finder. We update this tool weekly and allow members to personalize directories based on provider specialty, location, or secondary language. Members can also access the Provider Finder by calling the toll-free customer service number. For dentists in our BlueCare Dental network, members see a score that compares them to other dentists within the same specialty and geographic area. The rating system, called DentaQual, compares dentists with their peers using composite scores based on treatment outcomes, commitment to best practices, cost effectiveness, patient retention, and treatment recommendations.

3.11.2 The successful Offeror shall handle customer service calls related to the plan and provide a dedicated toll-free customer service number for City members. Trained staff must be available for member inquires at minimum between the hours of 8:00 am and 5:00 pm Mountain Time.

Our dental services are structured so that dental claims and customer service functions are handled in dedicated dental service centers. While we are not designating member service resources specifically for City of Albuquerque, our dental-only service centers have dedicated member services staff, defined as handling only dental benefits. All customer advocates are trained to respond to a wide variety of questions from members, providers, groups, and agents.

In addition, each unit has a technician who is responsible for fielding more advanced/complex inquiries or adjustments. Using this approach for all accounts further enables our exemplary service and customer satisfaction levels.

City of Albuquerque members have toll-free access to dental customer advocates 7 a.m. to 5 p.m. Mountain time, Monday to Friday (excluding major U.S. holidays).

3.11.3 The successful Offeror shall provide sufficient staff and technology to be able to run ad hoc financial and utilization reporting, assist the City in development and distribution of plan materials to members regarding plan design features, wellness initiatives, educational information, and member service information.

BCBSNM acknowledges and confirms.

3.11.4 The successful Offeror shall provide a standard report package which includes at a minimum the following reports and frequency:

- **Monthly Reporting**
  - **Premium and paid claims by entity**
  - **Enrollment, both contracts and members, by entity and coverage tier**

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- **Quarterly Reporting**
  - **Utilization data**
  - **Financial data, to include billed charges, allowed charges, paid amounts year to date, member share, etc.**
  - **Enrollment data contract year to date**
  - **Top providers for dental offices, physicians, etc.**
- **Annual Reporting**
  - **Dental 36-month claim lag report**
  - **Performance Guarantee Reporting**

We have three dental reporting packages available to all clients, the Dental Client Report, the Monthly Financial Report and the Blue Insight Utilization Analysis Report.

Dental Client Report
The Dental Client Report package includes dental utilization, claim experience, top dental procedures, top dental providers (in and out of network), claims savings, and claim dollar utilization. This package highlights key analysis criteria show fiscal status, focusing on what drives costs. The report includes utilization information on experience, utilization by category, and in-network versus out-of-network savings. Incurred year-over-year utilization data is shown. This report is available from your account executive twice a year.

Monthly Financial Report & The Blue Insight Utilization Analysis Report
The Monthly Financial Report and the Blue Insight Utilization Analysis Report contain similar information that includes a dental financial analysis chart, service type analysis information, dental loss ratio, and an enrollment overview section. Employers access the Monthly Financial Report and the Blue Insight Utilization Analysis Report through Blue Access for Employers.

These reports are also available through Blue Insight reporting, and groups receive our monthly financial and utilization dental reports as a PDF. Our standard reporting package is comprehensive and should meet most financial and utilization reporting needs.

Blue Insight reports are available 12 days after the close of the reporting period. The monthly report presents financial and utilization components for the current reporting month, as well as renewal year-to-date. It is also available each month through Blue Access for Employers.

We provide the following information in these reports:

- Customized reports to include your logo.
- Standard executive summary reports.
- Drill-down and reach through functionality.
- Benchmarking data against our book of business.
- Monthly data loads with rolling 38 months of data.

Please refer to the Monthly Financial Report sample and the Blue Insight Utilization Analysis Report sample, for examples of this reporting package.

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BlueCross BlueShield of New Mexico

Disruption Analysis

Per the RFP instructions, this file is considered confidential and has been segregated. Please refer to the Legally Confidential folder located in the Technical Proposal section to access this file.

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BlueCross BlueShield of New Mexico

Access Analysis

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SAMPLE - PRELIMINARY, SUBJECT TO CHANGE, FOR DISCUSSION PURPOSES ONLY
BCBSNM has developed this standard Group Administration Document ("GAD") that describes the administrative services, roles, and responsibilities of BCBSNM and Groups. Unless specifically stated otherwise in our response, BCBSNM assumes your agreement to the terms and conditions herein.

BlueCross BlueShield of New Mexico

GROUP ADMINISTRATION DOCUMENT

HEALTH CARE BENEFITS

WHEREAS, the "Group" or "Employer" has purchased health care insurance from Blue Cross and Blue Shield of New Mexico (hereinafter called "BCBSNM" or "Plan"), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, and has executed a Benefit Program Application; and

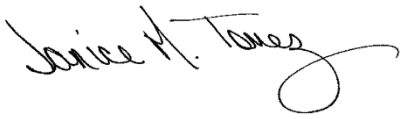
WHEREAS, the Benefit Program Application establishes the Group Contract Date; and

WHEREAS, BCBSNM hereby accepts such Benefit Program Application, subject to the financial and administrative relationships and responsibilities of both parties for the purpose of providing health care benefits on behalf of Eligible Persons;

NOW THEREFORE, the Group Contract is issued in consideration of the Benefit Program Application and of the timely payment of premiums as required herein. The Group Contract shall become effective on the Group Contract Date specified on the Benefit Program Application and will be continued in effect by the payment of premiums at the rates determined by the Plan in accordance with the provisions in Premiums and Group Contract Changes until terminated as provided in Termination of the Group Contract.

IN WITNESS WHEREOF, the Plan has caused the Group Contract to be issued and delivered at its Administrative Office in Albuquerque, New Mexico.

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company



President of Blue Cross and Blue Shield of New Mexico

SAMPLE

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INTRODUCTION

The Group Contract and changes to the Group Contract is comprised of:

1. This Group Administration Document;
2. The Benefit Program Application;
3. The Benefit Booklet;
4. The Summary of Benefits and Coverage;
5. The Drug Plan Rider;
6. The ID Cards; and
7. Any other applications, riders, enclosures, addenda, exhibits, and endorsements to any of them, if any.

This Group Administration Document contains those aspects of the Group Contract more specifically applicable to the Group. The Benefit Booklet contains information more specifically applicable to Members. In the event of any conflict between any components of the health care benefit plan, this Group Administration Document prevails. All statements made by the Group and Eligible Persons shall in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a claim under the Group Contract, unless it is contained in a written application. No change in the Group Contract shall be valid unless approved by an executive officer of the insurance company and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Group Contract or to waive any of its provisions.

The issuance of this Group Contract supersedes all previous contracts between the Group and the Plan which are in force on the Group Contract Date.

I. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

Additional definitions applicable to the Group Contract are contained in the Benefit Booklet and the Benefit Program Application.

Benefit Booklet – the document issued by the Plan to the Subscriber. The Benefit Booklet describes the health care benefit plan purchased by the Group and being administered by the Plan pursuant to the Group Contract.

Benefit Program Application – means the document through which the Group has applied for health care insurance from the Plan and by which renewals and/or other Group Contract changes may be documented.

Benefits – the payment, reimbursement and/or indemnification of any kind which a Member will receive from and through the Plan under the Group Contract.

Certificate of Creditable Coverage – a document providing information which is intended to enable an individual to establish his/her prior creditable coverage.

COBRA Continuation Coverage – coverage under a group health plan that satisfies the provisions of COBRA (Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended).

Coinsurance – the percentage of Covered Charges for Covered Services for which the Member is responsible.

Copayment – the fixed-dollar amount (or, in some cases, a percentage) that a Member must pay to a health care Provider in order to receive a specific service or benefit covered under this Group Contract.

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Covered Charge – the charge that the Plan will use as the basis for Benefit determination for Covered Services incurred by a Member under the Group Contract. The criteria the Plan will use to establish the Covered Charge is set forth in the Benefit Booklet.

Covered Service – a service or supply specified in the Group Contract for which Benefits will be provided when rendered by a Provider.

Deductible – a specified amount of Covered Services that a Member must incur before the Plan will start to pay its share of the remaining Covered Services.

Dependent – a Member other than the Subscriber as specified in the Eligibility section of the Benefit Booklet.

Effective Date – according to the Eligibility section of the Benefit Booklet, the date on which coverage for a Member begins.

Eligible Person – a person entitled to apply to be a Subscriber as specified on the Benefit Program Application.

Group – a corporation, proprietorship, partnership, or other recognized legal entity, which, as an agent for its employees, has agreed to the establishment of a premium collection or payment system for the purpose of affording its employees the opportunity of acquiring Plan coverage for health care expenses.

Group Contract – this Group Administration Document, the Benefit Program Application, the Benefit Booklet, the Summary of Benefits and Coverage, the Drug Plan Rider, the ID Cards, and any other applications, riders, enclosures, addenda, exhibits, and amendments or endorsements, if any, between the Plan and the Group, referred to as the Group Contract.

Group Contract Date – the date, specified on the Benefit Program Application, on which coverage under the Group Contract commences for the Group.

Group Contract Date Anniversary – the date the Group Contract will renew and each twelve (12)- consecutive-month renewal date thereafter.

Identification Card – the card issued to the Subscriber/Member by the Plan, bearing the Subscriber's/Member's name, identification number, and Group number.

Late Fee means a charge payable to the Plan when Employers pay premiums past the due date.

Medicare – the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare Secondary Payer ("MSP") means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

Member – the Subscriber and each of his or her Dependents (if any) enrolled under the Group Contract.

Out-of-Network Provider – a Provider that has not entered into an agreement with the Plan to be a part of the Participating Provider Network as set forth in the Benefit Booklet.

Participating Provider – a Provider that has entered into an agreement with the Plan to be a part of the Participating Provider Network as set forth in the Benefit Booklet.

Physician – a person who is a professional practitioner of a healing art defined and recognized by law, and who holds a Physician license duly issued by the state or territory of the United States in which the person is authorized to practice medicine or surgery or other procedures and provide

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services within the scope of such license.

Plan – Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

Provider – a Hospital, Physician, other facility or other practitioner of the healing arts or Provider of medical services or supplies licensed to render Covered Services and performing within the scope of such license.

Reinstatement Fee – a charge payable to the Plan to reinstate the Group Contract when termination occurs due to non-payment of premium.

Service Area – BCBSNM's service area is the geographic area where BCBSNM is licensed to conduct business (the State of New Mexico).

Service Mark – the names "Blue Cross" and/or "Blue Shield" and the associated logos, along with all related or derivative marks including, but not limited to, any Blue Cross or Blue Shield formulations or designs.

Subscriber – an Eligible Person who has enrolled for coverage.

Surcharges – means local, state or federal taxes, surcharges or other fees or amounts paid by the Plan which are imposed upon or resulting from the Group Contract, or are otherwise payable by the Plan. Surcharges may or may not be related to a particular claim for benefits.

Value-Based Program - means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Member health outcomes; (ii) Member Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Member access; (vi) Member experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Members, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

II. RECORDS OF MEMBER ELIGIBILITY AND CHANGES IN MEMBER ELIGIBILITY

A. The Group must furnish the Plan with any data required by the Plan for coverage of Members under the Group Contract. Data includes, but is not limited to, records and information provided to the Plan for determining eligibility and/or premiums for this Group Contract. In addition, the Group must provide prompt notification to the Plan of the effective date of any changes in a Member's coverage status under the Group Contract.

B. All such notifications by the Group to the Plan (including, but not limited to, forms, electronic files and tapes) must be furnished in a format approved by the Plan and must include all information reasonably required by the Plan to effect changes. It is also Group's obligation to obtain the required consent(s) from Subscriber for the Plan to contact Subscribers by telephone, or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Minor clerical errors in keeping or reporting data relative to coverage under the Group Contract will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. Examples of such minor clerical errors include, but are not limited to, errors appearing in an individual's name, address, or birth date as well as typographical errors. The term "minor clerical errors" as used herein does not include Group errors which materially affect an individual's coverage under the Group Contract. It is further understood and agreed that the Group is liable for any substantive error made by the Group in keeping or reporting data which may materially affect an individual's coverage under the Group Contract and for any benefits paid for a terminated Member if the Group had

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not timely notified the Plan of such Member's termination.

In the event of errors or delays in recording or reporting data by the Group, retroactive changes will not be made effective prior to the current month and two (2) previous months.

C. No waiting period may exceed ninety (90) days unless permitted by applicable law. If the Plan's records show that the Group has a waiting period that exceeds the time period permitted by applicable law, then the Plan reserves the right to begin a Subscriber's coverage on a date that the Plan believes is within the required period.

D. During the term of the Group Contract and within one-hundred eighty (180) days after the termination of the Group Contract, the Plan may, upon at least thirty (30) days prior written notice to the Group, conduct reasonable audits of the Group's membership records with respect to eligibility.

E. The Group hereby agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorney's fees and costs) or liability that may arise from or in connection with untimely and/or inaccurate data provided by the Group or on the Group's behalf to the Plan, or data furnished by the Group or on the Group's behalf to the Plan in a format not approved by the Plan.

III. PREMIUMS AND GROUP CONTRACT CHANGES

A. The amount of premiums shall be the amount determined by the Plan for the Benefits of the Group Contract, as filed with the New Mexico Office of the Superintendent of Insurance.

B. The Plan may establish new premiums for any of the individual or aggregate Benefits of the Group Contract on any of the following dates or occurrences, upon which further premiums shall be paid.

1. Any Group Contract Date Anniversary, provided that the Plan notifies the Group of such new premium within the timeframe specified on the Benefit Program Application;

2. Any premium due date, provided the Plan notifies the Group of such new premium within the timeframe specified on the Benefit Program Application;

3. Whenever the Benefits under the Group Contract are changed;

4. Whenever a class of persons is made eligible or is eliminated from eligibility;

5. Whenever the enrollment fluctuates by ten percent (10%) or more;

6. Whenever the Plan is obligated to pay any new taxes, Surcharges or other fees imposed upon or resulting from the Group Contract including, but not limited to, premium taxes or taxes on the Plan's Benefits or services provided under the Group Contract; and

7. Whenever there is a legislative or regulatory mandate or requirement for a change in Benefits which would require additional premiums.

C. If the age, or, if applicable, tobacco use status, geographic location, or number of family members upon which a particular premium is based have been misstated, the Group may be responsible for paying the Plan an adjusted amount which will provide the Plan with the correct premium calculated from the coverage date of a particular Member.

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D. Premium rates are based upon the amount of taxes, fees, Surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, Surcharges or other amounts which the Plan is required to pay or remit are increased during the Group Contract year, the Plan reserves the right, at its option, to charge the Group for such amounts or adjust the premium rates to reflect such increase, on the effective date of such increase. Upon request, the Group shall furnish to the Plan in a timely manner all information necessary for the calculation or administration of any such taxes, fees, Surcharges or amounts.

E. As required to comply with ERISA or other applicable law, discretion and authority for determining Benefits and premiums are vested in the Plan, not the Group. Any changes in Benefits or premiums shall not affect any Member during the coverage period for which premiums have been paid.

F. All premiums for coverage shall be paid by the Group, as the agent of the Subscriber, to the Plan and shall be payable on or before the Group Contract Date. All further premiums shall be due and payable in advance of and no later than the due date for the coverage period as stated in the Group billing statement given to the Group.

G. Group agrees that all premiums are payable to Plan on or in advance of each premium due date. A check is not a payment until it is honored by a bank. Plan reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt. The payment of any premium shall not maintain coverage under the Group Contract in force beyond the date when the next payment becomes due; however, a grace period of at least thirty (30) days or as indicated on the Benefit Program Application, during which time this Group Contract will remain in force, shall be granted for payment of each amount due after the first premium payment. The Group is liable for payment of the premium for the time coverage is in effect during the grace period.

H. Failure of the Group to pay premiums or other payment required by the Group Contract to the Plan on or before the due date described above shall automatically terminate and cancel all coverage for Members at the end of the coverage period for which premiums are paid.

I. If the Group is in default of its obligation to pay premiums or other payment or if any other default hereunder has occurred and is continuing, then any indebtedness from the Plan to the Group (including any and all contractual obligations of the Plan to the Group) may be offset and/or recouped and applied toward the payment of the Group's obligations hereunder , whether or not such obligations, or any part thereof are due the Group.

J. If any renewal premium plus applicable Reinstatement Fee is not paid within the time granted the Group for payment, a subsequent acceptance of premium by BCBSNM or by any agent duly authorized by BCBSNM to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if BCBSNM or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by BCBSNM or, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless BCBSNM has previously notified the Group in writing of its disapproval of such application. In all other respects the Group and BCBSNM shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid.

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K. The Plan reserves the right to reinstate the Group Contract upon such terms and conditions as the Plan determines to be acceptable. Terms and conditions of reinstatement may include a Reinstatement Fee determined by BCBSNM, and not to exceed one percent (1.0%) of unpaid premiums.

L. The Plan shall have no liability for any care and services, including maternity services, occurring after the date and time of such termination and cancellation, except as described in Section VI. "Termination of a Member's Coverage under the Group Contract".

M. If the Employer fails to pay premiums when due, the Plan, at its option, may assess a Late Fee for the late premiums from the due date of any amount(s) payable to Plan by Employer. This Late Fee shall be an amount equal to the amount resulting from multiplying the past due premiums times the lesser of:

1. The rate of up to one percent (1%) per month which equates to an amount of twelve percent (12%) per annum; or

2. The maximum rate permitted by state law.

IV. MINIMUM GROUP PARTICIPATION REQUIREMENTS

A. The Plan may request information from the Group on a periodic basis to determine the Group's compliance with the minimum Group participation requirements, if any.

B. The percentage of enrollment of Eligible Persons which may be required to be maintained is set forth in the Benefit Program Application or other appropriate document.

C. The aggregate number of Eligible Persons enrolled under the Group Contract and the Group's alternate Plan Group Contract (if applicable) shall be used in the calculation of the required percentage and number of Eligible Persons which may be required to be enrolled and maintained.

D. A person whose eligibility has been continued, as set forth in the Benefit Booklet or other appropriate document, will count toward the percentage and number of Eligible Persons which may be required to be maintained as described above.

E. The following persons will not count against the required percentage of enrollment as described above:

1. An Eligible Person who is enrolled under the COBRA Continuation Coverage provisions of the Group Contract; or

2. An Eligible Person with coverage through a Group, individual policy, SHOP Exchange policy; Indian Health Services (IHS), Medicare, Medicaid, or Military.

F. The minimum contribution amount which may be required from the Group is fifty percent (50%) of the premium for Employee Only (Single) Coverage: however, if the Group offers multiple plan options, this amount can be based on the lowest cost medical plan option.

V. TERMINATION OF THE GROUP CONTRACT

A. The Group Contract will be terminated for the Group's non-payment of the appropriate payment when due or for the Group's failure to perform any obligation required by the Group Contract, as described above. If the Group Contract is terminated or premiums are not submitted, coverage will terminate for all affected Members as of the end of the last-paid billing period. If the Group fails to submit premium payments to BCBSNM, it is the Group's responsibility to advise Members of BCBSNM Plan termination. The Group shall provide proof to BCBSNM of the notification to Members in the event of such termination.

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The obligation of the Group to notify Members and provide proof to BCBSNM of such notification shall survive the termination of this Group Contract.

B. If the Group contracts for, implements and installs another group health care and services program concurrent with the Group Contract, but not underwritten and provided or approved by the Plan, the Group Contract shall automatically and without notice, terminate as of the effective date of such other coverage or program.

C. The Plan may request information from the Group on a periodic basis to determine the Group's compliance with the minimum Group participation requirements stated in the Group Contract. The Group Contract may be terminated by the Plan by written notice at the end of the coverage period for which premiums have been paid, or by written notice given thirty (30) days prior to such termination by the Plan, for any of the following reasons:

1. The Group fails to provide the information necessary for the Plan to determine the Group's compliance with the minimum Group participation requirements, if any; or

2. The Group fails to meet the enrollment requirements for minimum percentage and number of Eligible Persons, if any.

D. The Plan can cease to offer either a particular product or all coverage it offers in the particular market.

E. The Plan can refuse to renew the Group Contract if the Group's participants all leave the network Service Area, or if the coverage is provided through a bona fide association and the Group's membership ends.

F. The Group Contract shall be terminated retroactive to the Group Contract Date if the Group commits fraud or material misrepresentation in applying for or obtaining coverage under the Group Contract.

VI. TERMINATION OF A MEMBER'S COVERAGE UNDER THE GROUP CONTRACT

A. A Subscriber's coverage (including coverage for his or her Dependents, if any) shall be terminated retroactive to the Effective Date if the Group or Subscriber commits fraud or material misrepresentation in applying for or obtaining coverage under the Group Contract. A Member's coverage shall terminate immediately if he or she files a fraudulent claim.

B. If a Member ceases to meet the definition of Member, such Member's coverage will automatically terminate at the end of the coverage period in which eligibility ceases, unless specified otherwise on the Benefit Program Application, except that:

1. When a Member ceases to be an Eligible Dependent by reason of death, coverage for that Member will cease on the date of death.

2. In the case of a Member covered under the COBRA Continuation Coverage provisions of this Group Contract, coverage shall cease on the earliest to occur of the following dates:

a. the date the coverage period ends following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;

b. the first day of the month that begins more than thirty (30) days after the date of the Social Security Administration's final determination that the Member is no longer disabled (when coverage has been extended from

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eighteen (18) months to twenty-nine (29) months due to disability);

c. the date on which the Group stops providing any group health plan to any employee;

d. the date on which coverage stops because of a Member's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;

e. the date on which the Member first becomes (after the date of the election) covered under any other group health plan; or

f. the date on which the Member becomes (after the date of the election) entitled to benefits under Medicare.

C. In the event the required contribution, if any, is not paid for continuation of a Subscriber's coverage under the Group Contract, the Subscriber's coverage will terminate at the end of the coverage period for which payment of premiums has been made.

D. Termination of the Group Contract automatically terminates all of the Subscriber's coverage at the same time and date. It is the responsibility of the Group to notify all the Subscribers of the termination of the coverage. However, coverage will be terminated regardless of whether the notice is given.

E. In no event will retroactive adjustments to premium be allowed prior to the current month and two (2) previous months. The Employer will be required to pay premium for all months, as billed, except those for which the Plan has agreed to retroactively refund premium.

VII. RELEASE OF INFORMATION AND MEDICAL RECORDS

A. Each Member agrees that any person or entity having information relating to an illness or injury for which Benefits are claimed under the Group Contract may furnish it to the Plan (including copies of records). In addition, the Plan may furnish such information to other entities providing similar benefits at their request.

B. All claim information, including, but not limited to, medical records, received by the Plan in the performance of its duties hereunder will be kept confidential by the Plan and except for reasonably necessary use by the Plan in connection with the performance of its duties hereunder, the Plan shall not disclose such confidential claim information without the authorization of the Member or as otherwise permitted by applicable law.

C. The Plan may release to the Group, claim information regarding an illness or injury for which Benefits are claimed and copies of records to the extent required or permitted by applicable law, including, but not limited to, the Health Insurance Portability and Accountability Act, ("HIPAA"). Any information so obtained by the Group shall be kept confidential, as required by applicable law.

VIII. PAYMENT OF BENEFITS AND ASSIGNMENT OF BENEFITS

A. All payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by each Subscriber to make such payments directly to such Providers. However, the Plan reserves the right to pay any Benefits that are payable under the terms of this Group Contract directly to the Subscriber, unless reasonable evidence of a properly executed and enforceable assignment of Benefit payment has been received by the Plan sufficiently in advance of the Plan's Benefit payment. The Plan reserves the right to require submission of a copy of the

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assignment of Benefit payment.

B. Once Covered Services are rendered by a Provider, the Subscriber request for the Plan not to pay the claim submitted by such Provider and no such request by a Subscriber or his agent will be given effect. Furthermore, the Plan will have no liability to the Subscribers or any other person because of its rejection of such request.

C. Except for the assignment of Benefit payment described above, coverage under the Group Contract and a Subscriber's claims or rights under the Group Contract, including, but not limited to, claims for payment of Benefits, are expressly non-assignable and non-transferable in whole, or in part, to any person or entity, including any Provider, at any time. Any such assignments or transfer of claim for payment of Benefits or coverage shall be considered null and void. Coverage under this Group Contract is expressly non-assignable or non-transferable and will be forfeited if the Subscriber attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under this Group Contract.

D. For Covered Services provided to a Member under the Group Contract, Benefits will be based upon the Covered Charge for such services, as determined by the Plan. Participating Providers have agreed to charge Plan Members no more than the Covered Charge for Covered Services. However, Members who receive Covered Services from Out-of-Network Providers may be responsible for amounts which exceed the Covered Charge, in addition to the Copayment, Deductible and/or Coinsurance amounts.

E. If the age, or, if applicable, tobacco use status, geographic location, or number of family members upon which a particular premium is based have been misstated, the Group may be responsible for paying the Plan an adjusted amount which will provide the Plan with the correct premium calculated from the Effective Date of a particular Subscriber.

IX. PLAN'S RIGHT OF RECOUPMENT

A. Each Member agrees to reimburse the Plan for Benefits it has paid and for which the Member was not eligible under the terms of the Group Contract. This payment is due and payable immediately upon notification by the Plan. Also, the Plan has the right to determine that any overpayments, wrong payments, or any excess payments made under the Group Contract are an indebtedness which may be recovered by the Plan. The Plan's acceptance of premiums or payment of Benefits under the Group Contract does not waive its rights to enforce these provisions in the future.

B. To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each Member agrees that the Plan shall have a first lien on any settlement proceeds, and the Member shall reimburse and pay the Plan, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from another party or the Member's insurer or from any carrier providing uninsured/underinsured motorist coverage. Each Member shall reimburse the Plan on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not the Member is made whole or is fully compensated for any injuries.

C. Each Member is required to hold in trust for the Plan any money (up to the amount of Benefits paid by the Plan) recovered as described above. Each Member is required to cooperate and furnish information and assistance which the Plan may require to obtain this reimbursement, including signing legal documents.

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D. Failure of the Member to comply with the above provisions may result in termination of the Member's coverage and/or legal action to enforce collection, including pursuing refund from the Group.

X. LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

The Plan will not seek recovery of any excess or erroneous payment made under the Group Contract more than eighteen (18) months after the payment is made, unless:

A. The payment was made because of suspected fraud or abuse committed by the Member or the Provider;

B. The payment was made due to professional miscoding or claims submission error;

C. Retroactive adjustments are required by federal or state agencies; or

D. The Member or Provider has otherwise agreed to make a refund to the Plan for overpayment of a claim.

XI. GENERAL PROVISIONS

A. Agency Relationships:

1. Nothing in the Group Contract shall be construed to constitute the Group as an agent of BCBSNM. The Group is the agent of the Subscribers, not the Plan.

2. Providers are not employees, agents or other legal representatives of BCBSNM.

B. Applicable Law: The Group Contract is issued and delivered in the State of New Mexico, is governed by the laws thereof, is subject to all the terms and provisions set forth in all of the sections hereof, which are fully incorporated into and made a part of the Group Contract, and is acknowledged by the signed Benefit Program Application of the Group and signed acceptance of the Plan officers. In the event of any controversy between the Group and/or Members and the Plan, this provision will apply.

C. Authority: The Group Contract is subject to compliance with all provisions of New Mexico's Insurance Code and any changes are subject to approval of the Superintendent of Insurance.

D. Benefit Booklet: The Plan will provide the Subscriber with the Benefit Booklet that describes the benefits, limitations, exclusions and requirements of the Group Contract.

E. Benefits to Which Members are Entitled:

1. The liability of the Plan is limited to the Benefits for Covered Services specified in the Group Contract and described in the Benefit Booklet.

2. No person other than a Member is entitled to receive Benefits under the Group Contract. Such right to Benefits and coverage is not transferable.

F. Certificates of Creditable Coverage:

Unless otherwise directed by the Employer or by a designated entity acting on behalf of the Employer in writing, the Plan shall issue a Certificate of Creditable Coverage, upon request of either the Group or a Member, consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Group Contract and information provided to the Plan by the Employer. The Employer or a designated entity on the Employer's behalf may agree in writing to prepare and distribute such Certificate of Creditable Coverage, and in such instance, the Plan will not be required

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to duplicate provision of such Certificate of Creditable Coverage.

G. **Discontinuance of a Particular Product:** BCBSNM may discontinue the Group's benefit plan product under the Group Contract if BCBSNM:

1. Provides ninety (90) days advance notice to the Group and Members (or such other notice, if any, required by applicable law or regulatory guidance);

2. Offers the Group an option to purchase other coverage offered to other employers of similar circumstance, including, but not limited to, employer size; and

3. Acts uniformly without regard to the claims experience of the Group or the health status of any existing, new or potentially new Members.

4. The Plan may discontinue coverage under this policy as otherwise permitted by applicable law or regulatory guidance.

H. **Discontinuance of All Coverage:**
BCBSNM may discontinue all coverage in the large group market in a state in accordance with applicable law and provided that BCBSNM:

1. Provides one hundred eighty (180) days advance notice to the Group and Members (or such other notice, if any, required by applicable law); and

2. Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the state in such market(s).

I. **Electronic Exchange of Data:** In the event the Group and the Plan exchange data and information electronically, the Group agrees to transfer on a timely basis all required data to the Plan via secure electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Plan, a copy of which shall be furnished to the Group upon written request to the Plan. The Group authorizes the Plan to submit such data and information in the specified electronic format. In the event the Group is unable or unwilling to transfer data in the specified electronic format, the Plan is under no obligation to receive or transmit data in any other format, unless required by law to do so. In the event garbled or intercepted transmissions occur, the Plan and the Group agree to redirect the information via another mutually agreeable means. Minimum Group size may be required for electronic transmissions.

The Group consents to receive a Benefit Booklet, via an electronic file or access to an electronic file, provided by the Plan to the Group for delivery to each Insured. In the event the Plan, provides to the Group an electronic file of any document describing the Benefits under, or the administration of, the Group Contract for the Group's use, including, but not limited to, the Group's or the Plan's posting of such documents on the intranet and/or internet, the Group acknowledges and agrees that such electronic file is not intended to meet the Group's requirements for compliance under ERISA.

The Group further acknowledges and agrees that it is solely responsible for providing employees access, via the intranet, internet, paper copy or otherwise, to the most current version of any electronic file provided to the Group by the Plan. In addition, in all instances the electronic file of the most current document issued to the Group by the Plan for use by the Group is the legal document used to administer the Group Contract and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Group is solely responsible for, and holds the Plan harmless from, any and all claims for loss, liability or damages arising from the use or posting of the electronic file on the intranet and/or internet.

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The Group agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs), liability or claim that may arise from or in connection with the electronic transfer of data from the Group or the Group's third party consultant and/or vendor to the Plan or from the Plan to the Group, pursuant to Section XI., Z. "Providing Data to Group's Vendor(s)" of this Group Contract, the Group's third-party consultant and/or vendor, including liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information, including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmissions and for any claim arising from the Group's use or posting of electronic files on the intranet and/or internet.

J. **Employer Notification to Subscribers:** It is the responsibility of the Group to notify all Subscribers in the event of a uniform modification of coverage or uniform termination of coverage.

K. **Entire Group Contract; Changes:** This Group Administration Document, including any addenda attached hereto, the Benefit Program Application, the Drug Plan Rider, the Summary of Benefits and Coverage, the ID Cards, the individual enrollment/change forms/applications, if any, of the Subscribers, and the Benefit Booklet constitute the entire Group Contract of insurance between the Group and the Plan. No change in the Group Contract will be effective until approved by an authorized Plan officer. This approval must be noted on or attached to the Group Contract. No agent or representative of the Plan other than a Plan officer may otherwise change the Group Contract or waive any of its provisions.

All statements made by the Group or by any individual Subscriber shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under the Group Contract, unless it is contained in a written application.

The issuance of this Group Contract supersedes all previous contracts or policies between the Group and the Plan which are in force on the Group Contract Date.

L. **ERISA:** This provision applies to any Group which implements any employee welfare benefit plan as defined by Section 3 (2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1. The Group (or (i) if the Group is a trust, the grantor of such trust or (ii) if the Group is an association, each member of such association who pays premiums under such Group Contract) has established and as sponsor maintains pursuant to other written documents a health benefit program (''Group's ERISA Health Benefit Program'')affording benefits to its eligible employees or eligible members and their dependents, through the purchase of insurance, which Group's ERISA Health Benefit Program is an ''employee welfare benefit plan'' within the meaning of ERISA. Notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member, if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in the Group Contract or as otherwise accepted in writing by the Plan. The administrator under ERISA for a Group's ERISA Health Benefit Program is the Group or such other persons (other than the Plan) appointed by the Group (or (i) if the Group is

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a trust, by the grantor of such trust or (ii) if the Group is an association, by each member of such association who pays premiums under such Group Contract). Nothing in a Group's ERISA Health Benefit Program will affect the obligations of the Plan with respect to the Group Contract. The Plan will not be required to examine the provisions of a Group's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.

2. The Group Contract is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Group Contract is an asset of the Group. No assets of the Plan or amounts which have been paid to the Plan under the Group Contract are assets of or under Group's ERISA Health Benefit Program.

M. Identification Cards: The Plan will provide Identification Cards.

N. Initial Plan Participation Requirements, Benefit Plan Status, Plan Documents, Retaliation:

1. It is the Group's responsibility, prior to the Effective Date of the Group Contract (i) to determine initial plan participation requirements and categories of coverage options for employees, former employees, officers and directors in compliance with all applicable law, including, but not limited to, discontinuing any waiting periods that are longer than permitted by applicable law; (ii) to comply with nondiscrimination requirements applicable to its benefit plan, including, but not limited to, those related to highly compensated individuals; and (iii) to determine its regulatory status, including but not limited to determining whether it meets the federal and state law (as applicable) definitions of "small group", "large group", "MEWA", and/or "Association". The Group will promptly notify the Plan of its determinations (and any changes thereto) and will promptly notify the Plan when a person has satisfied the initial participation requirements and also meets the definition of a Subscriber under the Policy. In addition, The Group (iv) is responsible for establishing and/or amending its own plan documents as necessary; (v) must not retaliate against any employee for engaging in activities protected by applicable law, including, but not limited to, receiving subsidized coverage under a qualified health plan through an exchange; and (vi) ensuring that Health Savings Accounts and Health Reimbursement Accounts are funded in accordance with the Group's funding decisions that the Group has communicated to the Plan, if any. In no event will the Plan have responsibility for such initial plan participation or plan status determinations or for Group's plan documents, actual or alleged retaliation, or funding decisions. Upon request, the Group will provide the Plan with information to substantiate such determinations and responsibilities.

The Group hereby agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs) or liability resulting from the Group's failure to carry out its responsibilities or obligations as set forth in this Group Contract. If a person is added to the Group Contract and later determined to have been ineligible, the Plan reserves the right to terminate or rescind such person's coverage to the extent permitted by applicable law. If a person is added to the Group Contract and it is later determined the Group reported an Effective Date of the Group Contract earlier than what would apply, based on the waiting period and eligibility conditions the Group identified, the Plan reserves the right to retroactively adjust the Effective Date of the Group Contract.

2. This section M.2 applies to the extent that the Group directs the Plan to offer to

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Subscribers who participate in a high deductible group health plan coverage for drugs prior to satisfaction of the otherwise required deductible (the "Preventive Drug Program"). The Group acknowledges that the Preventive Drug Program is a plan design decision of the Group in its role as plan sponsor and that certain drugs under the Preventive Drug Program may be either to treat disease or for a preventive purpose. The Plan does not provide legal or tax advice to the Group and the Group is not relying on the Plan for any tax or legal advice in connection with the Preventive Drug Program. As the Preventive Drug Program is a plan design decision of the Group, the Group will indemnify the Plan against, and hold the Plan harmless from, any and all loss, damage, fine, penalty, tax, charge, liability, cost, and expense, including without limitation, attorneys' fees and disbursements, that may be incurred by, imposed upon, paid by or asserted against the Plan which is related to or arises from the Preventive Drug Program.

O. **Limitation of Actions:** No civil action shall be brought to recover on this Group Contract or any individual certificate pursuant to the Group Contract, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of this Group Contract. No such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Plan.

P. **Medicare Secondary Payer ("MSP") Provisions:**
The Group has certain obligations under the MSP statute.

1. For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), the Plan shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and the Plan can effectively coordinate health care payments consistent with the MSP rules. The Group hereby authorizes and directs the Plan to disclose to CMS, periodically, information pertaining to Medicare–eligible Members under the Plan. So that the Plan may make accurate primary/secondary MSP determinations. The Group agrees to timely and accurately respond to the Plan's requests for information.

2. It shall be the Group's responsibility to notify the Plan promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by the Group or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by the Group that place it in, or take it out of, the scope of the MSP statute.

3. The Group acknowledges that the Group shall be responsible for any Civil Money Penalties ("CMP") imposed against the Plan as a result of the Group's failure to promptly notify the Plan of any change in the number of individuals employed by the Group or status of its employees that might affect the order of payment under the MSP statute.

4. **Disclosure Statement**
The Group acknowledges that the Plan has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare as Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administer Medicare.

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Q. Member/Provider Relationship:

1. The choice of a Provider is solely the Member's and the Plan will not interfere with the Member's relationship with any Provider.

2. Providers are not employees, agents or other legal representatives of BCBSNM.

3. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Plan is not liable for any act or omission of any Provider or the agent or employee of any Provider. The Plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Member. Professional services which can only be legally performed by a Provider are not provided by the Plan.

4. The use or nonuse of an adjective such as "Participating" or "Out-of-Network" in modifying the term "Provider" shall in no way be construed as a recommendation, referral, or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use, or non-designation of Participating or Out-of-Network or other similar modifier or the use of a term such as Non-Participating should not be construed as carrying any statement of inference, negative or positive, as to the skill or quality of such Provider.

5. Each Provider provides Covered Services only to the Members and does not otherwise interact with or provide any services to any Group (other than as an individual Member) or any Group's ERISA Health Benefit Program.

6. The Plan may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and guidelines to rate and rank Physicians, and may publish and make available to Group and Members certain Physician-specific information that includes, and is not limited to, ratings, rankings, and other comparisons of a Physician's performance against certain standards, measures and other Physicians. Plan may publish and/or share such information with Group, Members and other third parties. Notwithstanding this or any other provisions of this Group Contract to the contrary, in no event shall any reference or statement by Plan about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee related to future services provided by any Physician or Provider or the anticipated outcome of such services.

R. Member Rights: A Member shall have no rights or privileges except as specifically provided in the Group Contract.

S. Notice: Any notice required under the Group Contract, the Benefit Booklets or any individual certificate will be a written notice. The Plan may provide such notices electronically to the extent permitted by applicable law. If such notice is given to the Group by mail it will be addressed to it at its office address stated in the attached Benefit Program Application, if any, or to its address as it appears on the records of the Group. If such notice is given to the Plan it will be sent to the Plan's address stated in the Benefit Program Application. If such notice is given to the Subscriber by mail, it will be sent to the Subscriber's address as it appears on the records of the Plan or in care of the Group. The Group, the Plan, or a Subscriber may, by written notice, indicate a new address for giving notice.

Premium payments from the Group to the Plan should be addressed to the address specified in the Group billing statement.

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T. Overpayments:

If the Plan pays Benefits under this Group Contract and it is found that the payment was more than it should have been, or was made in error ("Overpayment") the Plan has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such Benefits were paid, or (ii) any insurance company or plan or (iii) any other persons, entities, or organizations, including, but not limited to, Providers. The Plan will follow its recovery processes, including, but not limited to those items described below ("Recovery Process(es)").

Unless otherwise agreed upon between the Plan and a Provider, if no refund is received, the Plan has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

1. any future Benefit payment made to any person or entity under this Group Contract, whether for the same or a different person; or,

2. any future benefit payment made to any person or entity under another Plan-administered self-funded benefit program and/or Plan-administered insured benefit program or policy; or,

3. any future benefit payment made to any person or entity under another Plan-insured group benefit plan or individual policy, or

4. any future benefit payment, other payment, made to any person or entity; or,

5. any future payment owed to one or more Providers; or,

6. for deductions for two (2) or more Overpayments collectively, from future payments owed to another policy or plan as part of a single transaction, resulting in Overpayment recovery amount, which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to offset as otherwise set forth in this Section.

Further, the Plan has the right to reduce this Group Contract's payment to a Provider by the amount necessary to recover another Plan policy's or plan's overpayment to the same Provider and to remit the recovered amount to the other Plan policy or plan. The Group authorizes and agrees to the Plan's recovery of Overpayments in accordance with its Recovery Process, and the Group has no separate or independent right to recover any Overpayments from the Plan, Providers, or another policy or plan.

U. Premium Rebates or Premium Abatements:

Rebate. In the event federal or state law requires BCBSNM to rebate a portion of annual premiums paid, BCBSNM will provide any rebate as required or allowed by such federal or state law.

Abatement. BCBSNM may from time to time determine to abate (all or some of) the premium due under the Group Contract for particular period(s). "Abatement" for purposes of this section shall include suspension or deferral of premium payment.

Any abatement of premium by BCBSNM represents a determination by BCBSNM not to collect premium for the applicable period(s) and does not affect a reduction in the rates under the Group Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

Administrative. The Group hereby gives the Plan assurances that the Group is obligated to, and will, pay or credit such rebates or abatements to its Subscribers to the extent and in the manner required by applicable law. The Group shall provide BCBSNM with any

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information, records and documentation that BCBSNM may require or request with regard to the subject matter of this Section in a time, form and manner specified by BCBSNM.

BCBSNM will rely upon such information, records and documentation as accurate and complete.

BCBSNM makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of the Group and any Subscriber or former Subscriber (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations. The Employer shall assure appropriate notification to federal and state tax agencies and that any payment to the Subscriber and former Subscribers (if applicable) will be accompanied by appropriate federal and state documentation, e.g., Form 1099 or W-2.

The Group agrees to indemnify and hold BCBSNM harmless against any and all claims, demands, costs, fines, losses, interest, settlements, judgments, damages, penalties, taxes, expenses (including reasonable attorneys' fees) or other liabilities resulting from the Employer's failure to carry out its responsibilities or obligations as set forth in this Section of this Group Contract.

V. Proprietary Materials:

1. Types of materials as may be used by the Parties. The Group acknowledges that the Plan has developed, acquired, or owns certain Business Confidential Information. "Business Confidential Information" includes, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures and any other information that reasonably should be understood to be confidential whether developed or acquired before or after the Group Contract Date of this Group Contract. "Business Confidential Information" also includes modifications, enhancements, derivatives, and improvements of the Business Confidential Information described in the preceding sentence.

The Group shall not use or disclose to any third-party Business Confidential Information without prior written consent of the Plan. If the Group believes it is required by law to disclose Business Confidential Information of the Plan, it shall provide written notice to the Plan, so that the Plan has the opportunity to object and ensure appropriate confidentiality protections are in place.

Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Plan may include the Group in its list of clients.

2. BCBSNM/Association Ownership. The Group acknowledges that the Plan's Proprietary Marks and Business Confidential Information are the sole property of

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the Blue Cross and Blue Shield Association or of the Plan and agrees not to contest the Blue Cross and Blue Shield Association's or the Plan's ownership or the license granted to the Plan for use of such Proprietary Marks.

W. Renewability of the Group Contract: The Group Contract shall be renewable at the option of the Group to all Subscribers except in the following instances:

1. Non-payment of required premiums;

2. An intentional fraudulent act or practice or intentional misrepresentation by the Group;

3. Noncompliance with BCBSNM's minimum participation requirements, if any;

4. Noncompliance with BCBSNM's Group contribution requirements, if any;

5. Termination of the benefit plan in accordance with the "Discontinuance of A Particular Product" provision in this Group Administration Document;

6. In the case of a network plan, when there is no longer any Subscriber in connection with the Plan who lives, resides or works in the BCBSNM Service Area or in the area in which BCBSNM is authorized to do business;

7. Cessation of the Group's membership in a bona fide association, but only if coverage is terminated uniformly without regard to the health status of any Subscriber; or

8. Where otherwise permitted by applicable law or regulatory guidance.

X. Separate Financial Arrangements Regarding Prescription Drugs:

1. Separate Financial Arrangements with Participating Prescription Drug Providers:
The Group's experience account under the Group Contract, if any, the maximum amount of Benefits payable by BCBSNM and all required Deductible and/or Coinsurance amounts under the Group Contract shall be calculated on the basis of the Provider's billed charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and BCBSNM, whichever is less.

BCBSNM hereby informs the Group and all Members that the Plan has contracts, either directly or indirectly, with prescription drug providers (''Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including the Members under the Group Contract, and that pursuant to BCBSNM's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, BCBSNM may receive discounts for prescription drugs dispensed to Members under the Group Contract.

The Group understands that BCBSNM may receive such discounts during the term of the Group Contract. Coinsurance is based on Covered Charges for Covered Services. BCSBNM will apply discounts as required by NMSA 59A-23-12.3.

2. Separate Financial Arrangements with Pharmacy Benefit Managers:
BCBSNM hereby informs the Group and all Members that the Plan owns a significant portion of the equity of Prime Therapeutics, LLC and that BCBSNM has entered into one or more agreements with Prime Therapeutics, LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the

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provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSNM is a party, including the Members under the Group Contract. Pharmacy Benefit Managers and BCBSNM have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, the mail-order pharmacy and specialty pharmacy shall be operated through a third party, which may be an affiliate or partially owned by Prime Therapeutics, LLC. Pharmacy Benefit Managers may share a portion of those rebates with BCBSNM.

The Group understands that BCBSNM may receive such rebates during the term of the Group Contract. BCBSNM will apply those rebates as required by NMSA 59A-23-12.3.

Y. **Service Mark:** On behalf of the Group and its Members, the Group hereby expressly acknowledges its understanding that the Group Contract constitutes a contract solely between the Group and BCBSNM. BCBSNM is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The Association permits BCBSNM to use the Blue Cross and Blue Shield Service Mark(s) in BCBSNM's Service Area and BCBSNM is not contracting as the agent of the Association. The Group further acknowledges and agrees that it has not entered into the Group Contract based upon representations by any person other than authorized persons of BCBSNM and that no person, entity or organization other than BCBSNM shall be held accountable or liable to the Group for any of BCBSNM's obligations to the Group created under the Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNM, other than those obligations created under other provisions of this Group Contract.

Z. **Severability:** In case any one or more of the provisions contained in the Group Contract shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of the Group Contract and the Group Contract shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

AA. **Providing Data to Group's Vendors:**

1. If the Group directs the Plan to provide data directly to the Group's third-party consultant and/or vendor (the "Group's Vendor"), and the Plan agrees in its sole discretion, the Group acknowledges and agrees that it shall require the Group's Vendors to execute the Plan's then-current data exchange agreement as required by the Plan. The Group hereby acknowledges and agrees, and Group's Vendor(s) shall acknowledge and agree:

a. That the requested documents, records and other information (for the purposes of this Section, "Confidential Information") are proprietary and confidential in nature and that the release of Confidential Information may reveal the Plan's Business Confidential Information.

b. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for the purposes of this Section, collectively, "Information") and to prevent unauthorized use or disclosure by Group's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under the

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Group Contract, to the same extent that it protects its own Confidential Information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed and consistent with the Inter-Plan provisions of this Group Contract.

d. To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

e. To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

f. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of the contract or as required by law.

g. To not sell, re-sell or lease the Information.

h. To securely return or securely destroy the Information at the direction of the Plan or within a reasonable time after the termination of this Group Contract, not to exceed sixty (60) days thereafter.

i. To notify the Plan in the event of any unauthorized access, impermissible disclosure or breach of the Group's Information.

2. Group shall:

a. Provide the Plan in writing the names of any Group's Vendor(s) with whom the Plan is authorized to release, disclose, or exchange data, and provide written authorization and specific directions with respect to such release, disclosure, or exchange for Plan administration functions. If Group's Vendor(s) is/are under contract to perform services that that are not considered Plan administration functions and involve the use, access, or disclosure of Protected Health Information as defined by HIPAA, the Plan shall execute a HIPAA compliant Insured Group Certification ("IGC") that identifies Group's Vendor(s) and includes the other information requested in the IGC.

b. Indemnify, defend (at the Plan's request), and hold harmless the Plan and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Plan in connection with any claim based upon the Plan's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Group's Vendor(s), if consistent with Group's directions, of any information and/or documentation or breach by Group's Vendor(s) of any obligation described in the Group Contract. In lieu of defense by the Group, the Plan shall have the option, at its sole discretion to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Group.

BB. Dispute Resolution

Any dispute arising out of or related to this Group Contract shall be resolved in accordance with the procedures specified in this section. This section shall not apply to disputes with

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or appeals or grievances brought by Subscribers or Members covered under this Group Contract.

1. **Initial Notice and Negotiation.** The Group or the Plan shall give written notice to the other party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the parties shall seek to resolve that dispute through informal discussions between authorized representatives of the parties with appropriate authority to approve any resolution. All negotiations pursuant to this section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

2. **Confidential Arbitration.** In the event the parties fail to agree with respect to any matter covered herein and only after making good faith efforts to resolve any dispute under this Group Contract under this section, the Group or the Plan may submit the dispute to confidential, binding arbitration before the American Arbitration Association ("AAA"), subject to the following:

   a. For matters in which the amount in controversy is $10,000 or less, the Plan shall select an arbitrator. For matters in which the amount in controversy exceeds $10,000, the arbitration shall be conducted by a single arbitrator selected by the parties from a list furnished by the AAA. If the parties are unable to agree on an arbitrator from the list, AAA shall appoint an arbitrator.

   b. Arbitration shall be held in Albuquerque, New Mexico.

   c. Arbitration proceedings will be governed by the AAA Commercial Rules.

   d. The arbitrator shall be required to issue a written opinion resolving all disputes in any matter and designating one party as the prevailing party, regardless of the amount in controversy.

   e. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction over the dispute.

   f. The arbitrator's fees and any costs imposed by the arbitrator will be shared equally by the parties. All costs and expenses, including but not limited to reasonable attorney and witness fees shall be borne by the non-prevailing party or as apportioned by the arbitrator.

   g. This provision precludes the Employer from filing an action at law or in equity and from having any dispute covered by this Group Contract heard by a judge or jury.

   h. Except as may be required by law, neither a party nor an arbitrator may disclose the existence, content, or results of any arbitration pursuant to this Section without the prior written consent of both parties.

3. Nothing in this Section is related to individual member rights or prevents a party from electing to bring an action or seek remedy as available to them, as provided by law.

4. Except as provided otherwise in this Group Contract, each party is required to continue to perform its obligations under this Group Contract pending final resolution of any dispute arising out of or relating to this Group Contract.

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XII. OUT-OF-AREA SERVICES

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

Typically, when accessing care outside the geographic area the Plan serves, Members obtain care from health care Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from health care providers in the Host Blue geographic area that do not have a contractual agreement ("Non-participating Providers") with the Host Blue. The Plan remains responsible for fulfilling our contractual obligations to Members. The Plan's payment practices in both instances are described below.

A. BlueCard® Program

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

Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of Subscriber liability on claims for Covered Services will be based on the lower of the Participating Provider's billed charges for Covered Services or the negotiated price made available to the Plan by the Host Blue.

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

1. An actual price. An actual price is a negotiated rate of payment in effect at a time a claim is processed without any other increases or decreases; or
2. 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
3. An average price. An average price is a percentage of billed charges for Covered Services 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.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be

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received from Providers). However, the BlueCard® Program requires that the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The method of claims payment by Host Blues is taken into account by the Plan in determining your premiums.

B. Special Cases: Value-Based Programs

BlueCard® Program
The Plan has included a factor for bulk distributions from Host Blues in the Group's premium for Value-Based Programs when applicable under this Group Contract.

C. Return of Overpayments
Recoveries from a Host Blue or its participating and non-participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recovery amounts determined in the ways noted above will generally require correction on a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Group Account, they will be credited to the Plan. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

D. 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 insured accounts. If applicable, the Plan will include any such surcharge, tax or other fee in determining the Group's premium.

E. Non-participating Providers Outside the Plan's Service Area

1. Subscriber's Liability Calculation
Payments for out-of-network emergency services will be governed by applicable federal and state law. The Subscriber cannot be balance billed for emergency care from a non-participating provider. When Covered Services are provided outside of the Plan's Service Area by non-participating Providers, the amount(s) a Subscriber pays for such services will generally be based on either the Host Blue's non-participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Subscriber may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

2. Exceptions
In some exception cases, the Plan may pay claims from non-participating healthcare Providers outside of the Plan's Service Area based on the Provider's billed charge. This may occur in situations where a Subscriber did not have reasonable access to a Participating Provider, as determined by the Plan to be in compliance with applicable state law, or as required by the New Mexico Office of the Superintendent of Insurance. In other exception cases, at the Group's direction, the Plan may pay such claims based on the payment the Plan would make if the Plan were paying a non-participating Provider inside of the Plan's Service Area. This may occur where the Host Blue's corresponding payment would be more than the Plan's in-Service Area non-participating Provider payment. The Plan may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in these exception situations, the Member may be responsible for the difference between the amount that the non-participating

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healthcare Provider bills and payment the Plan will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

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 Blue Cross Blue Shield Global® Core when accessing Covered Services. Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although 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.

2. Inpatient Services

In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Members claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services.

3. Outpatient Services

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

4. Submitting a Blue Cross Blue Shield Global® Core Claim

When Members pay for Covered 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 claim form and send the claim form with the Provider's itemized bill(s) to the service center (address on the form) to initiate claims processing. The claim form is available from Blue Cross and Blue Shield of New Mexico, the service center or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

XIII. NOTICE OF ANNUAL MEETING

The Group is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of members of said Company. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The Plan pays indemnification or advances expenses to directors, officers, employees, or agents consistent with the Plan's bylaws then in force and as otherwise required by applicable law.

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For purposes of the aforementioned paragraph, the term "member" means the group, trust, association or other entity to which the Group Contract has been issued. It does not include Members under the Group Contract. Further, for purposes of determining the number of votes to which the Group may be entitled, any reference to "premium(s)" shall mean "charge(s)."

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Blue Cross and Blue Shield of New Mexico (BCBSNM) has developed a standard Group Administration Document (GAD) that describes the administrative services and the roles and responsibilities of BCBSNM and a group customer client. BCBSNM's bid is conditioned upon the group's agreement to the terms and conditions of BCBSNM's GAD. While we are unable to modify the GAD and the Benefit Program Application (BPA), due to state regulations and legislation, we are able to modify the benefit booklet(s) and any other applications, schedule(s) or coverage, riders, enclosures, addenda, exhibits and amendment to any of them, and our contract offerings in other ways in order to incorporate mutually agreed upon benefits and services requested to meet City of Albuquerque's needs and expectations. Please note these additional terms and conditions may be subject to approval by the New Mexico Office of the Superintendent of Insurance.

CITY OF ALBUQUERQUE TERMS AND CONDITIONS

IMPORTANT NOTICE: BY COMMENCING SERVICES OR PROVIDING GOODS UNDER THIS CONTRACT OR PURCHASE ORDERS, SUPPLIER ACCEPTS ALL TERMS AND CONDITIONS HEREIN

1. **Contract:** The Contractor accepts these Terms and Conditions and agrees that, to the extent Contractor's terms conflict, these Terms and Conditions shall govern. These Terms and Conditions, the specifications for goods or services (if applicable), and any non-conflicting Contractor terms and conditions shall constitute and be referred to as "this Contract."

   (a) If the City and Contractor have executed an agreement (two-party agreement) that includes terms and conditions related to the goods or services, the provisions of that two-party agreement shall govern and control in the event of a conflict between these Terms and Conditions and that two-party agreement.

   (b) If the City issues a procurement contract, these Terms and Conditions shall control. Any different or additional terms that are found in any quotes, estimates, purchase order acknowledgements, on a web site, or otherwise are superseded by these Terms and Conditions and will be of no force or effect unless agreed to in writing by both the City and the Contractor.

   (c) If this Contract results from a Request for Bids (RFB) or Request for Quotes (RFQ), these Terms and Conditions and the RFB or RFQ shall govern. If there is a conflict between these Terms and Conditions and the RFB or RFQ, the RFB or RFQ shall control. In the event of inconsistencies or contradictions between language contained in the RFB or RFQ, and the bid or quote submitted in response, the RFB or RFQ will prevail, followed by these Terms and Conditions.

2. **Invoices and Payments:**

   (a) The Contractor shall include the Department name and complete purchase order number on all invoices, packing slips, shipping notices, freight bills, and correspondence concerning the order. Invoices shall be sent to one of the following: Trancepta: abq.invoices@submit.transcepta.com; Accounting email: Accounts.payable@cabq.gov; or, regular mail: PO Box 1985, Albuquerque, NM 87103. Visit the Accounting website for more information about getting invoices paid: https://www.cabq.gov/dfa/accounting/how-do-i-get-paid

   (b) Unless otherwise stated, the Contractor shall not receive any compensation until all services have been completed or goods received, final inspection has been made, the goods or services have been accepted by an authorized representative of the City, and complete and correct invoices have been received by the City following the invoicing process detailed herein.

3. **Taxes:** The Contractor is responsible for determining whether taxes are applicable to the order, and for payment of the tax. Applicable taxes shall be included in each invoice and may not be billed more than sixty (60) days after providing the goods or services to which the taxes apply.

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4. **Payment:** The City's payment terms are net thirty (30) days unless otherwise stated. The City shall not pay late fees, finance fees, or collection fees. Any Contractor that accepts payments by credit card on behalf of the City must be Payment Card Industry Data Security Standard compliant.

5. **Title:** Title to all goods and services provided pursuant to this Contract shall pass to the City at the time of payment free and clear of all liens, claims, security, interest and encumbrances.

6. **No Cost Plus:** Pursuant to Section 5-5-9(B) of the Purchasing Ordinance, the City shall not enter into any contract which is a cost-plus-percentage of cost contract.

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7. **Responsibility to Monitor Contract:** The Contractor shall ensure that it does not bill for goods or services in an amount that exceeds the total contract amount. If at any time the Contractor determines that payment for goods or services may or will exceed the total amount provided in this Contract, the Contractor shall notify the City in writing, as soon as possible after making that determination. If the Contractor's billing exceeds the amount of this Contract, the City may stop or delay payment.

8. **Price Escalation*:*** A request for escalation of Contract pricing may be made under the following conditions:

(a) Offered prices must be firm for a least ninety (90) consecutive calendar days after written notification of a Contract.

(b) The Contractor shall provide written notice to the City of any requested price increases.

(c) All requests for price increases shall be accompanied by:

1) a letter from the Contractor's supplier certifying the price increase to the Contractor; or

2) evidence of verifiable market conditions resulting in increased costs such as mandated labor rate increases and significant fuel or energy cost increases.

(d) All revisions to Contract pricing shall become effective after they are approved by the City.

(e) All supplier invoices shall be subject to auditing by the City and furnished without delay upon request.

(f) The City reserves the right to cancel a Contract and solicit a new contract if a requested price escalation is unacceptable to the City. Cancellation of this Contract shall not affect any outstanding orders.

(g) All approved price changes resulting from this escalation clause shall be firm for a period of ninety (90) consecutive calendar days after approval by the City.

(h) The Contractor shall notify the City within five (5) working days of subsequent price de-escalations from its supplier or cost reductions in areas where pricing increases were previously implemented. The Contractor will reduce its pricing to the City immediately to pass on such de- escalations and reductions unless otherwise agreed by the parties.

(i) All approvals required by this subsection must be in writing by the City Chief Procurement Officer or designee.

9. **Termination for Cause:** If, for any reason, the Contractor fails to fulfill its obligations under this Contract in a timely and proper manner, or if the Contractor violates any provision of this Contract, the City has the right to terminate this Contract by giving written notice of the termination to the Contractor and specifying a termination effective date at least thirty (30) days after notice is provided. In such event, all finished or unfinished documents, data, maps, studies, surveys, drawings, models, photographs, and reports prepared by the Contractor under this Contract shall, at the option of the City, become the City's property, and the Contractor shall be entitled to receive just and equitable compensation for any services satisfactorily completed or goods received under this Contract. Notwithstanding any other provision of this section, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Contract by the Contractor,

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and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

10. **Termination for the Convenience of the City:** The City may terminate this Contract at any time by giving at least fifteen (15) consecutive calendar days' notice in writing of such termination to the Contractor. In such event, the Contractor shall be paid under the terms of this Contract for all goods or services provided to and accepted by the City, if ordered or accepted by the City prior to the effective date of termination.

11. **Termination for Lack of Appropriations:** Notwithstanding any other provision in this Contract, the terms of this Contract are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Contract. If sufficient appropriations and authorizations are not made by the City Council, or if the City Council un-appropriates or deauthorizes funds during a fiscal year, this Contract may be terminated upon thirty (30) days' written notice given by the City to all other parties to this Contract. Such event shall not constitute an event of default. All payment obligations of the City and all of its interest in this Contract will cease upon the date of termination. The City's determination as to whether sufficient appropriations are available or have been made shall be accepted by all parties and shall be final.

12. **FOB Destination and Inspection:** The risk of loss, injury and destruction, and legal title to the goods remains with the Contractor until the goods reach the location of the City. All goods delivered are subject to inspection upon receipt by City. The City's count will be accepted by the Contractor as final and conclusive on all shipments not accompanied by a packing slip. All rejected goods shall remain the property of the Contractor and will be returned at the Contractor's expense.

13. **Responsibility for Damage:** The Contractor shall be responsible for any damage caused during removal or installation services or at any time during the performance of this Contract. Damage shall be reported immediately to the designated City representative.

14. **Removal of Debris and Cleaning the Area:** The Contractor shall, during the progress of any services, remove and dispose of all debris and keep the work premises clean and safe. When the services are complete, the Contractor shall remove all construction equipment and surplus materials (except materials that are to remain the property of the City) and leave the premises in a clean condition satisfactory to the City.

15. **Risks:** All risks of deterioration, destruction, and loss of materials and equipment stored at the site of the services shall be borne by the Contractor.

16. **Working Conditions:** The City is not responsible for obstacles, unfavorable conditions, or hazards, which may be encountered by the Contractor, both above and below ground. These conditions are part of the risk and responsibility of the Contractor.

17. **Inspections:**

(a) The City reserves the right to inspect materials provided by the Contractor to determine their quality, fitness and suitability. Inspection of these materials may be conducted whenever the City considers it necessary.

(b) All goods or services found inferior to the quality specified, deficient, or incorrect in weight, measurement, workmanship, handicraft or otherwise, may be rejected as a whole or in part and then shall be removed by the Contractor at the Contractor's own risk and expense promptly after notice of rejection. The Contractor shall assume responsibility for taking the necessary action to correct or replace the rejected items, within the time frame specified in the notice of rejection.

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18. **Warranties:** All materials furnished by the Contractor shall be free from defects and imperfections. Workmanship shall be in accord with the best industry standards and practices. Both materials and workmanship shall be subject to the approval of the City.

(a) Materials furnished by the Contractor shall be accompanied by the manufacturer's written warranty against defects in quality, craftsmanship, and materials. The Contractor shall provide any such warranties prior to award of this Contract.

(b) The Contractor agrees that the goods or services furnished under this Contract shall be covered by the most favorable commercial warranties the Contractor gives to any customer for such items. Further, the Contractor agrees that the rights and remedies provided in such warranties extend to the City and are in addition to and do not limit any rights afforded to the City. The Contractor agrees not to disclaim warranties of fitness for a particular purpose of merchantability. Warranties shall become effective at the time of acceptance of the goods or services

(c) The Contractor guarantees that the materials supplied are capable of the performance required and agrees to make such changes, adjustments or replacements as are immediately necessary in order for the materials to meet the requirements at no cost to the City. If defects or specification failures are discovered, the City shall have the right, notwithstanding acceptance and payment, to require the unit or item to be properly furnished in accordance with the Specifications and applicable drawings at the cost and expense of the Contractor or the Contractor's surety.

19. **New Material:** All materials, supplies, equipment, and vehicles provided shall be new, the latest in production and manufactured within the last twelve (12) months (computed from the date and time of bid opening) unless otherwise indicated. This does not apply to materials, supplies, equipment or vehicles used by the Contractor to provide the required items of tangible personal property, services or construction.

20. **Delivery, Acceptance and Guarantee:**

(a) No Delivery before Purchase Order is Issued: Contractor shall not deliver goods or commence services prior to the issuance of a Purchase Order or other notice to proceed issued by the City.

(b) Cancellation for Non-Delivery: The City reserves the right to cancel any order not delivered by a guaranteed date stipulated in this Contract without liability on the City's part.

(c) Acceptance of Delivery: Acceptance by the City of any delivery shall not relieve the Contractor of any guarantee or warranty, expressed or implied. Such acceptance of delivery shall not be considered an acceptance of services or goods not in accordance with the Specifications. Such acceptance of delivery shall not waive the City's right to require replacement of defective material or inadequate service.

21. **Debarment, Suspension, Ineligibility and Exclusion Compliance.** The Contractor certifies that it has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Contractor agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor during the term of this Contract, the Contractor will notify the City immediately.

22. **Conflict of Interest**: No officer, agent or employee of the City will participate in any decision relating to this Contract which affects that person's financial interest, the financial interest of his or her spouse

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or minor child or the financial interest of any business in which he or she has a direct or indirect financial interest.

23. **Interest of Contractor:** The Contractor agrees that it presently does not have, and shall acquire no direct or indirect interest which conflicts in any manner or degree with the performance of the terms of this Contract. The Contractor will not employ any person who has any such conflict of interest to assist the Contractor in performing the Services.

24. **No Collusion:** The Contractor represents that this Contract is entered into by the Contractor without collusion on the part of the Contractor with any person or firm, without fraud, and in good faith. The Contractor also represents that no gratuities, in the form of entertainment, gifts or otherwise, were, or will be, offered or given by the Contractor or any agent or representative of the Contractor, to any officer or employee of the City for the purpose or with the intention of securing: this Contract; a subsequent Agreement; more favorable treatment with respect to this Contract; or more favorable treatment with respect to making any determinations regarding performance under this Contract.

25. **Discrimination Prohibited, Civil Rights Compliance:** The parties hereto shall not discriminate against any person on the basis of race, color, religion, sex, gender, gender identity, sexual orientation, pregnancy, childbirth or condition related to pregnancy or childbirth, spousal affiliation, national origin, ancestry, age, physical or mental handicap or serious medical condition, or disability as defined in the Americans With Disabilities Act of 1990, as now enacted or hereafter amended. The Contractor agrees to comply and act in accordance with all provisions of the Albuquerque Human Rights Ordinance, the New Mexico Human Rights Act, Titles VI and VII of the U.S. Civil Rights Act of 1964, as amended, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and all federal, New Mexico and City laws and rules related to the enforcement of civil rights. Questions regarding civil rights or affirmative action compliance requirements should be directed to the City's Office of Civil Rights.

26. **Americans with Disabilities Act Compliance:** The Contractor agrees to meet all the requirements of the Americans With Disabilities Act of 1990, and all applicable rules and regulations (the "ADA") that are imposed directly on the Contractor or that would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify, and hold harmless the City, its officials, agents, and employees from and against any and all claims, actions, suits, or proceedings of any kind brought against any of those parties as a result of any act or omission of the Contractor or its agents in violation of the ADA.

27. **Goods Produced Under Decent Working Conditions:** It is the policy of the City not to purchase, lease, or rent goods for use, or for resale at City-owned enterprises, that were produced under sweatshop conditions. The Contractor certifies that any goods offered to the City were produced under decent working conditions. The City defines "under decent working conditions" as production in a factory in which child labor and forced labor are not employed; in which adequate wages and benefits are paid to workers; in which workers are not required to work more than 48 hours per week (or less if a shorter workweek applies); in which employees are free from physical, sexual or verbal harassment; and in which employees can speak freely about working conditions and can participate in and form unions. [Council Bill No. M-8, Enactment No. 9-1998].

28. **Graffiti Free:** The Contractor will be required to furnish graffiti free equipment, facilities or other items as may be required to complete the services. Failure of the Contractor to comply with this requirement may result in a cancellation of this Contract.

29. **Independent Contractor:** Neither the Contractor nor its employees are considered to be employees of the City for any purpose whatsoever. The Contractor is considered as an independent contractor at all times in performing its obligations under this Contract. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers'

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Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

30. **Reports and Information:** At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Contract. Unless otherwise authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to this Contract until the final product is submitted to the City.

31. **Establishment and Maintenance of Records:** Records shall be maintained by the Contractor in accordance with applicable laws and requirements prescribed by the City with respect to all matters covered by this Contract. Except as otherwise authorized by the City, such records shall be maintained for a period of four (4) years after receipt of final payment under this Contract.

32. **Ownership, Publication, Reproduction and Use of Material:**. No material produced in whole or in part under this Contract shall be subject to copyright in the United States or in any other country. The City shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Contract.

33. **Public Records:** The parties acknowledge that the City is a government entity subject to the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq., NMSA 1978). Notwithstanding any other provision of this Contract, the City shall not be responsible to the Contractor for any disclosure of Confidential Information pursuant to that Act or pursuant to the City's public records act laws, rules, regulations, instructions or any other legal requirement.

34. **Force Majeure:** The City shall not be liable for failure to perform its obligations under this Contract, for any loss or damage of any kind, or for any consequences resulting from delay or inability to perform, due to causes beyond the reasonable control and without the fault or negligence of the City. Such causes ("Force Majeure Events") include, but are not restricted to: acts of God or the public enemy; acts of State, Federal or local governments; shortage or inability to obtain materials; breakdowns or delays of carriers, manufacturers, or suppliers; freight embargoes; theft; fire; flood; epidemics or pandemics; quarantine restrictions; strikes; lockouts; unusually severe weather; and defaults of subcontractors due to any of the above. If a Force Majeure Event causes any failure to perform, the City shall promptly inform the Contractor in writing of such event, indicating the expected duration thereof and the period for which suspension in performance is requested. The parties shall consult with each other in good faith with respect to modification of this Contract to reflect such suspension or other changes (if any) desired by the City as a result thereof. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this Contract.

35. **Indemnity:** The Contractor agrees to defend, indemnify, and hold harmless the City and its officials, agents, and employees from and against any and all claims, suits, demands, actions, or proceedings of any kind brought against any of those persons because of any injury or damage received or sustained by any person, persons, or property, which injury is arising out of or resulting from the Contractor's provision of goods or services under this Contract, or by reason of any asserted act or omission, neglect, or misconduct of the Contractor or Contractor's agents, employees or subcontractors, or the agents or employees of any subcontractor of Contractor, whether direct or indirect. The defense and indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Contract.

36. **Patent Indemnity:** If any item furnished pursuant to this Contract shall be covered by any patent, copyright, or application for patent or copyright, the Contractor shall defend, indemnify and save harmless the City from any and all loss, cost or expense or any all claims suits, or judgments as a

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result of the use of such item in violation of rights under such patent, copyright, or application for patent or copyright.

37. **Insurance.** Unless this requirement has been waived by the City's Risk Manager, the Contractor shall procure and maintain at its expense until final payment by the City insurance in the kinds and amounts listed below with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Contract, whether performed by it or its agents. Before commencing services, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days written notice be given to:

Risk Manager, Department of Finance and Administrative Services City of Albuquerque
P.O. Box 470
Albuquerque, New Mexico 87I03

before a policy is cancelled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided. The kinds and amounts of insurance required are set out below and additional insurance may be required as set out in the Specifications or Solicitation Instructions.

(a) Commercial General Liability Insurance: A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$2,000,000	Per Occurrence
$2,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage shall specifically insure the hold harmless provisions of this Contract.

(b) Automobile Liability Insurance: An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

(c) Workers' Compensation Insurance: Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico (the "Act"). If the Contractor employs fewer than three employees and has determined that he is not subject to the Act, the Contractor will certify, in a signed statement, that the Contractor is not subject to the Act. The Contractor will notify the City and comply with the Act if he becomes subject to the Act during the term of this Contract.

(d) Increased Limits. If, during the term of this Contract, the City requires the Contractor to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Contractor's compensation will be made.

38. **Audits and Inspections:** At any time during normal business hours and as often as the City may deem necessary, the Contractor shall make all of the Contractor's records with respect to all matters

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covered by this Contract available to the City for examination. The Contractor shall allow the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment, and other data related to all matters covered by this Contract. The Contractor understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. and Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and to appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 9 of the Albuquerque City Charter.

39. **Assignment, Transfer and Subcontracting:** The Contractor shall not assign, transfer or subcontract any portion of this Contract without the express written consent of the City. Any goods or services subcontracted hereunder shall be specified by written contract or agreement and shall be subject to each provision of this Contract.

40. **Construction and Severability:** If any part of this Contract is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Contract so long as the remainder of this Contract is reasonably capable of completion.

41. **Enforcement:** The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Contract.

42. **Compliance with Laws:** The Contractor shall, in performance of this Contract, fully comply with all applicable federal, state, or local laws, rules and regulations.

43. **Governing Law/Venue:** This Contract is governed by and construed and enforced in accordance with the laws of the State of New Mexico and the City of Albuquerque. The venue for actions arising in connection with this Contract is Bernalillo County, New Mexico.

44. **Use by Other Public Governmental Agencies**: With the agreement of the Contractor, other public governmental agencies may purchase from this Contract, unless otherwise stated, subject to the following:

(a) Extension of the use of this Contract shall in no way impede on the Contractor's ability to fulfill the pricing, terms and conditions of this Contract with the City; and

(b) The City shall have no responsibility to verify whether the other public governmental agency is a legitimate entity to which it may extend this option or whether the entity is authorized under its applicable laws, rules and regulations to use this Contract.

45. **Federal Contract Requirements:** All Contractors with contracts or purchase orders funded in whole or in part with federal funds are required to comply with 2 CFR Part 200, Appendix II. By commencing services or providing goods under this Contract, the Contractor certifies compliance with the following, as applicable.

(a) Equal Employment Opportunity. This provision shall apply to all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3.

(1) The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following:

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Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

(2) The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(3) The Contractor will not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This provision shall not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.

(4) The Contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the Contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(5) The Contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(6) The Contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(7) In the event of the Contractor's noncompliance with the nondiscrimination clauses of this Contract or with any of the said rules, regulations, or orders, this Contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(8) The Contractor will include the portion of the sentence immediately preceding paragraph (1) and the provisions of paragraphs (1) through (8) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to section 204 of Executive Order 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance:

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(9) Provided, however, that in the event a Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the administering agency, the Contractor may request the United States to enter into such litigation to protect the interests of the United States.

(10) The Contractor further agrees that it will be bound by the above equal opportunity clause with respect to its own employment practices when it participates in federally assisted construction work: Provided, that if the applicant so participating is a State or local government, the above equal opportunity clause is not applicable to any agency, instrumentality or subdivision of such government which does not participate in work on or under this Contract.

(11) The Contractor agrees that it will assist and cooperate actively with the administering agency and the Secretary of Labor in obtaining the compliance of contractors and subcontractors with the equal opportunity clause and the rules, regulations, and relevant orders of the Secretary of Labor, that it will furnish the administering agency and the Secretary of Labor such information as they may require for the supervision of such compliance, and that it will otherwise assist the administering agency in the discharge of the agency's primary responsibility for securing compliance.

(12) The Contractor further agrees that it will refrain from entering into any contract or contract modification subject to Executive Order 11246 of September 24, 1965, with a contractor debarred from, or who has not demonstrated eligibility for, Government contracts and federally assisted construction contracts pursuant to the Executive Order and will carry out such sanctions and penalties for violation of the equal opportunity clause as may be imposed upon contractors and subcontractors by the administering agency or the Secretary of Labor pursuant to Part II, Subpart D of the Executive Order. In addition, the applicant agrees that if it fails or refuses to comply with these undertakings, the administering agency may take any or all of the following actions: cancel, terminate, or suspend in whole or in part this grant (contract, loan, insurance, guarantee); refrain from extending any further assistance to the applicant under the program with respect to which the failure or refund occurred until satisfactory assurance of future compliance has been received from such applicant; and refer the case to the Department of Justice for appropriate legal proceedings.

(b) Davis Bacon Act. This provision shall be applicable to all prime construction contracts in excess of $2,000.

(1) All transactions regarding this contract shall be done in compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) and the requirements of 29 CFR Part 5, as may be applicable.

(2) The Contractor shall: comply with 40 U.S.C. 3141-3144, and 3146-3148 and the requirements of 29 C.F.R. Part 5, as applicable; pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor; pay wages not less than once a week; and report all suspected or reported violations of these laws to the City, which will report the same to the Federal awarding agency.

(c) Copeland "Anti-Kickback" Act. This provision shall be applicable to all prime construction contracts in excess of $2,000.

(1) Contractor shall comply with 18 U.S.C. §874, 40 U.S.C. §3145, and the requirements of 29 CFR Part 3, as may be applicable, which are incorporated by reference into this contract.

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(2) The Contractor or Subcontractor shall insert in any subcontracts the clause above and such other clauses as the applicable federal agency may by appropriate instructions require, and also a clause requiring the subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for the compliance by any subcontractor with all of these contract clauses.

(3) A breach of this Contract clauses above may be grounds for termination of this contract, and for debarment as a contractor or subcontractor as provided in 29 CFR §5.12.

(d) Contract Work Hours and Safety Standards Act. These provisions shall apply to all contracts over $100,000 that involve mechanics or laborers.

(1) The Contractor shall comply with 40 U.S.C. §§ 3702 and 3704, and the requirements of 29 CFR Part 5.

(2) Overtime requirements. No Contractor or subcontractor contracting for any part of this Contract work which may require or involve the employment of laborers or mechanics shall require or permit any such laborer or mechanic in any workweek in which he or she is employed on such work to work in excess of forty hours in such workweek unless such laborer or mechanic receives compensation at a rate not less than one and one-half times the basic rate of pay for all hours worked in excess of forty hours in such workweek.

(3) Violation; liability for unpaid wages; liquidated damages: In the event of any violation of the clause set forth in paragraph (b)(1) of 29 CFR §5.5, the Contractor or any subcontractor responsible therefor shall be liable for the unpaid wages. In addition, such contractor and subcontractor shall be liable to the United States, for liquidated damages. Such liquidated damages shall be computed with respect to each individual laborer or mechanic, including watchmen and guards, employed in violation of the clause set forth in paragraph (b)(1) of 29 CFR §5.5.

(4) Withholding for unpaid wages and liquidated damages: The City shall upon its own action or upon written request of an authorized representative of the Department of Labor withhold or cause to be withheld, from any moneys payable on account of work performed by the Contractor or subcontractor under any such contract or any other federal contract with the same prime contractor, or any other federally- assisted contract subject to the Contract Work Hours and Safety Standards Act, which is held by the same prime contractor, such sums as may be determined to be necessary to satisfy any liabilities of such Contractor or subcontractor for unpaid wages and liquidated damages as provided in the clause set forth in paragraph (b)(2) of 29 CFR §5.5.

(5) Subcontracts: The Contractor or subcontractor shall insert in any subcontracts the clauses set forth in paragraphs (b)(1) through (4) of 29 CFR §5.5, and also a clause requiring the subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for compliance by any subcontractor or lower tier subcontractor with the clauses set forth in paragraphs (b)(1) through (4) of 29 CFR §5.5.

(e) Rights to Inventions Made under a Contract or Agreement. These provisions shall apply to all funding agreements under 37 CFR § 401.2(a). If the federal award meets the definition of “funding agreement” under 37 CFR §401.2(a) and the City wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that “funding agreement,” the City and Contractor must comply with the requirements of 37 CFR Part 401 (Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements), and any implementing regulations issued by the awarding agency.

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(f) Clean Air Act and Federal Water Pollution Control Act. These provisions shall apply to all contracts and subgrants over $150,000. The Contractor shall:

(1) Comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. §7401 et seq. as amended, and the Federal Water Pollution Control Act as amended (33 U.S.C. §1251-1387);

(2) Report each violation of those laws to the City and understands and agrees that the City will, in turn, report each violation as required to assure notification to the applicable federal agency, and the appropriate Environmental Protection Agency Regional Office; and

(3) Include these requirements in each subcontract exceeding $150,000 financed in whole or in part with federal assistance provided by the applicable federal agency.

(g) Debarment and Suspension. These provisions shall apply to all contracts. This contract is a covered transaction for purposes of 2 CFR Part 180 and 2 CFR Part 3000. As such, the Contractor is required to verify that none of the Contractor's principals (defined at 2 CFR §180.995) or its affiliates (defined at 2 CFR §180.905) are excluded (defined at 2 CFR §180.940) or disqualified (defined at 2 CFR §180.935).

(1) The Contractor certifies to the best of its knowledge and belief, that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this contract been convicted or had a civil judgment against them for commission or fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or Local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

(d) Have not within a three-year period preceding this agreement had one or more public transactions (Federal, State or Local) terminated for cause or default.

(2) Where the Contractor is unable to certify to any of the statements in this certification, such Contractor shall notify the City in writing.

(3) The Contractor must comply with 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction Contractor enters into.

(4) This certification is a material representation of fact relied upon by the City. If it is later determined that the Contractor did not comply with 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, in addition to remedies available to the City, the federal government may pursue available remedies, including but not limited to, suspension and/or debarment.

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(5) With respect to competitive solicitations, the Contractor agrees to comply with the requirements of 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, while this offer is valid and throughout the period of any contract that may arise from this offer. This bidder or proposer further agrees to include a provision requiring such compliance in the bidder's or proposer's lower tier covered transactions.

(6) The Contractor certifies the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Contractor understands and agrees that the provisions of 31 U.S.C. Chapter 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

(h) Byrd Anti-Lobbying Amendment. These provisions apply to all contracts. The Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee or Member of Congress in connection with the awarding of any Federal Agreement, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal Agreement, grant, loan or cooperative agreement.

(2) If any funds other the Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal Agreement, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-agreements, sub-grants, and agreements under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) For purposes of this Certification, this Contract shall be considered a federal agreement. This certification is a material representation of fact upon which reliance is placed when this transaction was made or entered into. Submission of this certification is prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(5) The Contractor, certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Contractor understands and agrees that the provisions of 31 U.S.C. Chapter 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

(i) Procurement of Recovered Materials (2 CFR § 323). These provisions shall apply if the purchase price of an item exceeds $10,000 (including value of item acquired over the year).

(1) In the performance of this contract, the Contractor shall make maximum use of products containing recovered materials that are EPA- designated items unless the product cannot be acquired:

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(a) Competitively within a time frame providing for compliance with the contract performance schedule;

(b) Meeting contract performance requirements; or

(c) At a reasonable price.

(2) Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive- procurement-guideline-cpg-program.

(3) The Contractor also agrees to comply with all other applicable requirements of Section 6002 of the Solid Waste Disposal Act.

(j) Prohibition on certain telecommunications and video surveillance services or equipment (2 CFR § 216. These provisions shall apply to all contracts.

(1) Recipients and sub recipients are prohibited from obligating or expending loan or grant funds to:

(a) Procure or obtain;

(b) Extend or renew a contract to procure or obtain; or

(c) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(d) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

(e) Telecommunications or video surveillance services provided by such entities or using such equipment.

(f) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

(2) In implementing the prohibition under Public Law 115-232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

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(3) See Public Law 115-232, section 889 for additional information.

(4) See also § 200.471.

(k) Domestic preferences for procurements (2 CFR § 200.322). These provisions apply to all contracts.

(1) As appropriate and to the extent consistent with law, the non-federal entity should, to the greatest extent practicable under a Federal award, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). The requirements of this section must be included in all subawards including all contracts and purchase orders for work or products under this award.

(2) For purposes of this section:

(a) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.

(b) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

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BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is July 1, 2024. There was a delay in the execution of this agreement, and the hereby parties ratify all actions taken from the start of the term of the Agreement through to the execution of the same. Further, the parties explicitly agree that all of the terms and conditions of the Agreement, including but not limited to insurance requirements and indemnification, are applicable continuously commencing on the date of execution of the Agreement.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number: NM324605

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and consent to all of its terms and conditions as of the date and year specified below.

NA

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

DocuSigned by: Charles Davis

By: Charles Davis

Title: Vice President, Sales

Date: September 3, 2024

CITY OF ALBUQUERQUE ("EMPLOYER")

9/10/2024 | 8:20 AM MDT

DS

By: DocuSigned by: Assistant City Attorney

Title: Samantha Sengel

Date: 9/16/2024 | 4:01 PM MDT

DS

By: DocuSigned by: Donna Sandoval

Title: Donna Sandoval

Date: 9/11/2024 | 9:35 AM MDT

DS

By: DocuSigned by: Ian Stoker

Title: Ian Stoker

Date: 9/10/2024 | 8:23 AM MDT

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies, and third-party representatives, except with written permission of Claim Administrator.

Blue Cross Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

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This Agreement made as of the Effective Date, by and between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and Employer, for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a Plan as defined herein; and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4; and

WHEREAS, Employer on behalf of the Plan desires to retain Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, the Parties agree that it is desirable to set forth more fully the obligations, duties, rights, and liabilities of Claim Administrator and Employer.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services set forth in Exhibit 1 in connection with the administration of the Plan ("Services").

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state, or local laws that may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state, and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state, and local rules, laws, and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements, and disclosure requirements that may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state, or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or through Claim Administrator.

1.3 **Claim Appeals.** Appeals will be reviewed with a new full and fair review. If the denial reason was due to medical necessity or experimental/investigational clinical rationale, the appeal will be reviewed by a qualified Physician who had no involvement in the initial review or any prior reviews. If, pursuant to such review, the clinical decision is upheld, then the Covered Person may have the right to seek Independent External Review. The decision of the independent review organization ("IRO") will be final and binding.

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by IROs as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall Claim Administrator have any liability or responsibility for any claim determination, act, or omission by an IRO in connection with any Independent External Review.

1.5 **Claim Administrator Review of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days' prior written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the Services, Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed

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by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, any subsidiary or affiliate of Claim Administrator, and any successor entity or entities to Claim Administrator, whether by merger, consolidation, or reorganization, without prior written approval by Employer. In the event that Claim Administrator subcontracts any of the work or Services covered by this Agreement solely for Employer, Claim Administrator will seek prior written approval from the Employer.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of Claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed. Employer shall remain fully responsible and liable for the performance of any of Employer's Vendor(s) (as defined below) to the extent Employer contracts for services related to the Plan or delegates to other entities any of its obligations under the Plan.

The Parties acknowledge and agree Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

2.2 **Employer's Vendor's Responsibility**. Employer will identify to Claim Administrator any of Employer's Vendor(s). Employer represents and warrants that it has entered into separate contracts with any of Employer's Vendors. Employer agrees that in connection with any services the Employer's Vendor(s) perform related to the Plan, Employer's Vendor(s) shall not engage with or contact any Providers except as permitted by Claim Administrator. Employer agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of Employer's Vendor(s). Employer also agrees Claim Administrator or any of Claim Administrator's affiliates, delegates, subcontractors, or assigns performance under this Agreement shall be excused to the extent they are unable to perform due to the performance or lack of performance of Employer's Vendor(s).

2.3 **Employer's Direction as to Benefit Design.** Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in a benefit matrix, highlight sheets, and similar documentation (collectively, "Matrix"), and the ASO BPA. Employer agrees that Claim Administrator shall process Claims in accordance with the Matrix and the ASO BPA. Employer agrees Claim Administrator may rely on the most current version of the Matrix and the ASO BPA as the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

2.4 **Eligibility.** Employer shall determine eligibility for coverage under the Plan. Employer is responsible for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination. Any clerical errors with respect to eligibility will not invalidate coverage that would otherwise be validly in force or continue coverage that would otherwise validly terminate. Such errors will be corrected according to Claim Administrator's reasonable administrative practices including, but not limited to, those related to Timely notification of a change in a Covered Person's status.

2.5 **Notices to Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 6.1, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 3 to Covered Persons.

2.6 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by Claim Administrator with respect to any Covered Persons.

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Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies, and third-party representatives, except with written permission of Claim Administrator.

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c. Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement.

d. By providing Covered Persons information that may include a telephone and text number, the Employer agrees that Claim Administrator may use that information to secure the Covered Person's consent to contact them via their preferred method of communication (e.g., phone, text, email) with the Claim Administrator.

e. Employer is responsible for ensuring that the terms of this Agreement are consistent with the terms of the Plan.

2.7 **Grandfathered Health Plans (If Applicable).** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least sixty (60) days' advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide notice thereof as required) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference into and become part of this Agreement, and Employer represents and warrants that the information it submits on such Form is true, complete, and accurate.

2.8 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans (If Applicable).** If Claim Administrator provides Services for any retiree-only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans are not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's exempt plan status or any representation regarding any Plan's exempt plan status.

2.9 **Summary of Benefits and Coverage ("SBC").** Unless otherwise provided in the applicable ASO BPA and SBC Addendum (if applicable), Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and that Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

2.10 **Massachusetts Health Care Reform Act.** If elected by Employer on the applicable ASO BPA, Claim Administrator will provide required written statements of creditable coverage to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, in accordance with the Massachusetts Health Care Reform Act based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that it has or will review the Plan for Massachusetts Health Care Reform Act compliance, and, to the best of its knowledge, that such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator will not verify and is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

2.11 **Employer Audits Claim Administrator.** (a) During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days' prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Any review of Claim information by Employer or an authorized agent of Employer to

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Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies, and third-party representatives, except with written permission of Claim Administrator.

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evaluate Claim Administrator's performance of the administrative services provided according to the terms of this Agreement shall be subject to the terms of this Section. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer's agent shall agree to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims. (b) In the event that the audit reveals a significant problem materially impacting accurate claims processing (validated finding of less than 90% accuracy), Claim Administrator shall use its best efforts to present Employer with a corrective action plan within thirty (30) days of the notification of audit findings. The plan will include all corrective action measures to be taken within three months and include a report to Employer describing the full measure of the corrective actions.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 **Use and Disclosure of Covered Persons' Information.** The Parties acknowledge and agree that they have entered into a Business Associate Agreement ("BAA") as required by HIPAA. The Parties agree the BAA will govern the use, access, or disclosure of all personally identifiable information ("PII"), including Protected Health Information ("PHI"), Claim Administrator may collect or receive. While Claim Administrator does not anticipate receiving or collecting PII about Covered Persons that is not PHI, Claim Administrator agrees to protect and secure any PII of Covered Persons according to the terms of the BAA and agrees to fulfill any other obligations related to PII as required therein.

3.2 **Electronic Exchange of Information.** If Employer and Claim Administrator exchange data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the Parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons, and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data, and other information to Employer in the electronic format mutually agreed to by the Parties.

3.3 **Providing Data to Employer's Vendor(s).** If Employer requests for itself or directs Claim Administrator to provide data directly to Employer's third-party consultant and/or vendor ("Employer's Vendor(s)"), Employer acknowledges and agrees that it will execute and shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement. Employer hereby acknowledges and agrees, and Employer's Vendor(s) shall acknowledge and agree:

a. That the requested documents, records, and other information (for purposes of this Section 3, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.

b. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 3, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its

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employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed.

d. To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

e. To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

f. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.

g. To not sell, re-sell, or lease the Information.

h. To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter.

Employer shall provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose, or exchange data and provide written authorization and specific directions with respect to such release, disclosure, or exchange. If Employer's Vendor(s) perform services that involve the use, access or disclosure of PHI as defined by HIPAA, the identity of Employer's Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 **Business Confidential Information and Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information ("BCI"). Employer shall not use or disclose such Business Confidential Information, to any third party without prior written consent of Claim Administrator. Within five (5) business days of the execution of the Agreement, Claim Administrator will provide to Employer a version of this Agreement and its Exhibits with BCI redacted. Employer may utilize the redacted version to satisfy public records requests. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has the opportunity to object and ensure appropriate confidentiality protections are in place.. Neither Party shall use the name, symbols, copyrights, trademarks, or service marks ("Proprietary Marks") of the other Party or the other Party's respective clients in advertising or promotional materials without prior written consent of the other Party; provided, however, that Claim Administrator may include Employer in its list of clients.

3.5 **Claim Administrator/Association Ownership.** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association ("BCBSA" or "the Association"). Employer agrees not to contest (i) the Association's ownership of, or the license granted by the Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

3.6 **Infringement.** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Association and utilized by Claim Administrator under a license with the Association.

3.7 **Records.**

a. **Records Retention.** Claim Administrator shall retain all Claim records for the longer of (i) the time period required by applicable law or (ii) the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator. The failure to agree upon a retention period shall not constitute breach of this Agreement.

b. **Record Requests.** For a period of one (1) year following termination of this Agreement, Claim Administrator shall, upon the request of the Employer for general purposes ("Data Reclamation Request"), provide to Employer, a copy of all Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of

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Claim Administrator. Within a mutually agreeable time frame of receipt of the Data Reclamation Request, Claim Administrator shall transmit the dataset in a form mutually agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. The time period for general record requests does not impact nor restrict any legal, regulatory, or mandated data requests.

3.8 **Use of Data for Industry Improvement Activities.** Claim Administrator may use or disclose a limited data set or de-identified data ("Data") as permitted by the executed BAA, HIPAA, and other applicable federal and state laws for the purpose of supporting industry improvement activities such as analytic reviews, research studies, and other similar projects focused solely on promoting quality health care, managing health care costs, reducing administrative costs, or enhancing the Plan's performance. Any Data used or disclosed will be managed and coordinated by the Claim Administrator or by the Association including any vendors that assist the Claim Administrator and the BCBSA in the industry improvement activities. The Data shall not be sold, used, or disclosed for the financial benefit or profit of the Claim Administrator, BCBSA, or vendor.

SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS, AND DISPUTE RESOLUTION

4.1 **Litigation.** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against Employer that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either Party under the Plan and this Agreement. Employer shall undertake the defense of such action and be responsible for the costs of defense of Employer, including but not limited to attorneys' fees and costs, external claim reviews, and other expenses. Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action brought against Claim Administrator, in which event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists.

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator is authorized to follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement. Nor will Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Section 4.2(a.-e.) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

a. **Reductions from Future Payments to Network Providers.** Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or (ii) if the Provider is a Network Provider, from Other Plans, up to an amount equal to the Overpayment (collectively, "Offset").

b. **Cross-Plan Offsets for Network Providers.** Claim Administrator has the right to reduce Another Plan's payment to a Network Provider by the amount necessary to recover the Plan's Overpayment to the same Network Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Network Provider by the amount necessary to recover Another Plan's Overpayment to the same Network Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

c. **Division of Recovery for Multiple Plans.** If Claim Administrator has made Overpayments to a Network Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively against future payments owed to Another Plan as part

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of a single transaction, resulting in an Overpayment recovery amount which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 4.

d. **Employer Authorization for Offsets and Cross-Plan Offsets.** Employer authorizes and directs Claim Administrator to perform Offsets and Cross-Plan Offsets. Cross-Plan Offsets will be carried out consistent with the terms of the Provider contract. Notwithstanding the foregoing, Employer acknowledges and agrees that claims processed through Inter-Plan Arrangements with other Blue Cross and/or Blue Shield licensees operate under rules and procedures issued by the Association, and the recovery policies and procedures of each Blue Cross and/or Blue Shield independent licensee may apply.

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator shall administer Overpayment recoveries in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan. Employer agrees that it will not perform or engage any other party to perform Overpayment recovery activities with respect to Providers or Covered Persons without prior written consent of Claim Administrator.

4.3 **Third Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third parties' fees, as defined in the ASO BPA, associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

4.4 **Adjudication of Preventive Care.** If, either on the applicable ASO BPA or other document, Employer directs Claim Administrator to process and adjudicate Claims at one hundred percent (100%) of the applicable Allowable Amount and/or Allowable Charge**,** regardless of whether the high-deductible health plan's deductible has been met ("First Dollar Coverage"), Employer acknowledges and agrees that such direction is a benefit design decision and the responsibility of the Employer. Notwithstanding any other provision of this Agreement, Employer shall indemnify and hold harmless (and upon request defend) Claim Administrator against claims brought by any employees of Employer, participants in any benefit plan provided by Employer, or any governmental agency, in connection with or arising out of, directly or indirectly of the First Dollar Coverage. Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to provide First Dollar Coverage.

4.5 **Assignment.** Except as otherwise permitted by Section 1 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both Parties. Any such attempted assignment in the absence of the prior written consent of the Parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates, or successors to the Parties.

4.6 **Applicable Law.** This Agreement shall be governed by and construed in accordance with applicable federal laws and the laws of the state of New Mexico without regard to any state choice–of–law statutes. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Albuquerque, New Mexico**.** Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

4.7 **Notice and Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such, including but not limited to initiation of Dispute Resolution under Section 4.11 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to

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allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon Timely prior written notification to the other Party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

4.8 **Limitations; Limitation of Liability.** No action or dispute shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents, or independent contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of gross negligence, fraud, or criminal actions by Claim Administrator.

4.9 **Dispute Resolution.** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this section, which shall be the sole and exclusive procedures for the resolution of any such disputes.

a. **Initial Notice and Negotiation.** Employer or Claim Administrator shall give written notice to the other Party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the Parties shall seek to resolve that dispute through informal discussions between authorized representatives of the Parties with appropriate authority to approve any resolution. All negotiations pursuant to this section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

b. Except as provided otherwise in this Agreement, each Party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

4.10 **Transparency and Surprise Billing Procedures.** Unless another effective date is stated for a specific service, for plan years on or after January 1, 2022, Claim Administrator agrees to provide Employer the services and processes described in this section consistent with the Consolidated Appropriations Act of 2021 ("CAA"), Transparency in Coverage Final Rule, and the No Surprises Act ("NSA").

a. **Transparency Procedures.**

1. ***Contracted Provider Data Verification.*** Claim Administrator will maintain a central database of Contracted Providers' demographic information, which shall include name, address, phone number, specialty, and web address ("Data Elements"). Claim Administrator will initiate an outreach to Contracted Providers to verify the accuracy of the Data Elements up to ninety (90) days following the last recorded update or verification. Claim Administrator has implemented commercially reasonable procedures to track the receipt of updated data from a Contracted Provider and update the central database within appropriate timeframes.

2. ***Directory of Verified Contracted Providers.*** Claim Administrator will provide an online Provider directory representing the Contracted Providers who render Covered Services which may be billed to plans and policies administered by Claim Administrator. This directory shall include Providers contracted with Claim Administrator, Providers contracted with any Blue Cross and Blue Shield Plan, and any other entity performing Covered Services on behalf of Claim Administrator. The directory will not reflect services administered by external claims administrators or other Providers not contracted through Claim Administrator.

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Providers who fail to confirm the accuracy of the Data Elements may be subject to removal from the Provider directory until they confirm the accuracy of their information.

To the extent information for the Provider directory is provided by a third party, Claim Administrator shall not be responsible for delays in updates to Provider data directories, or misinformation due to such delays in receiving information from such third party.

3. ***Provider Network Status Verification.*** Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide written, electronic, or print confirmation of the Provider's Network status within an appropriate timeframe. This verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

   Employer acknowledges that Claim Administrator will not issue a written confirmation of Provider Network status when request is sought through a third-party service center.

4. ***ID Cards.*** Claim Administrator will include up to four (4) lines of text for deductible limits and up to four (4) lines of text for out-of-pocket maximum limits for major medical coverage on the member ID card. The limits will reflect both family and individual limits when applicable to policy, together with in- and out-of-network limits.

   For policies that include prescription drug coverage through Prime with an independent out-of-pocket maximum limit or Deductible, one (1) line of text for deductible limits and one (1) line of text for out-of-pocket maximum limits will be included on the ID card.

   Claim Administrator will include a phone number and a website URL for consumer assistance information on ID cards issued by Claim Administrator.

   Claim Administrator will issue physical ID cards in accordance with its standard processes and will not re-issue physical ID cards unless requested by Employer, in which case additional charges may apply. All newly issued physical ID cards will contain the information reflected in this section.

5. ***Machine-Readable Files.*** Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by the Centers for Medicare and Medicaid Services ("CMS") standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The files will not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the performance, acts, or omissions of any of Employer's Vendors.

6. ***Cost Sharing Estimator Tool.*** Claim Administrator will make available a Cost Sharing Estimator Tool ("CSET") to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through either self-service tools or telephone upon member request, a secure member portal, and via a mobile application, for active policies, and include services in accordance with the following schedule:

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Effective with the plan year beginning on or after January 1, 2023, enrollees will be able to search for the cost of five hundred (500) services, as defined by CMS, covered by the Plan administered by Claim Administrator, to identify the estimated cost for the procedure, illustrate how the member's benefits will apply to the procedure, and disclose if there may be any prerequisites to care, such as requiring a prior authorization for a service or procedure.

For each plan year beginning on or after January 1, 2024, the services that can be estimated through the CSET will be expanded to support all services and procedures covered by the Plans that are administered by Claim Administrator.

To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the acts or omissions of any of Employer's Vendors.

7. ***Drug Cost Reporting.*** Claim Administrator will provide on behalf of Employer, based on the type of pharmacy coverage and data Claim Administrator administers and maintains for Employer, health and drug cost reporting to the extent within the possession of Claim Administrator as contemplated by Section 204 of the CAA according to Claim Administrator's standard processes and procedures, unless otherwise mutually agreed in writing.

8. ***Continuity of Care.*** In the event of a Provider or facility termination for reasons other than failure to meet quality standards or fraud, Claim Administrator shall notify individuals enrolled under the Plan who are continuing care patients with respect to the Provider or facility at the time of the termination. Claim Administrator will provide each individual who is a continuing care patient of a terminated Provider or facility, the opportunity to request to continue to have the treatment provided under the same benefits provided, under the same terms and conditions as would have applied under the Plan had the termination not occurred, for a specified duration (for purposes of this section, "Continuity of Care"). Claim Administrator will identify continuing care patients and provide Continuity of Care in accordance with Claim Administrator policies.

9. ***Required Disclosure/Notices.*** Claim Administrator will post the disclosure on patient protections against balance billing on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the Plan's behalf.

10. ***Mental Health Parity.*** Claim Administrator has or will timely establish processes and procedures, in accordance with sound professional practices and prevailing industry standards, reasonably necessary for Claim Administrator to timely support good faith requests of Employer for data or other documentation that Employer may need to analyze and document the Plan's compliance with applicable Mental Health Parity requirements, including amendments to Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008. So long as Employer has elected to implement Claim Administrator's standard non-quantitative treatment limitations ("NQTLs") and so long as Claim Administrator administers both mental health/substance abuse benefits and medical/surgical benefits on behalf of Employer, this may include applicable comparative documentation with respect to Claim Administrator's administered NQTLs under the Plan which may be necessary for addressing and complying with the requirement to analyze and document NQTL parity between mental health/substance abuse benefits and medical/surgical benefits, as required by Division BB, Title II, Section 203 of the CAA and guidance issued thereunder. In addition, in the event that the U.S. Department of Labor or other regulatory agency ("Agency") with competent jurisdiction over the Plan initiates an audit or other assessment related to the Plan's compliance with mental health parity requirements, including the obligation to perform and/or make available the comparative analyses described above, Claim Administrator agrees to provide expedited support to enable Employer and the Plan

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to timely provide documentation requested by the Agency. Both Parties agree and understand that no data or other documentation provided by Claim Administrator under this Section shall be reasonably interpreted as a certification of the compliance of the Plan or any Claim Administrator's administered NQTLs or other processes with State or Federal Mental Health Parity requirements. Employer agrees that compliance of the Plan with such requirements is solely the responsibility of Employer.

b. Surprise Billing Requirements of the No Surprises Act.

1. ***Qualifying Payment Amount*****.** As it pertains to Employer's self-funded plans, Employer acknowledges that NSA requires, among other things, that member cost-share for certain items and services the Plan covers are calculated based on the lesser of the Provider's billed charge or the NSA's "Qualifying Payment Amount" ("QPA"). With respect to the calculation of QPA, Employer elects to use and adopts the QPA calculated by Claim Administrator based on Claim Administrator's self-funded business and not a QPA customized for Employer's Plan(s).

2. ***Negotiation and Independent Resolution Process*****.** Employer acknowledges that Claim Administrator will make on the Plan's behalf an initial payment amount on Claims consistent with Employer's direction as established by Employer's Plan and this Agreement. For covered NSA-eligible items and services reported on Claims from nonparticipating Providers (i.e., generally noncontracted), a Provider may seek additional payment through a dispute process established by the NSA and related regulations. This process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

Employer authorizes Claim Administrator, or for Claims for service rendered outside of Claim Administrator's service area another Blue Cross and Blue Shield licensee, to represent the Plan with respect to any Claim with items or services for which a Provider seeks to negotiate as provided by the NSA, or for which a Provider institutes IDR.

With respect to any negotiations where Claim Administrator represents the Plan to resolve any disputed Claim, Employer expressly authorizes Claim Administrator in such negotiations to attempt to resolve any disputed Claim, (i) for an amount not to exceed the greater of the QPA or the amount allowed on the initial notice of payment or denial of the claim, or (ii) as otherwise directed by Employer in the ASO BPA and agreed to by Claim Administrator.

Claim Administrator will maintain a summary description of its currently applicable approach to negotiation of services or Claims subject to the dispute resolution process of the NSA. The approach will be generally the same or similar for Claims under Employer's Plan as for similarly-situated Claims under Claim Administrator's fully insured health insurance policies.

Employer acknowledges and agrees that Claim Administrator shall follow its then-current negotiation approach, that such negotiations may not be successful, and may result in institution of IDR despite the approach outlined above or as otherwise directed by the Employer (with or without exhaustion of the full settlement authority Employer may grant to Claim Administrator), which in turn may result in additional administrative fees, as well as IDR entity fees in the event of settlement after institution of an IDR or an IDR loss. Notwithstanding the additional administrative fee and other possible expenses, Employer acknowledges that the approach set forth herein, or as it may direct (subject to Claim Administrator's agreement) in the ASO BPA for attempting to resolve these Claims, notwithstanding the potential for IDR losses, is in the Plan's interest.

Negotiation services Claim Administrator provides shall include communicating with Provider, supplying requested documentation as appropriate, and proposing and documenting resolution of disputed Claims. Services in connection with an IDR shall also include handling interactions with the IDR entity and Provider, supplying requested information in connection with the IDR, and analyzing circumstances of disputed Claims to

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determine position on disputed Claims. On a quarterly basis, Claim Administrator shall provide Employer with information regarding the status of negotiations and IDR decisions.

Employer acknowledges that Claim Administrator undertakes negotiations at the direction of the Employer, undertakes such negotiations because they are necessary to the operation of the Plan, that the compensation to be paid to Claim Administrator for such negotiations is reasonable, and that, notwithstanding any other section of this Agreement, Claim Administrator does not act as a fiduciary, including under ERISA in connection with the negotiation or IDR of any disputed Claim. Employer is solely responsible for payment of any amounts determined to be payable as a result of such negotiations or awards entered through IDR on NSA-eligible items and services. Employer indemnifies and will hold Claim Administrator harmless with respect to any award entered in IDR and any subsequent payment made thereon and/or any judgment entered thereon. Employer acknowledges that other terms, conditions, or fees may apply with respect to any negotiations or IDR processes performed by another Blue Cross and Blue Shield licensee.

c. Effect of Future Changes in Law and Regulations. The laws and regulations that are the subject of this Section 4.12 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective ninety (90) days after such notice.

Employer acknowledges that Employer, and not Claim Administrator, shall be responsible for making the necessary adjustments to member-facing benefit forms to be consistent with Employer's election, including any amendments to governing Plan documents.

SECTION 5: NON-ERISA GOVERNMENT REGULATIONS

5.1 **In Relation to the Plan.** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of Employer, Employer agrees that Claim Administrator does not and will not accept any allocation or delegation of any responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator except as set forth in this Agreement. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator, or of the Plan except as set forth in this Agreement.

5.3 **Claim Administrator's Limited Fiduciary Responsibility.** Although Employer is exempt from ERISA, Employer hereby delegates to Claim Administrator the discretionary authority to administer claims in accordance with the terms of Employer's self-funded health care benefit plan and to make initial claim determinations concerning the availability of Plan benefits and final internal review and benefit determinations for appealed Claims. Claim Administrator hereby acknowledges and agrees that it shall act as a limited fiduciary to the Plan solely with respect to its performance of such claims processing and payment services and Employer acknowledges and agrees that Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, Employer acknowledges and agrees that Claim Administrator shall have no discretionary authority under its agreement with Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by Employer, Employer's other vendors and Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contractors, and subcontractors of any type. Employer further agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan participants or

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beneficiaries as a fiduciary, except with respect to claims processing and payment services, as set forth herein. In addition, Employer agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan Participants or beneficiaries with respect to any litigation, whether as a fiduciary or otherwise, including litigation by participants or beneficiaries or benefits under the Plan, except as may be required under Claim Administrator's indemnification obligations under this Agreement.

SECTION 6: OTHER PROVISIONS

6.1 **Term and Termination.** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein. This Agreement may be terminated as follows:

- **a.** By either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with ninety (90) days' prior written notice to the other party; or
- **b.** By both Parties on any date mutually agreed to in writing; or
- **c.** By either Party, in the event of conduct by the other Party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 4.9 above; or
- **d.** By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon Employer's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to Employer as provided in Section 7.1 of Exhibit 2 of this Agreement.

6.2 **Relationship of the Parties and Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented, or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers, or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. Nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents. Claim Administrator or its subsidiaries or affiliates may also have ownership interests in certain Providers who provide Covered Services to Covered Persons, and/or in vendors or other third parties who provide services related to this Agreement or provide services to certain Providers. Upon Employer request (not more than once per calendar year), Claim Administrator will provide a list of such entities to Employer.

6.3 **Entire Agreement.** This Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the Parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement shall prevail in the event of a conflict with any Prior Communications that either Party or a third party asserts to be a component of the Agreement between the Parties.

The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 – Claim Administrator Services
- **b.** Exhibit 2 – Fee Schedule and Financial Terms
- **c.** Exhibit 3 – Notices/Required Disclosures
- **d.** Exhibit 4 – ASO BPA
- **e.** Exhibit 5 – Blue Cross and Blue Shield Association Disclosures and Provisions
- **f.** Exhibit 6 – Recovery Litigation Authorization

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6.4 **Amending.** This Agreement may be amended only by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation, or order ("Law") or by Claim Administrator or the Association may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. If the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to dispute resolution, as set forth in Section 4.

6.5 **Severability; Enforcement; Force Majeure; Survival.** Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

Any delay or inconsistency by either Party in the enforcement of any part of this Agreement shall not constitute a waiver by that Party of any rights with respect to the enforcement of any part of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

Neither Party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, terrorism, cybersecurity crimes, or restraints of government.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 1 "Claim Administrator Responsibilities"; Section 2 "Employer Responsibilities"; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); and Section 8 of Exhibit 2 "Financial Obligations Upon Agreement Termination."

6.6 **Notice of Annual Meeting.** Employer is hereby notified that it is a member of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois, each year on the last Tuesday in October at 12:30 P.M. For purposes of this section, the term "member" means the group, trust, association, or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee, or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

6.7 **Appropriations.** Notwithstanding any other provision in this Agreement, the terms of this Agreement are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the City Council, or if the City Council un-appropriates or deauthorizes funds during a fiscal year, this Agreement may be terminated upon thirty (30) days' written notice given by the Employer to all other parties to this Agreement. Such event shall not constitute an event of default. The Employer's decision as to whether sufficient appropriations are available shall be accepted by all parties and shall be final. Notwithstanding anything else in the Agreement, the Contractor is entitled to payment for services rendered, subject to State Constitutional limitations thereon.

6.8 **Insurance.** The Claim Administrator shall procure and maintain at its expense until final payment by the Employer for Services covered by this Agreement, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, for operations under this Agreement. Before commencing the Services and upon the renewal of all coverages, the Claim Administrator shall furnish to the Employer a certificate or certificates, ACORD form or equivalent showing

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that it has satisfied this Section. Various types of required insurance may be written in one or more policies. Commercial general liability shall be primary with respect to operations provided. Kinds and amounts of insurance required are as follows:

a. **Commercial General Liability Insurance.** A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$2,000,000	Per Occurrence
$2,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 5,000	Medical Payments

Said policy of insurance must include coverage for operations performed for the Employer by the Claim Administrator, and contractual liability coverage. City of Albuquerque, New Mexico, a municipal corporation to be included as an additional insured.

b. **Automobile Liability Insurance.** An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work. City of Albuquerque, New Mexico, a municipal corporation to be included as an additional insured.

c. **Workers' Compensation Insurance.** Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensations Act of the State of New Mexico.

d. **Increased Limits.** If, during the term of this Agreement, the Employer requires the Claim Administrator to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Claim Administrator's compensation will be made. Any agreed to changes will be added to this agreement with a signed addendum.

6.9 **Discrimination Prohibited.** In performing the Services required hereunder, the Claim Administrator shall not discriminate against any person on the basis of race, color, religion, gender, sexual preference, sexual orientation, national origin or ancestry, age, physical handicap, or disability as defined in the Americans With Disabilities Act of 1990, as now enacted or hereafter amended.

6.10 **ADA Compliance.** In performing the Services required hereunder, the Claim Administrator agrees to meet all the requirements of the Americans With Disabilities Act of 1990, and all applicable rules and regulations (the 'ADA'), which are imposed directly on the Claim Administrator or which would be imposed on the Employer as a public entity and would be applicable to Claim Administrator's performance under this Agreement.

6.11 **Conflict of Interest.** No officer, agent or employee of the Employer will participate in any decision relating to this Agreement which affects that person's financial interest, the financial interest of his or her spouse or minor child or the financial interest of any business in which he or she has a direct or indirect financial interest.

6.12 **No Collusion.** The Claim Administrator represents that this Agreement is entered into by the Claim Administrator without collusion on the part of the Claim Administrator with any person or firm, without fraud and in good faith. The Claim Administrator also represents that no gratuities, in the form of entertainment, gifts or otherwise, were, or during the term of this Agreement, will be offered or given by the Claim Administrator or any agent or representative of the Claim Administrator to any officer or employee of the Employer with a view towards securing this Agreement or for securing more favorable treatment with respect to making any determinations with respect to performing this Agreement.

6.13 **Debarment, Suspension, Ineligibility and Exclusion Compliance.** The Claim Administrator certifies that it is not debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Claim Administrator agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor, the Contractor will notify the Employer immediately.

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6.14 **Public Records.** The parties acknowledge that the City is a government entity subject to the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq., NMSA 1978). In the event that the City receives an Inspection of Public Records Act request for production relating to this Agreement, the City shall provide Claim Administrator notice as described in section 3.4.

6.15 **Changes.** The Employer may, from time to time, request changes in the Services to be performed hereunder. Such changes, including any increase or decrease in the amount of the Claim Administrator's compensation, which are mutually agreed upon by and between the Employer and the Claim Administrator's, shall be incorporated in written amendments to this Agreement.

6.16 **Electronic Signatures.** The parties agree that this Agreement may be electronically signed and that the electronic signatures appearing on this Agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

6.17 **Approval Required.** This Agreement shall not become binding upon the Employer until approved by the highest approval authority of the Employer required under this Agreement.

SECTION 7: DEFINITIONS

Capitalized terms used in this Agreement shall have the meanings set forth in this Section 7, unless otherwise provided in the Agreement.

7.1 **"Administrative Charge"** means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

7.2 **"Allowable Amount"** means the maximum amount for dental benefits coverage, if elected on the most current ASO BPA, determined by the Claim Administrator to be eligible for consideration of payment for a particular service, supply, or procedure.

i. ***For Dentists contracting with the Claim Administrator*** – The Allowable Amount is based on the terms of the Dentist's contract and the Claim Administrator's methodology in effect on the date of service.

ii. ***For Dentists not contracting with the Claim Administrator*** – The Allowable Amount is based on the amount the Claim Administrator would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and the Claim Administrator:

i. ***For services performed in New Mexico*** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

ii. ***For services performed outside of New Mexico*** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.

iii. ***For multiple surgical procedures performed in the same operative area*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.

7.3 **"Allowable Charge"** means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. **For Medical Covered Services.**

i. ***For Network Providers -*** The Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

ii. ***For Providers other than Medical Network Providers ("Non-Contracting Providers")-*** The Allowable Charge will be the lesser of:

1. the Provider's billed charges, or;

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2. Claim Administrator's non-contracting Allowable Charge. Except as otherwise provided in this Section, the non-contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the Claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than one hundred percent (100%) of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, or is unable to be determined based on the information submitted on a Claim, the Allowable Charge for Non-Contracting Providers will be reimbursed at Claim Administrator's default percent of billed charges. Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event Claim Administrator does not have any Claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments. Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor. In the event the non-contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person may be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's non-contracting Allowable Charge for a particular service, the Covered Person may call the Customer Service number shown on the back of the Covered Person's Identification Card. Notwithstanding anything to the contrary in the Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be consistent with the In-Network benefit level for Covered Services provided, the amount the Provider has agreed to accept as payment for Covered Services in accordance with a single case agreement, or one-hundred percent (100%) of billed charges, whichever is less.

Each of these amounts is calculated excluding any Network or contracting Provider Copayment or Coinsurance imposed with respect to the Covered Person.

b. When Covered Services are received outside the state of New Mexico from a Provider who does not have a written agreement with Blue Cross and/or Blue Shield of New Mexico or with the local Blue Cross and/or Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and/or Blue Shield Plan ("Host Plan") servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

7.4 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and/or Blue Shield licensees through Inter-Plan Arrangements, that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications,

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enhancements, derivatives, and improvements of the Business Confidential Information described in the preceding sentence.

7.5 **"Claim"** means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex, and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

7.6 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction**.**

7.7 **"Claim Payment"** means the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Amount and/or Allowable Charge**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

7.8 **"Coinsurance"** means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

7.9 **"Contracting Dentist"** means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a dental Provider.

7.10 **"Copayment"** means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

7.11 **"Covered Employee"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.12 **"Covered Person"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.13 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

7.14 **"Dentist"** means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

7.15 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

7.16 **"Fee Schedule"** means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2.

7.17 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

7.18 **"HIPAA"** means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

7.19 **"Hospital"** means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

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7.20 **"Inpatient"** means the Covered Person is a registered room and board patient and treated as such in a health care facility.

7.21 **"Network"** means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

7.22 **"Non-Contracting Dentist"** means a Dentist who is not a Contracting Dentist as defined herein.

7.23 **"Outpatient"** means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

7.24 **"Overpayment"** means a payment to a Provider or a Covered Person that was more than it should have been based on the Plan's benefit design and Claim Administrator's or other Blue Cross and/or Blue Shield companies' Provider contracts and policies, or a payment that was made in error, including but not limited to, Provider's unsupported billing practices.

7.25 **"Physician"** means a physician duly licensed to practice medicine in any of its branches recognized by applicable state law.

7.26 **"Plan**" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

7.27 **"Primary Care Practitioner"** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to Covered Persons, who initiates the patient's referral for specialist care, who maintains continuity of patient care, who is a Network Provider at the time Covered Services are rendered, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care. Primary Care Practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also serve as Primary Care Practitioners, as defined by the State in which the professional is in practice (otherwise known as a "Primary Care Provider").

7.28 **"Provider"** means any Hospital, health care facility, laboratory, person, or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products, or supplies which are Covered Services.

7.29 **"Reminder Notice"** means a notice sent when claims have not been paid within 10 (ten) days.

7.30 **"Supplemental Charge"** means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any customized reports, forms, or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

7.31 **"Surcharges"** means local, state, or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global® Core Access Vendor Fees, paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits.

7.32 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within forty-eight (48) hours of notification to Employer by Claim Administrator, monthly fees (e.g., Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

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c. With respect to all Plan information due Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

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EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions on applicable benefit plan terms and design, including determination of pre-service or prior authorization of services. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits ("COB") processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS ("EOB")**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, when scheduled in advance based on staffing availability, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care Providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care Providers who render services to Covered Persons.

- **DISABLED DEPENDENT CERTIFICATION**

  Certify the disabled status of any dependent children of Covered Persons, based on Claim Administrator's review of information provided by Employer, the Covered Person, or the dependent's medical Provider(s), following either the Standard or Custom Rules as indicated on the most current ASO BPA, for purposes of administering the Employer's age limit for eligibility.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer from listing below:

  a. ***Enrollment Materials.*** Claim Administrator's Marketing Administration Division will provide implementation materials during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Prepare identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to a toll–free Customer Service telephone number.

  e. ***Medical Prior-Authorization Service Telephone Number.*** For those services determined by Employer and provided in writing to Claim Administrator that require prior authorization, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical prior-authorization service telephone number for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

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- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make Claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlements (as outlined in Exhibit 2, Section 6), and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting processes at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the Parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service ("IRS") 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND UNDERWRITING**

  Provide Claims projections and pricing of administrative services and stop–loss coverage.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and if the Employer is a target of a pattern of fraudulent or abusive activities inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 6.

- **EMPLOYER PORTAL (currently called "BLUE ACCESS FOR EMPLOYERS℠")**

  Provide Employer with an on-line resource that allows Employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about Claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called "BLUE ACCESS FOR MEMBERS℠")**

  Provide Member with an on-line resource that allows individuals access to information about their health care coverage and benefits, currently verifying the status of finalized Claims, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit plan coverage(s) under the Agreement, establish, arrange, and maintain a Network(s) through contractual arrangements with Providers.

- **MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING**

  Pursuant to Exhibit 3, Section 6 titled "Medicare Secondary Payer Information Reporting", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), Claim Administrator will issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, Claim Administrator will remit such funds to Employer, less any amount(s) owed to Claim Administrator from such funds, in accordance with Claim Administrator's established procedures, for disposition by Employer as may be required under applicable law. If requested by Employer via prior written notice as required by Claim Administrator, Claim Administrator will escheat

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such funds on behalf of Employer, less any amount(s) owed by payees to Claim Administrator, from such funds, to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the Parties in writing prior to their performance and may be subject to Supplemental Charge.

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Services under Exhibit 1 do not include providing Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term “Services” does not include backroom operations such as support functions.

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **ADVANCED PAYMENT REVIEW (“APR”)**

  Provide a program that may include post-service, prospective, and retrospective Claim coding or billing reviews to identify discrepancies, errors, or billing inconsistencies of Claim Payments as identified by Claim Administrator.

- **EXTERNAL REVIEW COORDINATION**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator’s coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan’s determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator. Audits relating to Wellbeing Management shall be subject to Claim Administrator’s then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING (“RBP”)**

  Assist Employer with establishing a maximum coverage amount for specified imaging, Inpatient, and Outpatient procedures derived from a pricing method based on either the Employee’s or Provider’s location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app, or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE (“SBC”)**

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

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- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator. Audits relating to Health Advocacy Solutions shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator.

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EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Fee Schedule Addendum, if applicable. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA and the PBM Fee Schedule Addendum, if applicable; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Fee Schedule Addendum, if applicable; or iii) the date the Agreement is terminated (or, if applicable, in the case of the PBM Fee Schedule Addendum, the date such PBM Exhibit is terminated).

Inter-Plan Arrangement Fees:

1.1 **BlueCard® Program/Network Access Fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable.

1.2 **Negotiated Arrangement/Custom Fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

1.3 **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**If applicable, such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or two thousand dollars ($2,000) per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

2.1 **"Employer Payment"** means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 **"Employer Payment Method"** means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 **"Employer Payment Period"** means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Exhibit 3 Section 6 titled "Medicare Secondary Payer Information Reporting.")

2.5 **"Run–Off Claim"** means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 **"Run–Off Period"** means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the

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Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of Service Charges.*** Employer will pay service charges to Claim Administrator in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Fee Schedule Addendum, if applicable, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining Service Charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Fee Schedule Addendum, if applicable, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing Service Charges.*** Such service charges shall be subject to change by Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that sixty (60) days' prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (e.g., benefit levels, census/demographics, producer/broker fees) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service Charges upon Termination.*** In the event the Agreement is terminated in accordance with the "Term and Termination" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a partial termination of Covered Employees by Employer, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

3.5 ***Additional Service Charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s); and/or
- **b.** Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to Employer, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or
- **d.** Any other fees for services mutually agreed upon by the Parties in writing.

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies, and third-party representatives, except with written permission of Claim Administrator.

3.6 ***Effect of Plan Enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely Payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's Payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's Liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "Claim Settlements." Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

4.3 ***Covered Person's Certain Liability.*** Under certain circumstances, if Claim Administrator pays the health care Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period**.**

5.2 ***Confirmation or Notification of Amount Due and Payment Due Date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

a. ***If Employer Payment Method is by Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.

b. ***If Employer Payment Method is other than Check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the Parties, of the amount due. Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

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SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current ASO BPA. The Claim settlement shall reflect the sum of the following:

a. Claim Payments paid by Claim Administrator in the particular Claim Settlement Period.

b. Claim Payments paid by Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the "Claim Settlement Total."

6.2 ***Employer Underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within ninety (90) days from the last day of the Claim Settlement Period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer Overpayment.*** If, within the Claim Settlement Period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer Fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent. If defaults are not cured following notice via email to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice.

7.2 ***When Claim Administrator Fails to Timely Notify.*** Pursuant to Section 6.5 "Severability; Enforcement; Force Majeure; Survival" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

7.3 ***Late Charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

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SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, or on the date which Employer terminates a part of the population of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or termination of Covered Employees but not the Agreement, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of termination of Covered Employees but not the Agreement.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

8.3 ***Final Settlement.*** A final settlement shall be made within ninety (90) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments or recoveries for Overpayments, including, but not limited to, subrogation or litigation activities, regardless of when such adjustments or recoveries occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed Funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old), less any amount(s) owed by payees to Claim Administrator from such funds, will be escheated by Claim Administrator on Employer's behalf to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

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EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **Claim Payment.** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in Section 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

1.2 **Claim Dispute.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

1.3 **Invalidity of Assignments.** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. If Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment; however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 "Claim Overpayments."

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship to a Provider.** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service nor that any Provider is a subcontractor of Claim Administrator with respect to any aspect of this Agreement. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

2.3 **Physician Ratings and Rankings.** Employer acknowledges that Claim Administrator may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and guidelines to rate and rank certain Physicians, and may publish and make available to Employer and Covered Persons certain Physician-specific information that includes, and is not limited to, ratings, rankings, and other comparisons of a Physician's performance against certain standards, measures and other physicians, and that Claim Administrator may publish and/or share such information with Employer,

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Covered Persons and other third parties. Notwithstanding this or any other provisions of this Agreement to the contrary, in no event shall any reference or statement by Claim Administrator about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee as to future services provided by any Physician or Provider or the anticipated outcome of such services.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non-Network Provider for a Covered Service in non-emergency situations, benefit payments to such non-Network Provider are not based upon the amount billed. Non-Network Providers may bill the Plan's Covered Person for any amount up to the difference between the billed charge and the amount the Claim Administrator has paid for the Plan's portion of the bill. For more detailed information regarding benefit payments for Network and Non-Network Providers, please see the definition of Allowable Charge in Section 7 Definitions of this Agreement. A Covered Person may obtain further information about the Network status of Providers and information on out-of-pocket expenses by calling the toll-free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

THIS SECTION 4 SHALL APPLY ONLY WITH RESPECT TO PRESCRIPTION DRUGS OBTAINED UNDER EMPLOYER'S MEDICAL BENEFIT

4.1 Claim Administrator hereby informs Employer and all Covered Persons that it has contracts, either directly or indirectly, with Providers for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with such Providers, under certain circumstances described therein, Claim Administrator may receive payments, discounts and/or other allowances for prescription drugs dispensed to Covered Persons under the Agreement. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

4.2 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or allowances except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. To the extent that Prime Therapeutics LLC ("Prime") provides administrative services as part of the specialty pharmacy program, Prime may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the specialty pharmacy.

4.3 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement.

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SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

THIS SECTION 5 SHALL APPLY ONLY WITH RESPECT TO PRESCRIPTON DRUGS OBTAINED UNDER EMPLOYER'S MEDICAL BENEFIT

5.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, the mail-order pharmacy and specialty pharmacy shall be operated through a third party, which may be an affiliate of or partially owned by Prime Therapeutics, LLC.

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. Employer understands that Claim Administrator may receive such rebates during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service charges specified in the Agreement or as otherwise set forth in the ASO BPA.

5.3 As of the Effective Date, the maximum that a PBM has disclosed to Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to PBM at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed.

SECTION 6: MEDICARE SECONDARY PAYER INFORMATION REPORTING

6.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the RRE and shall report information to CMS about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

6.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer's failure to provide accurate and timely information in response to Claim Administrator's request may impact Claim payments.

6.3 **Disclosure Statement:** Employer acknowledges that Claim Administrator has furnished it with a copy of a pamphlet titled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Association and reviewed by CMS, which administers Medicare.

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6.4 Notwithstanding any other provision herein, in instances where the Employer has carved out prescription drug coverage administration to an entity other than Claim Administrator, Claim Administrator shall not serve as the RRE for prescription drug coverage under the Plan.

SECTION 7: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

7.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

a. Claim Administrator on behalf of Employer has the right to reimbursement for all benefits Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, as a result of that sickness or injury, in the amount of the Provider's Allowable Charge for Covered Services for which Claim Administrator has provided benefits to the Covered Person.

b. Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

7.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to exercise for the same expenses for which Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for, and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 8.

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EXHIBIT 4
ASO BPA

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EXHIBIT 5
BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

1.1 **"Accountable Care Organization"** means a group of health care Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability to manage the total cost of care for their member populations.

1.2 **"Alternative Provider Compensation Arrangements"** means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

1.3 **"Alternative Provider Compensation Arrangement Payments"** means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Home payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments, and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 4.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 4.4 of this Exhibit. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 4.4 of this Exhibit). Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons. Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by Employer's Covered Persons per month. Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

1.4 **"Blue Cross Blue Shield Global Core Access Vendor Fees"** means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

1.5 **"Care Coordination"** means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's health care needs across the continuum of care.

1.6 **"Care Coordinator"** means an individual within a Provider organization who facilitates Care Coordination for patients.

1.7 **"Care Coordinator Fee"** means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

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1.8 **"Global Payment/Total Cost of Care"** means 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.

1.9 **"Host Blue"** means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

1.10 **"Negotiated Arrangement"** means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

1.11 **"Non-Participating Healthcare Provider"** means a health care Provider that does not have a contractual agreement with a Host Blue.

1.12 **"Participating Healthcare Provider"** means a health care Provider that has a contractual agreement with a Host Blue.

1.13 **"Patient-Centered Medical Home"** means a model of care in which each patient has an ongoing relationship with a Primary Care Practitioner who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

1.14 **"Provider Incentive"** means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to any measures or initiatives related to a particular population of Covered Persons.

1.15 **"Shared Savings"** means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed-upon terms and may include downside risk.

1.16 **"Value-Based Program"** means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

SECTION 2: ADMINISTRATIVE SERVICES ONLY

Claim Administrator provides administrative Claims payment services only as set forth in this Agreement and does not assume any financial risk or obligation with respect to Claims.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

Employer, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Claim Administrator to use the Blue Cross and/or Blue Shield Service Mark in the State of New Mexico, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

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SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 *Out-of-Area Services*

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access health care services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator. Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below. This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

4.2 *BlueCard Program*

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Healthcare Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Claim Administrator's action will be consistent with the spirit of this description.

a. *Liability Calculation Method – In General*

(1) Covered Person Liability Calculation.

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on Claims for Covered Services will be based on the lower of the Participating Healthcare Provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

(2) Employer's Liability Calculation.

The calculation of Employer's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may, for a particular service or services, exceed the billed charge in accordance with how the Host Blue has negotiated with its Participating Healthcare Provider(s) for specific health care services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the Covered Person'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.

b. *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 Claim Administrator by the Host Blue may be represented by one of the following:

(1) 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

(2) 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

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payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

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

The Host Blue determines whether it will use an actual, estimated or an 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 Covered Person 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 under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account. Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the 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.

c. ***BlueCard Program Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 4.9 below.

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer. A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its health care provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a health care provider may bill for non-covered health care services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator 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, Claim Administrator will pay the Host Blue's access fee and pass it along to Employer as stated above even though Employer paid little or had no Claim liability.

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4.3 *Negotiated Arrangements*

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue. In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom health care Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's Negotiated Arrangement(s) for national accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

a. *Covered Person and Employer Liability Calculation*

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section 4.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area. Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under Section 4.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments. If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments. Employer acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. *Fees and Compensation*

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 4.9 below. In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

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4.4 *Special Cases: Value-Based Programs*

a. *Value-Based Programs Overview*

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

b. *Value-Based Programs under The BlueCard Program*

(1) *Value-Based Programs Administration*

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these Provider payments to Claim Administrator, which Claim Administrator will pass on to Employer in the form of 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 a Host Blue:

a) ***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.

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

When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings. The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program. At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

b) 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, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the

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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/drawn down over time. The timeframe for the 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 in variance accounts. Note: Covered Persons 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.

(2) ***Care Coordinator Fees***

Host Blues may also bill Claim Administrator for Care Coordinator Fees for Provider services which Claim Administrator will pass onto Employer as follows:

a) PMPM billings; or

b) 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 US CMS.

As part of this Agreement, Claim Administrator and Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

c. ***Value-Based Programs under Negotiated Arrangements***

If Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in BlueCard Program section.

4.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. 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. Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or health care Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

4.6 ***Inter-Plan Arrangements: 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, Claim Administrator will charge any such surcharge, tax or other fee to Employer, which will be Employer's liability.

4.7 ***Non-Participating Healthcare Providers outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Health Care Providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's Non-Participating Healthcare Provider local

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payment or the pricing requirements required by applicable law. The Covered Person may be responsible for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

a. In certain situations, Claim Administrator may use other payment bases to determine the amount Claim Administrator will pay for services rendered by Non-Participating Health Care Providers, such as:

i. Billed charges for Covered Services;

ii. The payment Claim Administrator would make if the health care services had been obtained within Claim Administrator's service area;

iii. A special negotiated payment, as permitted under Inter-Plan Arrangements; or

iv. The lesser of

1. the amount described in (1), above; or

2. for professional Providers, a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or for hospital or facility Providers, a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, a Covered Person may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 4.9 below.

4.8 ***Blue Cross Blue Shield Global Core***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), the Covered Persons may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, the Covered Persons will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

(1) Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the service center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim

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Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

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

(3) Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons 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 service center address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the service center or online at bcbsglobalcore.com. If Covered Persons need assistance with their Claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day/seven days a week.

b. ***Blue Cross Blue Shield Global Core Program-Related Fees***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 4.9 below.

4.9 ***Modifications or Changes to Inter-Plan Arrangement Fees or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective in accordance with Section 6.1(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

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EXHIBIT 6
RECOVERY LITIGATION AUTHORIZATION

Employer hereby acknowledges and agrees that Claim Administrator may, at its election, pursue claims of Employer and/or the Plan, which are related to claims that Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

1. Claim Administrator shall have the right to select and retain legal counsel.

2. Any lawsuit filed or arbitration initiated by Claim Administrator will be done in the name of Claim Administrator for its own benefit, as well as on behalf of Employer and possibly other parties. Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of Employer and/or the Plan without Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of Employer and/or the Plan with attorneys identified as counsel for Employer or in the name of two or more parties, including Employer and Claim Administrator, with attorneys identified as counsel for Employer, Claim Administrator and possibly other parties.

3. The Parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit.

4. Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

5. Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated, or litigated.

6. Claim Administrator shall have the right to assign claims belonging to Employer and/or the Plan to a third party for the purpose of allowing the third party to pursue the claims on Employer's behalf via mediation, arbitration, or litigation. If such an assignment is made, the rights and obligations of Claim Administrator in this Exhibit 6 shall become the rights and obligations of the third party for purposes of the assigned claims only.

7. Any and all recoveries, net of all investigative and other expenses relating to the recovery made through any means pursuant to the provisions of this Exhibit, including any costs of settlement, mediation, arbitration, litigation or trial including attorney's fees, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by Claim Administrator on any reasonable basis it deems appropriate.

8. Any and all information, documents, communications, or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions, and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions, and reports to the full extent allowed by state or federal law. Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of Claim Administrator.

9. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

10. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.

11. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration, or settlement negotiation; therefore, Employer acknowledges that the efforts of Claim Administrator may not result in recovery or in full recovery in any particular case.

12. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require Claim Administrator to assert any claims on Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after Claim

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Administrator has asserted a claim on behalf of Employer and/or the Plan but before any recovery, Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

13. If Employer should desire to participate in a class or multi–district settlement rather than defer to Claim Administrator, Employer may revoke the grant of authority established herein for that specific matter by affirmatively opting into a class settlement and by notifying Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 4.9 Notice and Satisfaction of the Agreement.

14. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 4.9 Notice and Satisfaction of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes Claim Administrator, on behalf of Employer and/or the Plan, consistent with Section 2 above, to:

- **a.** Pursue, without advance notice to Employer, claims that Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, private lien resolution programs, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business, or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
- **b.** Opt out of any class action settlement or keep Employer and/or the Plan in the class, if Claim Administrator reasonably determines that it should do so;
- **c.** Investigate and pursue recovery of monies unlawfully, illegally, or wrongfully obtained from the Plan.

15. Employer further acknowledges and agrees that Claim Administrator's decision to pursue recovery in connection with particular claims shall be in Claim Administrator's sole discretion and Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of Employer and/or the Plan when, as, and if, Claim Administrator determines that such claims may be pursued in the common interest of the parties.

16. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Exhibit.

17. The Parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail with respect to the subject matter hereof.

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BlueCross BlueShield of New Mexico

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number:

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and consent to all of its terms and conditions as of the date and year specified below.

Sample

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO,
a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company

By:
Title: Divisional SVP and Chief Underwriter
Date: Effective Date of Coverage noted above

EMPLOYER NAME ("EMPLOYER")

By: _____
Title: _____
Date: _____

BCBSNM has developed this standard Administrative Services Agreement ("ASA") that describes the administrative services and roles and responsibilities of BCBSNM and a Group Customer. BCBSNM's proposal is based on the standard BCBSNM ASA. Unless specifically stated otherwise in our response, BCBSNM assumes your agreement to the terms and conditions of BCBSNM's standard ASA, but we are open to incorporating mutually agreed upon modifications to the ASA.

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Blue Cross Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

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This Agreement made as of the Effective Date, by and between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and Employer, for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a Plan as defined herein; and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4; and

WHEREAS, Employer on behalf of the Plan desires to retain Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, the Parties agree that it is desirable to set forth more fully the obligations, duties, rights, and liabilities of Claim Administrator and Employer.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services set forth in Exhibit 1 in connection with the administration of the Plan ("Services"). Employer agrees that it will not perform or engage any other party to perform the Services with respect to any Covered Persons while this Agreement is in effect.

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state, or local laws that may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state, and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state, and local rules, laws, and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements, and disclosure requirements that may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state, or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or through Claim Administrator.

1.3 **Claim Appeals.** Appeals will be reviewed with a new full and fair review. If the denial reason was due to medical necessity or experimental/investigational clinical rationale, the appeal will be reviewed by a qualified Physician who had no involvement in the initial review or any prior reviews. If, pursuant to such review, the clinical decision is upheld, then the Covered Person may have the right to seek Independent External Review. The decision of the independent review organization ("IRO") will be final and binding.

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by IROs as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall Claim Administrator have any liability or responsibility for any claim determination, act, or omission by an IRO in connection with any Independent External Review.

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1.5 **Claim Administrator Review of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days' prior written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the Services, Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, any subsidiary or affiliate of Claim Administrator, and any successor entity or entities to Claim Administrator, whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of Claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed. If Employer requests for itself or directs Claim Administrator to work directly with Employer's third-party consultants and/or subcontractors ("Employer's Vendor(s)") in connection with the Services Claim Administrator is providing to Employer, Employer acknowledges and agrees that the services offered by the Employer's Vendor(s) to Covered Persons are offered as a component of the Plan and are consistent with the Employer's Plan design and supported by the Employer's Plan documents. Employer shall remain fully responsible and liable for the performance of any of Employer's Vendors to the extent Employer contracts for services related to the Plan or delegates to other entities any of its obligations under the Plan and for communicating with Covered Persons about any potential consequences or implications related to the services provided by the Employer's Vendor(s). Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to work with Employer's Vendor(s).

The Parties acknowledge and agree Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

2.2 **Employer's Vendor's Responsibility**. Employer will identify to Claim Administrator any of Employer's Vendors and describe to Claim Administrator the services they provide to the Plan. Employer represents and warrants that it has entered into separate contracts with any of Employer's Vendors. Employer agrees that in connection with any services the Employer's Vendor(s) perform related to the Plan, Employer's Vendor(s) shall not engage with or contact any Providers except as authorized in writing by Claim Administrator. Employer agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of Employer's Vendor(s). Employer also agrees Claim Administrator or any of Claim Administrator's affiliates, delegates, subcontractors, or assigns performance under this Agreement shall be excused to the extent they are unable to perform or their performance is affected due to the actions or omissions of Employer's Vendor(s).

2.3 **Employer's Direction as to Benefit Design.** Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in a benefit matrix, highlight sheets, and similar documentation (collectively, "Matrix"), and the ASO BPA. Employer agrees that Claim Administrator shall process Claims in accordance with the Matrix and the ASO BPA. Employer agrees Claim Administrator may rely on the most current version of the Matrix and the ASO BPA as the authorized

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document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

2.4 **Eligibility.** Employer shall determine eligibility for coverage under the Plan. Employer is responsible for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination. Any clerical errors with respect to eligibility will not invalidate coverage that would otherwise be validly in force or continue coverage that would otherwise validly terminate. Such errors will be corrected according to Claim Administrator's reasonable administrative practices including, but not limited to, those related to Timely notification of a change in a Covered Person's status.

2.5 **Notices to Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 6.1, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 3 to Covered Persons.

2.6 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by Claim Administrator with respect to any Covered Persons.

c. Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement.

d. By providing Covered Persons information that may include a telephone and text number, the Employer agrees that Claim Administrator may use that information to secure the Covered Person's consent to contact them via their preferred method of communication (e.g., phone, text, email) with the Claim Administrator.

e. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.7 **Grandfathered Health Plans (If Applicable).** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least sixty (60) days' advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide notice thereof as required) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference into and become part of this Agreement, and Employer represents and warrants that the information it submits on such Form is true, complete, and accurate.

2.8 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans (If Applicable).** If Claim Administrator provides Services for any retiree-only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans are not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any Plan's exempt plan status or any representation regarding any Plan's exempt plan status.

2.9 **Summary of Benefits and Coverage ("SBC").** Unless otherwise provided in the applicable ASO BPA and SBC Addendum (if applicable), Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42

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USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and that Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

2.10 **Massachusetts Health Care Reform Act.** If elected by Employer on the applicable ASO BPA, Claim Administrator will provide required written statements of creditable coverage to Covered Persons residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, in accordance with the Massachusetts Health Care Reform Act based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies (1) that it has or will conduct or otherwise perform creditable coverage testing of the Plan for Massachusetts Health Care Reform Act compliance; and (2) to the best of its knowledge, that any such coverage under the Plan(s) qualifies as "creditable coverage" in accordance with the applicable Massachusetts Health Care Reform Act requirements. Employer acknowledges that Claim Administrator will not verify and is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges that Claim Administrator will have no obligation or responsibility to provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

2.11 **Employer Audits Claim Administrator.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days' prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Any review of Claim information by Employer or an authorized agent of Employer to evaluate Claim Administrator's performance of the administrative services provided according to the terms of this Agreement shall be subject to the terms of this Section. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator's policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information, and to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 **Use and Disclosure of Covered Persons' Information.** The Parties acknowledge and agree that they have entered into a Business Associate Agreement ("BAA") as required by HIPAA. The Parties agree the

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BAA will govern the use, access, or disclosure of all personally identifiable information ("PII"), including Protected Health Information ("PHI"), Claim Administrator may collect or receive. While Claim Administrator does not anticipate receiving or collecting PII about Covered Persons that is not PHI, Claim Administrator agrees to protect and secure any PII of Covered Persons according to the terms of the BAA and agrees to fulfill any other obligations related to PII as required therein.

3.2 **Electronic Exchange of Information.** If Employer and Claim Administrator exchange data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the Parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons, and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data, and other information to Employer in the electronic format mutually agreed to by the Parties.

3.3 **Providing Data to Employer's Vendor(s).** If Employer requests for itself or Claim Administrator to provide data directly to Employer's Vendor(s), Employer acknowledges and agrees that it will execute and shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement. Employer hereby acknowledges and agrees, and Employer's Vendor(s) shall acknowledge and agree:

a. That the requested documents, records, and other information (for purposes of this Section 3, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.

b. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 3, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed.

d. To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

e. To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

f. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.

g. To not sell, re-sell, or lease the Information.

h. To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter.

Employer shall provide Claim Administrator in writing the names of any Employer's Vendors with whom Claim Administrator is authorized to release, disclose, or exchange data and provide written authorization and specific directions with respect to such release, disclosure, or exchange. If Employer's Vendor(s) perform services that involve the use, access or disclosure of PHI as defined by HIPAA, the identity of Employer's Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 **Business Confidential Information and Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information ("BCI"). Employer shall not use or disclose such Business Confidential Information, including this Agreement, to any third party without prior written consent of Claim Administrator. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, to any entity or person, including but not limited to any Covered Person, any

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Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has the opportunity to object and ensure appropriate confidentiality protections are in place. Employer will at all times remain responsible for maintaining the confidentiality of this Agreement and shall ensure that any affiliated entities or third-party representatives to whom the Agreement is disclosed are bound in writing not to further disclose this Agreement without the prior written consent of Claim Administrator. Neither Party shall use the name, symbols, copyrights, trademarks, or service marks ("Proprietary Marks") of the other Party or the other Party's respective clients in advertising or promotional materials without prior written consent of the other Party; provided, however, that Claim Administrator may include Employer in its list of clients.

3.5 **Claim Administrator/Association Ownership.** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association ("BCBSA" or "the Association"). Employer agrees not to contest (i) the Association's ownership of, or the license granted by the Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

3.6 **Infringement.** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Association and utilized by Claim Administrator under a license with the Association.

3.7 **Records.**

a. **Records Retention.** Claim Administrator shall retain all Claim records for the longer of (i) the time period required by applicable law or (ii) the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator. The failure to agree upon a retention period shall not constitute breach of this Agreement.

b. **Record Requests.** For a period of one (1) year following termination of this Agreement, Claim Administrator shall, upon the request of the Employer for general purposes ("Data Reclamation Request"), provide to Employer, a copy of all Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator. Within a mutually agreeable time frame of receipt of the Data Reclamation Request, Claim Administrator shall transmit the dataset in a form mutually agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. The time period for general record requests does not impact nor restrict any legal, regulatory, or mandated data requests.

3.8 **De-Identified Data.** Employer authorizes Claim Administrator to deidentify PHI or PII. Claim Administrator may use or disclose a limited or de-identified data set for any purpose permitted by HIPAA and/or the HIPAA Privacy Rule in effect as of the effective date of this Agreement, unless subsequently prohibited by superseding law or expressly restricted under the BAA entered into between the Parties.

SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS, AND DISPUTE RESOLUTION

4.1 **Litigation.** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against one or both Parties that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either Party under the Plan and this Agreement. Employer shall undertake the defense of such action and be responsible for the costs of defense, including but not limited to attorneys' fees and costs, external claim reviews, and other expenses. Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action, in which event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such

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actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists. Some defense support by Claim Administrator, such as external claim review, may require an additional fee, the costs of which shall be Employer's responsibility.

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator is authorized to follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement. Nor will Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Section 4.2(a.-e.) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

a. **Reductions from Future Payments to Network Providers.** Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or (ii) if the Provider is a Network Provider, from Other Plans, up to an amount equal to the Overpayment (collectively, "Offset").

b. **Cross-Plan Offsets for Network Providers.** Claim Administrator has the right to reduce Another Plan's payment to a Network Provider by the amount necessary to recover the Plan's Overpayment to the same Network Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Network Provider by the amount necessary to recover Another Plan's Overpayment to the same Network Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

c. **Division of Recovery for Multiple Plans.** If Claim Administrator has made Overpayments to a Network Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 4.

d. **Employer Authorization for Offsets and Cross-Plan Offsets.** Employer authorizes and directs Claim Administrator to perform Offsets and Cross-Plan Offsets. Cross-Plan Offsets will be carried out consistent with the terms of the Provider contract. Notwithstanding the foregoing, Employer acknowledges and agrees that claims processed through Inter-Plan Arrangements with other Blue Cross and/or Blue Shield licensees operate under rules and procedures issued by the Association, and the recovery policies and procedures of each Blue Cross and/or Blue Shield independent licensee may apply.

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator shall administer Overpayment recoveries in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan. Employer agrees that it will not perform or engage any other party to perform Overpayment recovery activities with respect to Providers or Covered Persons without prior written consent of Claim Administrator.

4.3 **Third Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied

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according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third parties' fees, as defined in the ASO BPA, associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

4.4 **Claim Administrator Indemnifies Employer.** Claim Administrator hereby agrees to indemnify and hold harmless Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements, or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Claim Administrator or its directors, officers, or employees (other than acts or omissions of Claim Administrator done at Employer's direction) which have been adjudged to be (i) grossly negligent, fraudulent, or criminal or (ii) in material breach of the terms of this Agreement.

4.5 **Employer Indemnifies Claim Administrator.** Employer agrees to indemnify and hold harmless Claim Administrator and its directors, officers, and employees against any and all loss, liability, damages, fines, penalties, taxes, and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, governmental inquiries or actions, settlements, or judgments brought or asserted against Claim Administrator in connection with the design, operation, or administration of the Plan, including but not limited to (a) the Plan's grandfathered health plan status, if applicable, (b) the Plan's exempt plan status, if applicable, (c) any failure to provide information or the provision of inaccurate information to Claim Administrator, (d) any disclosure of information Employer directs Claim Administrator to make, (e) any damages caused by Employer's Vendor(s), or (f) selection of Employer's Essential Health Benefits benchmark for the purpose of ACA; unless the liability therefor was the direct consequence of the acts or omissions of Claim Administrator or its directors, officers, or employees (other than acts or omissions of Claim Administrator done at Employer's direction) and the acts or omissions are adjudged to be (i) grossly negligent, dishonest, fraudulent, or criminal or (ii) in material breach of the terms of this Agreement.

4.6 **Directions Regarding First Dollar Coverage.** If, either on the applicable ASO BPA or other document, Employer directs Claim Administrator to process and adjudicate Claims at one hundred percent (100%) of the applicable Allowable Amount and/or Allowable Charge**,** regardless of whether the high-deductible health plan's deductible has been met ("First Dollar Coverage"), Employer acknowledges and agrees that such direction is a benefit design decision and the responsibility of the Employer. Notwithstanding any other provision of this Agreement, Employer shall indemnify and hold harmless (and upon request defend) Claim Administrator against claims brought by any employees of Employer, participants in any benefit plan provided by Employer, or any governmental agency, in connection with or arising out of, directly or indirectly of the First Dollar Coverage. Employer acknowledges and agrees that Claim Administrator shall have no fiduciary obligation with respect to the directions to provide First Dollar Coverage.

4.7 **Assignment.** Except as otherwise permitted by Section 1 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both Parties. Any such attempted assignment in the absence of the prior written consent of the Parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates, or successors to the Parties.

4.8 **Applicable Law.** This Agreement shall be governed by and construed in accordance with applicable federal laws and the laws of the state of New Mexico without regard to any state choice–of–law statutes. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Albuquerque, New Mexico**.** Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

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4.9 **Notice and Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) of any complaint or concern the other Party may have about the performance of obligations under this Agreement and to allow the notified Party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such, including but not limited to initiation of Dispute Resolution under Section 4.11 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon Timely prior written notification to the other Party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

4.10 **Limitations; Limitation of Liability.** No action or dispute shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents, or independent contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of gross negligence, fraud, or criminal actions by Claim Administrator.

4.11 **Dispute Resolution.** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this section, which shall be the sole and exclusive procedures for the resolution of any such disputes.

a. **Initial Notice and Negotiation.** Employer or Claim Administrator shall give written notice to the other Party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the Parties shall seek to resolve that dispute through informal discussions between authorized representatives of the Parties with appropriate authority to approve any resolution. All negotiations pursuant to this section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

b. **Confidential Arbitration.** In the event the Parties fail to agree with respect to any matter covered herein and only after making good faith efforts to resolve any dispute under this Agreement under this section, Employer or Claim Administrator may submit the dispute to confidential, binding arbitration before the American Arbitration Association ("AAA"), subject to the following:

1. The arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the AAA. If the Parties are unable to agree on an arbitrator from the list, AAA shall appoint an arbitrator.

2. Arbitration shall be held in Albuquerque, New Mexico.

3. Arbitration proceedings will be governed by the AAA Commercial Rules.

4. The arbitrator shall be required to issue a written opinion resolving all disputes in any matter and designating one Party as the prevailing Party.

5. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction over the dispute.

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6. The arbitrator's fees and any costs imposed by the arbitrator will be shared equally by the Parties. All costs and expenses, including but not limited to reasonable attorney and witness fees shall be borne by the non-prevailing Party or as apportioned by the arbitrator.

7. This provision precludes Employer from filing an action at law or in equity and from having any dispute covered by this Agreement heard by a judge or jury.

8. Except as may be required by law, neither a Party nor an arbitrator may disclose the existence, content, or results of any arbitration pursuant to this section without the prior written consent of both Parties.

c. Except as provided otherwise in this Agreement, each Party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

4.12 **Transparency and Surprise Billing Procedures.** Claim Administrator agrees to provide Employer the services and processes described in this section consistent with the Consolidated Appropriations Act of 2021 ("CAA"), Transparency in Coverage Final Rule, and the No Surprises Act ("NSA").

a. Transparency Procedures.

1. ***Network Provider Data Verification.*** Claim Administrator will maintain a central database of Network Providers' demographic information, which shall include name, address, phone number, specialty, and, if available, web address ("Data Elements"). Claim Administrator will initiate an outreach to Network Providers to verify the accuracy of the Data Elements up to ninety (90) days following the last recorded update or verification. Claim Administrator has implemented commercially reasonable procedures to track the receipt of updated data from a Network Provider and update the central database within appropriate timeframes.

2. ***Directory of Verified Network Providers.*** Claim Administrator will provide an online Provider directory representing the Network Providers who render Covered Services which may be billed to plans and policies administered by Claim Administrator. This directory shall include Providers contracted with Claim Administrator, Providers contracted with any Blue Cross and/or Blue Shield Plan, and any other entity performing Covered Services. The directory will not reflect services administered by external claims administrators or other Providers not contracted through Claim Administrator.

Providers who fail to confirm the accuracy of the Data Elements may be subject to removal from the Provider directory until they confirm the accuracy of their information.

To the extent information for the Provider directory is provided by a third party, Claim Administrator shall not be responsible for delays in updates to Provider data directories, or misinformation due to such delays in receiving information from such third party.

3. ***Provider Network Status Verification.*** Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide written, electronic, or print confirmation of the Provider's Network status within an appropriate timeframe. This verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

Employer acknowledges that Claim Administrator will not issue a written confirmation of Provider Network status when request is sought through a third-party service center.

4. ***ID Cards.*** Claim Administrator will include up to four (4) lines of text for deductible limits and up to four (4) lines of text for out-of-pocket maximum limits for major medical coverage

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on the member ID card. The limits will reflect both family and individual limits when applicable to policy, together with in- and out-of-network limits.

For policies that include prescription drug coverage through Prime with an independent out-of-pocket maximum limit or Deductible, one (1) line of text for deductible limits and one (1) line of text for out-of-pocket maximum limits will be included on the ID card.

Claim Administrator will include a phone number and a website URL for customer assistance information on ID cards issued by Claim Administrator.

Claim Administrator will issue physical ID cards in accordance with its standard processes and will not re-issue physical ID cards unless requested by Employer, in which case additional charges may apply. All newly issued physical ID cards will contain the information reflected in this section.

5. ***Machine-Readable Files.*** Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by the Centers for Medicare and Medicaid Services ("CMS") standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The files will not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine-Readable Files, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the performance, acts, or omissions of any of Employer's Vendors.

6. ***Cost Sharing Estimator Tool.*** Claim Administrator will make available a Cost Sharing Estimator Tool ("CSET") to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through either self-service tools or telephone upon member request, a secure member portal, and via a mobile application, for active policies, and include services in accordance with the following schedule:

   Effective with the plan year beginning on or after January 1, 2023, enrollees will be able to search for the cost of five hundred (500) services, as defined by CMS, covered by the Plan administered by Claim Administrator, to identify the estimated cost for the procedure, illustrate how the member's benefits will apply to the procedure, and disclose if there may be any prerequisites to care, such as requiring a prior authorization for a service or procedure.

   For each plan year beginning on or after January 1, 2024, the services that can be estimated through the CSET will support all services and procedures covered by the Plans that are administered by Claim Administrator.

   To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors, or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the acts or omissions of any of Employer's Vendors.

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7. ***Drug Cost Reporting.*** Claim Administrator will provide on behalf of Employer, based on the type of pharmacy coverage and data Claim Administrator administers and maintains for Employer, health and drug cost reporting to the extent within the possession of Claim Administrator as contemplated by Section 204 of the CAA according to Claim Administrator's standard processes and procedures, unless otherwise mutually agreed in writing.

8. ***Continuity of Care.*** In the event of a Provider termination for reasons other than failure to meet quality standards or fraud, Claim Administrator shall notify individuals enrolled under the Plan who are continuing care patients with respect to the Provider at the time of the termination. Claim Administrator will provide each individual who is a continuing care patient of a terminated Provider, the opportunity to request to continue to have the same benefits provided, under the same terms and conditions as would have applied under the Plan had the termination not occurred, with respect to the treatment provided by the Provider for a specified duration (for purposes of this section, "Continuity of Care"). Claim Administrator will identify continuing care patients and provide Continuity of Care in accordance with Claim Administrator policies.

9. ***Required Disclosure/Notices.*** Claim Administrator will post the disclosure on patient protections against balance billing on its public website where information is normally made available to participants, beneficiaries, and enrollees, on the Plan's behalf.

10. ***Mental Health Parity.*** Claim Administrator will, consistent with industry standards, support reasonable requests of Employer for data or other documentation that Employer may need to analyze and document the Plan's compliance with applicable Mental Health Parity requirements, including amendments to Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008. So long as Employer has elected to implement Claim Administrator's standard non-quantitative treatment limitations ("NQTLs") and so long as Claim Administrator administers both mental health/substance abuse benefits and medical/surgical benefits on behalf of Employer, Claim Administrator will provide, when requested by Employer, the most current documentation with respect to Claim Administrator's administered NQTLs under the Plan which may be necessary for Employer to meet the NQTL documentation requirements set forth in the CAA and released guidance. In addition, in the event that the U.S. Department of Labor or other regulatory agency ("Agency") with competent jurisdiction over the Plan initiates an audit or other assessment related to the Plan's compliance with mental health parity requirements, including the obligation to perform and/or make available the comparative analyses described above, Claim Administrator agrees to provide expedited support to enable Employer and the Plan to timely provide or otherwise make available or accessible the documentation requested by the reviewing entity. Both Parties agree and understand that no data or other documentation provided by Claim Administrator under this Section shall be reasonably interpreted as the Claim Administrator's certification of the compliance of the Plan or any Claim Administrator's administered NQTLs or other processes with State or Federal Mental Health Parity requirements nor does it obviate the Employer's obligation under MHPAEA to independently comparatively analyze each NQTL applied in its Plan. Employer agrees that assessing and making conclusions as to the compliance of the Plan with such NQTL requirements is solely the responsibility of Employer.

b. Surprise Billing Requirements of the No Surprises Act.

1. ***Qualifying Payment Amount.*** As it pertains to Employer's self-funded plans, Employer acknowledges that NSA requires, among other things, that member cost-share for certain items and services the Plan covers are calculated based on the lesser of the Provider's billed charge or the NSA's "Qualifying Payment Amount" ("QPA"). Up and until October 31, 2024, with respect to the calculation of QPA, Employer elects to use and adopts the QPA

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calculated by Claim Administrator based on Claim Administrator's self-funded business. Employer acknowledges litigation is pending over various regulatory provisions that govern QPA. The referenced litigation (or agency rulemaking or guidance related to the litigation) could require changes to how QPA is calculated for Employers' self-funded plans. Pursuant to Claim Administrator's understanding of previous agency guidance, Claim Administrator calculates QPA for self-funded plans based on all of Claim Administrator's self-funded business, i.e., QPAs are not calculated specific to each Employer's self-funded plan(s). It may be infeasible or impracticable for Claim Administrator to make certain changes to how such calculations are made, maintained, and/or used in processing Claims for Employer's Plans on or after November 1, 2024. To illustrate, such limitations could include, but are not limited to, the following: Claim Administrator does not have access to contracts or contracted rates of other claim administrators; and Claim Administrator's current capabilities and the fees and expenses charged to Employer herein do not support calculating, maintaining, and/or processing Claims with Employer- or Plan-specific QPA calculations. If the litigation (or agency rulemaking or guidance related to the litigation) requires changes to how QPAs are calculated for self-funded plans, and Claim Administrator agrees such changes to QPA calculations are practicable and feasible for Claim Administrator to make, maintain, and use in processing Claims, and Claim Administrator opts not charge additional fees or expenses for any such changes, Claim Administrator may institute such changes to calculation of QPA without further notice; otherwise, the Parties shall mutually agree in writing whether and how Claim Administrator shall calculate QPA for Claims beginning on or after November 1, 2024.

2. ***Negotiation and Independent Resolution Process.*** Employer acknowledges that Claim Administrator will make on the Plan's behalf an initial payment amount on Claims consistent with Employer's direction as established by Employer's Plan and this Agreement. For covered NSA-eligible items and services reported on Claims from nonparticipating Providers (i.e., generally noncontracted), a Provider may seek additional payment through a dispute process established by the NSA and related regulations. This process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

   Employer authorizes Claim Administrator, or for Claims for service rendered outside of Claim Administrator's service area another Blue Cross and/or Blue Shield licensee, to represent the Plan with respect to any Claim with items or services for which a Provider seeks to negotiate as provided by the NSA, or for which a Provider institutes IDR.

   With respect to any negotiations where Claim Administrator represents the Plan to resolve any disputed Claim, Employer expressly authorizes Claim Administrator in such negotiations to attempt to resolve any disputed Claim, (i) for an amount not to exceed the greater of the QPA or the amount allowed on the initial notice of payment or denial of the claim, or (ii) as otherwise directed by Employer in the ASO BPA and agreed to by Claim Administrator.

   Claim Administrator will maintain a summary description of its currently applicable approach to negotiation of services or Claims subject to the dispute resolution process of the NSA. The approach will be generally the same or similar for Claims under Employer's Plan as for similarly-situated Claims under Claim Administrator's fully insured health insurance policies.

   Employer acknowledges and agrees that Claim Administrator shall follow its then-current negotiation approach, that such negotiations may not be successful, and may result in institution of IDR despite the approach outlined above or as otherwise directed by the Employer (with or without exhaustion of the full settlement authority Employer may grant to Claim Administrator), which in turn may result in additional administrative fees, as well

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as IDR entity fees in the event of settlement after institution of an IDR or an IDR loss. Notwithstanding the additional administrative fee and other possible expenses, Employer acknowledges that the approach set forth herein, or as it may direct (subject to Claim Administrator's agreement) in the ASO BPA for attempting to resolve these Claims, notwithstanding the potential for IDR losses, is in the Plan's interest.

Negotiation services Claim Administrator provides shall include communicating with Provider, supplying requested documentation as appropriate, and proposing and documenting resolution of disputed Claims. Services in connection with an IDR shall also include handling interactions with the IDR entity and Provider, supplying requested information in connection with the IDR, and analyzing circumstances of disputed Claims to determine position on disputed Claims. On a quarterly basis, Claim Administrator shall provide Employer with information regarding the status of negotiations and IDR decisions.

Employer acknowledges that Claim Administrator undertakes negotiations at the direction of the Employer, undertakes such negotiations because they are necessary to the operation of the Plan, that the compensation to be paid to Claim Administrator for such negotiations is reasonable, and that, notwithstanding any other section of this Agreement, Claim Administrator does not act as a fiduciary, including under ERISA in connection with the negotiation or IDR of any disputed Claim. Employer is solely responsible for payment of any amounts determined to be payable as a result of such negotiations or awards entered through IDR on NSA-eligible items and services. Employer indemnifies and will hold Claim Administrator harmless with respect to any award entered in IDR and any subsequent payment made thereon and/or any judgment entered thereon. Employer acknowledges that other terms, conditions, or fees may apply with respect to any negotiations or IDR processes performed by another Blue Cross and/or Blue Shield licensee.

c. Effect of Future Changes in Law and Regulations. The laws and regulations that are the subject of this Section 4.12 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective sixty (60) days after such notice.

Employer acknowledges that Employer, and not Claim Administrator, shall be responsible for making the necessary adjustments to its ERISA Plan Document(s) (if applicable) and Summary Plan Description(s) to be consistent with Employer's election, including any amendments to governing Plan documents.

SECTION 5: ERISA

5.1 **In Relation to the Plan.** Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of Employer, Employer agrees that no allocation or delegation of any responsibilities under the Plan or any other employee welfare benefit plan of Employer is effective with respect to or accepted by Claim Administrator.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's employee welfare benefit plan as defined under ERISA. Employer represents and warrants that (i) Employer has a named Plan Administrator and a Named Fiduciary within the meaning

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of §414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of §3(16)(A) of ERISA; and (iii) Claim Administrator is not a fiduciary of Employer, the Plan Administrator, or of the Plan.

5.3 **In Relation to Claim Administrator's Responsibilities.** Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of Employer's Plan. As such, Claim Administrator is intended to be a service provider but not a fiduciary with respect to Employer's ERISA employee welfare benefit plan. Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of Employer's ERISA welfare benefit plan. Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

SECTION 6: OTHER PROVISIONS

6.1 **Term and Termination.** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein. This Agreement may be terminated as follows:

a. By either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with ninety (90) days' prior written notice to the other party; or

b. By both Parties on any date mutually agreed to in writing; or

c. By either Party, in the event of conduct by the other Party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 4.9 above; or

d. By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon Employer's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to Employer as provided in Section 7.1 of Exhibit 2 of this Agreement.

6.2 **Relationship of the Parties and Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented, or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers, or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. Nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents. Claim Administrator or its subsidiaries or affiliates may also have ownership interests in certain Providers who provide Covered Services to Covered Persons, and/or in vendors or other third parties who provide services related to this Agreement or provide services to certain Providers. Upon Employer request (not more than once per calendar year), Claim Administrator will provide a list of such entities to Employer.

6.3 **Entire Agreement.** This Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the Parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are

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superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement shall prevail in the event of a conflict with any Prior Communications that either Party or a third party asserts to be a component of the Agreement between the Parties.

The Exhibits and Addenda of this Agreement are:

a. Exhibit 1 – Claim Administrator Services

b. Exhibit 2 – Fee Schedule and Financial Terms

c. Exhibit 3 – Notices/Required Disclosures

d. Exhibit 4 – ASO BPA

e. Exhibit 5 – Blue Cross and Blue Shield Association Disclosures and Provisions

f. Exhibit 6 – Recovery Litigation Authorization

g. Exhibit 7 – Pharmacy Benefit Management Services

6.4 **Amending.** This Agreement may be amended by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation, or order ("Law") or by Claim Administrator or the Association may be implemented by Claim Administrator upon at least sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer does not object within sixty (60) days after receiving such notice, the proposed amendment will be deemed to be agreed upon and will become a part of this Agreement. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. In the event of such objection, if the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to terminate the Agreement, as set forth in Section 6.1, or, at its option, Claim Administrator may cease performing the obligations impacted by such Law.

6.5 **Severability; Enforcement; Force Majeure; Survival.** Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

Any delay or inconsistency by either Party in the enforcement of any part of this Agreement shall not constitute a waiver by that Party of any rights with respect to the enforcement of any part of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

Neither Party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, terrorism, cybersecurity crimes, or restraints of government.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 1 "Claim Administrator Responsibilities"; Section 2 "Employer Responsibilities"; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); and Section 8 of Exhibit 2 "Financial Obligations Upon Agreement Termination."

6.6 **Notice of Annual Meeting.** Employer is hereby notified that it is a member of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois, each year on the last Tuesday in October at 12:30 P.M. For purposes of this section, the

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term "member" means the group, trust, association, or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee, or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 7: DEFINITIONS

Capitalized terms used in this Agreement shall have the meanings set forth in this Section 7, unless otherwise provided in the Agreement.

7.1 **"Administrative Charge"** means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

7.2 **"Allowable Amount"** means the maximum amount for dental benefits coverage, if elected on the most current ASO BPA, determined by the Claim Administrator to be eligible for consideration of payment for a particular service, supply, or procedure.

i. ***For Dentists contracting with the Claim Administrator*** – The Allowable Amount is based on the terms of the Dentist's contract and the Claim Administrator's methodology in effect on the date of service.

ii. ***For Dentists not contracting with the Claim Administrator*** – The Allowable Amount is based on the amount the Claim Administrator would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and the Claim Administrator:

i. ***For services performed in New Mexico*** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

ii. ***For services performed outside of New Mexico*** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.

iii. ***For multiple surgical procedures performed in the same operative area*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.

7.3 **"Allowable Charge"** means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. **For Medical Covered Services.**

i. ***For Network Providers -*** The Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

ii. ***For Providers other than Medical Network Providers ("Non-Contracting Providers")-*** The Allowable Charge will be the lesser of:

1. the Provider's billed charges, or;

2. Claim Administrator's non-contracting Allowable Charge. Except as otherwise provided in this Section, the non-contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the Claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than one hundred percent (100%)

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of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, or is unable to be determined based on the information submitted on a Claim, the Allowable Charge for Non-Contracting Providers will be reimbursed at Claim Administrator's default percent of billed charges. Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event Claim Administrator does not have any Claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments. Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor. In the event the non-contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person may be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's non-contracting Allowable Charge for a particular service, the Covered Person may call the Customer Service number shown on the back of the Covered Person's Identification Card. Notwithstanding anything to the contrary in the Plan, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be consistent with the In-Network benefit level for Covered Services provided, the amount the Provider has agreed to accept as payment for Covered Services in accordance with a single case agreement, or one-hundred percent (100%) of billed charges, whichever is less.

Each of these amounts is calculated excluding any Network or contracting Provider Copayment or Coinsurance imposed with respect to the Covered Person.

b. When Covered Services are received outside the state of New Mexico from a Provider who does not have a written agreement with Blue Cross and/or Blue Shield of New Mexico or with the local Blue Cross and/or Blue Shield Plan, the Allowable Charge will be determined by the Blue Cross and/or Blue Shield Plan ("Host Plan") servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

c. ***For Prescription Drug Benefits,*** the Allowable Charge is determined as follows:

i. **Participating Pharmacy –** For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Charge, for purposes of calculating Employer Payment and the Covered Persons' required deductible and Coinsurance, shall be the cost mutually agreed upon by Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference, if applicable.

ii. **Out-of-Network Pharmacy –** For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription

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drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered, the Allowable Charge for purposes of calculating both Employer Payment and the Covered Persons' required deductible and Coinsurance shall be the lesser of the charge which the particular Out-of-Network Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus twenty-five percent (25%) unless otherwise agreed upon by Claim Administrator and Employer.

7.4 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and/or Blue Shield licensees through Inter-Plan Arrangements, that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications, enhancements, derivatives, and improvements of the Business Confidential Information described in the preceding sentence.

7.5 **"Claim"** means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex, and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

7.6 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction**.**

7.7 **"Claim Payment"** means the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Amount and/or Allowable Charge**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments." The term "Claim Payment" also can include payments for services to Employer's Vendor(s) or Claim Administrator's subcontractors.

7.8 **"Coinsurance"** means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

7.9 **"Contracting Dentist"** means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a dental Provider.

7.10 **"Copayment"** means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

7.11 **"Covered Employee"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.12 **"Covered Person"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

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7.13 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

7.14 **"Dentist"** means a person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

7.15 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

7.16 **"Fee Schedule"** means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2.

7.17 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

7.18 **"HIPAA"** means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

7.19 **"Hospital"** means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged, or similar institutions.

7.20 **"Inpatient"** means the Covered Person is a registered room and board patient and treated as such in a health care facility.

7.21 **"Network"** means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

7.22 **"Outpatient"** means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

7.23 **"Overpayment"** means a payment to a Provider or a Covered Person that was in excess of the actual correct amount based on the Plan's benefit design and Claim Administrator's or other Blue Cross and/or Blue Shield companies' Provider contracts and policies, or a payment that was made in error, including but not limited to, Provider's unsupported billing practices.

7.24 **"Physician"** means a physician duly licensed to practice medicine in any of its branches recognized by applicable state law.

7.25 **"Plan**" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

7.26 **"Primary Care Practitioner"** means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to Covered Persons, who initiates the patient's referral for specialist care, who maintains continuity of patient care, who is a Network Provider at the time Covered Services are rendered, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care. Primary Care Practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also serve as Primary

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Care Practitioners, as defined by the State in which the professional is in practice (otherwise known as a "Primary Care Provider").

7.27 **"Provider"** means any Hospital, health care facility, laboratory, person, or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products, or supplies which are Covered Services.

7.28 **"Reminder Notice"** means a notice sent when claims have not been paid within 10 (ten) days.

7.29 **"Supplemental Charge"** means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any customized reports, forms, or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

7.30 **"Surcharges"** means local, state, or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global® Core Access Vendor Fees, paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits.

7.31 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within forty-eight (48) hours of notification to Employer by Claim Administrator, monthly fees (e.g., Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

c. With respect to all Plan information due Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

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EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions on applicable benefit plan terms and design, including determination of pre-service or prior authorization of services. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits ("COB") processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS ("EOB")**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, when scheduled in advance based on staffing availability, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care Providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care Providers who render services to Covered Persons.

- **DISABLED DEPENDENT CERTIFICATION**

  Certify the disabled status of any dependent children of Covered Persons, based on Claim Administrator's review of information provided by Employer, the Covered Person, or the dependent's medical Provider(s), following either the Standard or Custom Rules as indicated on the most current ASO BPA, for purposes of administering the Employer's age limit for eligibility.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer from listing below:

  a. ***Enrollment Materials.*** Claim Administrator's Marketing Administration Division will provide implementation materials during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Prepare identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to a toll–free Customer Service telephone number.

  e. ***Medical Prior-Authorization Service Telephone Number.*** For those services determined by Employer and provided in writing to Claim Administrator that require prior authorization, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical prior-authorization service telephone number for Covered Persons and their health care Providers to call for assistance.

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- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make Claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlements (as outlined in Exhibit 2, Section 6), and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting processes at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the Parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service ("IRS") 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND UNDERWRITING**

  Provide Claims projections and pricing of administrative services and stop–loss coverage.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and if the Employer is a target of a pattern of fraudulent or abusive activities inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 6.

- **EMPLOYER PORTAL (currently called "BLUE ACCESS FOR EMPLOYERS℠")**

  Provide Employer with an on-line resource that allows Employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about Claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called "BLUE ACCESS FOR MEMBERS℠")**

  Provide Member with an on-line resource that allows individuals access to information about their health care coverage and benefits, currently verifying the status of finalized Claims, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit plan coverage(s) under the Agreement, establish, arrange, and maintain a Network(s) through contractual arrangements with Providers.

- **MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING**

  Pursuant to Exhibit 3, Section 6 titled "Medicare Secondary Payer Information Reporting", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

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- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), Claim Administrator will issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, Claim Administrator will remit such funds to Employer, less any amount(s) owed to Claim Administrator from such funds, in accordance with Claim Administrator's established procedures, for disposition by Employer as may be required under applicable law. If requested by Employer via prior written notice as required by Claim Administrator, Claim Administrator will escheat such funds on behalf of Employer, less any amount(s) owed by payees to Claim Administrator, from such funds, to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the Parties in writing prior to their performance and may be subject to Supplemental Charge.

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Services under Exhibit 1 do not include providing Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term “Services” does not include backroom operations such as support functions. The term Services does not include services provided by Employer’s Vendor(s).

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **ADVANCED PAYMENT REVIEW (“APR”)**

  Provide a program that may include post-service, prospective, and retrospective Claim coding or billing reviews to identify discrepancies, errors, or billing inconsistencies of Claim Payments as identified by Claim Administrator.

- **ADDITIONAL PROGRAMS OR SERVICES**

  Claim Administrator may offer additional programs or services for an additional fee if elected by Employer and identified as a Service in the most recent BPA or other Exhibit to this Agreement.

- **EXTERNAL REVIEW COORDINATION**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator’s coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan’s determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, cancer services and support, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator. Audits relating to Wellbeing Management shall be subject to Claim Administrator’s then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. Such Services may be subject to a service charge and/or additional Claim Charge.

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- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING ("RBP")**

  Assist Employer with establishing a maximum coverage amount for specified imaging, Inpatient, and Outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app, or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE ("SBC")**

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, cancer services and support, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator. Audits relating to Health Advocacy Solutions shall be subject to Claim Administrator's then current external clinical audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. Such Services may be subject to a service charge and/or additional Claim Charge.

- **FLEXACCESS™**

  Claim Administrator or its designee(s) will proactively enroll Covered Persons into a program designed to lower prescription drug costs through manufacturer copay assistance programs. Under this program, copays for a select list of applicable drugs are maximized within the benefit plan design, and the manufacturer-provided copay assistance programs are applied to offset medication costs. The manufacturer copay assistance will not apply to Covered Persons' deductibles and out-of-pocket maximum accumulators. Through active outreach to Covered Persons, Claim Administrator or its designee(s) will help Covered Persons attempt to enroll in a copay assistance program prior to paying for any Covered Person's claim.

- **FLEXACCESS™ QUALIFIED HDHP**

  Claim Administrator or its designee(s), through active outreach to Covered Persons, will help Covered Persons attempt to enroll in a manufacturer assistance program. Under this program, the manufacturer provided assistance may be used by the Covered Person at the point of sale to offset their out-of-pocket medication costs. Claim Administrator or its designee(s) will ensure manufacturer assistance funds used by Covered Persons do not apply to the Covered Persons accumulators.

- **GENE THERAPY SOLUTION: CELL AND GENE NAVIGATION & GENE OUTCOMES**

  Provide (1) the mutually agreed upon member navigation services for Covered Persons who are eligible to receive gene and cellular therapy services to assist such Covered Persons with obtaining services at a participating Provider, and (2) access to payments resulting from outcome-based agreements held, directly or indirectly, with Manufacturers of gene and cellular therapy drugs. Claim Administrator may receive payments in the event that select gene or cellular therapy treatments fail to meet the outcome-based metrics set forth in the outcome-based agreement with the Manufacturer. Claim Administrator will pay Employer

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the agreed upon percentage of the outcome based payment set forth in the BPA of the outcome based payment received by Claim Administrator. Notwithstanding the foregoing, the Employer will not be eligible to receive any payments received from outcome-based agreements after final settlement, following the termination of this Agreement and the completion of any applicable Run-Off period.

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EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Fee Schedule Addendum, if applicable. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA and the PBM Fee Schedule Addendum, if applicable; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Fee Schedule Addendum, if applicable; or iii) the date the Agreement is terminated (or, if applicable, in the case of the PBM Fee Schedule Addendum, the date such PBM Exhibit is terminated).

Inter-Plan Arrangement Fees:

1.1 **BlueCard® Program/Network Access Fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable.

1.2 **Negotiated Arrangement/Custom Fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

1.3 **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**If applicable, such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or two thousand dollars ($2,000) per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

2.1 **"Employer Payment"** means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 **"Employer Payment Method"** means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 **"Employer Payment Period"** means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Exhibit 3 Section 6 titled "Medicare Secondary Payer Information Reporting.")

2.5 **"Run–Off Claim"** means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

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2.6 **"Run–Off Period"** means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of Service Charges.*** Employer will pay service charges to Claim Administrator in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Fee Schedule Addendum, if applicable, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining Service Charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Fee Schedule Addendum, if applicable, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing Service Charges.*** Such service charges shall be subject to change by Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that sixty (60) days' prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (e.g., benefit levels, census/demographics, producer/broker fees) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service Charges upon Termination.*** In the event the Agreement is terminated in accordance with the "Term and Termination" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a partial termination of Covered Employees by Employer, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

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3.5 ***Additional Service Charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s); and/or
- **b.** Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to Employer, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or
- **d.** Any other fees for services mutually agreed upon by the Parties in writing.

3.6 ***Effect of Plan Enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely Payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

3.8 ***Shared Savings Programs*****.** Claim Administrator may offer programs that include compensation to the Claim Administrator based on shared savings as may be described in the most recent BPA or in another mutually agreed writing between the Parties. In general, these "Shared Savings Programs" measure savings as reductions in expected or actual Claims costs by reason of the Employer's adoption of the program. Employer acknowledges and agrees that Claim Administrator does not act as a fiduciary under ERISA when engaging in activities related to Shared Savings Programs under this Section because such activities do not constitute an exercise of discretion or control over Plan assets or Plan administration.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's Payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's Liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "Claim Settlements." Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

4.3 ***Covered Person's Certain Liability.*** Under certain circumstances, if Claim Administrator pays the health care Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

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SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period**.**

5.2 ***Confirmation or Notification of Amount Due and Payment Due Date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

a. ***If Employer Payment Method is by Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.

b. ***If Employer Payment Method is other than Check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the Parties, of the amount due. Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current ASO BPA. The Claim settlement shall reflect the sum of the following:

a. Claim Payments paid by Claim Administrator in the particular Claim Settlement Period.

b. Claim Payments paid by Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the "Claim Settlement Total."

6.2 ***Employer Underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within ninety (90) days from the last day of the Claim Settlement Period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer Overpayment.*** If, within the Claim Settlement Period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

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SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer Fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent. If defaults are not cured following notice via email to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice.

7.2 ***When Claim Administrator Fails to Timely Notify.*** Pursuant to Section 6.5 "Severability; Enforcement; Force Majeure; Survival" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

7.3 ***Late Charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, or on the date which Employer terminates a part of the population of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or termination of Covered Employees but not the Agreement, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of termination of Covered Employees but not the Agreement.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

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8.3 ***Final Settlement.*** A final settlement shall be made within ninety (90) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments or recoveries for Overpayments, including, but not limited to, subrogation or litigation activities, regardless of when such adjustments or recoveries occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed Funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old), less any amount(s) owed by payees to Claim Administrator from such funds, will be escheated by Claim Administrator on Employer's behalf to the state of payee's last known address in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

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EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **Claim Payment.** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in Section 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

1.2 **Claim Dispute.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

1.3 **Invalidity of Assignments.** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. If Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment; however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 "Claim Overpayments."

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship to a Provider.** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service nor that any Provider is a subcontractor of Claim Administrator with respect to any aspect of this Agreement. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

2.3 **Physician Ratings and Rankings.** Employer acknowledges that Claim Administrator may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and

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guidelines to rate and rank certain Physicians, classify certain Physicians into tiers, and may publish and make available to Employer and Covered Persons certain Physician-specific information that includes, and is not limited to, ratings, rankings, tiers, and other comparisons of a Physician's performance against certain standards, measures and other physicians, and that Claim Administrator may publish and/or share such information with Employer, Covered Persons and other third parties. Notwithstanding this or any other provisions of this Agreement to the contrary, in no event shall any reference or statement by Claim Administrator about a Physician or Provider be construed as a recommendation or referral to such Physician or Provider, or as a guarantee as to future services provided by any Physician or Provider or the anticipated outcome of such services.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non-Network Provider for a Covered Service in non-emergency situations, benefit payments to such non-Network Provider are not based upon the amount billed. Non-Network Providers may bill the Plan's Covered Person for any amount up to the difference between the billed charge and the amount the Claim Administrator has paid for the Plan's portion of the bill. For more detailed information regarding benefit payments for Network and Non-Network Providers, please see the definition of Allowable Charge in Section 7 Definitions of this Agreement. A Covered Person may obtain further information about the Network status of Providers and information on out-of-pocket expenses by calling the toll-free number on their identification card or by accessing online tools and services such as Blue Access for Members or Provider Finder.

SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

4.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the "Allowable Charge", subsection (c)(i). All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the "Allowable Charge", subsection (c)(ii).

4.2 Claim Administrator hereby informs Employer and all Covered Persons that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Claim Administrator may receive payments, discounts and/or other allowances for prescription drugs dispensed to Covered Persons under the Agreement. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

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4.3 Employer understands that Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or allowances except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate Covered Persons' deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the Parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts, payments and/or other allowances that Prime has negotiated with pharmacies (or other suppliers) are passed through to Claim Administrator. For the administrative services that Prime provides as part of the mail order and specialty pharmacy program, Prime may keep as its fee a portion of the discounts and/or other allowances that it has negotiated with the mail-order and/or specialty pharmacy. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

4.4 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement.

SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

5.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, the mail-order pharmacy and specialty pharmacy shall be operated through a third party, which may be an affiliate of or partially owned by Prime Therapeutics, LLC.

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). PBM may contract with pharmaceutical manufacturers through a group purchasing organization and, in such case, rebates collected by PBM and paid to Claim Administrator will be net of any fee the group purchasing organization may retain for its role in securing rebates. Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM and

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Claim Administrator's own rebate contracts with pharmaceutical manufacturers. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls, and rebate arrangements between Claim Administrator and pharmaceutical manufacturers. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Claim Administrator may provide Employer with a rebate credit, the amount of which is set forth in the ASO BPA (the "Rebate Credit"). The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets notwithstanding the actual amount of rebates, payments, discounts and/or other allowances provided to Claim Administrator by the PBM or pharmaceutical manufacturers. Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its Plan have no right to, or legal interest in, any portion of the rebates, payments, discounts and/or other allowances provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates, payments, discounts and/or other allowances. Rebate Credits shall not continue after termination of the prescription drug program.

5.3 As of the Effective Date, the maximum that a PBM has disclosed to Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and a half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to PBM at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed.

SECTION 6: MEDICARE SECONDARY PAYER INFORMATION REPORTING

6.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the RRE and shall report information to CMS about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

6.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer's failure to provide accurate and timely information in response to Claim Administrator's request may impact Claim payments.

6.3 **Disclosure Statement:** Employer acknowledges that Claim Administrator has furnished it with a copy of a pamphlet titled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Association and reviewed by CMS, which administers Medicare.

6.4 Notwithstanding any other provision herein, in instances where the Employer has carved out prescription drug coverage administration to an entity other than Claim Administrator, Claim Administrator shall not serve as the RRE for prescription drug coverage under the Plan.

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6.5 Employer acknowledges that Employer shall be responsible for any Civil Money Penalties ("CMP") imposed against Claim Administrator as a result of Employer's failure to promptly notify Claim Administrator of any change in the number of individuals employed by Employer or status of its Employees that might affect the order of payment under the MSP statute.

SECTION 7: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

7.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

a. Claim Administrator on behalf of Employer has the right to reimbursement for all benefits Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, as a result of that sickness or injury, in the amount of the Provider's Allowable Charge for Covered Services for which Claim Administrator has provided benefits to the Covered Person.

b. Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

7.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to exercise for the same expenses for which Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 8: REPLACEMENT COVERAGE

A Covered Person may, under certain circumstances, as specified below, apply for, and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 8.

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EXHIBIT 4
ASO BPA

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EXHIBIT 5
BLUE CROSS AND BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

1.1 **"Accountable Care Organization"** means a group of health care Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability to manage the total cost of care for their member populations.

1.2 **"Alternative Provider Compensation Arrangements"** means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

1.3 **"Alternative Provider Compensation Arrangement Payments"** means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Home payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments, and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 4.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 4.4 of this Exhibit. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 4.4 of this Exhibit). Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons. Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by Employer's Covered Persons per month. Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

1.4 **"Blue Cross Blue Shield Global Core Access Vendor Fees"** means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

1.5 **"Care Coordination"** means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's health care needs across the continuum of care.

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1.6 **"Care Coordinator"** means an individual within a Provider organization who facilitates Care Coordination for patients.

1.7 **"Care Coordinator Fee"** means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

1.8 **"Global Payment/Total Cost of Care"** means 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.

1.9 **"Host Blue"** means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

1.10 **"Negotiated Arrangement"** means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

1.11 **"Non-Participating Healthcare Provider"** means a health care Provider that does not have a contractual agreement with a Host Blue.

1.12 **"Participating Healthcare Provider"** means a health care Provider that has a contractual agreement with a Host Blue.

1.13 **"Patient-Centered Medical Home"** means a model of care in which each patient has an ongoing relationship with a Primary Care Practitioner who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

1.14 **"Provider Incentive"** means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to any measures or initiatives related to a particular population of Covered Persons.

1.15 **"Shared Savings"** means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed-upon terms and may include downside risk.

1.16 **"Value-Based Program"** means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

SECTION 2: ADMINISTRATIVE SERVICES ONLY

Claim Administrator provides administrative Claims payment services only as set forth in this Agreement and does not assume any financial risk or obligation with respect to Claims.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

Employer, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Claim Administrator to use the Blue Cross and/or Blue Shield Service Mark in the State of New Mexico, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and

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agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

SECTION 4: INTER-PLAN ARRANGEMENTS

4.1 *Out-of-Area Services*

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Covered Persons access health care services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator. Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator's payment practices in both instances are described below. This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

4.2 *BlueCard Program*

The BlueCard Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Healthcare Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Claim Administrator's action will be consistent with the spirit of this description.

a. ***Liability Calculation Method – In General***

(1) Covered Person Liability Calculation.

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on Claims for Covered Services will be based on the lower of the Participating Healthcare Provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

(2) Employer's Liability Calculation.

The calculation of Employer's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may, for a particular service or services, exceed the billed charge in accordance with how the Host Blue has negotiated with its Participating Healthcare Provider(s) for specific health care services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the Covered Person'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

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such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

b. ***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 Claim Administrator by the Host Blue may be represented by one of the following:

(1) 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

(2) 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

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

The Host Blue determines whether it will use an actual, estimated or an 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 Covered Person 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 under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account. Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the 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.

c. ***BlueCard Program Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 4.9 below.

Claim Administrator will charge these fees as follows:

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(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer. A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its health care provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a health care provider may bill for non-covered health care services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator 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, Claim Administrator will pay the Host Blue's access fee and pass it along to Employer as stated above even though Employer paid little or had no Claim liability.

4.3 *Negotiated Arrangements*

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue. In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom health care Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's Negotiated Arrangement(s) for national accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

a. ***Covered Person and Employer Liability Calculation***

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section 4.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area. Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under Section 4.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments. If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any

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payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments. Employer acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 4.9 below. In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

4.4 ***Special Cases: Value-Based Programs***

a. ***Value-Based Programs Overview***

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

b. ***Value-Based Programs under The BlueCard Program***

(1) ***Value-Based Programs Administration***

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these Provider payments to Claim Administrator, which Claim Administrator will pass on to Employer in the form of 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 a Host Blue:

a) ***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.

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

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When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings. The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program. At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

b) 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, Employer will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement. Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for the 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 in variance accounts. Note: Covered Persons 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.

(2) ***Care Coordinator Fees***

Host Blues may also bill Claim Administrator for Care Coordinator Fees for Provider services which Claim Administrator will pass onto Employer as follows:

a) PMPM billings; or

b) 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 US CMS.

As part of this Agreement, Claim Administrator and Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

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c. ***Value-Based Programs under Negotiated Arrangements***

If Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in BlueCard Program section.

4.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. 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. Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim Payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or health care Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

4.6 ***Inter-Plan Arrangements: 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, Claim Administrator will charge any such surcharge, tax or other fee to Employer, which will be Employer's liability.

4.7 ***Non-Participating Healthcare Providers outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by Non-Participating Health Care Providers, the amount(s) a Covered Person pays for such services will be based on either the Host Blue's Non-Participating Healthcare Provider local payment or the pricing requirements required by applicable law. The Covered Person may be responsible for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

a. In certain situations, Claim Administrator may use other payment bases to determine the amount Claim Administrator will pay for services rendered by Non-Participating Health Care Providers, such as:

i. Billed charges for Covered Services;

ii. The payment Claim Administrator would make if the health care services had been obtained within Claim Administrator's service area;

iii. A special negotiated payment, as permitted under Inter-Plan Arrangements; or

iv. The lesser of

1. the amount described in (1), above; or

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2. for professional Providers, a payment based on publicly available data and historic reimbursement to Providers for the same or similar professional services, adjusted for geographical differences where applicable; or for hospital or facility Providers, a payment based on publicly available data reflecting the approximate costs that hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the hospital or facility.

In these situations, a Covered Person may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 4.9 below.

4.8 ***Blue Cross Blue Shield Global Core***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), the Covered Persons may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, the Covered Persons will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

(1) Inpatient Services

In most cases, if Covered Persons contact the service center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the service center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

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

(3) Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons 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 service center

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address on the form to initiate Claims processing. The Claim form is available from Claim Administrator, the service center or online at bcbsglobalcore.com. If Covered Persons need assistance with their Claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day/seven days a week.

b. ***Blue Cross Blue Shield Global Core Program-Related Fees***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is 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. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 4.9 below.

4.9 ***Modifications or Changes to Inter-Plan Arrangement Fees or Compensation***

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Claim Administrator shall provide Employer with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective in accordance with Section 6.1(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

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EXHIBIT 6
RECOVERY LITIGATION AUTHORIZATION

Employer hereby acknowledges and agrees that Claim Administrator may, at its election, pursue claims of Employer and/or the Plan, which are related to claims that Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

1. Claim Administrator shall have the right to select and retain legal counsel.

2. Any lawsuit filed or arbitration initiated by Claim Administrator will be done in the name of Claim Administrator for its own benefit, as well as on behalf of Employer and possibly other parties. Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of Employer and/or the Plan without Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of Employer and/or the Plan with attorneys identified as counsel for Employer or in the name of two or more parties, including Employer and Claim Administrator, with attorneys identified as counsel for Employer, Claim Administrator and possibly other parties.

3. The Parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit.

4. Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

5. Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated, or litigated.

6. Claim Administrator shall have the right to assign claims belonging to Employer and/or the Plan to a third party for the purpose of allowing the third party to pursue the claims on Employer's behalf via mediation, arbitration, or litigation. If such an assignment is made, the rights and obligations of Claim Administrator in this Exhibit 6 shall become the rights and obligations of the third party for purposes of the assigned claims only.

7. Any and all recoveries, net of all investigative and other expenses relating to the recovery made through any means pursuant to the provisions of this Exhibit, including any costs of settlement, mediation, arbitration, litigation or trial including attorney's fees, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by Claim Administrator on any reasonable basis it deems appropriate.

8. Any and all information, documents, communications, or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions, and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions, and reports to the full extent allowed by state or federal law. Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of Claim Administrator.

9. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

10. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.

11. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation,

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arbitration, or settlement negotiation; therefore, Employer acknowledges that the efforts of Claim Administrator may not result in recovery or in full recovery in any particular case.

12. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require Claim Administrator to assert any claims on Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after Claim Administrator has asserted a claim on behalf of Employer and/or the Plan but before any recovery, Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

13. If Employer should desire to participate in a class or multi–district settlement rather than defer to Claim Administrator, Employer may revoke the grant of authority established herein for that specific matter by affirmatively opting into a class settlement and by notifying Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 4.9 Notice and Satisfaction of the Agreement.

14. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 4.9 Notice and Satisfaction of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes Claim Administrator, on behalf of Employer and/or the Plan, consistent with Section 2 above, to:

a. Pursue, without advance notice to Employer, claims that Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, private lien resolution programs, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business, or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;

b. Opt out of any class action settlement or keep Employer and/or the Plan in the class, if Claim Administrator reasonably determines that it should do so;

c. Investigate and pursue recovery of monies unlawfully, illegally, or wrongfully obtained from the Plan.

15. Employer further acknowledges and agrees that Claim Administrator's decision to pursue recovery in connection with particular claims shall be in Claim Administrator's sole discretion and Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of Employer and/or the Plan when, as, and if, Claim Administrator determines that such claims may be pursued in the common interest of the parties.

16. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Exhibit.

17. The Parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail with respect to the subject matter hereof.

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EXHIBIT 7
PHARMACY BENEFIT MANAGEMENT SERVICES
(GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT)

1. **Pharmacy Management:** Claim Administrator has contracted with Prime Therapeutics LLC (Prime) and/or other pharmacy benefit manager(s), mail order pharmacies, specialty pharmacies or other pharmacies to furnish certain pharmacy benefit management and other prescription drug benefit programs, including Rebate management and fee schedule management, including but not limited to MAC List management. Other services Prime will provide may include certain account management, clinical management, Drug List management, and Utilization Management services as set forth in the agreement between Prime and Claim Administrator. Claim Administrator reserves the right to contract with other pharmacy benefit managers and pharmacies directly for such services or to authorize Prime to subcontract certain services pursuant to the terms of Claim Administrator's agreement with Prime. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

   Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. Employer further understands and agrees that fees and compensation that Prime receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator, administrative fees charged by Prime to pharmacies or compensation otherwise received by Prime related to network administration, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Pharmacy Benefit Management services to be provided include Drug List management services, Rebate Management Services; management of the pharmacy networks for Members; Claims processing (electronic and paper); management of clinical management programs; reporting and account support services. Claim Administrator pays a fee to Prime for pharmacy benefit management services, which may be factored into the pricing set forth in the ASO BPA and the PBM Fee Schedule Addendum to the ASO BPA (the "BPA Addendum").

3. **Drug List Services:** Claim Administrator utilizes its own Drug List and Prime supports Claim Administrator in the development, maintenance and updating of such Drug List. Prime performs Drug List exception reviews in accordance with the agreement between Prime and Claim Administrator. Prime provides Drug List management services, in accordance with NCQA and URAC standards, to Claim Administrator in supporting Claim Administrator Pharmacy and Therapeutics ("P&T") and Business Committees. Employer acknowledges and agrees that Claim Administrator may, in a manner consistent with the Benefit Plan, promote the dispensing of pharmaceuticals in a manner consistent with the designated Drug List selected by Employer.

4. **Prime's Rebate and Manufacturer Administrative Fee Management:** In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers directly or through a group purchasing organization to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement.

   In addition, Prime has advised Claim Administrator that Prime receives Manufacturer Administrative Fees for bona fide administrative services provided to the Manufacturer. Claim Administrator may also negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement. Prime or Claim Administrator contracts with Manufacturers directly or indirectly, for Rebates and Manufacturer Administrative Fees on its own behalf (or Claim Administrator's behalf, as applicable) and for its own benefit (or Claim Administrator's benefit, as applicable), and not on behalf of Employer. Accordingly, Prime (or Claim Administrator, as applicable) retains all right, title and interest to

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any and all actual Rebates, payments, discounts, or other allowances and/or Manufacturer Administrative Fees received from manufacturers. Prime has advised Claim Administrator that Rebate arrangements are based on formulary status, market share, or other similar arrangements with Manufacturers. Employer will be provided with applicable Rebate Credits as set forth in the Agreement, the BPA, the Section of this PBM Exhibit titled "Rebates" and in the PBM Fee Schedule Addendum to the BPA but otherwise shall have no right, title or interest in Rebates, payments, discounts, or other allowances received by Prime, Claim Administrator under its agreement with Prime, or Claim Administrator under its agreements with Manufacturers. Employer shall have no right, title, or interest in Manufacturer Administrative Fees. Prime may retain Manufacturers Administrative Fees or pass them along, in whole or in part, to Claim Administrator in accordance with Prime's agreement with Claim Administrator. As of the Effective Date, Prime has disclosed to Claim Administrator that the maximum that Prime will receive from any Manufacturer for Manufacturer Administrative Fees is five and one-half percent (5.5%) of the wholesale acquisition cost ("WAC") for all products of such Manufacturer dispensed during any given calendar year to members of Claim Administrator, as applicable; provided, however, Claim Administrator will advise Employer if such maximum has changed.

5. **Disclosures:** All other disclosures set forth in the Agreement will apply to pharmacy benefit management services.

6. **Pharmacy Network:**

   a. **Network Establishment and Maintenance:** In Prime's agreement with Claim Administrator, Prime has agreed it is responsible for providing and maintaining a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. Employer acknowledges that in negotiating the Agreement and this Exhibit, it has taken into consideration that Claim Administrator and/or Prime will keep all or a portion of the discounts and/or other allowances that Claim Administrator or its pharmacy benefits manager has negotiated with the Network Participant. Prime will implement the methodology described in the Allowable Charge when calculating the Copayment/Deductible, and Coinsurance amounts. Prime will reimburse Network Participants in accordance with the applicable Network Contract. Employer acknowledges actual network savings achieved may vary by Network Participant and plan size and/or other demographics. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member and/or the Member's Physician.

   b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts to not make payments to Providers that are not licensed as required by law or that have been debarred, suspended or otherwise excluded from a federal or state program.

   c. **Prime Maximum Allowable Cost ("MAC") Lists:** Prime owns and will maintain proprietary database listings of multi-source pharmaceutical drug products and supplies that also identifies a recommended maximum allowable cost for drugs or supplies within specified categories, commonly referred to as Prime's MAC Lists. Prime's MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Employer after 30 days' prior written request submitted by Employer to Claim Administrator, and subject to Employer's execution of Prime's non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. Prime's MAC List will only be made available for viewing at Prime's corporate headquarters or another secured location designated by Prime.

   d. **Pharmacy Locator:** Prime will provide a means, either toll-free telephone line or electronic, to enable Members to identify Network Participants in a particular area.

   e. **Mail Service:** Prime will provide or cause to be provided a mail order prescription drug service through which Members may receive Covered Prescription Drug Products and Services through the mail ("Mail Service"). Upon termination of the Agreement between Claim Administrator and Employer, Prime agrees to provide or cause to be provided mail order open refill and prior

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authorization files for purposes of transition to any new vendor selected by Employer at Prime's standard rate.

f. **Pharmacy Network Audit Services:** Prime will perform or cause to be performed pharmacy Claims audits to promote Network Participant contract integrity.

g. **Audits:** In addition to the audit rights available pursuant to Section 2.11 of the Agreement or as otherwise required by law, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the Agreement. Subject to the audit terms pursuant to Section 2.11 of the Agreement or as otherwise required by law, Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from Claim Administrator or Prime without prior written approval by Prime or Claim Administrator as applicable. Employer will bear its own cost and expenses for all such audits.

h. **Specialty Pharmacy:** Claim Administrator and Prime have contracted with Specialty Pharmacies and/or vendors to provide Members with access to in-network benefits for covered Specialty Drugs.

7. Claims Processing

a. **Adjudication of Prescription Drug Claims from Network Participants:** Prime will process Claims for Prescription Drugs Products and Services electronically submitted by Network Participants through the Claims Adjudication System, according to Benefit Plan benefit and eligibility information submitted by Claim Administrator to Prime and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Prime will also process and pay Paper Claims received from a Member at the benefit level set forth in the Benefit Plan, and based on the Allowable Charge, in accordance with the terms of the Benefit Plan, provided that the Benefit Plan allows such reimbursement.

b. **Material Change to AWP:** If after the Effective Date: (i) changes to the formula, methodology or manner in which AWP is calculated or reported by Medi-Span take effect or (ii) Medi-Span ceases to publish AWP for the Covered Prescription Drug Services under this Exhibit, then the financial terms of this Exhibit shall be automatically adjusted at the time of such change to return the Parties to their respective economic positions as they existed under the Agreement immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Exhibit shall immediately and automatically be converted to an alternative pricing benchmark determined by Prime. Claim Administrator shall inform Employer in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services and give Employer a reasonable opportunity to review such new benchmark. Thereafter, Employer will be deemed to have approved the designation, which will become part of this Agreement, unless Employer terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract.

c. **Statement of Account:** Prime will furnish to Claim Administrator, at least weekly, a statement of account of the amount of payments that have become due for Claims processed by Prime.

d. **NDC File:** Prime will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC.

e. **Help Desk Service:** Prime will provide help desk service for pharmacist assistance in processing a pharmacy Claim.

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f. **Benefit Plan Design:**

In the event Employer wishes to implement Benefit Plan design changes; for example, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the BPA Addendum may no longer be applicable. If such Benefit Plan design changes impact the existing pricing, a new BPA Addendum pricing must be negotiated. Revised pricing proposed by Claim Administrator shall be effective pursuant to Section 6.4 Amending and Ex. 2 Section 3.3 of this Agreement, provided that if Parties cannot agree on the terms of the new BPA Addendum pricing, Employer shall be allowed to (a) proceed to dispute resolution, as set forth in the Agreement or (b) terminate this Exhibit with 90 days' prior written notice to the other Party. Failure to reach agreement on the new Addendum pricing shall not be a breach of contract.

8. **Term:** This PBM Exhibit will be in effect for the term of the Agreement, or the Term as stated in the BPA Addendum, whichever is shorter (the "Term").

9. **Termination**

This Exhibit may be terminated as follows:

a. By either Party at the end of the Guarantee Period, upon ninety (90) days' prior written notice to the other Party; or

b. By both Parties on any date mutually agreed to in writing; or

c. By termination of the entire Agreement by either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA upon ninety (90) days' prior written notice to the other Party; or

d. By either Party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Exhibit, upon written notice as provided in the "Notice and Satisfaction" section of the Agreement; or

e. By Claim Administrator pursuant to Ex. 2 Section 7.1, upon Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and BPA Addendum.

If Employer terminates this Exhibit under sections 9(a), 9(b), or 9(c) above, or by Claim Administrator under sections 9(d) or 9(e), prior to the end of the Guarantee Period, then applicable network discount and/or minimum Rebate guarantees set forth in the BPA Addendum will not be effective for such Guarantee Period.

10. **Program Pricing Terms**

The pricing terms for Pharmacy Benefit Management services are as follows, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan:

a. **Pharmacy Program Claims**

i. Employer will reimburse Claim Administrator for Claims submitted under the pharmacy program based on the pricing set forth in the BPA Addendum.

ii. Payment by Employer is subject to applicable Copayment/Deductible and/or Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (i) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers one hundred percent (100%) of the Covered Prescription Drug Products and Services. Member Deductible and Coinsurance will be calculated as described in the

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Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes. Zero balance logic is not employed.

iii. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

b. Rebates for Drugs Covered under the Prescription Drug Program

In connection with Rebates earned for drugs covered under the prescription drug program, Rebate Credits are paid to Employer pursuant to the terms of the BPA Addendum and shall not continue after termination of the Prescription Drug Program or the PBM Exhibit. Additional information about rebates and Rebate Credits are included in the Agreement and the ASO BPA.

c. Specialty Drug Claims

If covered under Employer Benefit Plan, notwithstanding anything to the contrary in Sections a and b above and elsewhere in the Agreement, Employer will reimburse Claim Administrator for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the pricing set forth in the BPA Addendum, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other Specialty Pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims under the Specialty Drug program is not included in the retail and mail pharmacy pricing described in the BPA Addendum and the Specialty Drug pricing terms in the BPA Addendum will apply. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes.

d. Copayments/Deductibles/Coinsurance

The Brand Drug and Generic Drug Copayment/Deductible and Coinsurance will apply as indicated in the applicable Drug List and Benefit Plan for Employer.

11. DEFINITIONS

Certain terms are defined in the Administrative Services Agreement, but the following terms and phrases will have the meaning set forth below, for purposes of the services described in this Exhibit.

1. **"Average Wholesale Price"** or **"AWP"** means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.
2. **"Benefit Plan"** means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.
3. **"Brand Drug"** means, except as otherwise designated in the Additional Provisions of the BPA Addendum, a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.
4. **"Claim"** or **"Claims"** means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.
5. **"Claim Administrator"** has the meaning set forth in the Agreement.
6. **"Claims Adjudication"** means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network

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Contract, and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

7. **"Compound Drug"** means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added.
8. **"Coinsurance"** means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Allowable Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member's Benefit Plan.
9. **"Copayment/Deductible"** means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member's Benefit Plan.
10. **"Covered Prescription Drug Products and Services"** means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member's Benefit Plan, subject to any Copayment/Deductible or Coinsurance.
11. **"Dispensing Fee"** means the negotiated fee for Network Participants' professional service of filling a prescription and is added to the Ingredient Cost for the prescription.
12. **"Drug Utilization Review"** or **"DUR"** means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored, and acted upon consistent with the Member's Benefit Plan. DUR can be prospective, concurrent, or retrospective.
13. **"Drug List"** means a list of pharmaceutical products which is available to Network Participants, Members, physicians, or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.
14. **"Extended Supply Network"** or **"ESN"** means claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Eighty-Four (84) days' quantity supply of medication, provided that the Member's Benefit Plan provides for an ESN benefit.
15. **"Foreign Claim"** means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.
16. **"Generic Drug"** means, unless otherwise designated in the Additional Provisions of the BPA Addendum, a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.
17. **"Guarantee Period"** means the period of time set forth in the BPA Addendum for which the AWP network discount and Dispensing Fees and/or Rebates are guaranteed.
18. **"Ingredient Cost"** means the negotiated rate (e.g., discount of AWP or MAC) for a prescription drug dispensed by a Network Participant and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable for the given prescription drug and the professional service of dispensing such drug.
19. **"Legend Drugs"** means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution — Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

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20. **"Limited Distribution Drug"** or **"LDD"** means a Specialty Drug whose dispensing is restricted by the pharmaceutical manufacturer to specified pharmacies as reflected on the limited distribution list provided by Prime or Claim Administrator.
21. **"MAC List"** means the list of unit prices established by Prime for multi-source Covered Drugs, with each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by Prime and updated from time to time in accordance with this Exhibit and the BPA Addendum.
22. **"Mail Service"** means the service through which Members may receive Covered Prescription Drug Products and Services through the mail from a pharmacy designated by Claim Administrator or PBM to dispense prescription drugs from one or more central locations.
23. **"Manufacturer"** means a company that manufactures, and/or distributes pharmaceutical drug products.
24. **"Manufacturer Administration Fee"** means all negotiated fees received by Prime from any given Manufacturer, directly or through a group purchasing organization, relating to administration of Rebates under a Manufacturer Agreement.
25. **"Maximum Allowable Cost"** or **"MAC"** means the unit price established by Prime for a specific multi-source drug present on the MAC List at the time of service.
26. **"Member"** or **"Members"** means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.
27. **"Network Contract"** has the meaning set forth in the definition of "Network Participant."
28. **"Network Participant"** means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with Prime or Claim Administrator ("Network Contract") to provide Covered Prescription Drug Products and Services to Members, as may be amended. References to "Network Participant" may exclude Specialty Pharmacies and/or Mail Service pharmacies (separately defined in this Exhibit) as context dictates.
29. **"Paper Claims"** means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.
30. **"Pricing Source"** means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which establishes and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services.
31. **"Provider Tax"** means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.
32. **"Rebate(s)"** means any discount or other remuneration of any kind received or recovered by Prime, directly or through a group purchasing organization, from any Manufacturer which is directly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees or fees retained by a group purchasing organization for its role in securing Rebates and/or Manufacturer Administrative Fees.
33. **"Rebate Credit"** has the meaning set forth elsewhere in this Agreement.
34. **"Rebate Management Services"** means the services which Prime is obligated to provide pursuant to Section 4.
35. **"Specialty Drugs"** means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are for serious or chronic conditions, oral medications and/or that have special handling or storage requirements, or are infused medications. In addition, patient support and/or education may be

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required for these drugs. The list of Specialty Drugs is determined by Prime or Claim Administrator, may be further defined in the BPA Addendum, and subject to change.

36. **"Specialty Pharmacy(ies)"** means a pharmacy designated by Claim Administrator or PBM to dispense Specialty Drugs to a Member through the mail or other similar delivery method from one or more central locations.

37. **"Usual and Customary"** or **"U&C"** means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

38. **"Utilization Management"** means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members. Such services include, but are not limited to, the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.

39. **"Zero Balance Due Claim"** means any Claim where the Member cost share covers one hundred percent (100%) of the Allowable Charge for such Claim.

Sample

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Blue Cross and Blue Shield of New Mexico ("BCBSNM") values its relationship with the City of Albuquerque, which includes the contract negotiations that culminated in an executed Administrative Services Agreement, it's Exhibits, and all modifications or revisions made in accordance with its terms, unless otherwise specified ("Agreement"). For the proposed business for the City of Albuquerque, BCBSNM is open to incorporating mutually agreed-upon modifications to the Agreement. BCBSNM looks forward to working with the City of Albuquerque to negotiate those contract terms during the contracting phase after we have more information about the City of Albuquerque's specific needs and the actual services we will be delivering to the City of Albuquerque.

CITY OF ALBUQUERQUE TERMS AND CONDITIONS

IMPORTANT NOTICE: BY COMMENCING SERVICES OR PROVIDING GOODS UNDER THIS CONTRACT OR PURCHASE ORDERS, SUPPLIER ACCEPTS ALL TERMS AND CONDITIONS HEREIN

1. **Contract:** The Contractor accepts these Terms and Conditions and agrees that, to the extent Contractor's terms conflict, these Terms and Conditions shall govern. These Terms and Conditions, the specifications for goods or services (if applicable), and any non-conflicting Contractor terms and conditions shall constitute and be referred to as "this Contract."

   (a) If the City and Contractor have executed an agreement (two-party agreement) that includes terms and conditions related to the goods or services, the provisions of that two-party agreement shall govern and control in the event of a conflict between these Terms and Conditions and that two-party agreement.

   (b) If the City issues a procurement contract, these Terms and Conditions shall control. Any different or additional terms that are found in any quotes, estimates, purchase order acknowledgements, on a web site, or otherwise are superseded by these Terms and Conditions and will be of no force or effect unless agreed to in writing by both the City and the Contractor.

   (c) If this Contract results from a Request for Bids (RFB) or Request for Quotes (RFQ), these Terms and Conditions and the RFB or RFQ shall govern. If there is a conflict between these Terms and Conditions and the RFB or RFQ, the RFB or RFQ shall control. In the event of inconsistencies or contradictions between language contained in the RFB or RFQ, and the bid or quote submitted in response, the RFB or RFQ will prevail, followed by these Terms and Conditions.

2. **Invoices and Payments:**

   (a) The Contractor shall include the Department name and complete purchase order number on all invoices, packing slips, shipping notices, freight bills, and correspondence concerning the order. Invoices shall be sent to one of the following: Trancepta: abq.invoices@submit.transcepta.com; Accounting email: Accounts.payable@cabq.gov; or, regular mail: PO Box 1985, Albuquerque, NM 87103. Visit the Accounting website for more information about getting invoices paid: https://www.cabq.gov/dfa/accounting/how-do-i-get-paid

   (b) Unless otherwise stated, the Contractor shall not receive any compensation until all services have been completed or goods received, final inspection has been made, the goods or services have been accepted by an authorized representative of the City, and complete and correct invoices have been received by the City following the invoicing process detailed herein.

3. **Taxes:** The Contractor is responsible for determining whether taxes are applicable to the order, and for payment of the tax. Applicable taxes shall be included in each invoice and may not be billed more than sixty (60) days after providing the goods or services to which the taxes apply.

4. **Payment:** The City's payment terms are net thirty (30) days unless otherwise stated. The City shall not

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pay late fees, finance fees, or collection fees. Any Contractor that accepts payments by credit card on behalf of the City must be Payment Card Industry Data Security Standard compliant.

5. **Title:** Title to all goods and services provided pursuant to this Contract shall pass to the City at the time of payment free and clear of all liens, claims, security, interest and encumbrances.

6. **No Cost Plus:** Pursuant to Section 5-5-9(B) of the Purchasing Ordinance, the City shall not enter into any contract which is a cost-plus-percentage of cost contract.

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7. **Responsibility to Monitor Contract:** The Contractor shall ensure that it does not bill for goods or services in an amount that exceeds the total contract amount. If at any time the Contractor determines that payment for goods or services may or will exceed the total amount provided in this Contract, the Contractor shall notify the City in writing, as soon as possible after making that determination. If the Contractor's billing exceeds the amount of this Contract, the City may stop or delay payment.

8. **Price Escalation*:*** A request for escalation of Contract pricing may be made under the following conditions:

(a) Offered prices must be firm for a least ninety (90) consecutive calendar days after written notification of a Contract.

(b) The Contractor shall provide written notice to the City of any requested price increases.

(c) All requests for price increases shall be accompanied by:

1) a letter from the Contractor's supplier certifying the price increase to the Contractor; or

2) evidence of verifiable market conditions resulting in increased costs such as mandated labor rate increases and significant fuel or energy cost increases.

(d) All revisions to Contract pricing shall become effective after they are approved by the City.

(e) All supplier invoices shall be subject to auditing by the City and furnished without delay upon request.

(f) The City reserves the right to cancel a Contract and solicit a new contract if a requested price escalation is unacceptable to the City. Cancellation of this Contract shall not affect any outstanding orders.

(g) All approved price changes resulting from this escalation clause shall be firm for a period of ninety (90) consecutive calendar days after approval by the City.

(h) The Contractor shall notify the City within five (5) working days of subsequent price de-escalations from its supplier or cost reductions in areas where pricing increases were previously implemented. The Contractor will reduce its pricing to the City immediately to pass on such de- escalations and reductions unless otherwise agreed by the parties.

(i) All approvals required by this subsection must be in writing by the City Chief Procurement Officer or designee.

9. **Termination for Cause:** If, for any reason, the Contractor fails to fulfill its obligations under this Contract in a timely and proper manner, or if the Contractor violates any provision of this Contract, the City has the right to terminate this Contract by giving written notice of the termination to the Contractor and specifying a termination effective date at least thirty (30) days after notice is provided. In such event, all finished or unfinished documents, data, maps, studies, surveys, drawings, models, photographs, and reports prepared by the Contractor under this Contract shall, at the option of the City, become the City's property, and the Contractor shall be entitled to receive just and equitable compensation for any services satisfactorily completed or goods received under this Contract. Notwithstanding any other provision of this section, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of any breach of this Contract by the Contractor,

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and the City may withhold any payments to the Contractor for the purposes of set-off until such time as the exact amount of damages due the City from the Contractor is determined.

10. **Termination for the Convenience of the City:** The City may terminate this Contract at any time by giving at least fifteen (15) consecutive calendar days' notice in writing of such termination to the Contractor. In such event, the Contractor shall be paid under the terms of this Contract for all goods or services provided to and accepted by the City, if ordered or accepted by the City prior to the effective date of termination.

11. **Termination for Lack of Appropriations:** Notwithstanding any other provision in this Contract, the terms of this Contract are contingent upon the City Council of the City of Albuquerque making the appropriations necessary for the performance of this Contract. If sufficient appropriations and authorizations are not made by the City Council, or if the City Council un-appropriates or deauthorizes funds during a fiscal year, this Contract may be terminated upon thirty (30) days' written notice given by the City to all other parties to this Contract. Such event shall not constitute an event of default. All payment obligations of the City and all of its interest in this Contract will cease upon the date of termination. The City's determination as to whether sufficient appropriations are available or have been made shall be accepted by all parties and shall be final.

12. **FOB Destination and Inspection:** The risk of loss, injury and destruction, and legal title to the goods remains with the Contractor until the goods reach the location of the City. All goods delivered are subject to inspection upon receipt by City. The City's count will be accepted by the Contractor as final and conclusive on all shipments not accompanied by a packing slip. All rejected goods shall remain the property of the Contractor and will be returned at the Contractor's expense.

13. **Responsibility for Damage:** The Contractor shall be responsible for any damage caused during removal or installation services or at any time during the performance of this Contract. Damage shall be reported immediately to the designated City representative.

14. **Removal of Debris and Cleaning the Area:** The Contractor shall, during the progress of any services, remove and dispose of all debris and keep the work premises clean and safe. When the services are complete, the Contractor shall remove all construction equipment and surplus materials (except materials that are to remain the property of the City) and leave the premises in a clean condition satisfactory to the City.

15. **Risks:** All risks of deterioration, destruction, and loss of materials and equipment stored at the site of the services shall be borne by the Contractor.

16. **Working Conditions:** The City is not responsible for obstacles, unfavorable conditions, or hazards, which may be encountered by the Contractor, both above and below ground. These conditions are part of the risk and responsibility of the Contractor.

17. **Inspections:**

(a) The City reserves the right to inspect materials provided by the Contractor to determine their quality, fitness and suitability. Inspection of these materials may be conducted whenever the City considers it necessary.

(b) All goods or services found inferior to the quality specified, deficient, or incorrect in weight, measurement, workmanship, handicraft or otherwise, may be rejected as a whole or in part and then shall be removed by the Contractor at the Contractor's own risk and expense promptly after notice of rejection. The Contractor shall assume responsibility for taking the necessary action to correct or replace the rejected items, within the time frame specified in the notice of rejection.

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18. **Warranties:** All materials furnished by the Contractor shall be free from defects and imperfections. Workmanship shall be in accord with the best industry standards and practices. Both materials and workmanship shall be subject to the approval of the City.

(a) Materials furnished by the Contractor shall be accompanied by the manufacturer's written warranty against defects in quality, craftsmanship, and materials. The Contractor shall provide any such warranties prior to award of this Contract.

(b) The Contractor agrees that the goods or services furnished under this Contract shall be covered by the most favorable commercial warranties the Contractor gives to any customer for such items. Further, the Contractor agrees that the rights and remedies provided in such warranties extend to the City and are in addition to and do not limit any rights afforded to the City. The Contractor agrees not to disclaim warranties of fitness for a particular purpose of merchantability. Warranties shall become effective at the time of acceptance of the goods or services

(c) The Contractor guarantees that the materials supplied are capable of the performance required and agrees to make such changes, adjustments or replacements as are immediately necessary in order for the materials to meet the requirements at no cost to the City. If defects or specification failures are discovered, the City shall have the right, notwithstanding acceptance and payment, to require the unit or item to be properly furnished in accordance with the Specifications and applicable drawings at the cost and expense of the Contractor or the Contractor's surety.

19. **New Material:** All materials, supplies, equipment, and vehicles provided shall be new, the latest in production and manufactured within the last twelve (12) months (computed from the date and time of bid opening) unless otherwise indicated. This does not apply to materials, supplies, equipment or vehicles used by the Contractor to provide the required items of tangible personal property, services or construction.

20. **Delivery, Acceptance and Guarantee:**

(a) No Delivery before Purchase Order is Issued: Contractor shall not deliver goods or commence services prior to the issuance of a Purchase Order or other notice to proceed issued by the City.

(b) Cancellation for Non-Delivery: The City reserves the right to cancel any order not delivered by a guaranteed date stipulated in this Contract without liability on the City's part.

(c) Acceptance of Delivery: Acceptance by the City of any delivery shall not relieve the Contractor of any guarantee or warranty, expressed or implied. Such acceptance of delivery shall not be considered an acceptance of services or goods not in accordance with the Specifications. Such acceptance of delivery shall not waive the City's right to require replacement of defective material or inadequate service.

21. **Debarment, Suspension, Ineligibility and Exclusion Compliance.** The Contractor certifies that it has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government, the State of New Mexico, any local public body of the State, or any state of the United States. The Contractor agrees that should any notice of debarment, suspension, ineligibility or exclusion be received by the Contractor during the term of this Contract, the Contractor will notify the City immediately.

22. **Conflict of Interest**: No officer, agent or employee of the City will participate in any decision relating to this Contract which affects that person's financial interest, the financial interest of his or her spouse

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or minor child or the financial interest of any business in which he or she has a direct or indirect financial interest.

23. **Interest of Contractor:** The Contractor agrees that it presently does not have, and shall acquire no direct or indirect interest which conflicts in any manner or degree with the performance of the terms of this Contract. The Contractor will not employ any person who has any such conflict of interest to assist the Contractor in performing the Services.

24. **No Collusion:** The Contractor represents that this Contract is entered into by the Contractor without collusion on the part of the Contractor with any person or firm, without fraud, and in good faith. The Contractor also represents that no gratuities, in the form of entertainment, gifts or otherwise, were, or will be, offered or given by the Contractor or any agent or representative of the Contractor, to any officer or employee of the City for the purpose or with the intention of securing: this Contract; a subsequent Agreement; more favorable treatment with respect to this Contract; or more favorable treatment with respect to making any determinations regarding performance under this Contract.

25. **Discrimination Prohibited, Civil Rights Compliance:** The parties hereto shall not discriminate against any person on the basis of race, color, religion, sex, gender, gender identity, sexual orientation, pregnancy, childbirth or condition related to pregnancy or childbirth, spousal affiliation, national origin, ancestry, age, physical or mental handicap or serious medical condition, or disability as defined in the Americans With Disabilities Act of 1990, as now enacted or hereafter amended. The Contractor agrees to comply and act in accordance with all provisions of the Albuquerque Human Rights Ordinance, the New Mexico Human Rights Act, Titles VI and VII of the U.S. Civil Rights Act of 1964, as amended, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973, and all federal, New Mexico and City laws and rules related to the enforcement of civil rights. Questions regarding civil rights or affirmative action compliance requirements should be directed to the City's Office of Civil Rights.

26. **Americans with Disabilities Act Compliance:** The Contractor agrees to meet all the requirements of the Americans With Disabilities Act of 1990, and all applicable rules and regulations (the "ADA") that are imposed directly on the Contractor or that would be imposed on the City as a public entity. The Contractor agrees to be responsible for knowing all applicable requirements of the ADA and to defend, indemnify, and hold harmless the City, its officials, agents, and employees from and against any and all claims, actions, suits, or proceedings of any kind brought against any of those parties as a result of any act or omission of the Contractor or its agents in violation of the ADA.

27. **Goods Produced Under Decent Working Conditions:** It is the policy of the City not to purchase, lease, or rent goods for use, or for resale at City-owned enterprises, that were produced under sweatshop conditions. The Contractor certifies that any goods offered to the City were produced under decent working conditions. The City defines "under decent working conditions" as production in a factory in which child labor and forced labor are not employed; in which adequate wages and benefits are paid to workers; in which workers are not required to work more than 48 hours per week (or less if a shorter workweek applies); in which employees are free from physical, sexual or verbal harassment; and in which employees can speak freely about working conditions and can participate in and form unions. [Council Bill No. M-8, Enactment No. 9-1998].

28. **Graffiti Free:** The Contractor will be required to furnish graffiti free equipment, facilities or other items as may be required to complete the services. Failure of the Contractor to comply with this requirement may result in a cancellation of this Contract.

29. **Independent Contractor:** Neither the Contractor nor its employees are considered to be employees of the City for any purpose whatsoever. The Contractor is considered as an independent contractor at all times in performing its obligations under this Contract. The Contractor further agrees that neither it nor its employees are entitled to any benefits from the City under the provisions of the Workers'

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Compensation Act of the State of New Mexico, or to any of the benefits granted to employees of the City under the provisions of the Merit System Ordinance as now enacted or hereafter amended.

30. **Reports and Information:** At such times and in such forms as the City may require, there shall be furnished to the City such statements, records, reports, data and information, as the City may request pertaining to matters covered by this Contract. Unless otherwise authorized by the City, the Contractor will not release any information concerning the work product including any reports or other documents prepared pursuant to this Contract until the final product is submitted to the City.

31. **Establishment and Maintenance of Records:** Records shall be maintained by the Contractor in accordance with applicable laws and requirements prescribed by the City with respect to all matters covered by this Contract. Except as otherwise authorized by the City, such records shall be maintained for a period of four (4) years after receipt of final payment under this Contract.

32. **Ownership, Publication, Reproduction and Use of Material:**. No material produced in whole or in part under this Contract shall be subject to copyright in the United States or in any other country. The City shall have unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data or other materials prepared under this Contract.

33. **Public Records:** The parties acknowledge that the City is a government entity subject to the New Mexico Inspection of Public Records Act (Sections 14-2-1 et seq., NMSA 1978). Notwithstanding any other provision of this Contract, the City shall not be responsible to the Contractor for any disclosure of Confidential Information pursuant to that Act or pursuant to the City's public records act laws, rules, regulations, instructions or any other legal requirement.

34. **Force Majeure:** The City shall not be liable for failure to perform its obligations under this Contract, for any loss or damage of any kind, or for any consequences resulting from delay or inability to perform, due to causes beyond the reasonable control and without the fault or negligence of the City. Such causes ("Force Majeure Events") include, but are not restricted to: acts of God or the public enemy; acts of State, Federal or local governments; shortage or inability to obtain materials; breakdowns or delays of carriers, manufacturers, or suppliers; freight embargoes; theft; fire; flood; epidemics or pandemics; quarantine restrictions; strikes; lockouts; unusually severe weather; and defaults of subcontractors due to any of the above. If a Force Majeure Event causes any failure to perform, the City shall promptly inform the Contractor in writing of such event, indicating the expected duration thereof and the period for which suspension in performance is requested. The parties shall consult with each other in good faith with respect to modification of this Contract to reflect such suspension or other changes (if any) desired by the City as a result thereof. The rights and remedies of the City provided in this paragraph shall not be exclusive and are in addition to any other rights now being provided by law or under this Contract.

35. **Indemnity:** The Contractor agrees to defend, indemnify, and hold harmless the City and its officials, agents, and employees from and against any and all claims, suits, demands, actions, or proceedings of any kind brought against any of those persons because of any injury or damage received or sustained by any person, persons, or property, which injury is arising out of or resulting from the Contractor's provision of goods or services under this Contract, or by reason of any asserted act or omission, neglect, or misconduct of the Contractor or Contractor's agents, employees or subcontractors, or the agents or employees of any subcontractor of Contractor, whether direct or indirect. The defense and indemnity required hereunder shall not be limited by reason of the specification of any particular insurance coverage in this Contract.

36. **Patent Indemnity:** If any item furnished pursuant to this Contract shall be covered by any patent, copyright, or application for patent or copyright, the Contractor shall defend, indemnify and save harmless the City from any and all loss, cost or expense or any all claims suits, or judgments as a

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result of the use of such item in violation of rights under such patent, copyright, or application for patent or copyright.

37. **Insurance.** Unless this requirement has been waived by the City's Risk Manager, the Contractor shall procure and maintain at its expense until final payment by the City insurance in the kinds and amounts listed below with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Contract, whether performed by it or its agents. Before commencing services, the Contractor shall furnish to the City a certificate or certificates in form satisfactory to the City showing that it has complied with this Section. All certificates of insurance shall provide that thirty (30) days written notice be given to:

Risk Manager, Department of Finance and Administrative Services City of Albuquerque
P.O. Box 470
Albuquerque, New Mexico 87I03

before a policy is cancelled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. With respect to all coverages required other than workers' compensation, the City shall be named an additional insured. All coverages afforded shall be primary with respect to operations provided. The kinds and amounts of insurance required are set out below and additional insurance may be required as set out in the Specifications or Solicitation Instructions.

(a) Commercial General Liability Insurance: A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$2,000,000	Per Occurrence
$2,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage shall specifically insure the hold harmless provisions of this Contract.

(b) Automobile Liability Insurance: An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

(c) Workers' Compensation Insurance: Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico (the "Act"). If the Contractor employs fewer than three employees and has determined that he is not subject to the Act, the Contractor will certify, in a signed statement, that the Contractor is not subject to the Act. The Contractor will notify the City and comply with the Act if he becomes subject to the Act during the term of this Contract.

(d) Increased Limits. If, during the term of this Contract, the City requires the Contractor to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Contractor's compensation will be made.

38. **Audits and Inspections:** At any time during normal business hours and as often as the City may deem necessary, the Contractor shall make all of the Contractor's records with respect to all matters

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covered by this Contract available to the City for examination. The Contractor shall allow the City to audit, examine, and make excerpts or transcripts from such records, and to make audits of all contracts, invoices, materials, payrolls, records of personnel, conditions of employment, and other data related to all matters covered by this Contract. The Contractor understands and will comply with the City's Accountability in Government Ordinance, §2-10-1 et seq. and Inspector General Ordinance, §2-17-1 et seq. R.O.A. 1994, and also agrees to provide requested information and records and to appear as a witness in hearings for the City's Board of Ethics and Campaign Practices pursuant to Article XII, Section 9 of the Albuquerque City Charter.

39. **Assignment, Transfer and Subcontracting:** The Contractor shall not assign, transfer or subcontract any portion of this Contract without the express written consent of the City. Any goods or services subcontracted hereunder shall be specified by written contract or agreement and shall be subject to each provision of this Contract.

40. **Construction and Severability:** If any part of this Contract is held to be invalid or unenforceable, such holding will not affect the validity or enforceability of any other part of this Contract so long as the remainder of this Contract is reasonably capable of completion.

41. **Enforcement:** The Contractor agrees to pay to the City all costs and expenses including reasonable attorney's fees incurred by the City in exercising any of its rights or remedies in connection with the enforcement of this Contract.

42. **Compliance with Laws:** The Contractor shall, in performance of this Contract, fully comply with all applicable federal, state, or local laws, rules and regulations.

43. **Governing Law/Venue:** This Contract is governed by and construed and enforced in accordance with the laws of the State of New Mexico and the City of Albuquerque. The venue for actions arising in connection with this Contract is Bernalillo County, New Mexico.

44. **Use by Other Public Governmental Agencies**: With the agreement of the Contractor, other public governmental agencies may purchase from this Contract, unless otherwise stated, subject to the following:

(a) Extension of the use of this Contract shall in no way impede on the Contractor's ability to fulfill the pricing, terms and conditions of this Contract with the City; and

(b) The City shall have no responsibility to verify whether the other public governmental agency is a legitimate entity to which it may extend this option or whether the entity is authorized under its applicable laws, rules and regulations to use this Contract.

45. **Federal Contract Requirements:** All Contractors with contracts or purchase orders funded in whole or in part with federal funds are required to comply with 2 CFR Part 200, Appendix II. By commencing services or providing goods under this Contract, the Contractor certifies compliance with the following, as applicable.

(a) Equal Employment Opportunity. This provision shall apply to all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3.

(1) The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, sexual orientation, gender identity, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and that employees are treated during employment without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. Such action shall include, but not be limited to the following:

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Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

(2) The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, or national origin.

(3) The Contractor will not discharge or in any other manner discriminate against any employee or applicant for employment because such employee or applicant has inquired about, discussed, or disclosed the compensation of the employee or applicant or another employee or applicant. This provision shall not apply to instances in which an employee who has access to the compensation information of other employees or applicants as a part of such employee's essential job functions discloses the compensation of such other employees or applicants to individuals who do not otherwise have access to such information, unless such disclosure is in response to a formal complaint or charge, in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or is consistent with the Contractor's legal duty to furnish information.

(4) The Contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representatives of the Contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

(5) The Contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

(6) The Contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

(7) In the event of the Contractor's noncompliance with the nondiscrimination clauses of this Contract or with any of the said rules, regulations, or orders, this Contract may be canceled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

(8) The Contractor will include the portion of the sentence immediately preceding paragraph (1) and the provisions of paragraphs (1) through (8) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to section 204 of Executive Order 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance:

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(9) Provided, however, that in the event a Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the administering agency, the Contractor may request the United States to enter into such litigation to protect the interests of the United States.

(10) The Contractor further agrees that it will be bound by the above equal opportunity clause with respect to its own employment practices when it participates in federally assisted construction work: Provided, that if the applicant so participating is a State or local government, the above equal opportunity clause is not applicable to any agency, instrumentality or subdivision of such government which does not participate in work on or under this Contract.

(11) The Contractor agrees that it will assist and cooperate actively with the administering agency and the Secretary of Labor in obtaining the compliance of contractors and subcontractors with the equal opportunity clause and the rules, regulations, and relevant orders of the Secretary of Labor, that it will furnish the administering agency and the Secretary of Labor such information as they may require for the supervision of such compliance, and that it will otherwise assist the administering agency in the discharge of the agency's primary responsibility for securing compliance.

(12) The Contractor further agrees that it will refrain from entering into any contract or contract modification subject to Executive Order 11246 of September 24, 1965, with a contractor debarred from, or who has not demonstrated eligibility for, Government contracts and federally assisted construction contracts pursuant to the Executive Order and will carry out such sanctions and penalties for violation of the equal opportunity clause as may be imposed upon contractors and subcontractors by the administering agency or the Secretary of Labor pursuant to Part II, Subpart D of the Executive Order. In addition, the applicant agrees that if it fails or refuses to comply with these undertakings, the administering agency may take any or all of the following actions: cancel, terminate, or suspend in whole or in part this grant (contract, loan, insurance, guarantee); refrain from extending any further assistance to the applicant under the program with respect to which the failure or refund occurred until satisfactory assurance of future compliance has been received from such applicant; and refer the case to the Department of Justice for appropriate legal proceedings.

(b) Davis Bacon Act. This provision shall be applicable to all prime construction contracts in excess of $2,000.

(1) All transactions regarding this contract shall be done in compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) and the requirements of 29 CFR Part 5, as may be applicable.

(2) The Contractor shall: comply with 40 U.S.C. 3141-3144, and 3146-3148 and the requirements of 29 C.F.R. Part 5, as applicable; pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor; pay wages not less than once a week; and report all suspected or reported violations of these laws to the City, which will report the same to the Federal awarding agency.

(c) Copeland "Anti-Kickback" Act. This provision shall be applicable to all prime construction contracts in excess of $2,000.

(1) Contractor shall comply with 18 U.S.C. §874, 40 U.S.C. §3145, and the requirements of 29 CFR Part 3, as may be applicable, which are incorporated by reference into this contract.

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(2) The Contractor or Subcontractor shall insert in any subcontracts the clause above and such other clauses as the applicable federal agency may by appropriate instructions require, and also a clause requiring the subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for the compliance by any subcontractor with all of these contract clauses.

(3) A breach of this Contract clauses above may be grounds for termination of this contract, and for debarment as a contractor or subcontractor as provided in 29 CFR §5.12.

(d) Contract Work Hours and Safety Standards Act. These provisions shall apply to all contracts over $100,000 that involve mechanics or laborers.

(1) The Contractor shall comply with 40 U.S.C. §§ 3702 and 3704, and the requirements of 29 CFR Part 5.

(2) Overtime requirements. No Contractor or subcontractor contracting for any part of this Contract work which may require or involve the employment of laborers or mechanics shall require or permit any such laborer or mechanic in any workweek in which he or she is employed on such work to work in excess of forty hours in such workweek unless such laborer or mechanic receives compensation at a rate not less than one and one-half times the basic rate of pay for all hours worked in excess of forty hours in such workweek.

(3) Violation; liability for unpaid wages; liquidated damages: In the event of any violation of the clause set forth in paragraph (b)(1) of 29 CFR §5.5, the Contractor or any subcontractor responsible therefor shall be liable for the unpaid wages. In addition, such contractor and subcontractor shall be liable to the United States, for liquidated damages. Such liquidated damages shall be computed with respect to each individual laborer or mechanic, including watchmen and guards, employed in violation of the clause set forth in paragraph (b)(1) of 29 CFR §5.5.

(4) Withholding for unpaid wages and liquidated damages: The City shall upon its own action or upon written request of an authorized representative of the Department of Labor withhold or cause to be withheld, from any moneys payable on account of work performed by the Contractor or subcontractor under any such contract or any other federal contract with the same prime contractor, or any other federally- assisted contract subject to the Contract Work Hours and Safety Standards Act, which is held by the same prime contractor, such sums as may be determined to be necessary to satisfy any liabilities of such Contractor or subcontractor for unpaid wages and liquidated damages as provided in the clause set forth in paragraph (b)(2) of 29 CFR §5.5.

(5) Subcontracts: The Contractor or subcontractor shall insert in any subcontracts the clauses set forth in paragraphs (b)(1) through (4) of 29 CFR §5.5, and also a clause requiring the subcontractors to include these clauses in any lower tier subcontracts. The prime contractor shall be responsible for compliance by any subcontractor or lower tier subcontractor with the clauses set forth in paragraphs (b)(1) through (4) of 29 CFR §5.5.

(e) Rights to Inventions Made under a Contract or Agreement. These provisions shall apply to all funding agreements under 37 CFR § 401.2(a). If the federal award meets the definition of “funding agreement” under 37 CFR §401.2(a) and the City wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that “funding agreement,” the City and Contractor must comply with the requirements of 37 CFR Part 401 (Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements), and any implementing regulations issued by the awarding agency.

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(f) Clean Air Act and Federal Water Pollution Control Act. These provisions shall apply to all contracts and subgrants over $150,000. The Contractor shall:

(1) Comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, as amended, 42 U.S.C. §7401 et seq. as amended, and the Federal Water Pollution Control Act as amended (33 U.S.C. §1251-1387);

(2) Report each violation of those laws to the City and understands and agrees that the City will, in turn, report each violation as required to assure notification to the applicable federal agency, and the appropriate Environmental Protection Agency Regional Office; and

(3) Include these requirements in each subcontract exceeding $150,000 financed in whole or in part with federal assistance provided by the applicable federal agency.

(g) Debarment and Suspension. These provisions shall apply to all contracts. This contract is a covered transaction for purposes of 2 CFR Part 180 and 2 CFR Part 3000. As such, the Contractor is required to verify that none of the Contractor's principals (defined at 2 CFR §180.995) or its affiliates (defined at 2 CFR §180.905) are excluded (defined at 2 CFR §180.940) or disqualified (defined at 2 CFR §180.935).

(1) The Contractor certifies to the best of its knowledge and belief, that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this contract been convicted or had a civil judgment against them for commission or fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or Local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or Local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

(d) Have not within a three-year period preceding this agreement had one or more public transactions (Federal, State or Local) terminated for cause or default.

(2) Where the Contractor is unable to certify to any of the statements in this certification, such Contractor shall notify the City in writing.

(3) The Contractor must comply with 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, and must include a requirement to comply with these regulations in any lower tier covered transaction Contractor enters into.

(4) This certification is a material representation of fact relied upon by the City. If it is later determined that the Contractor did not comply with 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, in addition to remedies available to the City, the federal government may pursue available remedies, including but not limited to, suspension and/or debarment.

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(5) With respect to competitive solicitations, the Contractor agrees to comply with the requirements of 2 CFR Part 180, subpart C and 2 CFR Part 3000, subpart C, while this offer is valid and throughout the period of any contract that may arise from this offer. This bidder or proposer further agrees to include a provision requiring such compliance in the bidder's or proposer's lower tier covered transactions.

(6) The Contractor certifies the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Contractor understands and agrees that the provisions of 31 U.S.C. Chapter 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

(h) Byrd Anti-Lobbying Amendment. These provisions apply to all contracts. The Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee or Member of Congress in connection with the awarding of any Federal Agreement, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal Agreement, grant, loan or cooperative agreement.

(2) If any funds other the Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal Agreement, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including sub-agreements, sub-grants, and agreements under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) For purposes of this Certification, this Contract shall be considered a federal agreement. This certification is a material representation of fact upon which reliance is placed when this transaction was made or entered into. Submission of this certification is prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(5) The Contractor, certifies or affirms the truthfulness and accuracy of each statement of its certification and disclosure, if any. In addition, the Contractor understands and agrees that the provisions of 31 U.S.C. Chapter 38, Administrative Remedies for False Claims and Statements, apply to this certification and disclosure, if any.

(i) Procurement of Recovered Materials (2 CFR § 323). These provisions shall apply if the purchase price of an item exceeds $10,000 (including value of item acquired over the year).

(1) In the performance of this contract, the Contractor shall make maximum use of products containing recovered materials that are EPA- designated items unless the product cannot be acquired:

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(a) Competitively within a time frame providing for compliance with the contract performance schedule;

(b) Meeting contract performance requirements; or

(c) At a reasonable price.

(2) Information about this requirement, along with the list of EPA- designated items, is available at EPA's Comprehensive Procurement Guidelines web site, https://www.epa.gov/smm/comprehensive- procurement-guideline-cpg-program.

(3) The Contractor also agrees to comply with all other applicable requirements of Section 6002 of the Solid Waste Disposal Act.

(j) Prohibition on certain telecommunications and video surveillance services or equipment (2 CFR § 216. These provisions shall apply to all contracts.

(1) Recipients and sub recipients are prohibited from obligating or expending loan or grant funds to:

(a) Procure or obtain;

(b) Extend or renew a contract to procure or obtain; or

(c) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115-232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(d) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).

(e) Telecommunications or video surveillance services provided by such entities or using such equipment.

(f) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

(2) In implementing the prohibition under Public Law 115-232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

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(3) See Public Law 115-232, section 889 for additional information.

(4) See also § 200.471.

(k) Domestic preferences for procurements (2 CFR § 200.322). These provisions apply to all contracts.

(1) As appropriate and to the extent consistent with law, the non-federal entity should, to the greatest extent practicable under a Federal award, provide a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United States (including but not limited to iron, aluminum, steel, cement, and other manufactured products). The requirements of this section must be included in all subawards including all contracts and purchase orders for work or products under this award.

(2) For purposes of this section:

(a) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.

(b) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

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1.23 Insurance:

1.23.1 General Conditions: The City will require the successful Offeror, referred to as the Contractor, to procure and maintain at its expense during the term of the contract resulting from the RFP, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations of the Contractor under the contract. Upon execution of the contract and on the renewal of all coverages, the Contractor shall furnish to the City a ~~certificate or~~ certificate(s) in ACORD form or equivalent ~~satisfactory to the City as well as the rider or endorsement~~ showing that it has complied with these insurance requirements. Contractor ~~All certificates of insurance~~ shall provide that thirty (30) days written notice be given to the Risk Manager, Department of Finance and Administrative Services, City of Albuquerque, P.O. Box 470, Albuquerque, New Mexico, 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. ~~With respect to all coverages required other than professional liability or workers' compensation, t~~The City shall be named an additional insured on the Commercial General Liability and Auto Liability policies. The Commercial General Liability Insurance ~~. All coverages afforded~~ shall be primary with respect to operations provided.

1.23.2 Approval of Insurance: Even though the Contractor may have been given notice to proceed, it shall not begin any work under the contract resulting from this RFP until the required insurance has been obtained and the proper certificates ~~(or policies)~~ are filed with the City. Neither approval nor failure to disapprove certificates, policies, or the insurance by the City shall relieve the Contractor of full responsibility to maintain the required insurance in full force and effect. ~~If part of the contract is sublet, the Contractor shall include any or all subcontractors in its insurance policies, or require the subcontractor to secure insurance to protect itself against all hazards enumerated herein, which are not covered by the Contractor's insurance policies.~~

1.23.3 Coverage Required: The kinds and amounts of insurance required are as follows:

1.23.3.1 Commercial General Liability Insurance. A commercial general liability insurance policy with ~~combined~~ limits of liability for bodily injury or property damage as follows:
$2,000,000 Per Occurrence
$2,000,000 Policy Aggregate
$1,000,000 Products Liability/Completed Operations
$1,000,000 Personal and Advertising Injury
$ 5,000 Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor and contractual liability coverage. ~~shall specifically insure the hold harmless provisions of the contract resulting from this RFP.~~

1.23.3.2 Automobile Liability Insurance. A comprehensive automobile liability insurance policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. The policy must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

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1.23.3.3 Workers' Compensation Insurance. Workers' compensation insurance policy for the Contractor's employees, in accordance with the provisions of the Workers' Compensation Act of the State of New Mexico, (the "Act"). If the Contractor employs fewer than three employees and has determined that it is not subject to the Act, it will certify, in a signed statement, that it is not subject to the Act. The Contractor will notify the City and comply with the Act should it employ three or more persons during the term of the contract resulting from this RFP.

1.23.3.4 Cyber Liability Coverage. Cyber liability insurance in an amount not less than $2,000,000 combined single limit of liability per occurrence with a general aggregate of $2,000,000. This coverage should be required, unless specific circumstances that eliminate potential risks indicate otherwise, if the vendor/contractor may have cybernetic access to the City's confidential information, taxpayer data, information technology, personnel, healthcare, accounting, or finance systems.

1.23.3.5 Professional Liability~~/Medical Malpractice~~(Errors and Omissions) Insurance: Professional liability~~/medical malpractice~~ insurance policy shall be not less than $5,000,000.

1.23.4 Increased Limits: During the life of the contract the City may require the Contractor to increase the maximum limits of any insurance required herein. In the event that the Contractor is so required to increase the limits of such insurance, an appropriate adjustment in the contract amount will be made. Any agreed to changes will be reflected with an addendum to the Services Agreement.

1.23.5 Additional Insurance: The City may, as a condition of award of a contract, require a successful Offeror to carry additional types of insurance. The type and limit of additional insurance is dependent upon the type of services provided via the contract by the successful Offeror. Any agreed to changes will be reflected with an addendum to the Services Agreement.

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BlueCross BlueShield of New Mexico

References

Per the RFP instructions, this file is considered confidential and has been segregated. Please refer to the Legally Confidential folder located in the Technical Proposal section to access this file.

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BlueCross BlueShield of New Mexico

Account Team Biographies

Per the RFP instructions, this file is considered confidential and has been segregated. Please refer to the Legally Confidential folder located in the Technical Proposal section to access this file.

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New Mexico

2024 IMPACT REPORT

National Presence, **Local Care**



Employee Volunteerism

360+
employee volunteers

6.4K+
volunteer hours

$214K**
cash equivalent of volunteer hours

130+
events

190+
organizations served

$18K+
Matching Dollars awarded to 23 community partner organizations

** One hour of volunteering has a $33.49 cash equivalent, as calculated by Independent Sector from data provided by the U.S. Bureau of Labor Statistics (2024)

Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

487609.0225

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Community Investments

$4.7M+

contributed in grants and sponsorships to community organizations

Blue Impact℠

25
organizations served

99.3K+
people served

Blue Door Neighborhood Center℠ *

460+
visitors

100+
programs and events hosted

*Blue Door Neighborhood Center was open for programming 4 months in 2024.

Care Van®

2
vans

15.9K+
clients served

9.6K+
immunizations and other health services

150+
Care Van events

Special Beginnings® Maternal and Infant Health Initiative

10
partner organizations

1.5K+
people served

National Fitness Campaign

1
court built

2K+
people can access via a 10 minute or less walk

Impact History

35K
volunteer hours since 2019

69K
clients served via Care Van program since 2019

48K
immunizations and other health services provided via Care Van program since 2019

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Sustainability

214K+
lbs. of paper recycled

58.2K+
plastic bottles saved by utilizing bottle-less water dispensers

30
square miles pollinated through urban biodiversity programs



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This is only a sample of our standard limitations and exclusions. It is our plan to duplicate the current benefit schedule and major benefit provisions to the extent of our contractual regulatory filings and administrative capabilities. It is not our intent to match the incumbent carrier's contract language.
Notwithstanding anything previously stated to the contrary, we reserve the right to review and negotiate all contract terms.

Covered Dental Services

This section describes the services and supplies covered by this Certificate. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary". All Covered Services listed in this section are subject to the ***Exclusions & Limitations*** section of this Certificate, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* to find out what your Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service. If you do not have a *Schedule of Benefits*, please call a Customer Service Representative at the number shown on your Identification Card.

Your dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Certificate, it will mean Dentist or Physician**.**

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- Periodic oral evaluations for established patients.
- Problem-focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children, including counseling with primary caregiver.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

PREVENTIVE SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months. Additional Benefits will not be provided for prophylaxis based on degree of difficulty.
- Topical Fluoride Application – Benefits for Fluoride Application are only available to Subscribers under age 19 and are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Combination of prophylaxes and periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") are limited to two every 12 months.

Sample

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DIAGNOSTIC RADIOGRAPHS

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films – Benefits are limited to four horizontal films or eight vertical films once every 12 months. However, Benefits are not available for bitewing films taken on the same date as full-mouth films.
- Periapical films, as Medically Necessary for diagnosis – Benefits are limited to six films every 12 months.-

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

MISCELLANEOUS PREVENTIVE SERVICES

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants – Benefits for sealants are limited to one per permanent molar per lifetime and are available to Subscribers under age 16.
- Space Maintainers – Benefits for space maintainers are limited to a lifetime maximum of one appliance per missing tooth site for Subscribers under age 19.

Benefits are not available for nutritional, tobacco or oral hygiene counseling.

BASIC RESTORATIVE SERVICES

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

- Amalgam restorations – Benefits are limited to one per tooth surface every 12 months.
- Resin-based composite restorations – Benefits are limited to one per tooth surface every 12 months.

Benefits will not be provided for restorations placed within 12 months of the initial placement by the same Dentist.

NON-SURGICAL EXTRACTIONS

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

- Removal of retained coronal remnants – deciduous tooth.
- Removal of erupted tooth or exposed root.

NON-SURGICAL PERIODONTAL SERVICES

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes the following services:

- Periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- Periodontal maintenance procedures – Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

Sample

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Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary for documented Subscribers with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.

Separate Benefits will not be provided for local anesthesia, nitrous oxide analgesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.

ENDODONTIC SERVICES

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following "*Endodontic Services"*:

- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.
- Pulp vitality tests, endodontic endosseous implants or intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.
- Endodontic therapy if you discontinue endodontic treatment.

ORAL SURGERY SERVICES

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Certificate.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Sample

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Benefits will not be provided for the following Oral Surgery procedures:

- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

SURGICAL PERIODONTAL SERVICES

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes the following services.

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per site every 24 months.
- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.
- Distal or proximal wedge procedure.
- Anatomical crown exposures – Benefits are limited to one per quadrant every 24 months.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

MAJOR RESTORATIVE SERVICES

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- Single crown restorations.
- Gold foil and inlay/onlay restorations.
- Labial veneer restorations.

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Certificate or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

Sample

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PROSTHODONTIC SERVICES

Prosthodontics involves procedures Medically Necessary for providing artificial replacements for missing natural teeth and includes:

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60 month period whether placement was provided under this Certificate or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.
- Fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this Certificate or under any prior dental coverage.

Prosthetics placed over implants will be covered.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Benefits will not be provided for the following Prosthodontic Services:

- Treatment to replace teeth which were missing prior to the Effective Date, except those teeth missing due to congenital malformation.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

- Prefabricated crowns – Benefits are provided for stainless steel and resin-based crowns. Benefits are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.
- Post and core, pin retention, and crown and bridge repair services.
- Pulp cap – direct and indirect.
- Adjustments – Benefits will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures) are limited to a lifetime maximum of once per tooth or clasp.

IMPLANT SERVICES

Implant procedures and treatment include services for Subscribers as shown on your ***Schedule of Benefits,*** if your Group chose this optional implant service. Covered Services include an artificial device specifically designed to be placed surgically in the mouth as a means of replacing missing teeth.

Sample

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ORTHODONTIC SERVICES

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Subscribers covered for orthodontics as shown on your ***Schedule of Benefits,*** if your Group chose this optional orthodontic service.

Covered Services include:

- Diagnostic orthodontic records and radiographs **limited to a lifetime maximum of once per Subscriber.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to a lifetime maximum of one appliance per Subscriber.**

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic Benefit. Benefits cease when the Subscriber is no longer covered, whether or not the entire Benefit has been paid out.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the maximum for orthodontic services.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber is not covered.
- Benefits are not available for replacement or repair of an orthodontic appliance.
- For services in progress on the Effective Date, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

Sample

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Exclusions & Limitations

These general ***Exclusions & Limitations*** apply to all services described in this dental Certificate. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the ***Definitions*** section) licensed to perform services covered under this dental Certificate.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

- **Dental Procedures Which Are Not Medically Necessary**

  Please note that in order to provide you with dental care Benefits at a reasonable cost, this Certificate provides Benefits only for those Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.

  No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you, as determined by the Plan.

  The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- **Care By More Than One Dentist**

  If you change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

  In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by the Plan.

  If you and your Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for dental services, as determined by the Plan.

- **Non-Compliance with Prescribed Care**

  Any additional treatment and resulting liability which is caused by the lack of a Subscriber's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Subscriber.

EXCLUSIONS – WHAT IS NOT COVERED

No Benefits will be provided under this Certificate for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.

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- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Certificate or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Certificate.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants, unless your ***Schedule of Benefits*** shows that the dental plan chosen provides coverage for Implant Services.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Services or supplies received for behavior management or consultation purposes.
- Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - repay the Plan any money recovered from the employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional, tobacco or oral hygiene counseling.

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- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Orthodontic services and supplies, if your Group did not purchase the optional Orthodontic Services Benefit.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Charges for a partial or full denture or fixed bridge which includes replacement of a tooth which was missing prior to your Effective Date under this Certificate; except this exclusion will not apply if such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after your Effective Date.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis or occlusal adjustments.

The Plan may, without waiving these "*Exclusions"*, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the "*Exclusions"* listed above. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Certificate. The Subscriber must provide the Plan with all documents it needs to enforce its rights under this provision.

Sample

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State of New Mexico
Office of Superintendent of Insurance

CERTIFICATE

I, Alice T. Kane, Superintendent of Insurance for the State of New Mexico, do hereby certify that the attached copy of Certificate of Authority No. 69240903, dated July 1, 2017, and issued to

Health Care Service Corporation, A Mutual Legal Reserve Company.

is a true and correct copy of the one on file with the Office of Superintendent of Insurance.

OFFICE OF SUPERINTENDENT OF INSURANCE

In Witness Whereof, I have hereunto set my hand and affixed my official seal on this **5th** day of **February 2025**.

Alice T. Kane

Alice T. Kane
Superintendent of Insurance

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

State of New Mexico
Office of Superintendent of Insurance

No. 69240903 **2017**

Statutorily Amended

Certificate of Authority

Insurance Company

It is hereby certified, that the

Health Care Service Corporation, A Mutual Legal Reserve Company

DBA: Blue Cross and Blue Shield of New Mexico

300 East Randolph Street

Chicago, IL 60601

Organized under the laws of Illinois

has complied with the requirements of the laws of this State applicable to said Company and is hereby authorized to transact the business of

Accident and Health

Health Maintenance Organization

Qualified Dental Plan

Qualified Health Plan

Limited to Health, Health Maintenance Organization, Qualified Dental Plan and Qualified Health Plan Only

Insurance in accordance with its Charter or Certificate of Incorporation within the State of New Mexico, subject to the provisions and requirements of law.

OFFICE OF SUPERINTENDENT OF INSURANCE

In Witness Whereof, The Superintendent of Insurance of the State of New Mexico has caused this certificate to be signed and the seal of said Superintendent to be affixed hereto at the city of Santa Fe, this 1st day of July, 2017.

John S. Franchini
Superintendent of Insurance

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/23/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 155 N. WACKER, SUITE 1200 CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 CN101825276--CYBER-25-26	**CONTACT NAME:** Healthcare Team **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** Healthcare.AccountsCSS@marsh.com
INSURED HEALTH CARE SERVICE CORPORATION A MUTUAL LEGAL RESERVE COMPANY AND ITS SUBSIDIARIES 300 EAST RANDOLPH CHICAGO, IL 60601	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Aspen Specialty Insurance Company — 10717 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-010943459-02 **REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N	N / A					E.L. EACH ACCIDENT	$
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	NETWORK SECURITY CYBER			AX00L7525	04/01/2025	04/01/2026	LIMIT	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

HEALTH CARE SERVICE CORPORATION
300 EAST RANDOLPH STREET
CHICAGO, IL 60601

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA LLC

Ali Lenti

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/23/2025

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 155 N. WACKER, SUITE 1200 CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 CN101825276-ALL-GAXW-24-25	**CONTACT NAME:** Healthcare Team **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** Healthcare.AccountsCSS@marsh.com
INSURED HEALTH CARE SERVICE CORPORATION A MUTUAL LEGAL RESERVE COMPANY AND ITS SUBSIDIARIES 300 EAST RANDOLPH CHICAGO, IL 60601	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Old Republic Insurance Company — 24147 **INSURER B :** XL Specialty Insurance Company — 37885 **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-010943426-30 **REVISION NUMBER:** 3

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X **COMMERCIAL GENERAL LIABILITY** [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC [ ] OTHER:			MWZY 317249 24	11/01/2024	11/01/2025	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 10,000 $ 1,000,000 $ 1,000,000 $ 1,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO [ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY			MWTB 317250 24	11/01/2024	11/01/2025	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $			US00064403LI24A	11/01/2024	11/01/2025	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		MWC 317248 24	11/01/2024	11/01/2025	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

HEALTH CARE SERVICE CORPORATION
300 EAST RANDOLPH STREET
CHICAGO, IL 60601

CANCELLATION

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AUTHORIZED REPRESENTATIVE
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Ali Lenti

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 05/23/2025

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IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA LLC. 155 N. WACKER, SUITE 1200 CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 CN101825276-PL.-PL-24-25	**CONTACT NAME:** Healthcare Team **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** Healthcare.AccountsCSS@marsh.com
INSURED HEALTH CARE SERVICE CORPORATION A MUTUAL LEGAL RESERVE COMPANY AND ITS SUBSIDIARIES 300 EAST RANDOLPH CHICAGO, IL 60601	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** Homesite Insurance Company — 17221 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-010943427-11 **REVISION NUMBER:** 4

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** N	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	PROFESSIONAL LIABILITY/E&O			MPO-140076294-02	12/01/2024	12/01/2025	LIMIT OF LIABILITY	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

HEALTH CARE SERVICE CORPORATION
300 EAST RANDOLPH STREET
CHICAGO, IL 60601

CANCELLATION

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Ali Lenti

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BlueCross BlueShield of New Mexico

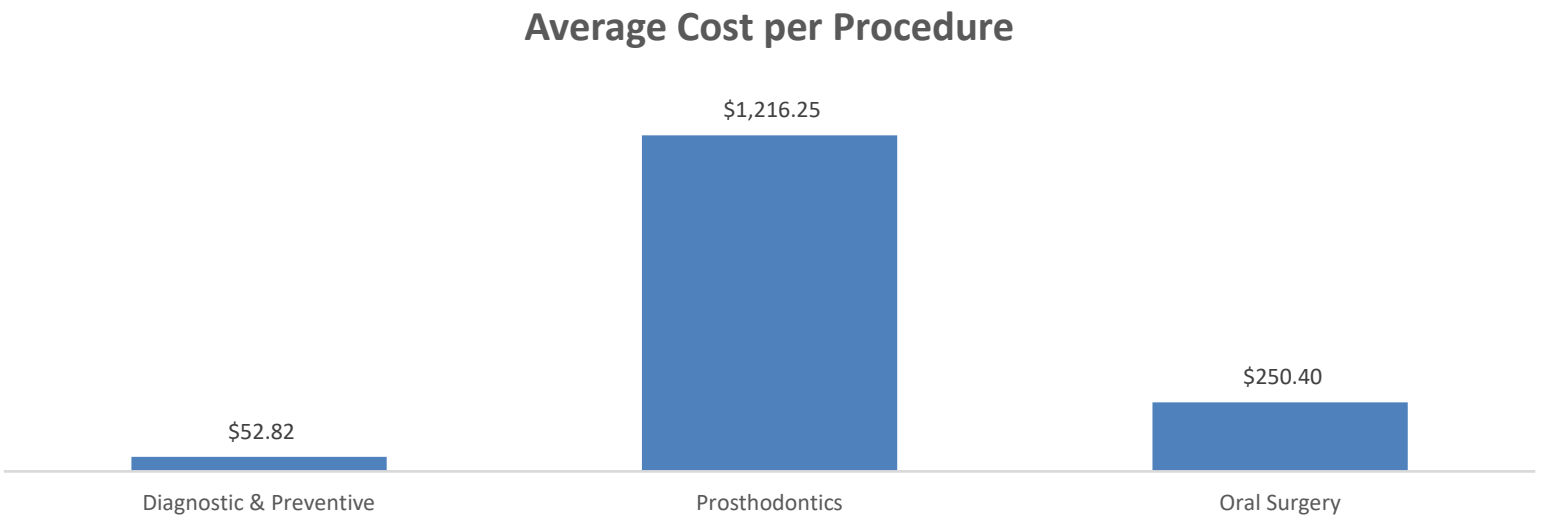
Dental Insight Report

Prepared for ABC COMPANY

Report Created on 4/4/2025

Current Paid: 01-2024 TO 12-2024
Prior Paid: 01-2023 TO 12-2023

	Current	Prior
Average Members	**5**	5
Membs w cleaning or exam	**2**	4
EEs w cleaning or exam	**1**	3
DEPs w cleaning or exam	**1**	1
Network Performance		
Utilization	**23.9%**	59.7%
Discount	**34.8%**	24.9%
Members with Claims	**60.0%**	80.0%
Savings	**58.4%**	57.4%



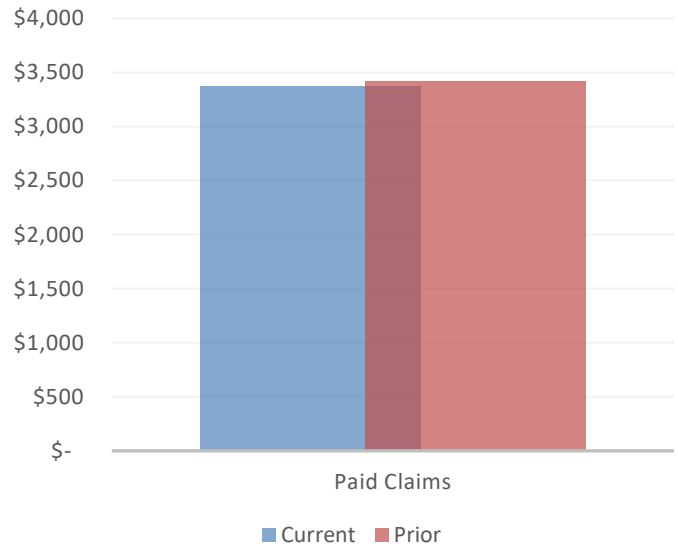
Proprietary and Confidential

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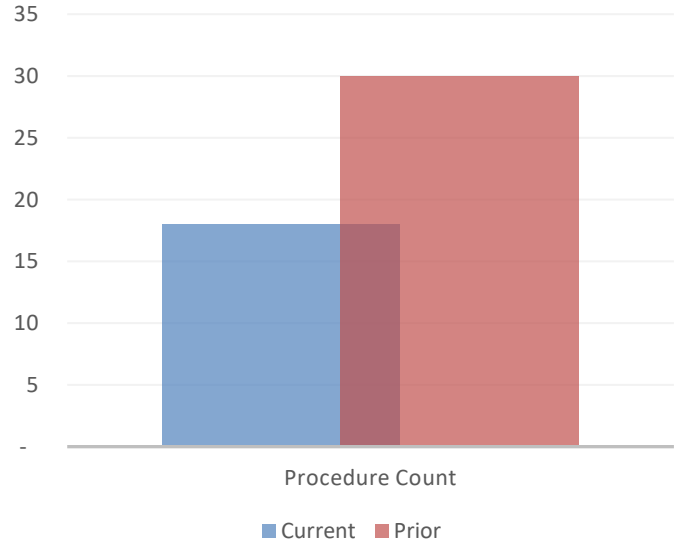
Dental Experience

Current Paid: 01-2024 TO 12-2024
Prior Paid: 01-2023 TO 12-2023

	Paid Claims	Procedure Count	Subscribers	Members
Current	$ 3,370	18	4	5
Prior	$ 3,421	30	4	5
Variance	$ (52)	(12)	-	-
%	-2%	-40%	0%	0%





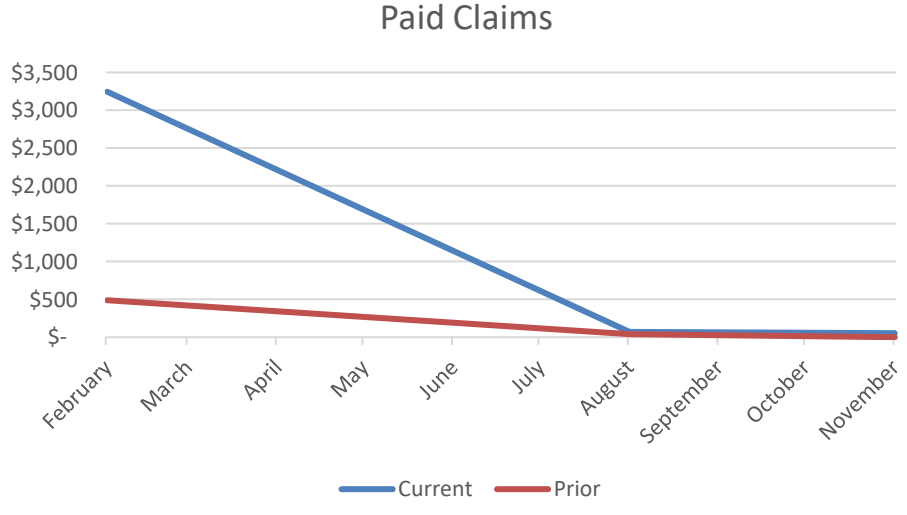


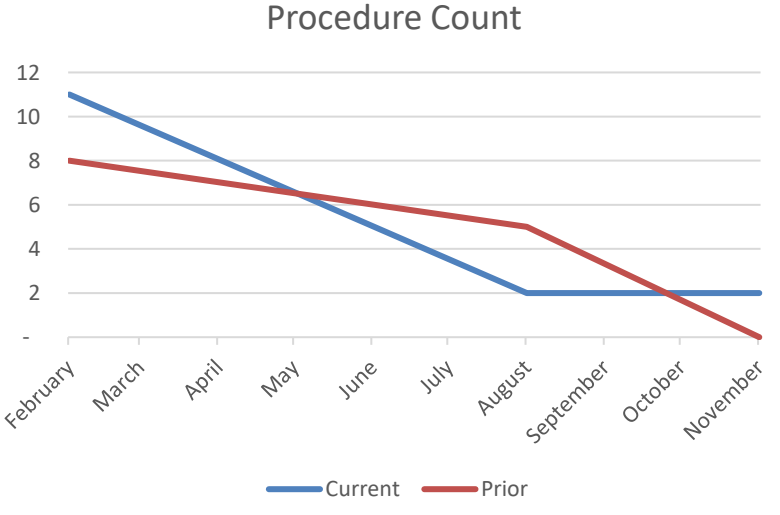
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Monthly Dental Experience

	Current				Prior			
Month	Paid Claims	Procedure Count	Subscribers	Members	Paid Claims	Procedure Count	Subscribers	Members
February	$ 3,245	11	4	5	$ 488	8	4	5
August	$ 71	2	4	5	$ 42	5	4	5
November	$ 53	2	4	5	$ -	-	4	5
Total	**$ 3,370**	**18**	**4**	**5**	**$ 3,421**	**30**	**4**	**5**





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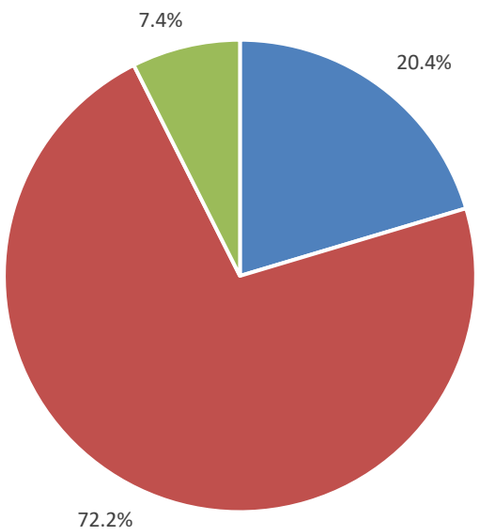
Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Dental Claim Dollar Utilization - Paid: 01-2024 TO 12-2024

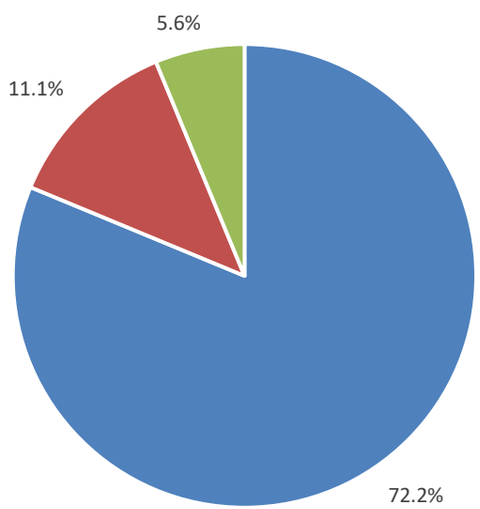
Average Members	5

Category	Paid Claims	Percent of all Claims	Number of Procedures	Percent of all Procedures	Claim Dollars per Member	Claim Dollars per Procedure	Claim Dollars PMPM	Procedures per 1,000 members per year Group	Procedures per 1,000 members per year Benchmark
Diagnostic & Preventive	$ 687	20.4%	13	72.2%	$ 137.33	$ 52.82	$ 11.44	2,600.00	2,700.67
Prosthodontics	$ 2,433	72.2%	2	11.1%	$ 486.50	$1,216.25	$ 40.54	400.00	35.82
Oral Surgery	$ 250	7.4%	1	5.6%	$ 50.08	$ 250.40	$ 4.17	200.00	145.79
Total	**$ 3,370**		**18**		**$ 673.91**	**$ 187.20**	**$ 56.16**	**3,600.00**	**3,797.50**

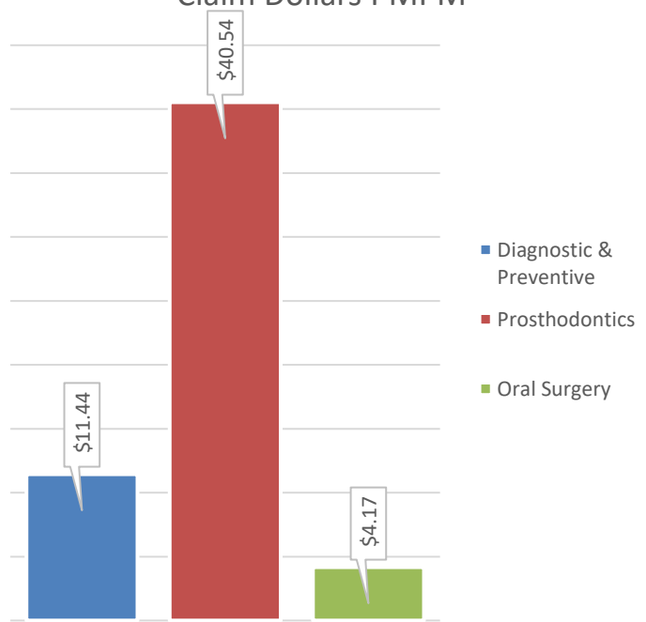
Percent of all Claims



Percent of all Procedures



Claim Dollars PMPM

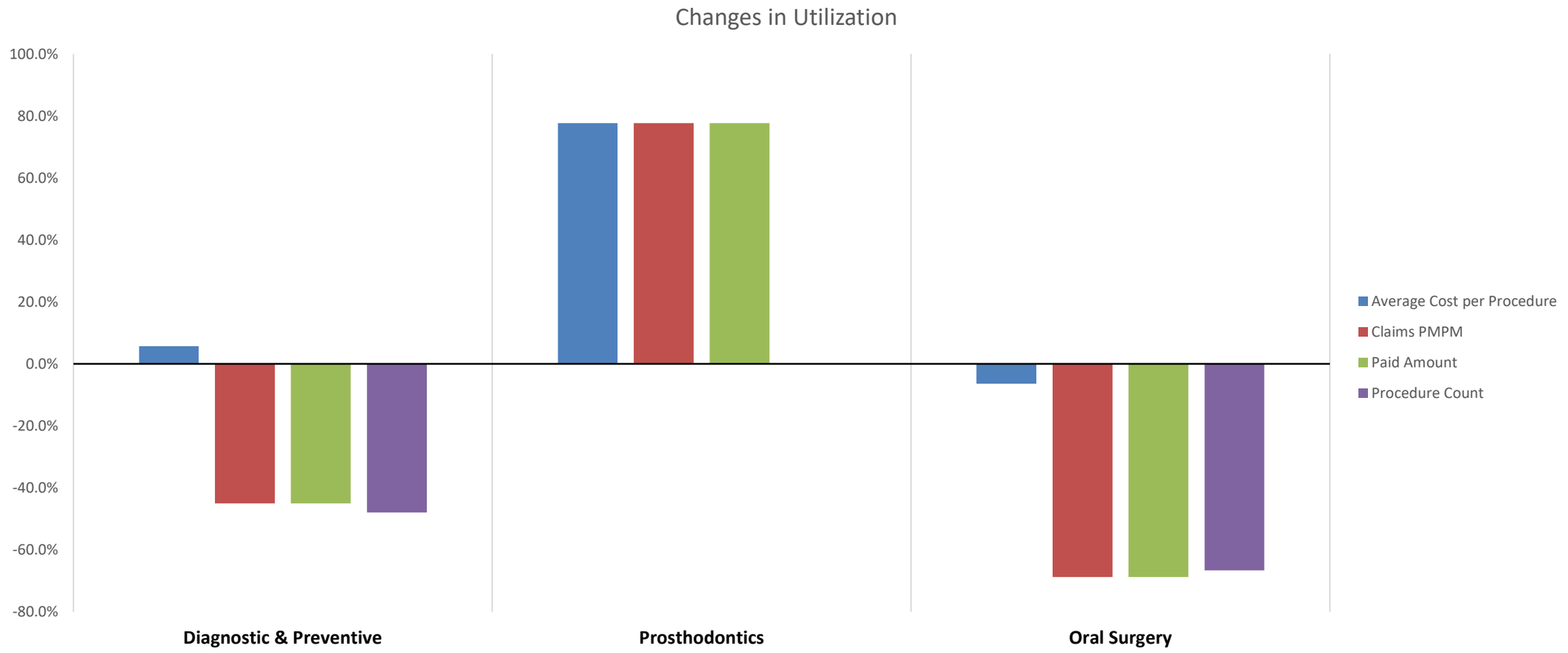


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Dental Claim Dollar Utilization - Paid: 01-2024 TO 12-2024

Category	Paid Amount			Procedure Count			Claims PMPM			Average Cost per Procedure		
	Current	Prior	% Difference	Current	Prior	% Difference	Current	Prior	% Difference	Current	Prior	% Difference
Diagnostic & Preventive	$ 687	$ 1,249	-45.0%	13	25	-48.0%	$ 11.44	$ 20.82	-45.0%	$ 52.82	$ 49.97	5.7%
Prosthodontics	$ 2,433	$ 1,369	77.7%	2	2	0.0%	$ 40.54	$ 22.82	77.7%	$ 1,216.25	$ 684.53	77.7%
Oral Surgery	$ 250	$ 803	-68.8%	1	3	-66.7%	$ 4.17	$ 13.38	-68.8%	$ 250.40	$ 267.65	-6.4%
Total	**$ 3,370**	**$ 3,421**	**-1.5%**	**18**	**30**	**-40.0%**	**$ 56.16**	**$ 57.02**	**-1.5%**	**$ 187.20**	**$ 114.04**	**64.1%**

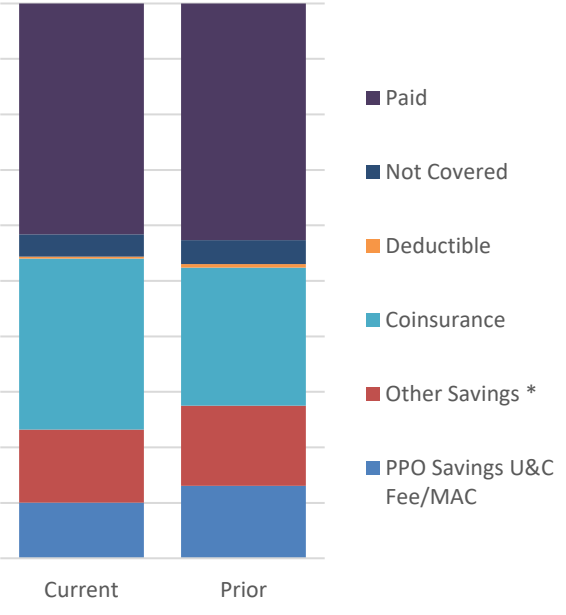


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Dental Claim Savings - Paid: 01-2024 TO 12-2024

		Current	% of Billed		Prior	% of Billed
Billed	$	8,099		$	8,023	
PPO Savings U&C Fee/MAC	$	813	10.0%	$	1,046	13.0%
Other Savings *	$	1,068	13.2%	$	1,159	14.4%
Coinsurance	$	2,495	30.8%	$	1,998	24.9%
Deductible	$	25	0.3%	$	50	0.6%
Not Covered	$	328	4.1%	$	349	4.4%
Paid	$	3,370	41.6%	$	3,421	42.6%
Savings		**$4,729**			**$4,601**	
Savings %		**58.4%**			**57.4%**	



** Other Savings include Utilization Management, Professional Review, Alternate Benefit, Plan Max*

Approved Claims

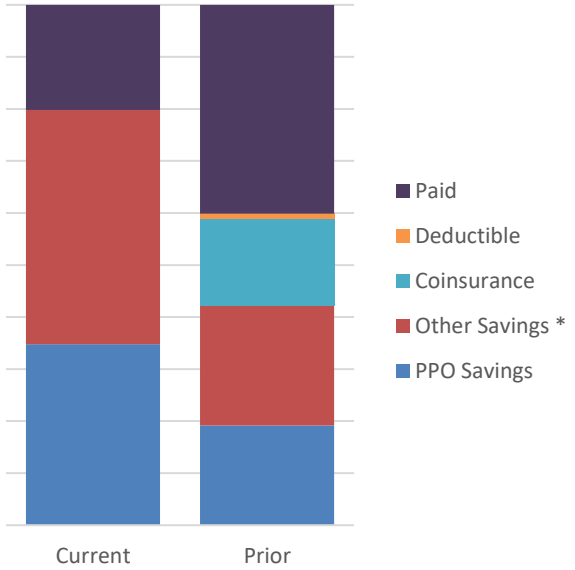
Billed	$	7,655	$	6,515
Allowed	$	6,861	$	5,469
Procedure Count		18		30

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Dental Claim Savings - In Network - Paid: 01-2024 TO 12-2024

		Current	% of Billed		Prior	% of Billed
Billed	$	1,829		$	5,048	
PPO Savings	$	636	34.8%	$	969	19.2%
Other Savings *	$	823	45.0%	$	1,159	23.0%
Coinsurance	$	-	0.0%	$	844	16.7%
Deductible	$	-	0.0%	$	50	1.0%
Paid	$	370	20.2%	$	2,026	40.1%
Savings		**$1,459**			**$3,022**	
Savings %		**79.8%**			**59.9%**	



** Other Savings include Utilization Management, Professional Review, Alternate Benefit, Plan Max*

Approved Claims

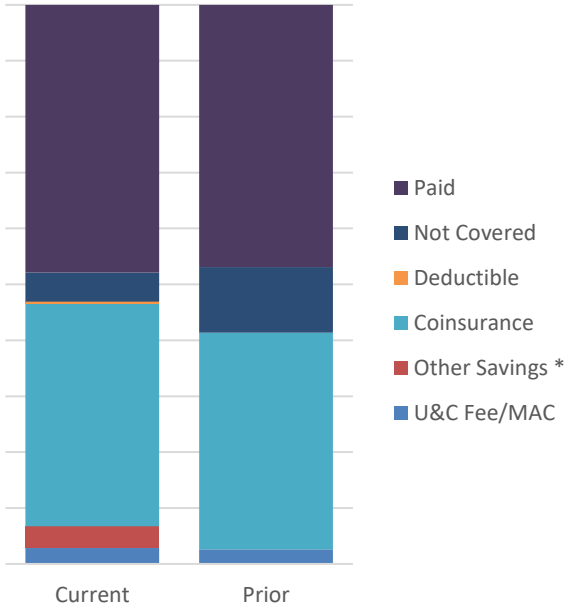
Billed	$	1,829	$	3,889
Allowed	$	1,193	$	2,920
Procedure Count		12		26
Network Discount		34.8%		24.9%

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Dental Claim Savings - Out of Network - Paid: 01-2024 TO 12-2024

		Current	% of Billed		Prior	% of Billed
Billed	$	6,270		$	2,975	
U&C Fee/MAC	$	177	2.8%	$	77	2.6%
Other Savings *	$	245	3.9%	$	-	0.0%
Coinsurance	$	2,495	39.8%	$	1,154	38.8%
Deductible	$	25	0.4%	$	-	0.0%
Not Covered	$	328	5.2%	$	349	11.7%
Paid	$	3,000	47.8%	$	1,396	46.9%
Savings		**$3,270**			**$1,580**	
Savings %		**52.2%**			**53.1%**	



** Other Savings include Utilization Management, Professional Review, Alternate Benefit, Plan Max*

Approved Claims

Billed	$	5,826	$	2,626
Allowed	$	5,668	$	2,549
Procedure Count		6		4

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Top 25 In Network Dental Providers - Paid: 01-2024 TO 12-2024

	Provider	Tax ID	Address	Paid	# of Procedures	Members Seen	% of Total Paid
1	ROBERT B MABRY DDS	473306765	225 E IDAHO AVE STE 14, LAS CRUCES, NM, 88005	$ 228	7	1	6.75%
2	NOHA OUSHY EISSA DDS	830559830	103 LIVINGSTON LOOP STE B3, SANTA TERESA, NM	$ 142	2	1	4.21%
3	NASIM SALLOUM DDS	871562016	7598 N MESA STE A1, EL PASO, TX, 79912	$ -	3	1	0.00%

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BlueCross BlueShield of New Mexico

Top 25 Out of Network Dental Providers - Paid: 01-2024 TO 12-2024

	Provider	Tax ID	Address	Paid	# of Procedures	Members Seen	% of Total Paid
1	FRANK V FEUILLE DDS	204226640	6901 HELEN OF TROY DR STE A, EL PASO, TX, 79911	$ 3,000	8	1	89.03%

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Top 25 Procedures - Paid: 01-2024 TO 12-2024

	Code	Description	Count	Paid
1	6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT	2	$ 2,433
2	7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVAT	1	$ 250
3	367	CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS; WITH OR WITHOUT CRANIUM	1	$ 224
4	1110	PROPHYLAXIS - ADULT	3	$ 189
5	140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	3	$ 131
6	120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	3	$ 96
7	274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	1	$ 32
8	220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	2	$ 15
9	2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	1	$ -
10	2740	CROWN - PORCELAIN/CERAMIC	1	$ -
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

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Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

BlueCross BlueShield of New Mexico

Blue Insight℠ Monthly Financial Report

ABC Company New Mexico



01/01/2024 to 12/31/2024

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Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

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Data Parameters

Current Period: The current reporting period represents claims paid from January 1, 2024 through December 31, 2024.

Prior Period: The prior reporting period represents claims paid from January 1, 2023 through December 31, 2023.

The report includes medical claims, pharmacy claims and dental claims.

Reporting Segments: ALL

Characteristics: ALL

Group/Sections: ALL

Member MSA: ALL

Group: ALL

Reporting Support Contact Information

For reporting support, please contact Client Reporting Service Center
Email: client_reporting@bcbsil.com
Hours of Operation: Monday - Friday: 8:00am - 5:00pm CT

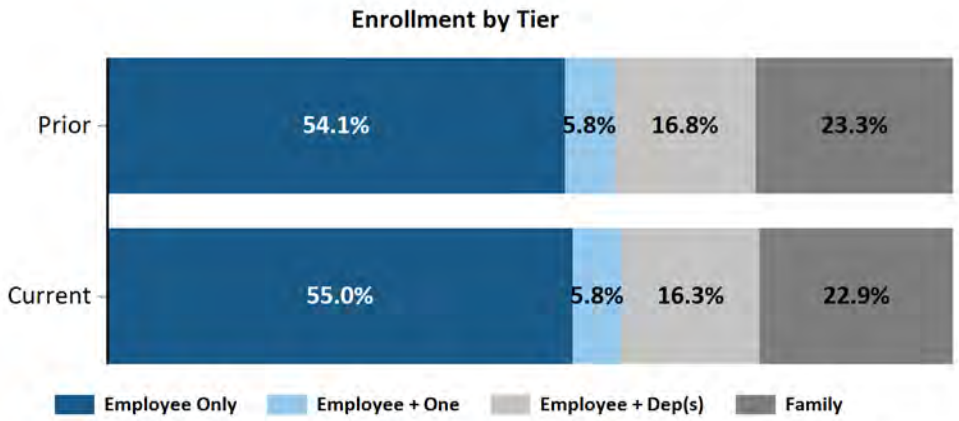
Report prepared on 04/17/2025

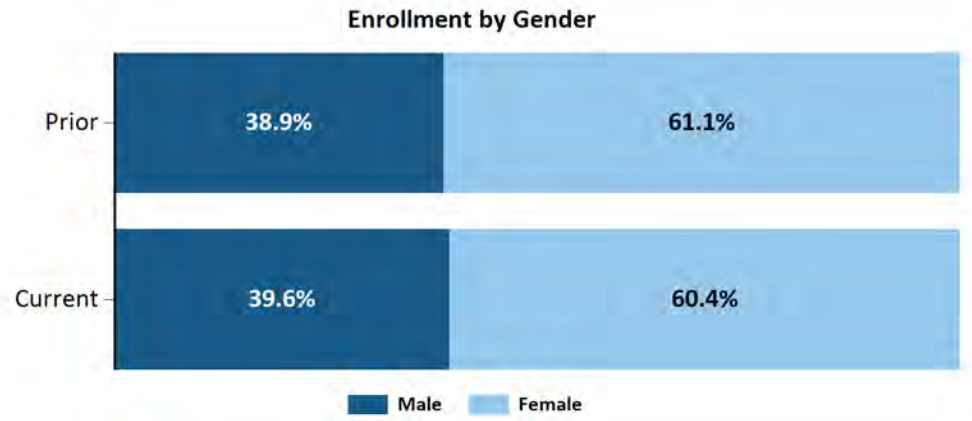
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Enrollment Overview

Report Description: Provides the current enrollment based on the current period.

Month	Medical Subscribers	Medical Members	Pharmacy Subscribers	Pharmacy Members	Dental Subscribers	Dental Members
Jan 2024	7,452	10,782	6,060	7,877		
Feb 2024	7,482	10,789	6,079	7,880		
Mar 2024	7,504	10,827	6,084	7,873		
Apr 2024	7,493	10,805	6,060	7,834		
May 2024	7,496	10,814	6,050	7,826		
Jun 2024	7,469	10,783	6,013	7,782		
Jul 2024	7,511	10,792	6,042	7,777		
Aug 2024	7,533	10,824	6,037	7,768		
Sep 2024	7,555	10,865	6,033	7,759		
Oct 2024	7,616	10,924	6,090	7,811		
Nov 2024	7,613	10,936	6,069	7,787		
Dec 2024	7,574	10,889	6,027	7,744		





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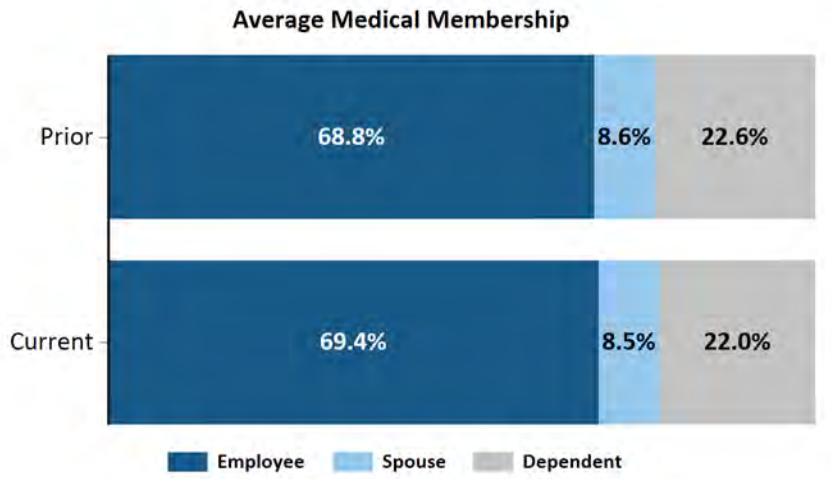
Enrollment Overview

Report Description: Provides medical demographics for the current period compared to the prior period and percent change.

Medical Demographics

	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Average Membership	**10,451**	**10,836**	**3.7%**
Employee	7,188	7,525	4.7%
Spouse	898	922	2.7%
Dependent	2,365	2,389	1.0%
Average Contract Size	1.5	1.4	-6.7%
Average Age	**35.6**	**35.7**	**0.3%**
Employee	41.9	41.9	
Spouse	46.0	45.9	-0.2%
Dependent	12.4	12.5	0.8%
% Under 30	36.2%	36.1%	
% 30 to 49	40.6%	40.6%	
% 50 to 64	20.3%	20.2%	
% 65+	2.9%	3.2%	
Gender			
Proportion of Males	38.9%	39.6%	
Proportion of Females	61.1%	60.4%	
Females Ages 20-44	32.1%	32.0%	

- Overall, membership **increased by 3.7%** between reporting periods
- The average age was 35.7 and **increased by 0.3%** between reporting periods.
- Contract size **decreased by 6.7%** between reporting periods.
- Females between the ages of 20 and 44 **decreased from 32.1% to 32.0%** between reporting periods.



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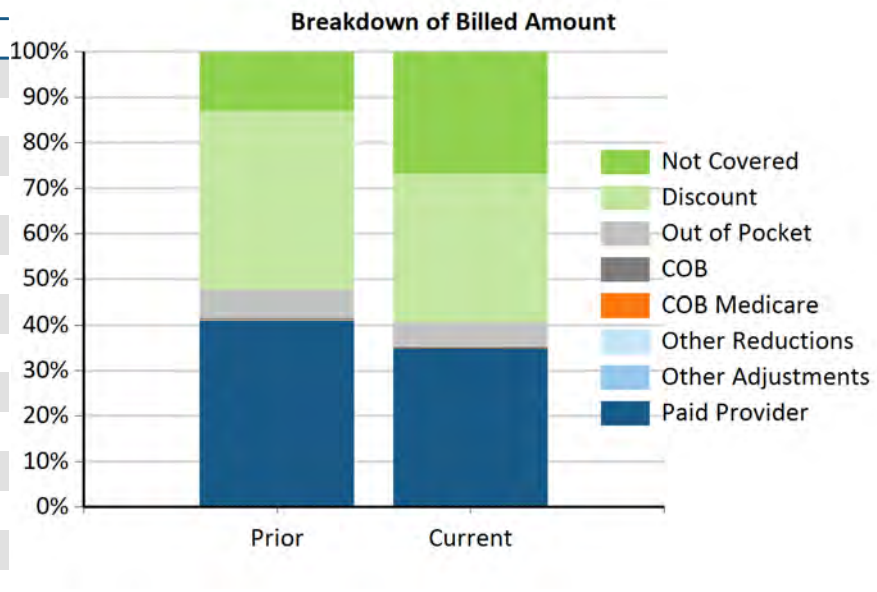
Financial Overview: Financial Summary

BlueCross BlueShield of New Mexico

Report Description: Provides a breakdown of the medical order of reduction from billed to paid for the current month, current period, prior period and a percent change. This report may highlight key measures and their potential impact on paid expenses.

Medical Order of Reduction

Paid Month	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Billed	$14,802,583	$145,157,314	$184,475,766	27.1%
Not Covered	$2,430,134	$18,897,943	$49,480,208	161.8%
Covered	$12,372,449	$126,259,371	$134,995,558	6.9%
Discount	$5,909,297	$57,229,027	$60,202,993	5.2%
Allowed	$6,463,152	$69,030,344	$74,792,565	8.4%
Out of Pocket	$703,128	$8,858,133	$10,059,436	13.6%
COB	$42,475	$461,699	$328,337	-28.9%
COB Medicare	$0	$211,356	$4,681	-97.8%
Other Reductions	$6,394	$106,652	$15,552	-85.4%
Other Adjustments	($26,139)	($2,621)	($17,780)	-578.3%
Paid - Provider	$5,737,293	$59,395,126	$64,402,339	8.4%
Other Payments	$3,117	$72,908	$45,449	-37.7%
Medical Paid	$5,740,411	$59,468,034	$64,447,788	8.4%



Group Liability Breakdown

Paid Month	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Medical Paid	$5,740,411	$59,468,034	$64,447,788	8.4%
Pharmacy Paid	$1,479,231	$15,684,746	$16,308,911	4.0%
Dental Paid	$0	$0	$0	0.0%
VBC Payments	$6,868	$78,063	$70,248	-10.0%
Total Paid Claims	$7,226,510	$75,230,843	$80,826,948	7.4%
Recoveries	($4,136)	($150,973)	($125,348)	17.0%
Total Paid Claims + Recoveries	$7,222,374	$75,079,870	$80,701,600	7.5%
Fees & Credits	($298,391)	($575,164)	$343,161	159.7%
HCA Draft Amount	$0	$0	$0	0.0%
Capitation Paid	$0	$0	$0	0.0%
Group Liability	$6,923,983	$74,504,705	$81,044,761	8.8%

Fees and Credits Breakdown

Paid Month	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Access Fee	$0	$0	$0	0.0%
Admin Fee	$319,152	$3,578,384	$3,788,431	5.9%
ASO Adjustments	($547,641)	($4,779,801)	($2,516,288)	47.4%
Rx Credit Fees	($474,756)	($3,676,477)	($5,713,130)	-55.4%
Aggregate Stop Loss	$3,087	$28,556	$35,473	24.2%
Specific Stop Loss	$411,603	$4,251,162	$4,783,219	12.5%
Extra Fees	$0	$0	$0	0.0%
ASO Other Services	$6,021	$71,166	$72,358	1.7%
ASO All Other	($15,858)	($48,154)	($106,903)	-122.0%
Summary	**($298,391)**	**($575,164)**	**$343,161**	**159.7%**

Other reductions *includes penalties, workers compensation savings, and subrogation savings.*
Other payments *includes Blue Card access fees and surcharges. Also displayed are other adjustments.*

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Financial Overview: Medical & Pharmacy Loss Ratio

Report Description: Provides the medical and pharmacy loss ratio and claims for the most recent reported twelve months.

Month	Premium	Medical Paid Claims	Pharmacy Paid Claims	Capitation	VBC Payments	Total Paid	Medical and Pharmacy Loss Ratio
Jan 2024	$0	$0	$0	$0	$0	$0	0.0%
Feb 2024	$0	$0	$0	$0	$0	$0	0.0%
Mar 2024	$0	$0	$0	$0	$0	$0	0.0%
Apr 2024	$0	$0	$0	$0	$0	$0	0.0%
May 2024	$0	$0	$0	$0	$0	$0	0.0%
Jun 2024	$0	$0	$0	$0	$0	$0	0.0%
Jul 2024	$0	$0	$0	$0	$0	$0	0.0%
Aug 2024	$0	$0	$0	$0	$0	$0	0.0%
Sep 2024	$0	$0	$0	$0	$0	$0	0.0%
Oct 2024	$0	$0	$0	$0	$0	$0	0.0%
Nov 2024	$0	$0	$0	$0	$0	$0	0.0%
Dec 2024	$0	$0	$0	$0	$0	$0	0.0%
Summary	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0.0%**



Key Findings: The medical and pharmacy loss ratio for the most recent reported month was **0.0% was similar to** than the average of the most recent reported twelve months, which was 0.0%.

Financial Overview: Network Overview

Report Description: This report displays the discount amount, discount percent, paid amount and paid percent for medical claims split by Medicare/Non-Medicare, in/out of network and service category for the current period.

Medicare Primary Indicator	Network Indicator	Service Category	Covered	Discount	Discount %	Paid	% Of Paid
No	In Network	Facility Inpatient	$23,795,754	$11,548,417	48.5%	$11,833,646	18.4%
		Facility Outpatient	$59,628,751	$21,184,487	35.5%	$34,374,728	53.3%
		Professional	$42,985,702	$22,856,506	53.2%	$16,429,815	25.5%
		Summary	**$126,410,208**	**$55,589,410**	**44.0%**	**$62,638,188**	**97.2%**
	Out of Network	Facility Inpatient	$1,034,820	$498,428	48.2%	$438,076	**0.7%**
		Facility Outpatient	$2,219,788	$1,213,131	54.7%	$601,531	**0.9%**
		Professional	$5,234,416	$2,814,203	53.8%	$768,002	**1.2%**
		Summary	**$8,489,024**	**$4,525,762**	**53.3%**	**$1,807,608**	**2.8%**
	Summary		**$134,899,231**	**$60,115,172**	**44.6%**	**$64,445,796**	**100.0%**
Yes	In Network	Facility Inpatient					
		Facility Outpatient	$28,041	$5,411	19.3%	$21,056	
		Professional	$67,903	$82,350	121.3%	($19,064)	
		Summary	**$95,943**	**$87,761**	**91.5%**	**$1,992**	
	Out of Network	Facility Inpatient					
		Facility Outpatient					
		Professional	$383	$60	15.7%		
		Summary	**$383**	**$60**	**15.7%**		
	Summary		**$96,326**	**$87,821**	**91.2%**	**$1,992**	
Summary			**$134,995,558**	**$60,202,993**	**44.6%**	**$64,447,788**	**100.0%**

Key Findings: The overall network savings discount (excluding Medicare) was **44.0%** for the current period. The in-network paid percent was **97.2%** for the current period.

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Financial Overview: Blue Card Savings Analysis

Report Description: The Blue Card Savings report illustrates the value of having access to other BCBS contracts within the United States through the Blue Card program. Savings from BCBS network discounts are passed to the client, providing savings on potentially costly out of state claims that would otherwise be paid at full provider billed amount.

Jan 2024 - Dec 2024

Par Plan State	Billed	Allowed	Effective Allowed Rate	Discount	Paid	Effective Paid Rate	Blue Card Access Fee
FL	$7,332,180	$2,059,217	28.1%	$4,813,433	$1,864,785	25.4%	$714
NC	$6,906,417	$3,249,915	47.1%	$3,397,301	$2,778,155	40.2%	$160
AL	$3,182,709	$849,998	26.7%	$1,998,235	$722,322	22.7%	$86
TX	$3,127,849	$1,110,864	35.5%	$1,875,581	$969,016	31.0%	$0
CO	$2,997,874	$1,085,458	36.2%	$1,797,434	$1,008,209	33.6%	$1,897
VA	$2,704,613	$713,831	26.4%	$1,774,216	$636,421	23.5%	$0
DC	$2,987,127	$1,154,057	38.6%	$1,699,219	$1,012,616	33.9%	$0
IL	$1,467,616	$659,576	44.9%	$710,440	$598,669	40.8%	$0
BC CA	$1,047,860	$414,257	39.5%	$537,960	$377,392	36.0%	$3,910
NJ	$867,983	$230,079	26.5%	$477,582	$197,026	22.7%	$24
All Other Blue Card	$36,129,678	$5,461,253	15.1%	$4,654,219	$5,004,302	13.9%	$24,035
All Other Non-Blue Card	$115,723,860	$57,804,061	50.0%	$36,467,374	$49,278,876	42.6%	$0
Summary	**$184,475,766**	**$74,792,565**	**40.5%**	**$60,202,993**	**$64,447,788**	**34.9%**	**$30,826**

Key Findings: FL had the greatest Blue Card savings amount, with a Discount amount of **$4,813,433**. The overall Effective Allowed Rate for the current period was **40.5%**.

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Financial Overview: Medical Claim Expense Distribution

Report Description: The distribution of medical paid expense by claimant and the average medical paid per claimant amount are shown for the current period.

Paid Band	Claimants	Claimants %	Paid	Paid %	Paid/Claimant
Less than $200	2,367	21.1%	($292,974)	-0.5%	($124)
$200 - $1,000	2,972	26.5%	$1,572,726	2.4%	$529
$1,001 - $5,000	3,512	31.4%	$8,515,465	13.2%	$2,425
$5,001 - $10,000	1,050	9.4%	$7,439,986	11.5%	$7,086
$10,001 - $30,000	920	8.2%	$15,435,644	24.0%	$16,778
$30,001 - $50,000	180	1.6%	$6,889,892	10.7%	$38,277
Summary <= $50,000	**11,001**	**98.2%**	**$39,560,739**	**61.4%**	**$3,596**

Paid Band	Claimants	Claimants %	Paid	Paid %	Paid/Claimant
$50,001 - $75,000	84	0.8%	$5,006,074	7.8%	$59,596
$75,001 - $100,000	40	0.4%	$3,504,853	5.4%	$87,621
$100,001 - $150,000	43	0.4%	$5,054,035	7.8%	$117,536
$150,001 - $200,000	9	0.1%	$1,584,989	2.5%	$176,110
$200,001 - $250,000	4	0.0%	$919,230	1.4%	$229,807
$250,001 - $500,000	14	0.1%	$5,064,085	7.9%	$361,720
$500,001+	5	0.0%	$3,753,785	5.8%	$750,757
Summary $50,001 or Greater	**199**	**1.8%**	**$24,887,050**	**38.6%**	**$125,061**
Combined Summary	**11,200**	**100.0%**	**$64,447,788**	**100.0%**	**$5,754**

Key Findings: The proportion of claimants who received less than $200 in services for the current period was **21.1%**. These claimants spent **-0.5%** of the total paid expenses and the average paid expense per claimant was **($124)**. **1.8%** of claimants had expenses over $50,001 for the current period. These claimants spent **38.6%** of the total paid expenses and the average paid expense per claimant was **$125,061**.

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Financial Overview: High Cost Claimants

Report Description: This report provides a detailed listing of the top 20 high cost claimants with paid expenses of $50,000 or more for the current period.

Jan 2024 - Dec 2024

Encrypted Member ID	Relationship	Age/Gender Band	Leading Diagnostic Category	Inpatient Paid	Outpatient Paid	Professional Paid	Pharmacy Paid	Paid	Currently Enrolled
3201764090459509576	Subscriber	Female 60-64	Blood	$783,567	$20,658	$14,758	$120,536	**$939,519**	Yes
2369314499026486488	Dependent	Female 20-29	Genitourinary	$16,536	$820,986	$3,339	$213	**$841,074**	Yes
8774191059829088454	Subscriber	Male 40-49	Neoplasms	$56,286	$691,203	$44,291	$0	**$791,780**	No
4091421536809128899	Spouse	Male 40-49	Circulatory	$664,711	$47,273	$16,520	$0	**$728,504**	Yes
5620996233024430255	Spouse	Female 50-59	Neoplasms	$281,003	$233,636	$59,016	$0	**$573,655**	No
3145179530739339561	Subscriber	Female 50-59	Digestive	$375,168	$53,071	$17,798	$0	**$446,037**	No
9190729621933666157	Subscriber	Male 40-49	Neoplasms	$27,004	$370,369	$21,588	$1,120	**$420,081**	No
1505768548659723622	Subscriber	Female 50-59	Neoplasms	$0	$415,253	$2,232	$0	**$417,485**	Yes
7458577253708021513	Subscriber	Female 65+	Neoplasms	$0	$404,452	$7,492	$531	**$412,475**	Yes
1616232036113838762	Subscriber	Female 40-49	Neoplasms	$54,939	$311,634	$36,607	$5,070	**$408,250**	No
8170906818975573018	Subscriber	Female 40-49	Neoplasms	$0	$404,708	$2,372	$59	**$407,139**	Yes
4934687334496737594	Subscriber	Female 40-49	Neoplasms	$0	$318,098	$6,109	$66,066	**$390,273**	Yes
7387013390746645542	Subscriber	Female 50-59	Endocrine	$46,715	$298,911	$25,843	$1,564	**$373,033**	Yes
8816959487870872347	Subscriber	Female 50-59	Not Available	$0	$7,655	$2,284	$353,841	**$363,780**	Yes
2534559120909822203	Subscriber	Female 30-39	Not Available	$0	$0	$1,609	$360,706	**$362,315**	Yes
6583278997534740983	Subscriber	Female 50-59	Neoplasms	$0	$325,208	$8,505	$219	**$333,932**	Yes
7775540984499804914	Subscriber	Female 30-39	Neoplasms	$0	$296,432	$26,365	$2,220	**$325,017**	Yes
1547520515085761871	Subscriber	Female 60-64	Genitourinary	$58,990	$240,567	$18,689	$4,042	**$322,288**	Yes
5186577796034396995	Spouse	Female 40-49	Neoplasms	$32,690	$231,435	$47,087	$0	**$311,212**	No
4795781249797480325	Subscriber	Male 50-59	Circulatory	$235,062	$25,377	$33,090	$1,439	**$294,968**	Yes
High Cost Claimant Total				**$2,632,671**	**$5,516,926**	**$395,594**	**$917,626**	**$9,462,817**	

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Financial Overview: Medical Out of Pocket

Report Description: Provides a distribution of claimants by their total medical out of pocket expenses for the current period compared to the prior period and percent change. This report helps determine the impact of any changes in plan design on out of pocket.

Claimant Distribution by Out of Pocket Expense Bands

	Jan 2023 - Dec 2023				Jan 2024 - Dec 2024				% Change	
Out of Pocket Band	**Claimants**	**Claimants %**	**Out of Pocket**	**Out of Pocket %**	**Claimants**	**Claimants %**	**Out of Pocket**	**Out of Pocket %**	**Claimants Change**	**Out of Pocket Change**
Less than $100	3,161	29.4%	$50,700	0.6%	3,230	28.8%	$60,638	0.6%	2.2%	19.6%
$101 - $200	966	9.0%	$143,190	1.6%	975	8.7%	$142,813	1.4%	0.9%	-0.3%
$201 - $300	613	5.7%	$152,201	1.7%	595	5.3%	$147,622	1.5%	-2.9%	-3.0%
$301 - $400	487	4.5%	$170,834	1.9%	501	4.5%	$175,116	1.7%	2.9%	2.5%
$401 - $500	462	4.3%	$208,554	2.4%	447	4.0%	$201,980	2.0%	-3.2%	-3.2%
$501 - $750	1,053	9.8%	$664,815	7.5%	994	8.9%	$625,323	6.2%	-5.6%	-5.9%
$751 - $1,000	954	8.9%	$833,081	9.4%	956	8.5%	$839,241	8.3%	0.2%	0.7%
$1,001 - $1,500	1,216	11.3%	$1,482,660	16.7%	1326	11.8%	$1,629,984	16.2%	9.0%	9.9%
$1,501 - $2,000	670	6.2%	$1,158,703	13.1%	755	6.7%	$1,296,461	12.9%	12.7%	11.9%
$2,001 - $2,500	413	3.8%	$932,076	10.5%	445	4.0%	$999,462	9.9%	7.7%	7.2%
$2,501 - $3,000	279	2.6%	$772,583	8.7%	362	3.2%	$986,998	9.8%	29.7%	27.8%
$3,001 - $4,000	222	2.1%	$759,534	8.6%	280	2.5%	$944,248	9.4%	26.1%	24.3%
$4,001 - $5,000	117	1.1%	$526,467	5.9%	145	1.3%	$662,588	6.6%	23.9%	25.9%
$Greater than $5,001	138	1.3%	$1,002,735	11.3%	189	1.7%	$1,346,962	13.4%	37.0%	34.3%
Summary	**10,751**	**100%**	**$8,858,133**	**100%**	**11,200**	**100%**	**$10,059,436**	**100%**	**4.2%**	**13.6%**

Out of Pocket Expense by Coverage Tier

	Jan 2024 - Dec 2024									
Coverage Tier	**Allowed**	**Deductible**	**Deductible % of Allowed**	**Copayment**	**Copay % of Allowed**	**Coinsurance**	**Coins % of Allowed**	**Out of Pocket**	**OPX % of Allowed**	**Paid**
Employee Only	$43,296,490	$3,298,978	7.6%	$1,657,911	3.8%	$1,315,861	3.0%	$6,272,750	14.5%	$36,938,906
Employee + One	$5,106,895	$339,418	6.6%	$127,557	2.5%	$158,995	3.1%	$625,970	12.3%	$4,413,555
Employee + Dependent(s)	$9,769,562	$772,098	7.9%	$340,946	3.5%	$224,840	2.3%	$1,337,884	13.7%	$8,343,525
Family	$16,619,617	$1,055,926	6.4%	$372,428	2.2%	$394,478	2.4%	$1,822,832	11.0%	$14,751,803
Summary	**$74,792,565**	**$5,466,419**	**7.3%**	**$2,498,843**	**3.3%**	**$2,094,175**	**2.8%**	**$10,059,436**	**13.4%**	**$64,447,788**

This is a claimant analysis, where only members who had a claim are included. The tables exclude all medical enrolled members that did not submit a claim.

This report is based on claim data and may not reflect client specific benefits being applied to member out of pocket. Please contact your Account Executive for ACCUMS reporting.

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Financial Overview: Lag Report

Report Description: Displays, by paid month, the medical dollars paid and the corresponding month incurred for a 12 month rolling paid period (if available for your account). This report provides insight into the monthly claim lag and can help identify IBNR.

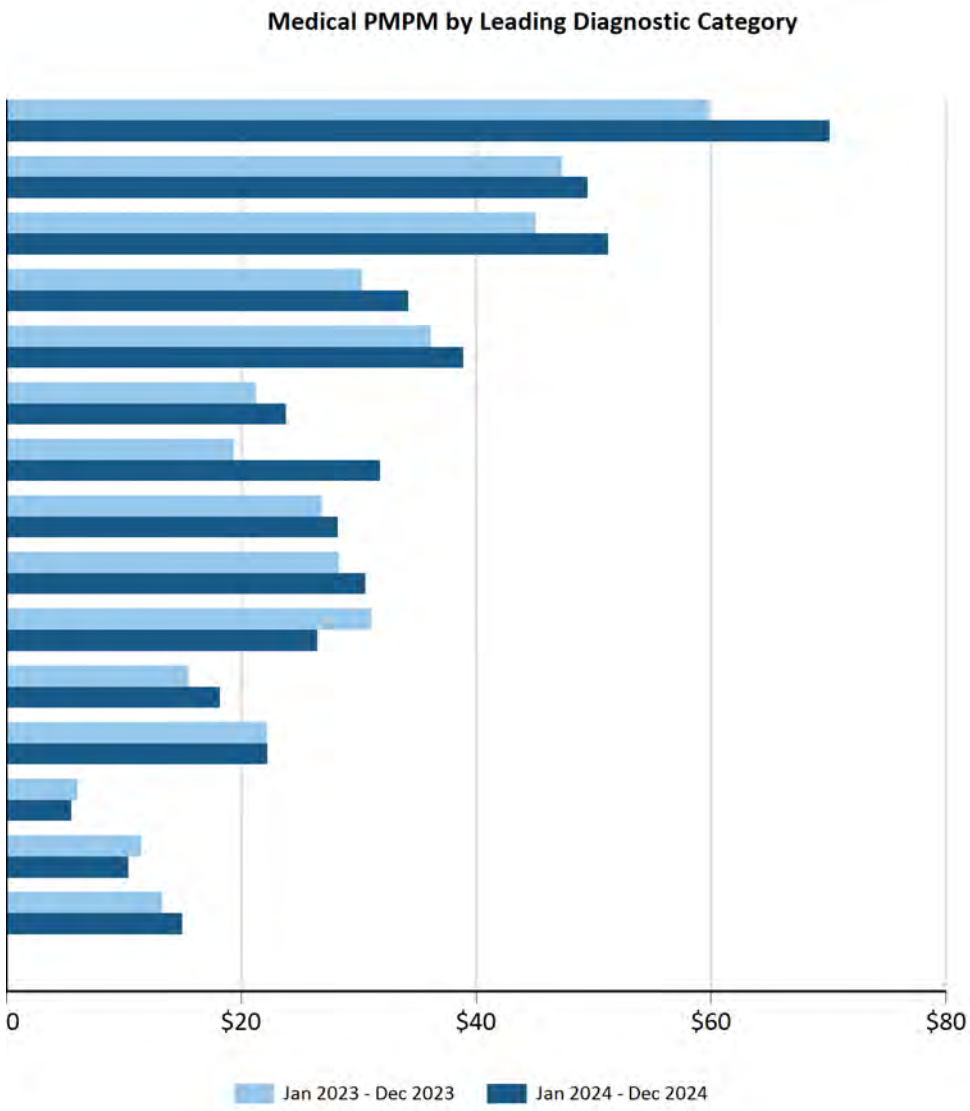
Incurred Month	Paid Month												
	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Summary
All Prior	$47,624	$65,948	$60,213	$16,070	($48,908)	($11,456)	($41,257)	($5,478)	($10,907)	($21,362)	($33,136)	$11,355	**$28,705**
Jan 2023	$1,957	($584)	$6,570	($3,821)	($220)	($8,584)	$483	$1,822	$8,425	($695)	$987	($675)	**$5,664**
Feb 2023	($7,443)	$3,835	($3,647)	($21,854)	($8,305)	$13,117	$10,817	$10,895	$19,168	$430	($156)	$621	**$17,479**
Mar 2023	$2,488	$586	($2,613)	($1,985)	$2,350	$2,116	$526	$4,059	$320	$8,324	($13,023)	$1,020	**$4,168**
Apr 2023	$13,659	$31,032	($1,269)	$3,477	($196)	$153	$3,089	$1,123	($568)	($73)	($38)	($34,401)	**$15,988**
May 2023	$4,841	$5,546	($22,841)	$3,980	$32,258	($145)	$1,206	$2,767	$663	$74	($313)	($865)	**$27,171**
Jun 2023	$50,085	$2,242	$19,378	$3,000	($1,898)	$8,907	($1,980)	$6,714	$563	($61,404)	($359)	$19	**$25,266**
Jul 2023	$43,526	$29,235	$7,396	($1,022)	($973,068)	$3,554	($1,885)	$2,796	$2,711,411	$166	$284	($5,790)	**$1,816,604**
Aug 2023	$80,860	$30,143	$46,676	$4,987	($1,008,103)	$41,366	$224	($8,500)	($527)	$351	$20	($37,808)	**($850,311)**
Sep 2023	$28,011	$16,833	$11,248	$137,095	($725,768)	$370	$1,061	$1,120	$5,361	$1,343	$2,768	($47)	**($520,607)**
Oct 2023	$114,836	$54,024	$19,525	$11,306	($18,195)	$14,730	$3,988	($10,546)	$2,272	$652	($26,863)	$20,284	**$186,012**
Nov 2023	$570,952	$113,822	$44,128	$16,739	$12,099	$7,752	($3,139)	$17,195	$2,346	($4,835)	$208	($6,041)	**$771,226**
Dec 2023	$2,217,218	$577,097	$63,784	$17,733	$10,718	$5,655	$86,808	$4,527	$631	$3,144	$1,981	($107,993)	**$2,881,301**
Jan 2024	$1,729,452	$2,081,137	$505,660	$252,497	$13,653	$27,140	$44,597	$21,762	$13,201	$1,453	$1,018	($16,996)	**$4,674,575**
Feb 2024		$1,654,841	$2,175,734	$583,095	$226,375	$416,575	$15,176	$23,042	$30,909	$2,913	$1,686	$2,985	**$5,133,330**
Mar 2024			$1,811,427	$2,434,613	$364,607	$187,325	$37,311	$232,974	$16,247	$9,348	$1,138	$2,476	**$5,097,466**
Apr 2024				$1,976,555	$2,356,725	$473,004	$108,185	$862,701	$21,831	$11,856	($52,173)	$2,034	**$5,760,719**
May 2024					$2,119,054	$2,249,270	$350,899	$84,196	$65,485	$35,706	$2,988	$23,264	**$4,930,862**
Jun 2024						$1,715,433	$2,440,401	$457,523	$74,193	$34,971	$104,129	$16,091	**$4,842,742**
Jul 2024							$2,314,779	$2,424,375	$356,120	$750,332	$20,322	$73,048	**$5,938,977**
Aug 2024								$2,188,924	$2,917,786	$378,605	$134,950	$84,269	**$5,704,533**
Sep 2024									$2,130,138	$2,450,068	$323,272	$148,846	**$5,052,324**
Oct 2024										$2,590,641	$2,727,488	$341,801	**$5,659,930**
Nov 2024											$2,020,747	$2,682,373	**$4,703,120**
Dec 2024												$2,540,542	**$2,540,542**
Summary	**$4,898,066**	**$4,665,736**	**$4,741,368**	**$5,432,465**	**$2,353,181**	**$5,146,284**	**$5,371,288**	**$6,323,989**	**$8,365,068**	**$6,192,008**	**$5,217,925**	**$5,740,411**	**$64,447,788**

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Financial Overview: Overall Medical Paid PMPM by Leading Diagnostic Category

Report Description: Lists the top 15 overall paid expense across inpatient facility, outpatient facility, and professional settings by leading diagnostic categories for the current month, current period, prior period and percent change.

Paid Period	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Leading Diagnostic Category	**Paid PMPM**	**Paid PMPM**	**Paid PMPM**	**Paid PMPM**
Neoplasms	$93	$60	$70	16.7%
Health Status	$56	$47	$49	4.3%
Musculoskeletal	$55	$45	$51	13.3%
Genitourinary	$44	$30	$34	13.3%
Digestive	$38	$36	$39	8.3%
Injury/Poisoning	$35	$21	$24	14.3%
Circulatory	$33	$19	$32	68.4%
Symptoms/Ill-Defined	$29	$27	$28	3.7%
Mental Health	$27	$28	$31	10.7%
Nervous	$26	$31	$26	-16.1%
Endocrine	$22	$16	$18	12.5%
Pregnancy	$21	$22	$22	0.0%
Eye	$13	$6	$6	0.0%
Infectious/Parasitic	$7	$11	$10	-9.1%
Respiratory	$7	$13	$15	15.4%
All Other	$21	$60	$39	-35.0%
All	**$527**	**$474**	**$496**	**4.6%**



Key Findings: The top three Leading Diagnostic Categories in the current reporting month based on Paid PMPM were **Neoplasms, Health Status, and Musculoskeletal**.

Pharmacy: Financial Summary

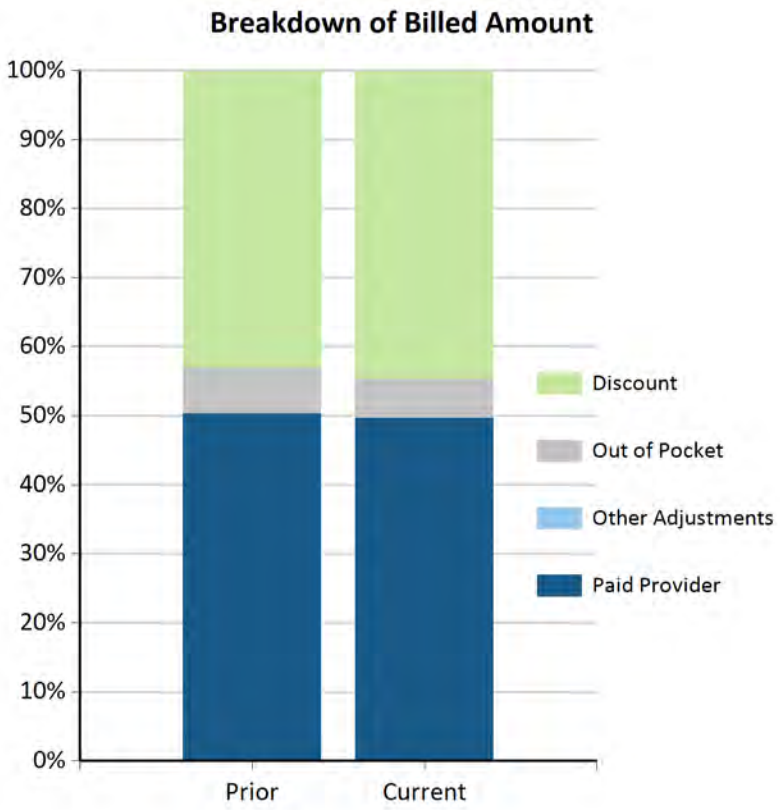
BlueCross BlueShield of New Mexico

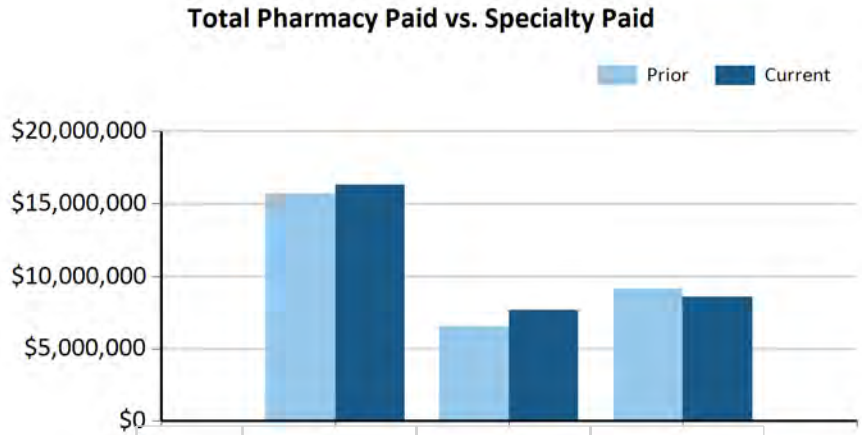
Report Description:

This report provides an overview of pharmacy order of reduction from billed to paid for the current month, current period, prior period, and percent change.

Pharmacy Order of Reduction

	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Billed	$2,796,111	$31,074,648	$32,728,272	5.3%
Discount	$1,222,749	$13,365,243	$14,608,353	9.3%
Allowed	$1,573,362	$17,709,405	$18,119,919	2.3%
Out of Pocket	$101,184	$2,085,560	$1,869,603	-10.4%
Other Adjustments	($7,053)	($60,900)	($58,596)	3.8%
Paid - Provider	$1,479,231	$15,684,746	$16,308,911	4.0%
Paid	$1,479,231	$15,684,746	$16,308,911	4.0%





		Total Paid	Specialty Paid	Non Specialty Paid
Prior		$15,684,746	$6,534,375	$9,150,370
Current		$16,308,911	$7,699,606	$8,609,306

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Pharmacy: Key Indicators

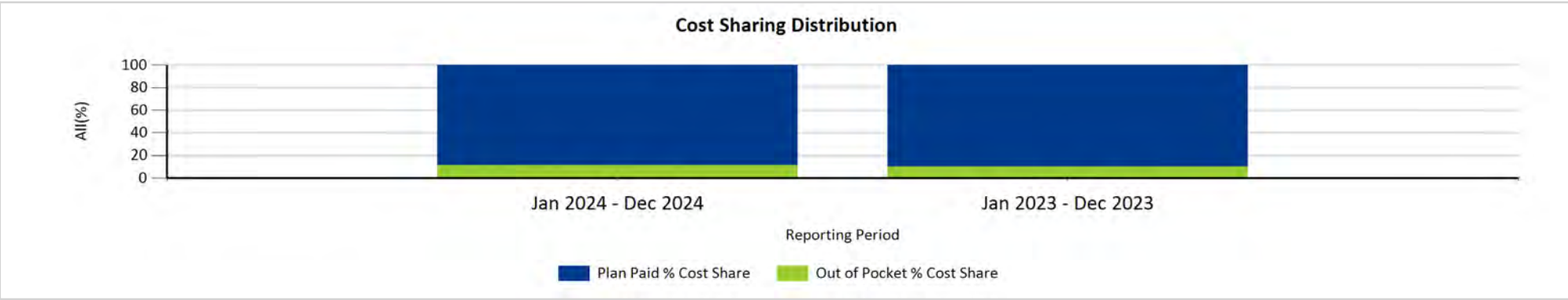
Report Description: This report provides an overview of the prescription expenses for the current month. Prescription expenses and percent changes between the current and prior reporting periods are provided as well.

Key Indicators Summary

Key Indicators Summary	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Unique Pharmacy Members	7,744	9,241	9,361	1.3%
Claimants	2,863	6,793	6,793	0.0%
Prescriptions	9,637	119,377	120,311	0.8%
Prescriptions PMPM	1.24	1.28	1.28	0.1%
Paid	$1,479,231	$15,684,746	$16,308,911	4.0%
Paid PMPM	$191.02	$168.46	$174.02	3.3%
Allowed	$1,573,362	$17,709,405	$18,119,919	2.3%
Allowed PMPM	$203.17	$190.21	$193.35	1.6%
Avg. Ingredient Cost/Prescription	$163.16	$148.09	$150.51	1.6%
Generic Dispensing Rate	84.4%	85.1%	86.0%	1.1%
Generic Substitution Rate	99.5%	99.0%	99.4%	0.4%
Out of Pocket Percent of Allowed	6.4%	11.8%	10.3%	-12.4%
Retail as a Percent of Prescriptions	94.2%	94.3%	94.4%	0.1%
Mail Order as a Percent of Prescriptions	5.8%	5.7%	5.6%	-1.9%
Specialty Percent of Total Prescriptions	1.3%	1.0%	1.1%	19.5%
Specialty Percent of Total Paid	46.4%	41.7%	47.2%	13.3%
Specialty Average Ingredient Cost/Prescription	$5,665.33	$6,366.96	$6,071.61	-4.6%

Cost Sharing Distribution

Cost Sharing Distribution	Dec 2024		Jan 2023 - Dec 2023		Jan 2024 - Dec 2024		% Change	
	Retail	Mail	Retail	Mail	Retail	Mail	Retail	Mail
Member Out of Pocket	6.3%	10.8%	11.8%	10.3%	10.2%	11.9%	-13.1%	14.7%
Plan Paid	93.7%	89.2%	88.2%	89.7%	89.8%	88.2%	1.8%	-1.7%



Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Pharmacy: Generic vs. Formulary Experience

Report Description: For the current period, the prescription drug expenses are displayed below for retail and mail order providers and broken out by drug type and formulary indicator.

			Total Expense		Member Expense		Plan Expense	
Retail Prescriptions	**Prescriptions**	**% of Total Prescriptions**	**Allowed**	**Allowed / Prescription**	**Out of Pocket**	**Out of Pocket / Prescription**	**Paid**	**Paid/ Prescription**
Generic	97,480	86%	$1,900,714	$19.50	$655,348	$6.72	$1,249,357	$12.82
Brand	16,126	14%	$15,746,862	$976.49	$1,158,309	$71.83	$14,643,270	$908.05
Summary	**113,606**	**100%**	**$17,647,577**	**$155.34**	**$1,813,657**	**$15.96**	**$15,892,626**	**$139.89**
Brand Type Breakdown								
Single-Source Brand	14,727	13%	$14,989,236	$1,017.81	$1,119,939	$76.05	$13,926,976	$945.68
Multi-Source Brand	1,399	1%	$757,626	$541.55	$38,370	$27.43	$716,293	$512.00
Multi-Source Brand w/ DAW1	166	0%	$18,278	$110.11	$3,092	$18.63	$12,944	$77.97
Multi-Source Brand w/ DAW2	574	1%	$198,721	$346.20	$18,526	$32.27	$180,335	$314.17
Brand Formulary	15,877	14%	$15,439,529	$972.45	$1,142,223	$71.94	$14,350,060	$903.83
Brand Non-Formulary	249	0%	$307,334	$1,234.27	$16,086	$64.60	$293,210	$1,177.55

			Total Expense		Member Expense		Plan Expense	
Mail Prescriptions	**Prescriptions**	**% of Total Prescriptions**	**Allowed**	**Allowed / Prescription**	**Out of Pocket**	**Out of Pocket / Prescription**	**Paid**	**Paid/ Prescription**
Generic	5,827	87%	$79,812	$13.70	$30,141	$5.17	$49,948	$8.57
Brand	878	13%	$392,530	$447.07	$25,806	$29.39	$366,337	$417.24
Summary	**6,705**	**100%**	**$472,342**	**$70.45**	**$55,947**	**$8.34**	**$416,285**	**$62.09**
Single-Source Brand	801	12%	$370,707	$462.81	$24,511	$30.60	$346,330	$432.37
Multi-Source Brand	77	1%	$21,823	$283.41	$1,296	$16.83	$20,007	$259.83
Multi-Source Brand w/ DAW1	18	0%	$760	$42.20	$215	$11.96	$0	$0.00
Multi-Source Brand w/ DAW2								
Brand Formulary	870	13%	$392,076	$450.66	$25,718	$29.56	$366,081	$420.78
Brand Non-Formulary	8	0%	$454	$56.71	$88	$10.97	$256	$32.02

			Total Expense		Member Expense		Plan Expense	
Total Prescriptions	**Prescriptions**	**% of Total Prescriptions**	**Allowed**	**Allowed / Prescription**	**Out of Pocket**	**Out of Pocket / Prescription**	**Paid**	**Paid/ Prescription**
Generic	103,307	86%	$1,980,527	$19.17	$685,488	$6.64	$1,299,304	$12.58
Brand	17,004	14%	$16,139,392	$949.15	$1,184,115	$69.64	$15,009,607	$882.71
Summary	**120,311**	**100%**	**$18,119,919**	**$150.61**	**$1,869,603**	**$15.54**	**$16,308,911**	**$135.56**
Brand Type Breakdown								
Single-Source Brand	15,528	13%	$15,359,943	$989.18	$1,144,450	$73.70	$14,273,307	$919.20
Multi-Source Brand	1,476	1%	$779,449	$528.08	$39,665	$26.87	$736,300	$498.85
Multi-Source Brand w/ DAW1	184	0%	$19,038	$103.47	$3,307	$17.97	$12,944	$70.35
Multi-Source Brand w/ DAW2	574	0%	$198,721	$346.20	$18,526	$32.27	$180,335	$314.17
Brand Formulary	16,747	14%	$15,831,605	$945.34	$1,167,941	$69.74	$14,716,141	$878.73
Brand Non-Formulary	257	0%	$307,787	$1,197.62	$16,174	$62.93	$293,466	$1,141.89

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Pharmacy: Top Non-Specialty Therapeutic Drug Classes

Report Description: The top 10 therapeutic and prescription drug classes for the current period are displayed below ranked by ingredient cost. new

Current/ Prior Rank		Plan Therapeutic Class	Prescriptions	Utilizing Members	Ingredient Cost	Avg. Ingredient Cost/ Prescription (Current)	Avg. Ingredient Cost/ Prescription (Prior)	% Generic	Rank by Volume
1	1	Incretin Mimetic Agents	2,889	390	$2,617,364	$905.98	$860.98		9
2	2	Calcitonin Gene-Related Peptide (CGRP) Receptor Antag	785	108	$826,069	$1,052.32	$1,059.95		37
3	4	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	1,134	153	$613,609	$541.10	$533.98		27
4	3	Insulin	1,627	175	$452,215	$277.94	$346.14		20
5	5	Sympathomimetics	2,872	1,069	$251,766	$87.66	$147.97	85.0%	10
6	7	Direct Factor Xa Inhibitors	466	63	$249,442	$535.28	$510.11		58
7		Antiviral Combinations	175	266	$241,252	$1,378.58	$4.42		97
8	6	Viral Vaccines	2,392	1,625	$234,461	$98.02	$92.29		13
9		Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	201	27	$105,290	$523.83	$510.51		91
10	10	Amphetamines	1,473	225	$89,820	$60.98	$111.67	94.8%	21
		All Other	104,927	6,410	$4,108,224	$39.15	$45.21	94.5%	
		Summary	**118,941**	**6,786**	**$9,789,512**	**$82.31**	**$88.24**	**86.6%**	

Current/ Prior Rank		Brand Name	Plan Therapeutic Class	Prescriptions	Utilizing Members	Ingredient Cost	Avg. Ingredient Cost/ Prescription (Current)	Avg. Ingredient Cost/ Prescription (Prior)	Generic Indicator	Rank by Volume
1	3	OZEMPIC INJ 8MG/3ML	Incretin Mimetic Agents	488	85	$442,976	$907.74	$864.04	NO	10
2	2	OZEMPIC INJ 2MG/3ML	Incretin Mimetic Agents	523	130	$397,569	$760.17	$711.82	NO	6
3	1	OZEMPIC INJ 4MG/3ML	Incretin Mimetic Agents	435	107	$388,015	$891.99	$856.03	NO	13
4	4	NURTEC TAB 75MG ODT	Calcitonin Gene-Related Peptide (CGRP) R	154	44	$237,356	$1,541.27	$1,622.09	NO	144
5		PAXLOVID TAB 300-100	Antiviral Combinations	168	182	$227,619	$1,354.88	$1,375.27	NO	125
6	5	MOUNJARO INJ 5MG/0.5	Incretin Mimetic Agents	201	68	$202,966	$1,009.78	$968.55	NO	97
7	13	JARDIANCE TAB 25MG	Sodium-Glucose Co-Transporter 2 (SGLT2	358	48	$199,407	$557.00	$523.28	NO	29
8	8	ELIQUIS TAB 5MG	Direct Factor Xa Inhibitors	336	45	$182,236	$542.37	$518.52	NO	35
9	12	MOUNJARO INJ 7.5/0.5	Incretin Mimetic Agents	166	56	$166,053	$1,000.32	$966.60	NO	128
10	6	TRULICITY INJ 1.5/0.5	Incretin Mimetic Agents	170	36	$155,579	$915.17	$872.22	NO	122
		All Other		115,942	6,779	$7,189,736	$62.01	$71.29		
		Summary		**118,941**	**6,786**	**$9,789,512**	**$82.31**	**$88.24**		

Pharmacy: Specialty Drug Analysis

BlueCross BlueShield of New Mexico

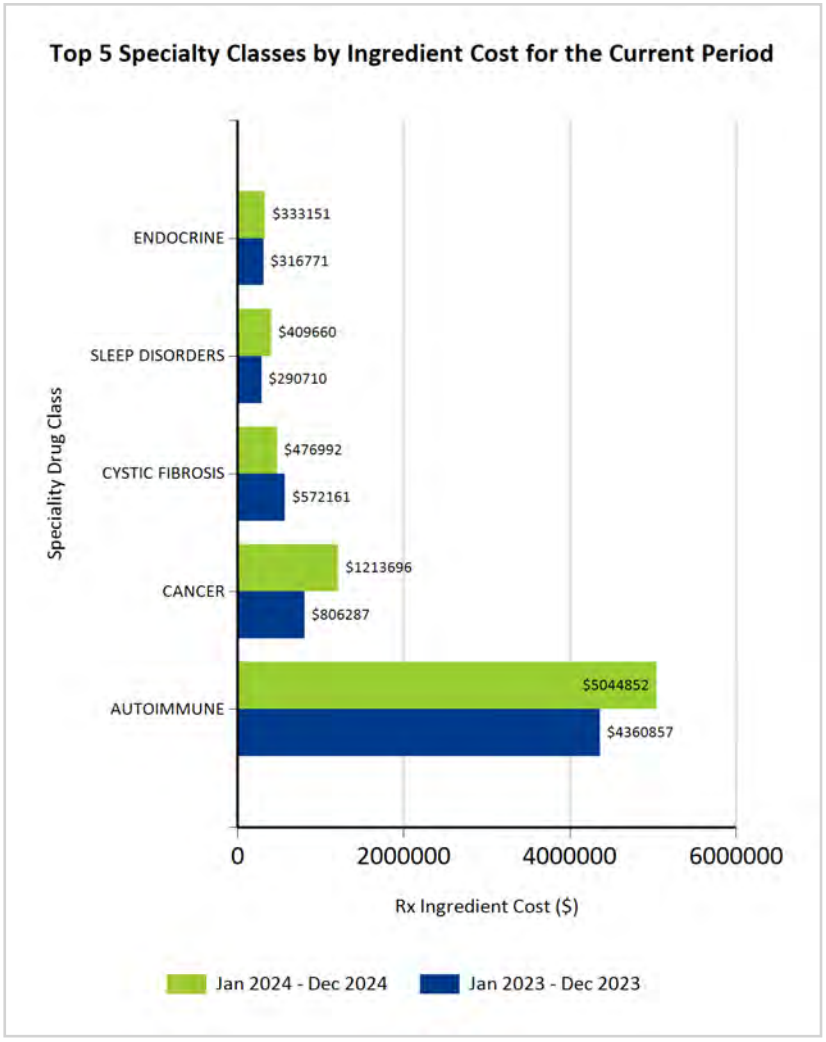
Report Description: Specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies. This report provides specialty drug analysis for the current month, current period, prior period and percent change.

Specialty Drug Key Indicators

	Dec 2024	Jan 2023 - Dec 2023	Jan 2024 - Dec 2024	% Change
Unique Pharmacy Members	7,744	9,241	9,361	1.3%
Claimants	108	199	219	10.1%
Percent of Utilizing Members	1.4%	2.2%	2.3%	8.6%
Prescriptions	124	1,138	1,370	20.4%
Specialty Percent of Total Paid	46.4%	41.7%	47.2%	13.3%
Percent of Total Prescriptions Paid	1.3%	1.0%	1.1%	19.5%
Paid	$686,322	$6,534,375	$7,699,606	17.8%
Paid PMPM	$88.63	$70.18	$82.16	17.1%
Average Ingredient Cost/Prescription	$5,665	$6,367	$6,072	-4.6%

Top 10 Specialty Drugs by Ingredient Cost for the Current Period

Brand Name	Specialty Class	Ingredient Cost	Prescriptions	Avg. Ingredient Cost/ Prescription	Specialty Claimants
STELARA INJ 90MG/ML	AUTOIMMUNE	$847,804	56	$15,139.36	7
HUMIRA PEN INJ 40/0.4ML	AUTOIMMUNE	$765,956	107	$7,158.47	18
DUPIXENT INJ 300/2ML	AUTOIMMUNE	$412,295	107	$3,853.23	16
SKYRIZI PEN INJ 150MG/ML	AUTOIMMUNE	$392,009	43	$9,116.49	8
SYMDEKO TAB 100-150	CYSTIC FIBROSIS	$286,830	11	$26,075.50	1
VERZENIO TAB 150MG	CANCER	$280,375	22	$12,744.33	2
HUMIRA INJ 40/0.4ML	AUTOIMMUNE	$276,106	40	$6,902.66	5
SOD OXYBATE SOL 500MG/ML	SLEEP DISORDERS	$276,042	14	$19,717.27	2
SPRYCEL TAB 100MG	CANCER	$201,163	15	$13,410.83	1
IBRANCE TAB 125MG	CANCER	$198,461	12	$16,538.39	1
All Other		$4,381,059	943	$4,645.87	169
Summary		**$8,318,101**	**1,370**	**$6,071.61**	**219**



Prior period is reflected only as it pertains to the Top 5 Speciality Classes of current period.

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Dental Financial Analysis

BlueCross BlueShield of New Mexico

Financial Overview: Jan 2024 - Dec 2024

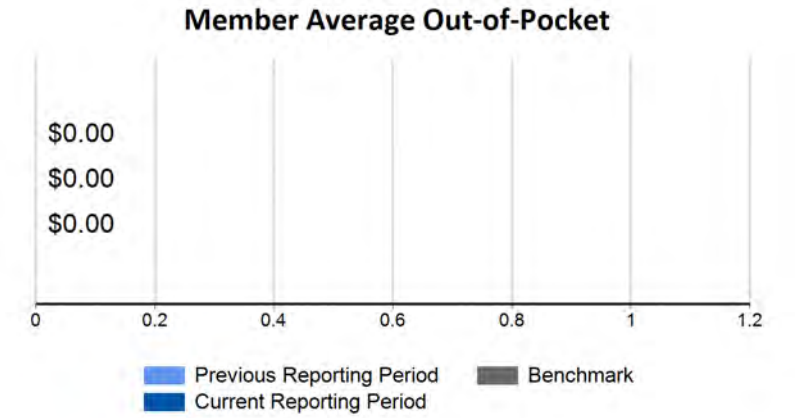
Service Category	Claimants	Claims	Average Cost per Claim	Previous Average Cost per Claim	% Change	PMPM	Benchmark	% Variance from Benchmark
PROSTHODONTICS, REMOVABLE	1	1	$0.00	$0.00	0%	$0.00	$0.00	0%
RESTORATIVE	1	3	$0.00	$0.00	0%	$0.00	$0.00	0%
Totals		**4**	**$0.00**	**$0.00**			**$0.00**	

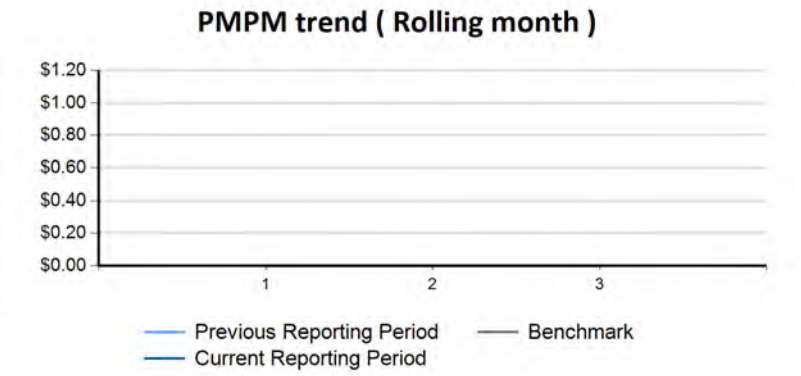
Top 10 Procedure Service Type

Description	Counts	Prior Reporting period count	PMPM by Service Type	Service Type PMPM Benchmark

* Service Type is the procedure detail of Service Category

- **PROSTHODONTICS, REMOVABLE** procedures accounted for **of total** dollars for the current reporting period.
- **Male PMPM** is **$0.00** less than **Female PMPM** for the current reporting period.



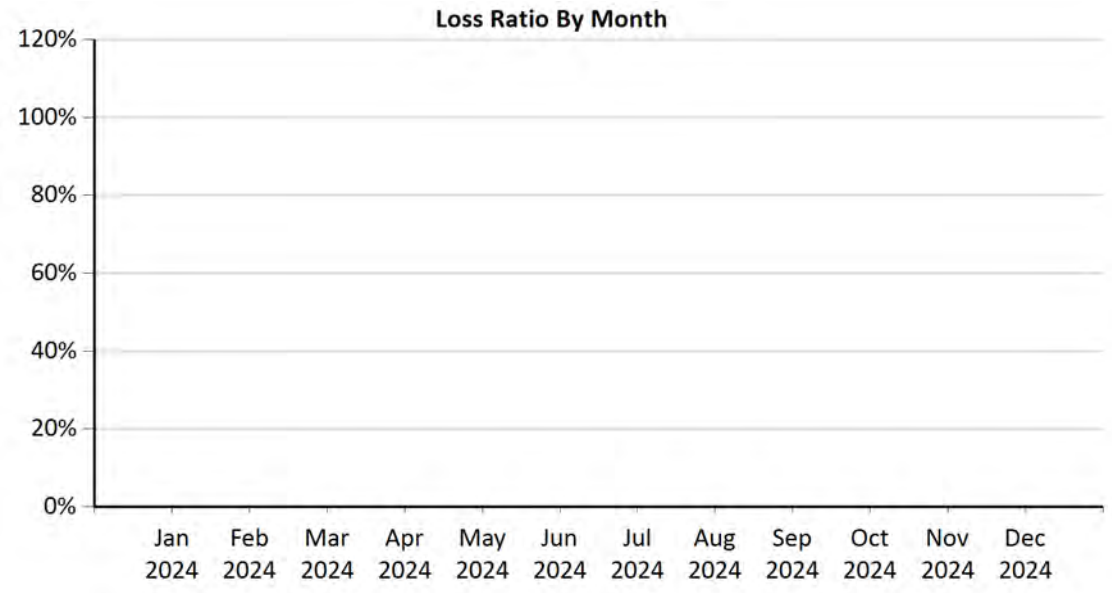


Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Dental: Loss Ratio

Report Description: Provides the dental loss ratio and claims for the most recent reported twelve months.

Month	Premium	Dental Paid Claims	Dental Loss Ratio
Jan 2024			
Feb 2024			
Mar 2024			
Apr 2024			
May 2024			
Jun 2024			
Jul 2024			
Aug 2024			
Sep 2024			
Oct 2024			
Nov 2024			
Dec 2024			
Summary			-



Key Findings: The dental loss ratio for the most recent reported month was **0.0% was similar to** than the average of the most recent reported twelve months, which was 0.0%.

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Appendix: ICD Category Definitions

Certain Conditions Original in the Perinatal Period: Includes infant-related conditions associated with prematurity and the newborn period until one month of age. Example conditions include prematurity, low birth weight, multiple births, various birth-related injuries, respiratory distress syndrome, and jaundice.

Certain Infectious and Parasitic Diseases: Includes communicable or transmissible diseases caused by bacteria and viruses that commonly cause widespread infection. Example conditions include sepsis, infectious shock, tuberculosis, and COVID-19. Of note: immunization claims, which were previously in this category in the CCS diagnostic category system, are now in the *Factors Influencing Health Status category*.

Congenital Malformations, Deformations, and Chromosomal Abnormalities: Includes any genetic condition and/or organ malformations present at birth. Example conditions within this category include Down Syndrome, various heart defects, diaphragmatic hernia, spina bifida, cleft palate, polycystic kidney disease, and limb malformations.

Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism: Includes conditions related to white or red blood cells, platelets, or plasma. Example conditions include various types of anemias (e.g., iron deficiency, aplastic, sickle cell) and coagulation disorders such as hemophilia, and various immunodeficiency conditions.

Diseases of the Circulatory System: Includes conditions involving the heart, arteries, and veins. Example conditions within this category include hypertension, heart attack, coronary heart disease, congestive heart failure, arrhythmias, aneurysms, atherosclerosis, blood clots, and stroke.

Diseases of the Digestive System: Includes conditions involving the digestive organs, which includes the mouth, esophagus, stomach, intestines, gall bladder, liver, and pancreas. Example conditions within this category include stomach and intestinal ulcers, acid reflux, gallstones, cirrhosis, autoimmune hepatitis, pancreatitis, appendicitis, and various hernias.

Diseases of the Ear and Mastoid Process: Includes conditions involve in the ears, such as hearing loss, ear infection, earache, and tinnitus. Of note: This category is new within the CCSR system; these conditions were previously included in the *Diseases of the Nervous System and Sense Organs* category in the CCS system.

Diseases of the Eye and Adnexa: Includes conditions involving the eyes, such as cataracts, myopia, glaucoma, macular degeneration, and conjunctivitis. Of note: This category is new within the CCSR system; these conditions were previously included in the *Diseases of the Nervous System and Sense Organs* category in the CCS system.

Diseases of the Genitourinary System: Includes conditions involving the kidneys, bladder, and genitalia, including infertility diagnoses. Example conditions within this category include chronic kidney disease, kidney stones, incontinence, endometriosis, ovarian cysts, female and male infertility, and prostate enlargement. Of note: management related to infertility falls within the *Pregnancy, Childbirth and the Puerperium* category.

Diseases of the Musculoskeletal System: Includes conditions involving the bones, cartilage, joints, muscles, and connective soft tissue. Example conditions include osteoarthritis, osteoporosis, spinal stenosis, spondylosis, intervertebral disc disorders, radiculopathy, rheumatoid arthritis, and lupus.

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Appendix: ICD Category Definitions

Diseases of the Nervous System: Includes conditions involving the brain, spinal cord, and nerves. Example conditions include multiple sclerosis, sleep apnea, migraine, fibromyalgia, carpal tunnel syndrome, myasthenia gravis, Parkinson's disease, Guillain-Barre syndrome, and spinal muscular atrophy. Of note: In the CCS system, this category previously included conditions related to the ears and eyes, but those conditions are now reported in the *Diseases of the Ear and Mastoid Process and Diseases of the Eye and Adnexa* categories, respectively.

Diseases of the Respiratory System: Includes conditions related to the airway and breathing, which includes the nose, bronchial tree, and lungs. Example conditions within this category include respiratory failure, throat infections, sinusitis, bronchitis, asthma, COPD, and pneumonia.

Diseases of the Skin and Subcutaneous Tissue: Includes conditions involving the skin, hair, and nails. Example conditions would be various skin/decubitus ulcers, cellulitis, psoriasis, dermatitis, alopecia, and fungal infections.

Endocrine, Nutritional and Metabolic Diseases: Includes conditions related to immune system functioning, nutrition, metabolism, and function of the endocrine glands, which include the thyroid, pituitary, pancreas, adrenal glands, ovaries, and testes. Example conditions would be diabetes, cystic fibrosis, thyroid disease, malnutrition, obesity, and hyperlipidemia. Of note: The immunodeficiency conditions that were previously reported in this category in the CCS system are now reported in the *Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism* category.

External Causes of Morbidity: Includes conditions related to accidents and exposure to harmful substances. Examples of conditions include injuries from motor vehicle accidents, exposure to the elements, and wounds from weapons or firearms.

Factors Influencing Health Status and Contact with Health Services: Includes diagnosis codes that are used for preventive screenings, immunizations, contraceptive management, post-operative rehabilitation, monitoring of post-operative organ transplants, and personal or family history of certain hereditary conditions such as cancer and heart disease. Note: Chemotherapy claims technically fall within this CCSR category, but the logic in Blue Insight ignores these codes to ensure that chemotherapy claims are categorized based on the underlying diagnoses they are treating, most of which are in the Neoplasms category. Also note: diagnosis codes for COVID-19 testing were previously reported in the *Infectious and Parasitic Diseases* category in the CCS system, but they are now reported under the *Factors Influencing Health Status* category.

Injury, Poisoning and Certain Other Consequences of External Causes: Includes treatment for injuries to the body, including various poisonings, as well as any complications from medical procedures and devices. Example conditions include sprains and strains, fractures, burns, lacerations, various drug or environmental poisonings, and complications from surgery.

Mental, Behavioral, and Neurodevelopmental Disorders: Includes psychiatric and behavioral conditions related to thinking, feeling, social skills or substance abuse. Example conditions include depression, anxiety, schizophrenia, eating disorders, autism, learning disorders, speech delay, Tourette's syndrome, and substance use disorders.

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Appendix: ICD Category Definitions

Neoplasms: Includes any abnormal growth of cells, either benign or malignant (cancer). Includes various cancer conditions and any abnormal growth of cells, including related chemotherapy, immunotherapy, and radiation therapy services. Example conditions within this category would be Leukemia, Hodgkin's Disease, breast, lung, prostate, skin, and colon cancers. Of note: Diagnosis codes for personal or family history of cancer (as opposed to an active cancer diagnosis) were previously included in this category in the CCS system, but they are now included in the *Factors Influencing Health Status* category.

Pregnancy, Childbirth and the Puerperium: Includes vaginal and cesarean deliveries, maternally-related conditions associated with contraception and fertility management, and any complication of pregnancy. Example claims include fertility testing, artificial insemination, tubal ligation, IUD placement, pregnancy-induced hypertension, bleeding related to pregnancy, gestational diabetes, early or threatened labor, ectopic pregnancy, and delivery procedures. Of note: An actual diagnosis of infertility falls in the Diseases of the *Genitourinary System* category.

Signs, Symptom and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified: Includes abnormal lab results that may suggest, but do not always confirm, a more specific diagnosis, as well as general symptoms for which a more specific diagnosis cannot be found after medical evaluation, which is common for urgent care and emergency room claims. Example conditions include abdominal pain, shortness of breath, chest pain, fainting, nausea, fever, swelling, and abnormal test results. Note: Preventive screening claims were previously included in this category in the CCS system but are now included in the *Factors Influencing Health Status* category.

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Glossary

Admin Fees: The charge to an account for HCSC's operational cost of doing business.

Administrative Services Only (ASO): A contract between HCSC and a self-funded plan where HCSC performs administrative services only and does not assume any financial risk. Services usually include claims processing but may include other services such as actuarial analysis and utilization review.

Aggregate: Constituting or amounting to a whole. For example, an aggregate account report includes data for the entire account.

Aggregate Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Aggregate stop loss provides protection against the accumulation of total claims for a group as a whole exceeding a stated level.

Allowed: Amount considered eligible for payment by the plan

ASO Adjustments: An amount added or deducted from ASO (Administrative Services Only) fees. This includes Stop Loss Reimbursements.

Average Age: The difference between the claimant's year of enrollment and year of birth. Calculated using the measure Average Age divided by the members represented in the report.

Average Contract Size: The average number of members per subscriber. It is calculated as: Medical Members / Medical Subscribers

Average Dependents: Calculated using the measure Member Months (filtered on the Relationship = Dependents) divided by the number of months in the report.

Average Ingredient Cost: Represents the cost of the medication and is determined from the lowest submission of the pharmacy network rate, Usual & Customary amount, or Maximum Allowable Cost (MAC)

Average Members: Calculated using the measure Member Months divided by the number of months included in the report.

Average Subscribers: Calculated using the measure Subscriber Months divided by the number of months included in the report.

Billed: Amount submitted for payment by the provider

Billing and Accounts Receivable System (BARS): An HCSC financial system where all Administrative Services Only (ASO) customer bills are generated.

Blue Card Access Fee: Interplan Teleprocessing Services fee charged on out-of-state claims for accessing the local plan's provider network

Brand Formulary: Brand name medications that are listed on the formulary

Brand Non-Formulary: Brand name medications that are not listed on the formulary

Claimants: Number of individual members submitting a claim

Claim Lag: The amount of time between the date a claim is incurred and the date the claim payment is made.

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Glossary

COB: Portion of amount considered eligible for payment that has been paid by another insurance company (Coordination of Benefits)

COB Medicare: Portion of amount considered eligible for payment that has been paid by Medicare

COBRA Members: Consolidated Omnibus Budget Reconciliation Act - A federal law which requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) when coverage under the plan would otherwise end.

Coinsurance: Portion of covered amount member is responsible to pay for the claim

Co-payment: Flat rate that the member is responsible to pay for the claim

Coverage Tier: Eligibility tiers which stratify enrollment data based on the employee and others enrolled under the employee's coverage. Varying benefits can be assigned to tiers.

Covered Amount: Amount eligible for payment based on the terms of the medical/dental benefits agreement.

DAW/1: Indicates that the physician has specified 'do not substitute' on the prescription.

DAW2: Indicates that the Physician has allowed a substitution, but the patient requested brand to be dispensed

Deductible: Portion of annual deductible amount member is responsible to pay applied to the claim.

Dental Loss Ratio: Calculated as the Dental Paid Claims Amount divided by the Billed Dental Premium Amount

Dental Paid Claims: An amount paid to cover the Health Plan's liability for dental services provided to members for claims that have been processed and approved for payment

Discount: Amount of reduction from billed amount that has been negotiated with the provider

Discount %: For medical claims, the discount percent is calculated as Discount / Covered

Dispensing Rate: The proportion of total drugs claims a certain drug or drug type is being dispensed

Drug Type: An indicator on each Rx claim that tells whether a prescription is single source brand, multi-source brand or generic item.

Effective Discount %: The effective discount percentage is calculated as: Discount / (Discount + Paid)

Fees and Credits: Includes all account-specific member and account level fees. Can include Specific Stop Loss, Aggregate Stop Loss, Administration, Access Fees, ASO Adjustments (either debits or credits), Rx Credits and other miscellaneous fees.

Females (20-44 years): The total number of members who are women between the ages of 20 and 44 years. The proportion of females (20-44 years) is calculated as: Member Months for Women between 20-44 years / Member Months

Formulary Compliance Rate: The percentage of drugs dispensed that were included in the formulary

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Glossary

Generic Dispensing Rate: Proportion of potential generic prescriptions that were filled as generic (excludes COVID claims).

Generic Drugs: A medication for which the patent has expired, allowing any manufacturer to produce and distribute the product under the chemical name.

Generic Substitution Rate: The rate in which generics were dispensed when a generic was available (excludes COVID claims).

Group Liability: Total Claim Expense plus Fees and Credits

HCC: High Cost Claimant, a claimant with total paid amount over a specified threshold (e.g., $30,000 or $50,000) within the reporting period

IBNR: An acronym for 'incurred but not reported'. IBNR claims are that group which are incurred before the fund reserving date, but not reported until after that date.

Ingredient Cost: The cost of the drug including sales tax, excluding dispensing fees.

In-Network Paid %: Percent of total paid expenses for in-network claims. It is calculated as: In-Network Paid / Paid

Inpatient Facility: Refers to Facility Inpatient claims

International Classification of Diseases (ICD): An official list of categories of diseases, physical and mental, issued by the World Health Organization (WHO).

Leading ICD Diagnostic Category: For each patient, summarize total paid amount for each diagnosis and its corresponding MDC. The MDC with the greatest paid amount for the patient becomes the Leading ICD Diagnostic Category for the reporting period

MAC Program Savings: Savings achieved by using the MAC (maximum allowable cost) discount on generic medications

Medical Paid Claims: An amount paid to cover the Health Plan's liability for medical (healthcare) services provided to members for claims that have been processed and approved for payment

Medical/Pharmacy Loss Ratio: Calculated as the combined Medical and Pharmacy Paid Claims Amount divided by the total Billed Premium Amount for Medical and Pharmacy, where appropriate

Member Months: Count of months of eligibility for members

Multi-Source Brand: Brand name medications with a generic equivalent

Network Indicator: An indicator that shows whether the claim was processed as in-network (e.g., in the Preferred Provider Organization network) or out-of-network and paid accordingly

Network Savings Discount: The discount that is applied when a member receives services from a contract provider.

Not Covered: Amount considered not eligible for payment by the plan (excludes the discount amount)

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Glossary

Other Adjustments: Minor payments or credits not captured in other specific expense measures

Other Payments: Combination of Blue Card access fees and surcharge expenses

Other Reductions: Combination of maximum reductions, penalties, workers compensation savings, and subrogation savings

Out of Pocket: Total amount that is the responsibility of the claimant. It is calculated as: (Copay + Deductible + Coinsurance)

Outpatient Facility: Refers to Facility Outpatient claims

Paid: Total amount paid by the plan, including access fees, adjustments, and surcharges

Paid-Provider: Amount paid to the provider by the plan

Paid/Claimant: Amount paid to the provider by the plan per claimant. It is calculated as: Paid / Claimants

Paid/Service: Amount paid to the provider by the plan per admission (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: Paid / Services

Paid PEPM: Amount paid to the provider by the plan per employee per month. It is calculated as: Paid / Subscriber Member Months

Paid PMPM: Amount paid to the provider by the plan per member per month. It is calculated as: Paid / Member Months

Penalty: Amount charged to the user of health care services for a non-approved contractual service

PEPM: Per employee per month

Pharmacy Discount %: For pharmacy claims, the discount percent is calculated as Discount / (Discount + Allowed)

Pharmacy Paid Claims: An amount paid to pharmacies (or members where applicable) to cover the Health Plan’s liability for pharmacy services provided to members for claims that have been processed and approved for payment. The calculation of “pharmacy paid claims” does not include pharmaceutical manufacturer rebates

Pharmacy Tier: An indicator on each Rx claim that tells whether a prescription is generic, preferred brand, non-preferred brand, specialty, or other

Plan Eligibility: Eligibility derived directly from the plan's enrollment system. It excludes eligibility created during data processing for claims without matching records in the enrollment system.

PMPM: Per member per month

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Glossary

Premium: An agreed upon fee paid to the Health Plan for coverage of medical and/or dental benefits for an established benefit period and set intervals

Professional: Services provided by physicians or other professional providers

Recoveries: Subrogation and/or Reimbursements for claims that are included in BARS but not in HCSC's data warehouse (since some of the reimbursements could be for members or claims that are no longer in our data warehouse). Recoveries are loaded from the BARS System and included in Blue Insight for reconciliation purposes.

Rx Credit Fees: Drug rebates that are credited back to the account.

Rx Paid PEPM: Prescription drug paid amount per employee per month

Rx Paid PMPM: Prescription drug paid amount per member per month

Service Category: A classification based on claim type

Service Type: Classification based on principal diagnosis or ICD Procedure Code

Services: Number of admissions (inpatient facility), number of visits (outpatient facility), number of claim lines (professional), or number of scripts (prescription Rx)

Services/1000: Number of services per 1,000 members. It is calculated as: (Services / Member Months) * 1000 * 12

Single Source Brand: Brand name medications with no generic equivalent

Specialty Drugs: Medications that generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more costly than alternative drugs or therapies.

Specific Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Specific (or individual) stop loss limits the cost of eligible medical expenses for each covered individual.

Subrogation Savings: Portion of amount eligible for payment originally paid by the plan but that has since been recovered through a legal action

Surcharge: Amount charged as a tax by certain States on facility claims

Therapeutic Drug Class: Used to categorize or group prescription drugs which are considered similar by the disease they treat or by the effect they have on the body

Total Paid: The total amount of medical and pharmacy dollars paid to cover healthcare services provided to members for claims that have been processed and approved for payment

Total Paid Claims + Recoveries: The total amount paid by the plan plus any amount recovered through subrogation.

Workers Compensation Savings: Portion of amount eligible for payment that has been paid a third party Workers Compensation carrier

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BlueCross BlueShield of New Mexico

Blue Insight℠
Utilization Analysis Report



ABC Company New Mexico

Incurred 12/01/2023 to 11/30/2024
Paid 12/01/2023 to 01/31/2025

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Data Parameters

Current Reporting Period: The current reporting period represents claims incurred from December 1, 2023 through November 30, 2024 and paid December 1, 2023 through January 31, 2025.
Prior Reporting Period: The prior reporting period represents claims incurred from December 1, 2022 through November 30, 2023 and paid December 1, 2022 through January 31, 2024.

Benchmark data is based on New Mexico group population. Select benchmark utilization and expense measures, such as PMPMs and rates per 1,000, have been adjusted to reflect the group's age and gender distribution.

High Cost Claimants (HCC) are defined as members with paid expenses greater than $50,000 within the reporting period.

The report includes medical and pharmacy claims.
Reporting Segments: ALL
Characteristics: ALL
Group/Sections: ALL
Member MSA: ALL
Group: ALL
Medicare Primary Indicator: ALL
Funding Type: ALL
Product Type: ALL
Employee Status: ALL
Database(s): ABC Company New Mexico

Reporting Support Contact Information

For reporting support, please contact Client Reporting Service Center
Email: client_reporting@bcbsil.com
Hours of Operation: Monday - Friday: 8:00am - 5:00pm CT

Report prepared on 04/17/2025

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Executive Summary

ABC Company New Mexico's overall **enrollment increased by 3.8%** between the two reporting periods. The average age among ABC Company New Mexico's members **increased from 35.6 to 35.7 years of age**. The gender mix of the population was **60.4% female and 39.6% male**.

The overall paid expense per member per month **(PMPM) increased by 1.7%** between the two reporting periods. The service category that impacted the paid PMPM trend the most was **inpatient facility, which decreased by 8.2%**. Additionally, paid PMPM for ABC Company New Mexico was **comparable to the benchmark**.

Inpatient paid PMPM decreased by 8.2% between reporting periods. The top two admission types by paid PMPM were Surgical and Medical. Surgical increased by 19.5%. Medical increased by 57.4%.

Outpatient paid PMPM increased by 2.9% between reporting periods. The top two outpatient facility visit types by paid PMPM were Surgical and Pharmacy & IV Therapy. Surgical increased by 1.1%. Pharmacy & IV Therapy increased by 13.0%.

Professional paid PMPM increased by 5.3% between reporting periods. The top two professional service types by paid PMPM were Evaluation & Management and Surgical. Evaluation & Management increased by 2.0%. Surgical increased by 1.7%.

Medical paid PMPM increased by 1.2% between reporting periods and was **comparable to the benchmark**.

Pharmacy paid PMPM increased by 3.0% between reporting periods.

ABC Company New Mexico's overall top four diagnostic categories by paid expense PMPM were **Neoplasms, Musculoskeletal, Health Status, and Digestive.** These four diagnostic categories accounted for 42.2% of the overall paid expenses in the current reporting period.

For **high cost claimants (HCC)** the **total paid expenses increased by 5.8%** between the two reporting periods. HCCs are defined as claimants whose total expense equaled or exceeded $50,000. The number of HCCs also increased by 17.0% from 235 to 275 during the same time frame. The proportion of paid expenses due to high cost claimants **increased from 41.5% to 41.9%** between reporting periods.

Paid **PMPM for Emergency Room (ER) visits remained stable 0.0%** between reporting periods. Total **ER visits/1,000 remained stable 0.0%** in the current reporting period and was **comparable to the benchmark**.

In the current reporting period, **primary care physicians (PCP) accounted for 35.1% of professional office visits compared to for the benchmark**. **PCPs accounted for 29.2% of professional office expenses.**

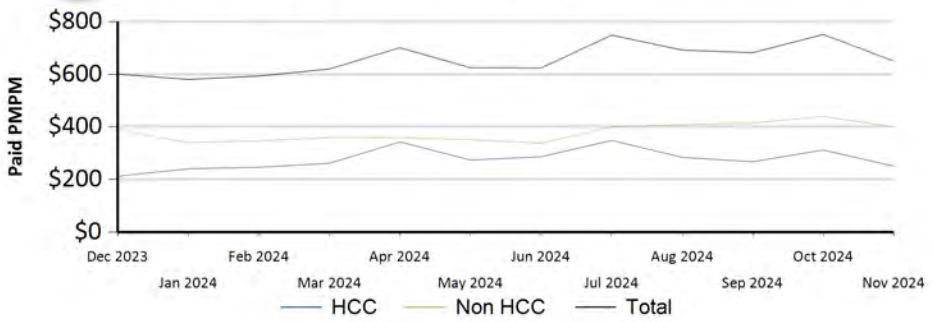
Executive Summary Dashboard

BlueCross BlueShield of New Mexico

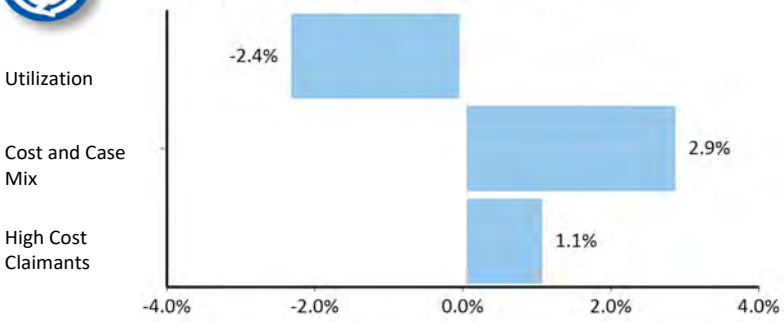
Key Metrics

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark
Allowed	$86,789,524	$90,720,804	4.5%	
Paid	$75,288,245	$78,885,515	4.8%	
Paid PMPM	$645.06	$655.80	1.7%	
Medical Plan Performance				
Plan Share	87.0%	86.5%		
In-Network Paid %	96.2%	97.6%		
Discount %	45.1%	44.3%		
Members	10,416	10,812	3.8%	
Subscribers	7,162	7,498	4.7%	
Dependents	3,255	3,314	1.8%	

Paid PMPM by Month - HCC vs. Non-HCC



Components of Paid PMPM Trend

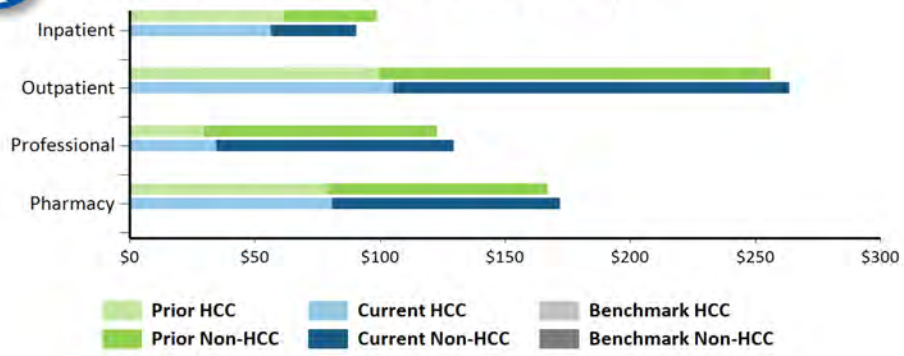




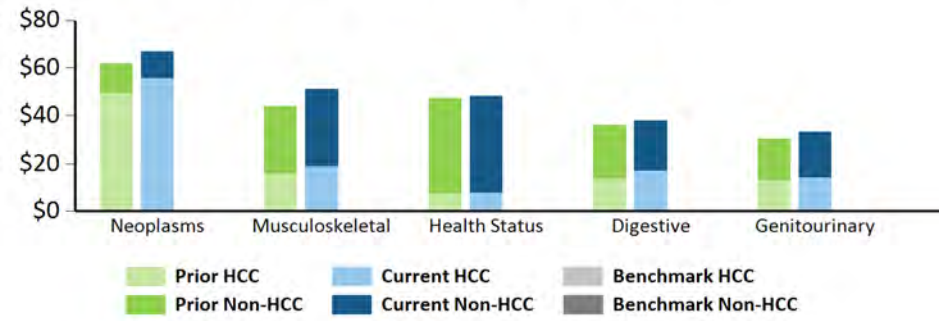
Claimant Distribution

	% of Total Paid			% of Total Unique Members		
Dollar Range	Prior	Current	Benchmark	Prior	Current	Benchmark
Non-Utilizers	0.0%	0.0%	0.0%	14.3%	15.1%	0.0%
$0-$50K	58.5%	58.1%	0.0%	83.8%	82.8%	0.0%
$50K-$100K	13.0%	15.0%	0.0%	1.1%	1.3%	0.0%
$100K-$300K	15.2%	16.3%	0.0%	0.6%	0.7%	0.0%
$300K and +	13.3%	10.6%	0.0%	0.1%	0.1%	0.0%
HCC Subtotal	**41.5%**	**41.9%**	**0.0%**	**1.9%**	**2.1%**	**0.0%**

Spend by Service Category (Paid PMPM)



Top Diagnostic Categories (Paid PMPM)

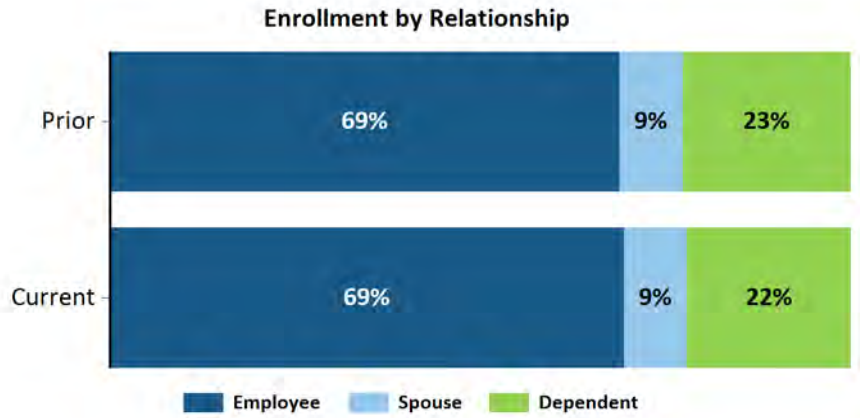


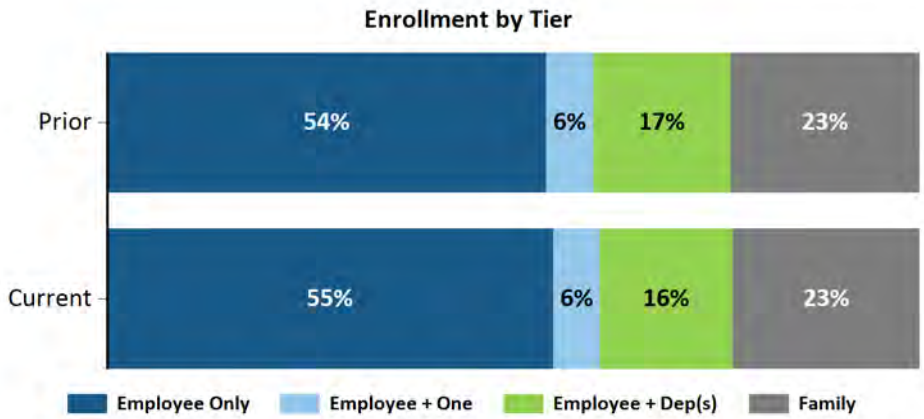
Enrollment Overview

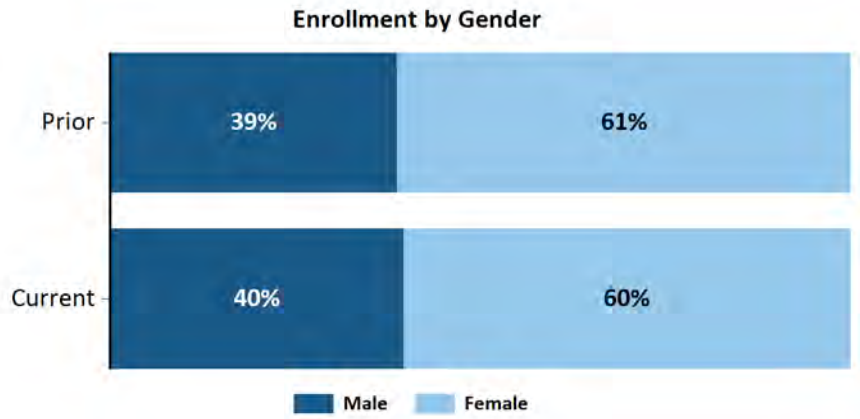
BlueCross BlueShield of New Mexico

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Average Membership	10,416	10,812	3.8%		
Employee	7,162	7,498	4.7%		
Spouse	894	921	3.1%		
Dependent	2,361	2,393	1.4%		
Average Contract Size	1.5	1.4	-0.9%	2.1	-29.9%
Average Age	35.6	35.7	0.4%	32.0	11.5%
Employee	41.9	41.9	-0.1%	40.9	2.5%
Spouse	46.0	45.9	-0.3%	44.8	2.4%
Dependent	12.4	12.5	0.9%	12.0	4.6%
% Under 30	36.2%	36.1%		46.0%	
% 30 to 49	40.6%	40.6%		34.8%	
% 50 to 64	20.3%	20.2%		16.6%	
% 65+	2.9%	3.1%		2.6%	
Gender					
% of Males	38.8%	39.6%		55.5%	
% of Females	61.2%	60.4%		44.5%	
% of Females Ages 20-44	32.1%	32.0%		19.1%	

- Overall, membership **increased by 3.8%** between reporting periods.
- The average age was 35.7 and **increased by 0.4%** between reporting periods.
- Contract size **decreased by 0.9%** between reporting periods.
- The percentage of females between ages 20 and 44 **decreased from 32.1% to 32.0%** between reporting periods.







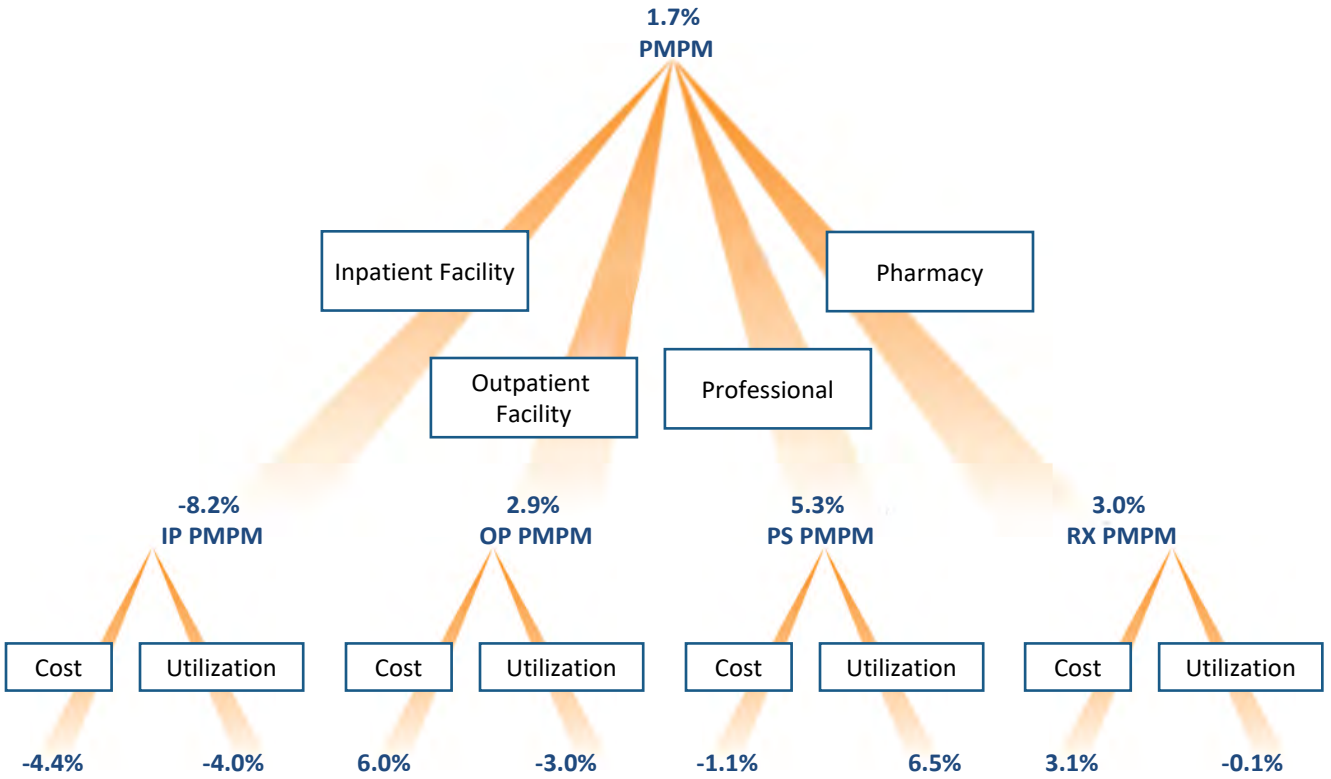
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Key Indicators

$655.80
Current Paid PMPM

1.7%
Change Year Over Year

0.0%
Same as Benchmark

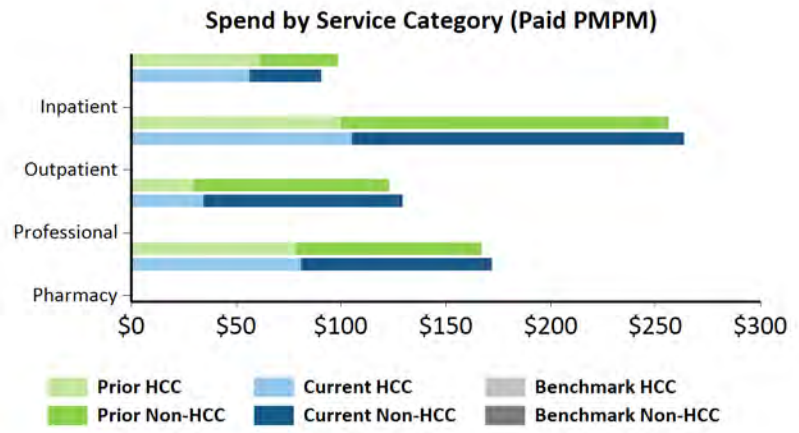


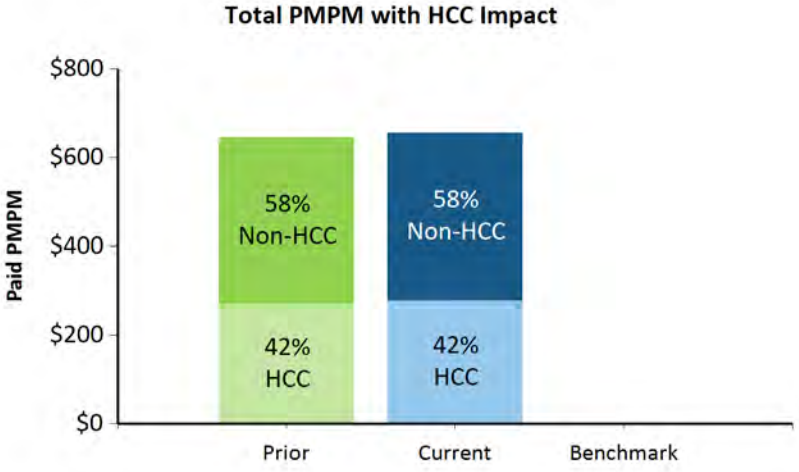
The above chart shows the % change from prior period to current period in paid PMPM, the % change in the amount paid per service (cost), and the % change in the number of services per 1,000 (utilization) by service category.

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Key Indicators

Service Category	Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Inpatient Facility	Paid PMPM	$98.76	$90.62	-8.2%		0.0%
	Paid PEPM	$143.64	$130.67	-9.0%		0.0%
	Allowed PMPM	$103.11	$94.05	-8.8%		0.0%
	Admissions/1,000	56.8	54.6	-4.0%		0.0%
	Days/1,000	245.2	239.4	-2.4%		0.0%
	Average Length of Stay	4.3	4.4	1.7%		0.0%
	Paid/Admission	$20,852	$19,927	-4.4%		0.0%
	Paid/Day	$4,833	$4,543	-6.0%		0.0%
Outpatient Facility	Paid PMPM	$256.25	$263.63	2.9%		0.0%
	Paid PEPM	$372.70	$380.15	2.0%		0.0%
	Allowed PMPM	$291.67	$297.22	1.9%		0.0%
	Visits/1,000	4,276.2	4,150.0	-3.0%		0.0%
	Paid/Visit	$719	$762	6.0%		0.0%
Professional	Paid PMPM	$122.96	$129.45	5.3%		0.0%
	Paid PEPM	$178.84	$186.67	4.4%		0.0%
	Allowed PMPM	$159.13	$169.52	6.5%		0.0%
	Services/1,000	15,257.0	16,245.3	6.5%		0.0%
	Paid/Service	$97	$96	-1.1%		0.0%
Medical Summary	**Paid PMPM**	**$477.97**	**$483.70**	**1.2%**		**0.0%**
	Paid PEPM	**$695.18**	**$697.48**	**0.3%**		**0.0%**
	Allowed PMPM	**$553.91**	**$560.79**	**1.2%**		**0.0%**
	In-Network Paid %	**96.2%**	**97.6%**			
	In-Network Services %	**94.8%**	**94.4%**			
	Plan Share %	**87.0%**	**86.5%**			
Pharmacy	Rx Paid PMPM	$167.09	$172.10	3.0%		0.0%
	Rx Paid PEPM	$219.68	$222.47	1.3%		0.0%
	Rx Allowed PMPM	$188.68	$191.66	1.6%		0.0%
	Prescriptions/Member	15.4	15.4	-0.1%		0.0%
	Paid/Prescription	$130	$134	3.1%		0.0%
Overall Summary	**Paid PMPM**	**$645.06**	**$655.80**	**1.7%**		**0.0%**
	Paid PEPM	**$914.86**	**$919.95**	**0.6%**		**0.0%**
	Allowed PMPM	**$742.59**	**$752.45**	**1.3%**		**0.0%**





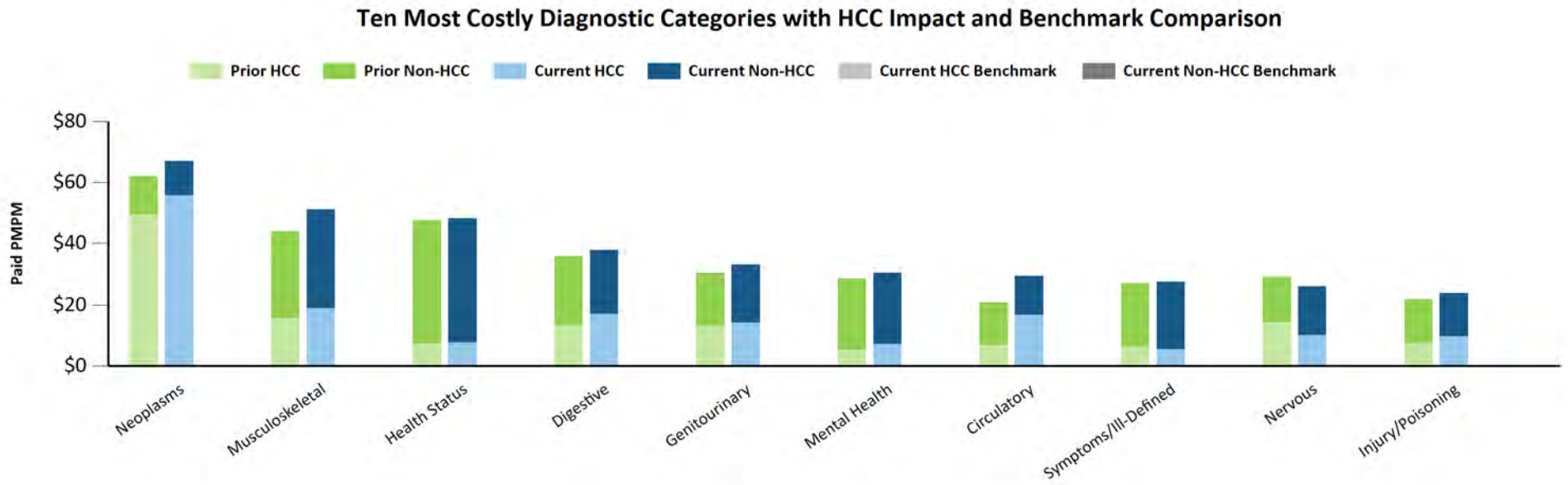
- Total medical **paid PMPM increased 1.2%** in the current reporting period and was **0.0% in line with the benchmark.**
- **Excluding high cost claimants**, the total paid PMPM trend was **0.9%**.

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Top Diagnostic Categories

Diagnostic Categories with Paid PMPM	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Neoplasms	$62.02	$66.99	8.0%		0.0%
Musculoskeletal	$43.96	$51.12	16.3%		0.0%
Health Status	$47.50	$48.25	1.6%		0.0%
Digestive	$36.07	$37.79	4.8%		0.0%
Genitourinary	$30.53	$33.19	8.7%		0.0%
Mental Health	$28.59	$30.59	7.0%		0.0%
Circulatory	$20.75	$29.58	42.6%		0.0%
Symptoms/Ill-Defined	$27.20	$27.65	1.7%		0.0%
Nervous	$29.20	$26.16	-10.4%		0.0%
Injury/Poisoning	$21.82	$23.81	9.2%		0.0%
All Others	$130.34	$108.56	-16.7%		0.0%
Total	$477.97	$483.70	1.2%		0.0%

- **Neoplasms** was the most costly diagnostic category and **paid PMPM increased 8.0%** between reporting periods.
- The **top 4** diagnostic categories accounted for **42.2%** of total medical costs in the current period.
- **The Circulatory** category experienced the largest percentage increase in the current period.

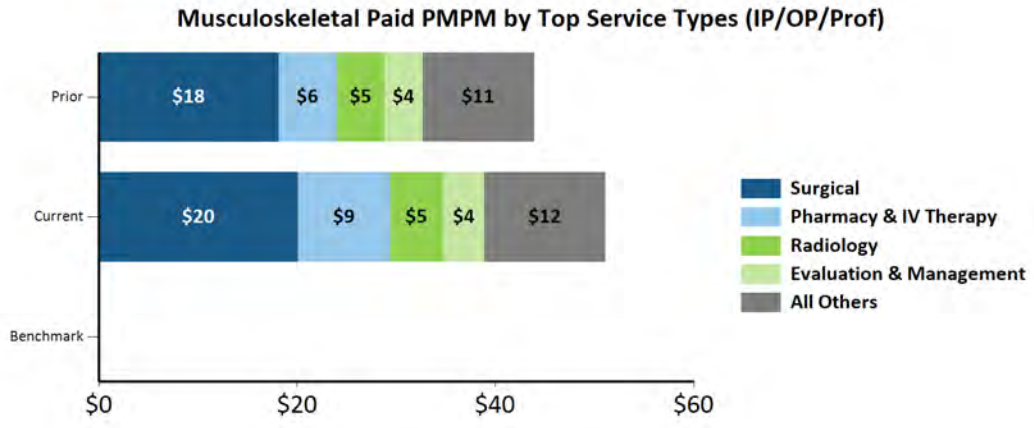


Musculoskeletal and Connective Tissue

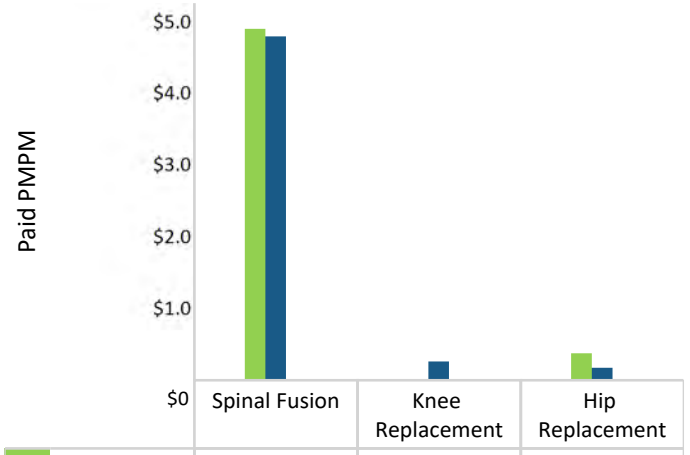
BlueCross BlueShield of New Mexico

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Inpatient					
Paid PMPM	$6.48	$6.37	-1.7%		0.0%
Admissions/1,000	1.3	2.0	51.4%		0.0%
Paid/Day	$12,459	$8,183	-34.3%	$0	0.0%
Paid/Admission	$57,845	$37,568	-35.1%	$0	0.0%
Outpatient					
Paid PMPM	$25.39	$32.13	26.6%		0.0%
Visits/1,000	515.4	519.4	0.8%		0.0%
Paid/Visit	$591	$742	25.6%	$0	0.0%
Professional					
Paid PMPM	$12.09	$12.62	4.4%		0.0%
Services/1,000	2,144.5	2,211.8	3.1%		0.0%
Paid/Service	$68	$68	1.2%	$0	0.0%
Total Medical					
Paid PMPM	$43.96	$51.12	16.3%		0.0%
Non High Cost	$28.30	$32.25	13.9%		0.0%
High Cost	$15.66	$18.87	20.5%		0.0%
Paid/Claimant	$1,934	$2,221	14.8%		0.0%
Claimants/1,000	272.7	276.3	1.3%		0.0%
% of Total Medical Paid	9.2%	10.6%		0.0%	

Musculoskeletal paid PMPM accounted for 10.6% of the total medical paid PMPM

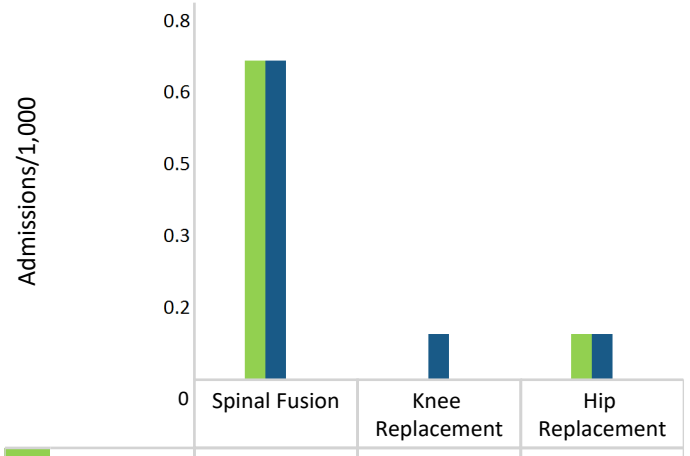


Common Inpatient Musculoskeletal Surgical Procedures Paid PMPM



	Spinal Fusion	Knee Replacement	Hip Replacement
Prior	$4.90	$0.00	$0.38
Current	$4.80	$0.26	$0.18
Benchmark	$0.00	$0.00	$0.00

Common Inpatient Musculoskeletal Surgical Procedures Admissions/1,000

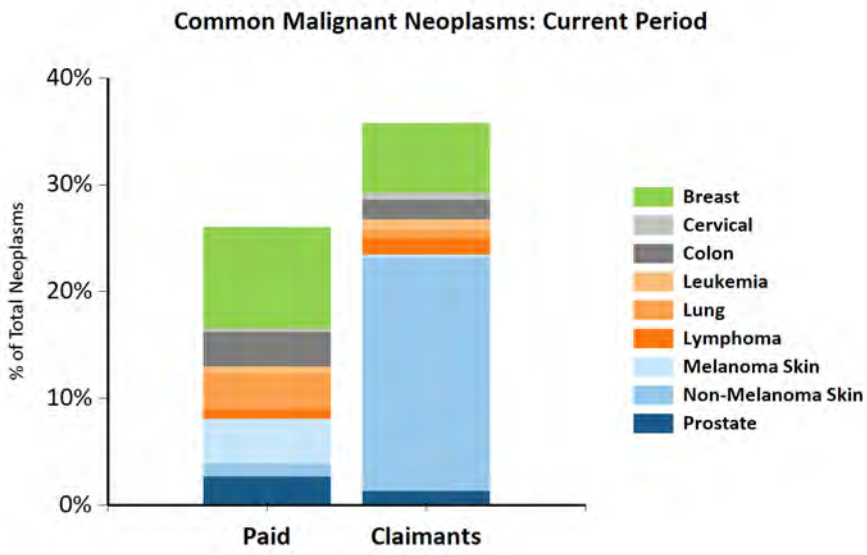


	Spinal Fusion	Knee Replacement	Hip Replacement
Prior	0.7	0.0	0.1
Current	0.7	0.1	0.1
Benchmark	0.0	0.0	0.0

Neoplasms

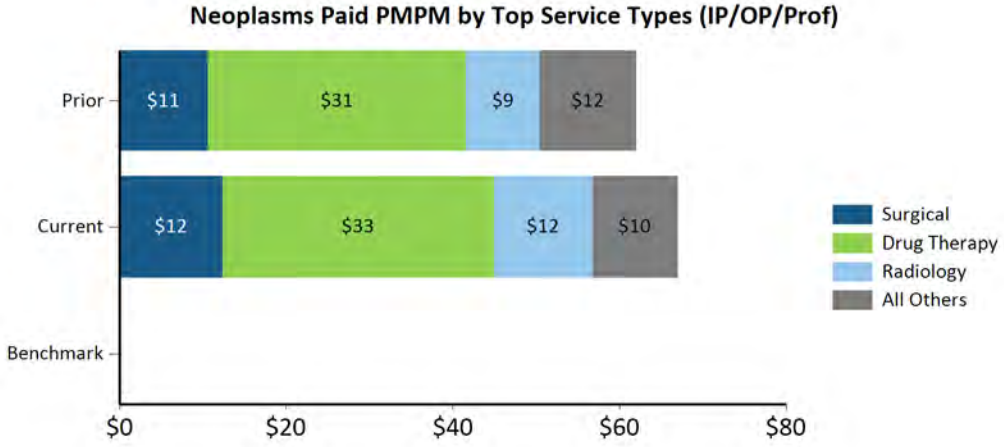
BlueCross BlueShield of New Mexico

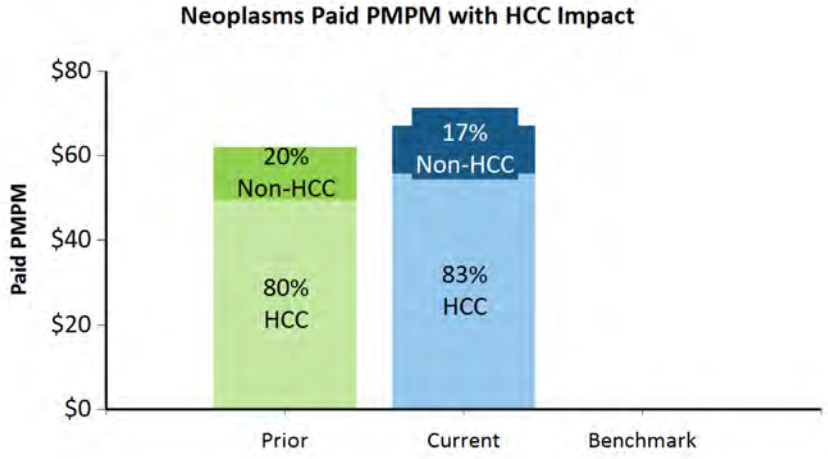
Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Inpatient					
Paid PMPM	$5.42	$6.33	16.9%		0.0%
Admissions/1,000	1.8	2.3	26.8%		0.0%
Paid/Day	$8,159	$5,591	-31.5%	$0	0.0%
Paid/Admission	$35,641	$32,872	-7.8%	$0	0.0%
Outpatient					
Paid PMPM	$48.65	$53.08	9.1%		0.0%
Visits/1,000	181.6	194.2	6.9%		0.0%
Paid/Visit	$3,214	$3,280	2.0%	$0	0.0%
Professional					
Paid PMPM	$7.95	$7.57	-4.8%		0.0%
Services/1,000	450.3	476.7	5.9%		0.0%
Paid/Service	$212	$191	-10.0%	$0	0.0%
Total Medical					
Paid PMPM	$62.02	$66.99	8.0%		0.0%
Non High Cost	$12.61	$11.29	-10.5%		0.0%
High Cost	$49.41	$55.70	12.7%		0.0%
Paid/Claimant	$8,152	$8,246	1.2%		0.0%
Claimants/1,000	91.3	97.5	6.8%		0.0%
% of Total Medical Paid	13.0%	13.8%		0.0%	



	Breast	Cervical	Colon	Leukemia	Lung	Lymphoma	Melanoma Skin	Non-Melanoma Skin	Prostate
Claimants	6.6%	0.7%	1.8%	1.0%	0.8%	1.5%	0.3%	21.8%	1.3%
Paid	9.5%	0.3%	3.2%	0.6%	3.4%	0.8%	4.2%	1.2%	2.7%

9.8% of members had a Neoplasms diagnosis compared to 0.0% of the book of business members



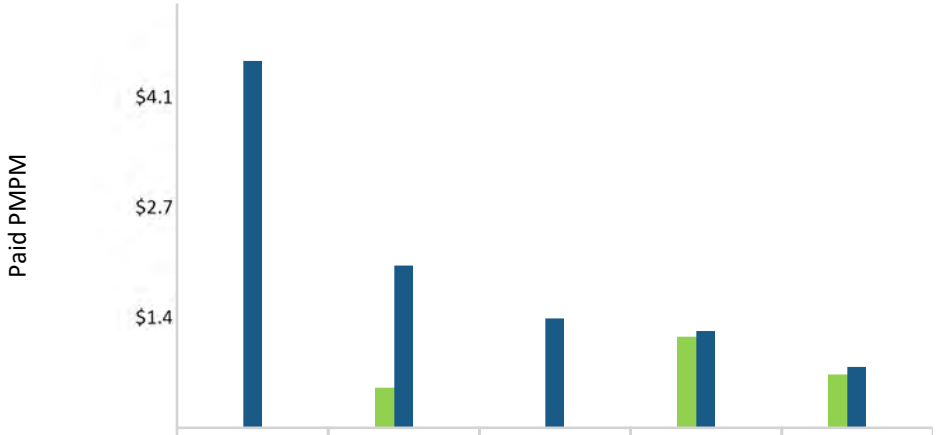


Circulatory

BlueCross BlueShield of New Mexico

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Inpatient					
Paid PMPM	$3.68	$13.17	>100%		0.0%
Admissions/1,000	4.2	4.6	9.5%		0.0%
Paid/Day	$3,455	$7,629	>100%	$0	0.0%
Paid/Admission	$10,445	$34,179	>100%	$0	0.0%
Outpatient					
Paid PMPM	$12.28	$11.20	-8.8%		0.0%
Visits/1,000	207.1	230.8	11.4%		0.0%
Paid/Visit	$711	$583	-18.1%	$0	0.0%
Professional					
Paid PMPM	$4.80	$5.21	8.6%		0.0%
Services/1,000	496.8	564.5	13.6%		0.0%
Paid/Service	$116	$111	-4.4%	$0	0.0%
Total Medical					
Paid PMPM	$20.75	$29.58	42.6%		0.0%
Non High Cost	$13.96	$12.91	-7.6%		0.0%
High Cost	$6.79	$16.68	>100%		0.0%
Paid/Claimant	$1,667	$2,326	39.5%		0.0%
Claimants/1,000	149.4	152.6	2.2%		0.0%
% of Total Medical Paid	4.3%	6.1%		0.0%	

Inpatient Circulatory Top Five Diagnoses by Paid PMPM



	Heart Inflammation	Heart Attack	Postoperative Circulatory Complication	High Blood Pressure	Stroke
Prior	$0.00	$0.54	$0.00	$1.23	$0.72
Current	$4.97	$2.20	$1.48	$1.31	$0.82
Benchmark	$0.00	$0.00	$0.00	$0.00	$0.00

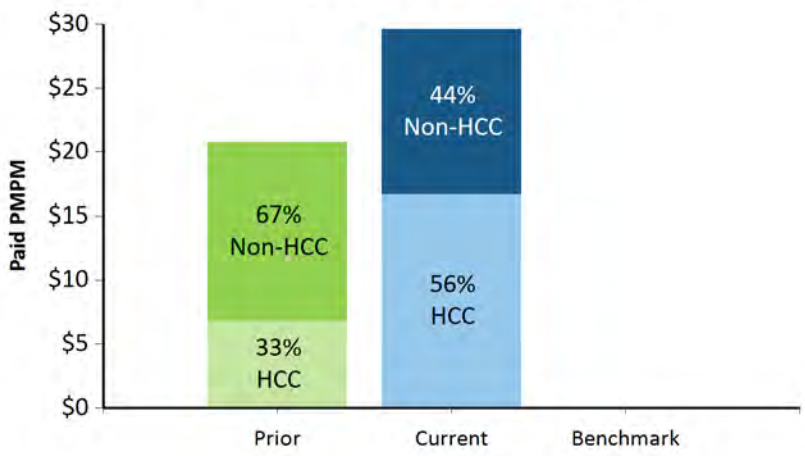
Circulatory paid PMPM accounted for 6.1% of the total medical paid PMPM

Common Circulatory Comorbidity: Claimants/1,000

	CAD	Diabetes	CHF	Hyperlipidemia	Hypertension
Current	11.8	45.8	5.2	57.6	91.1
Benchmark					

Claimants can be counted in more than one chronic condition category.

Circulatory Paid PMPM with HCC Impact

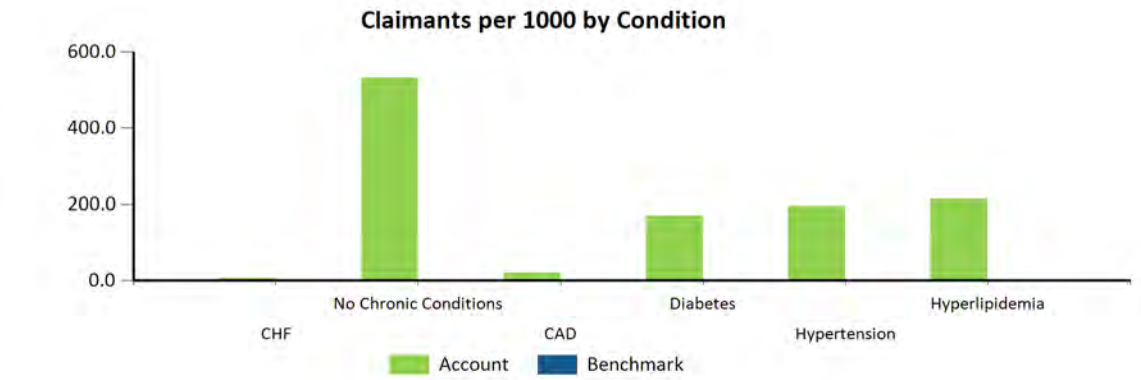


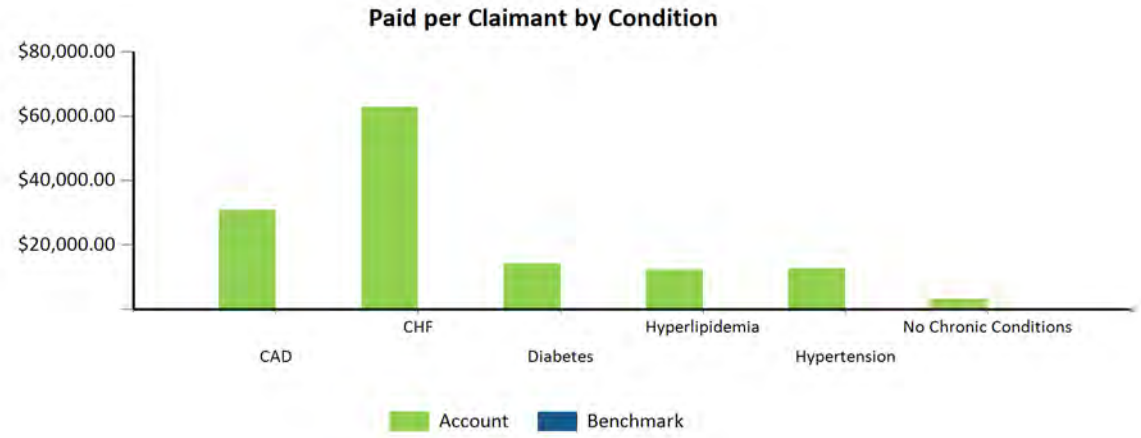
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Adult Chronic Conditions Analysis

Per the American Heart Association, three of the seven key health factors that increase the risks for heart disease and stroke include: High Blood Pressure (Hypertension), High Cholesterol (Hyperlipidemia) and High Blood Glucose (Diabetes). The below chart and bar graphs show key metrics for ABC Company New Mexico for five types of chronic conditions* along with comparative data for members who did not have any known type of chronic condition. All data reflects members aged 18 and above.

		Dec 2023 - Nov 2024	Benchmark	Benchmark Variance
Claimants/1,000	CHF	6.7		0.0%
	CAD	20.8		0.0%
	Diabetes	170.5		0.0%
	Hyperlipidemia	214.1		0.0%
	Hypertension	194.6		0.0%
	No Chronic Conditions	532.7		0.0%
Paid/Claimant	CHF	$62,778		0.0%
	CAD	$30,855		0.0%
	Diabetes	$14,148		0.0%
	Hyperlipidemia	$12,278		0.0%
	Hypertension	$12,541		0.0%
	No Chronic Conditions	$3,244		0.0%
Paid PMPM	CHF	$36.69		0.0%
	CAD	$56.51		0.0%
	Diabetes	$224.06		0.0%
	Hyperlipidemia	$238.09		0.0%
	Hypertension	$220.99		0.0%
	No Chronic Conditions	$150.94		0.0%





- **Hyperlipidemia** was the **most prevalent** chronic condition and was above the benchmark.
- **CHF** was the **most costly** chronic condition on a Paid/Claimant basis and was comparable to the benchmark.

* For a member to be included in one of these chronic condition categories, they must be 18 years or older and have had at least two claims for one of the chronic condition categories that were incurred within 180 days of each other and paid within the last 39 months. Paid per claimant and Paid PMPM rates are for those members in each chronic condition category for the most current reporting period. Costs include the total claimant cost and are not limited to the cost of the chronic condition. This report includes medical and pharmacy claims where applicable. Claimants and their claim spend can be counted in more than one chronic condition category in this report. CAD: Coronary Artery Disease; CHF: Chronic Heart Failure.

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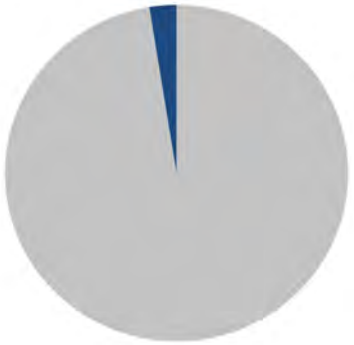
High Cost Claimants Overview

BlueCross BlueShield of New Mexico

2.54%

Of Membership

0.00% Benchmark



Accounted for

275

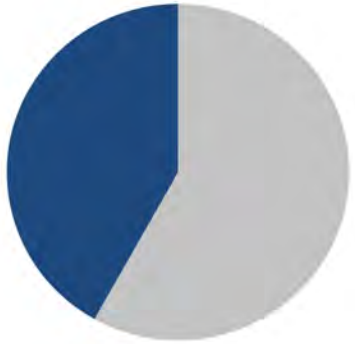
High Cost Claimants

235 prior

41.9%

of Total Paid

0.0% Benchmark



38.9%

Repeat HCCs

0.0% Benchmark

$33.0 M

Total Paid

$31.2 M in prior period

76.7%

Employees

0.0% Benchmark

44

Average Age

Benchmark

68.0%

Female

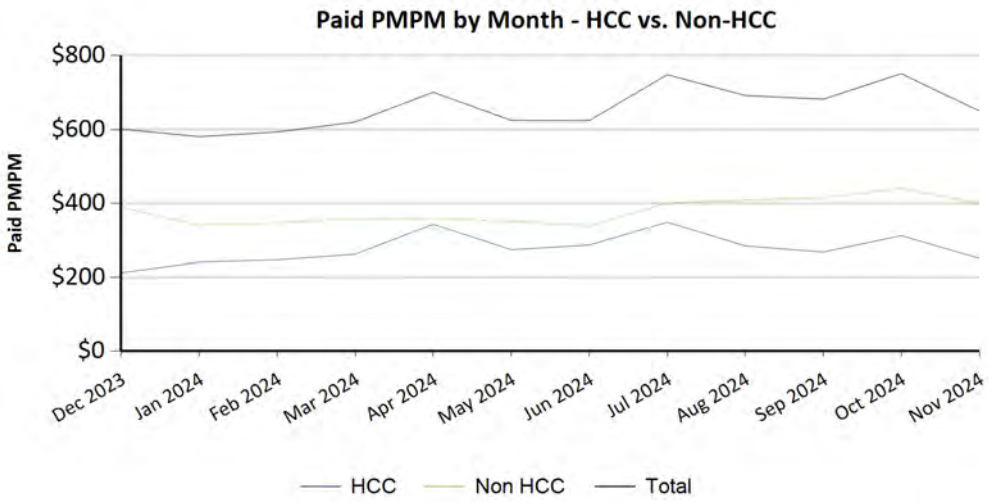
0.0% Benchmark

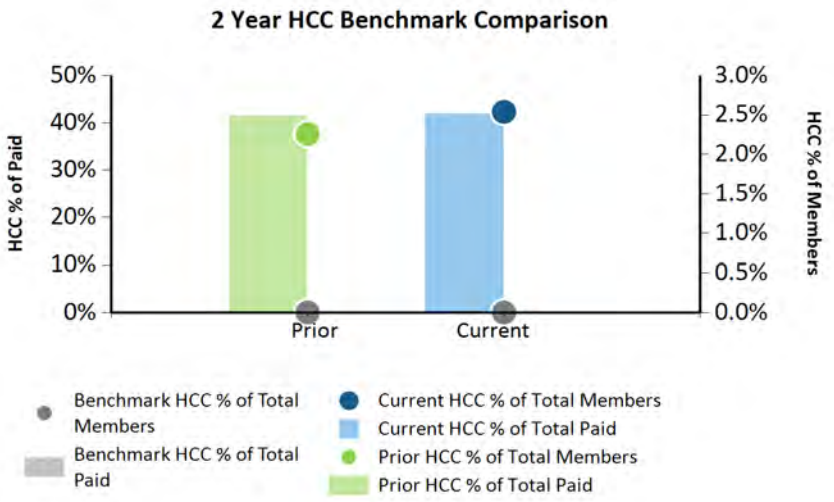
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High Cost Claimants Trend

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
High Cost Claimants	235	275	17.0%		
% of Total Members	2.26%	2.54%		0.00%	
HCC Paid	$31,220,026	$33,037,786	5.8%		
% of Total Paid	41.5%	41.9%		0.0%	
Total Paid PMPM	**$645.06**	**$655.80**	**1.7%**		**0.0%**
Non-High cost	$375.16	$378.69	0.9%		0.0%
High Cost	$269.90	$277.10	2.7%		0.0%
HCC Paid/Claimant	$132,851	$120,137	-9.6%	$0	0.0%

- **2.54%** of members were high cost claimants in the current period compared to **2.26%** in the prior period and **0.00%** for the benchmark.
- High cost claimants accounted for **41.9%** of total costs in the current period compared to **41.5%** in the prior period and **0.0%** for the benchmark.
- Paid PMPM for high cost claimants **increased by 2.7%** between the two reporting periods and was **0.0% comparable to** the benchmark.
- Paid PMPM excluding high cost claimants **increased by 0.9%** between the two reporting periods and was **0.0% comparable to** the benchmark.





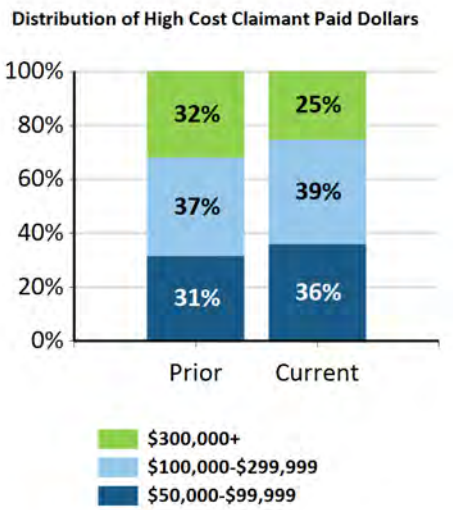
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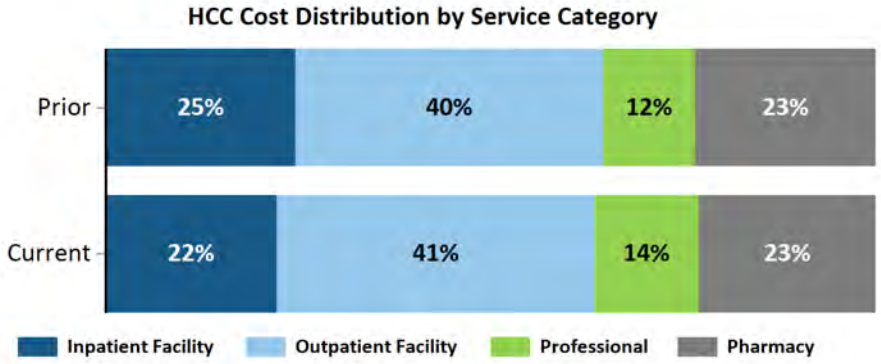
High Cost Claimants Additional Details

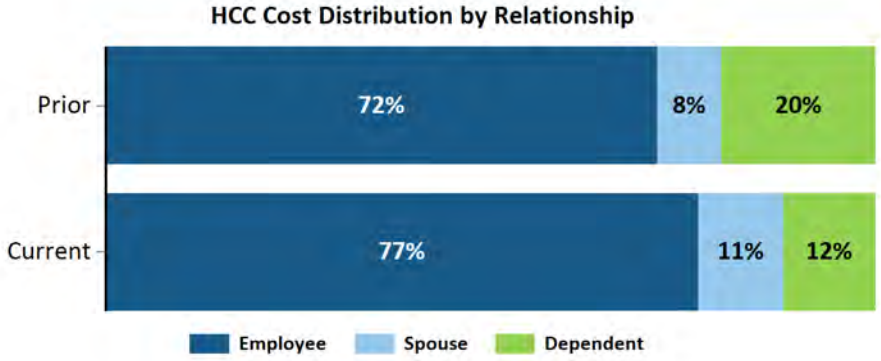
BlueCross BlueShield of New Mexico

Claimant Distribution by Paid Band

	Dec 2022 - Nov 2023			Dec 2023 - Nov 2024			% Change	
Dollar Range	Claimants	Paid	Paid %	Claimants	Paid	Paid %	Claimants	Paid
No Claims	1,812	$0	0.0%	1,981	$0	0.0%	9.3%	0.0%
$0-$49,999	10,622	$44,068,219	58.5%	10,841	$45,847,729	58.1%	2.1%	4.0%
$50,000-$99,999	143	$9,779,924	13.0%	170	$11,821,917	15.0%	18.9%	20.9%
$100,000-$299,999	75	$11,417,825	15.2%	88	$12,826,774	16.3%	17.3%	12.3%
$300,000+	17	$10,022,277	13.3%	17	$8,389,096	10.6%	0.0%	-16.3%
HCC Subtotal	**235**	**$31,220,026**	**41.5%**	**275**	**$33,037,786**	**41.9%**	**17.0%**	**5.8%**







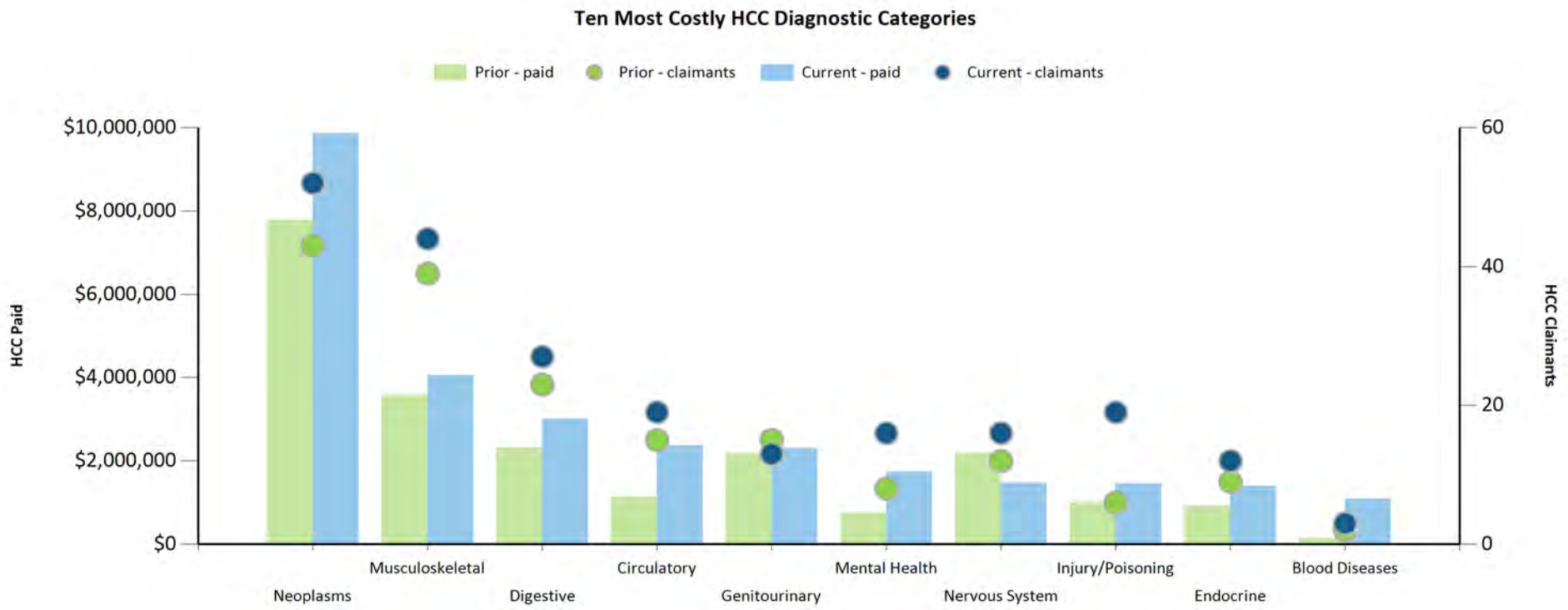
- The **$50,000-$99,999 HCC paid band** experienced the largest percent **increase** in paid dollars in the current reporting period.
- **275** claimants accounted for **41.9%** of the total paid amount in the current reporting period.
- By service category, **Outpatient Facility** accounted for the largest percent of high cost claimant paid dollars in the current reporting period.
- **Employee** accounted for the largest percent of high cost claimant paid dollars in the current reporting period.

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High Cost Claimants Diagnostic Categories

BlueCross BlueShield of New Mexico

	Dec 2022 - Nov 2023				Dec 2023 - Nov 2024			
Top 5 HCC Diagnostic Categories by Paid	**Claimants**	**Paid**	**Paid/Claimant**	**Paid %**	**Claimants**	**Paid**	**Paid/Claimant**	**Paid %**
Neoplasms	43	$7,780,515	$180,942	24.9%	52	$9,856,388	$189,546	29.8%
Musculoskeletal	39	$3,572,200	$91,595	11.4%	44	$4,049,200	$92,027	12.3%
Digestive	23	$2,333,971	$101,477	7.5%	27	$3,013,753	$111,620	9.1%
Circulatory	15	$1,128,309	$75,221	3.6%	19	$2,367,727	$124,617	7.2%
Genitourinary	15	$2,174,972	$144,998	7.0%	13	$2,297,385	$176,722	7.0%
All others	100	$14,230,059	$142,301	45.6%	120	$11,453,333	$95,444	34.7%
Summary	**235**	**$31,220,026**	**$132,851**	**100.0%**	**275**	**$33,037,786**	**$120,137**	**100.0%**



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High Cost Claimants Listing

BlueCross BlueShield of New Mexico

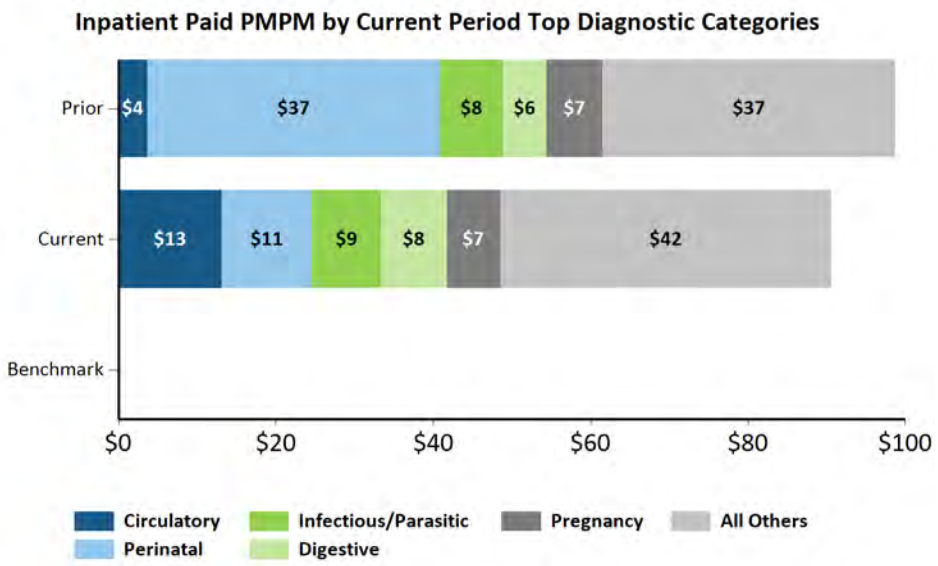
Rank	Relationship	Age/Gender Band	Leading Diagnostic Category	Leading Diagnosis	Inpatient Paid	Outpatient Paid	Professional Paid	Pharmacy Paid	Total Paid	Prior HCC	Prior Period Paid
1	Subscriber	Female 60-64	Blood	Aplastic anemia	$783,567	$20,305	$13,021	$121,576	**$938,469**	**YES**	**$87,876**
2	Dependent	Female 20-29	Genitourinary	Nephritis; nephrosis; renal sclerosis	$16,536	$812,431	$3,330	$0	**$832,297**	**YES**	**$477,471**
3	Subscriber	Male 50-59	Neoplasms	Skin cancers - melanoma	$56,286	$691,087	$41,817	$0	**$789,190**	**NO**	**$3,393**
4	Spouse	Male 40-49	Circulatory	Myocarditis and cardiomyopathy	$664,711	$47,058	$14,550	$0	**$726,319**	**NO**	**NA**
5	Spouse	Female 50-59	Neoplasms	Secondary malignancies	$281,003	$248,320	$63,169	$0	**$592,492**	**NO**	**$22,495**
6	Subscriber	Female 50-59	Digestive	Other specified and unspecified liver disease	$375,168	$56,313	$18,243	$0	**$449,724**	**YES**	**$199,901**
7	Subscriber	Female 65+	Neoplasms	Female reproductive system cancers - all other types	$0	$428,881	$7,797	$634	**$437,312**	**NO**	**$28,194**
8	Subscriber	Female 40-49	Neoplasms	Breast cancer - all other types	$0	$425,681	$2,224	$62	**$427,967**	**YES**	**$452,710**
9	Subscriber	Female 50-59	Neoplasms	Breast cancer - all other types	$0	$415,239	$2,106	$0	**$417,345**	**YES**	**$410,214**
10	Subscriber	Male 40-49	Neoplasms	Endocrine system cancers - pancreas	$27,004	$358,064	$19,961	$1,574	**$406,603**	**YES**	**$353,288**
11	Subscriber	Female 30-39	Mental Health	Bipolar and related disorders	$0	$0	$1,603	$365,362	**$366,965**	**YES**	**$291,908**
12	Subscriber	Female 40-49	Neoplasms	Breast cancer - all other types	$54,939	$268,105	$27,018	$5,070	**$355,132**	**YES**	**$327,723**
13	Subscriber	Female 50-59	Neoplasms	Benign neoplasms	$0	$8,311	$2,144	$340,986	**$351,441**	**YES**	**$311,184**
14	Subscriber	Female 50-59	Endocrine	Other specified and unspecified nutritional and metabolic disorders	$46,715	$271,980	$25,638	$1,564	**$345,897**	**NO**	**$272**
15	Subscriber	Female 30-39	Neoplasms	Breast cancer - all other types	$0	$295,067	$27,759	$1,772	**$324,598**	**NO**	**$3,673**
16	Subscriber	Female 60-64	Genitourinary	Chronic kidney disease	$58,990	$233,938	$18,769	$4,042	**$315,739**	**NO**	**$0**
17	Subscriber	Female 40-49	Neoplasms	Multiple myeloma	$0	$252,517	$5,852	$53,240	**$311,609**	**NO**	**$3,528**
18	Subscriber	Male 50-59	Circulatory	Postprocedural or postoperative circulatory system complication	$235,062	$25,910	$32,865	$103	**$293,940**	**NO**	**$3,420**
19	Subscriber	Female 50-59	Neoplasms	Female reproductive system cancers - endometrium	$0	$279,927	$8,378	$219	**$288,524**	**NO**	**$0**
20	Subscriber	Female 50-59	Digestive	Regional enteritis and ulcerative colitis	$0	$10,698	$2,378	$265,570	**$278,646**	**YES**	**$82,990**

* NA : member was not enrolled in prior period

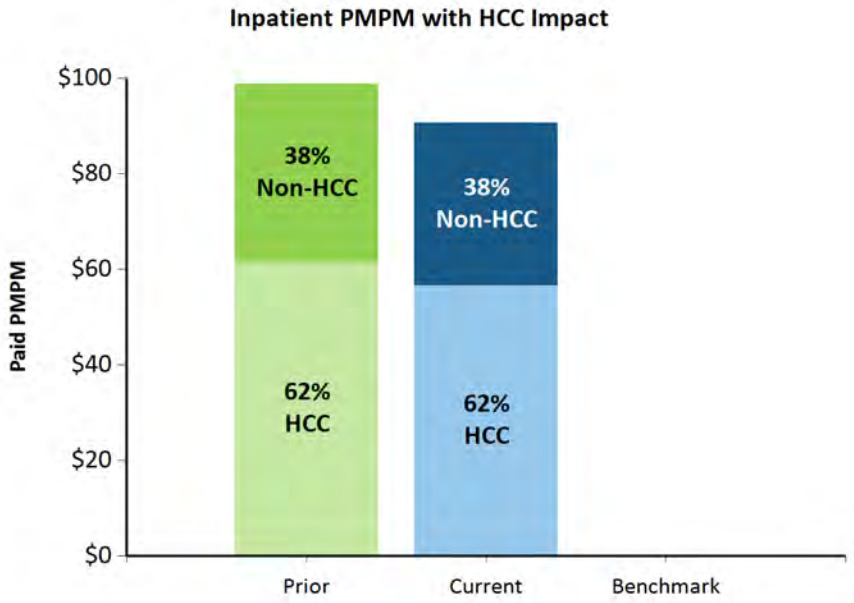
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Inpatient Facility Overview

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Allowed	$12,888,707	$12,202,377	-5.3%		
Allowed PMPM	$103.11	$94.05	-8.8%		0.0%
Paid	$12,344,528	$11,757,068	-4.8%		
Paid PEPM	$143.64	$130.67	-9.0%		0.0%
Paid PMPM	**$98.76**	**$90.62**	**-8.2%**		**0.0%**
Non-High Cost	$37.28	$34.12	-8.5%		0.0%
High Cost	$61.48	$56.50	-8.1%		0.0%
Admissions	592	590	-0.3%		
Admissions/1,000	56.8	54.6	-4.0%		0.0%
Days/1,000	245.2	239.4	-2.4%		0.0%
Average Length of Stay	4.3	4.4	1.7%	0.0	0.0%
Paid/Admission	$20,852	$19,927	-4.4%	$0	0.0%
In-Network Paid %	97.0%	97.0%		0.0%	
In-Network Admissions %	97.1%	96.8%		0.0%	



- Inpatient paid PMPM **decreased by 8.2%** between the two reporting periods and was **comparable to** the benchmark.
- High Cost Claimants accounted for **62.4% of total inpatient spend** compared to **62.2%** from the previous reporting period.
- Admissions/1,000 **decreased by 4.0%** between reporting periods and was **comparable to** the benchmark.
- **Circulatory** was the most costly diagnostic category for inpatient services in the current reporting period. It **increased >100%** and was **>100% higher than** the benchmark.

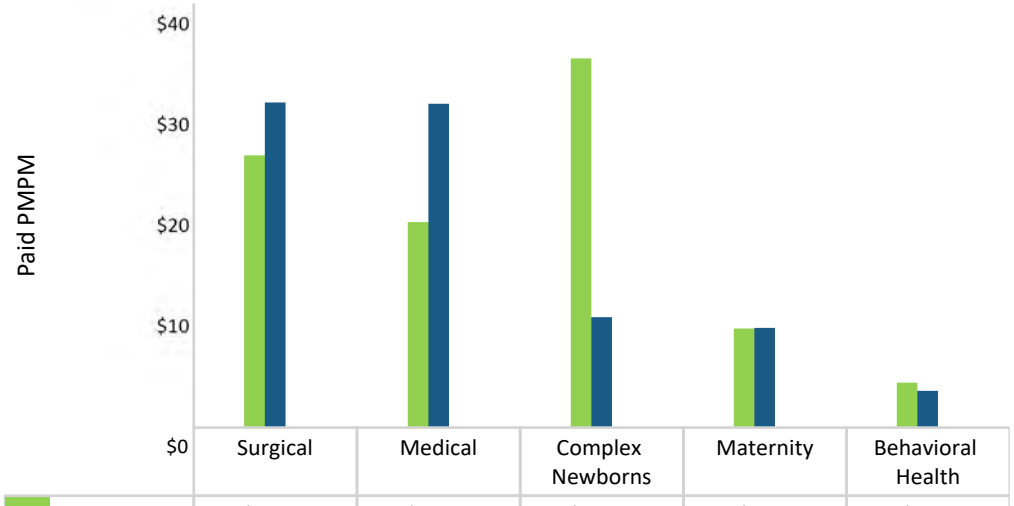


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Inpatient Facility - Details by Top 5 Service Types

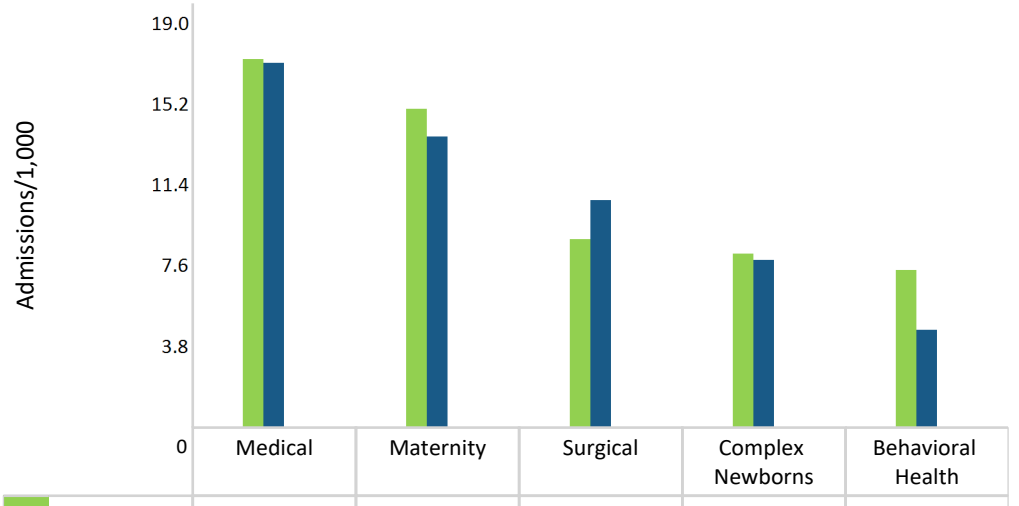
BlueCross BlueShield of New Mexico

Inpatient Paid PMPM by Service Type



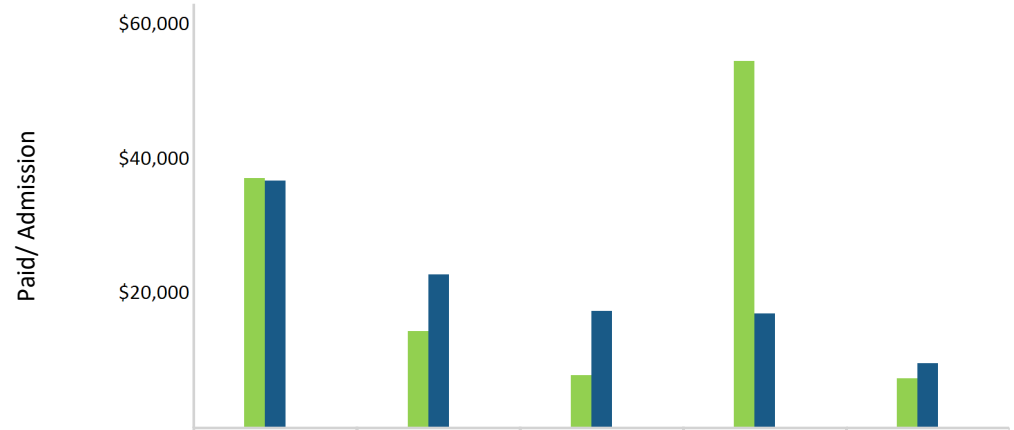
	Surgical	Medical	Complex Newborns	Maternity	Behavioral Health
Prior	$26.98	$20.38	$36.61	$9.79	$4.44
Current	$32.23	$32.08	$10.94	$9.88	$3.62
Benchmark	$0.00	$0.00	$0.00		$0.00

Inpatient Admissions/1,000 by Service Type



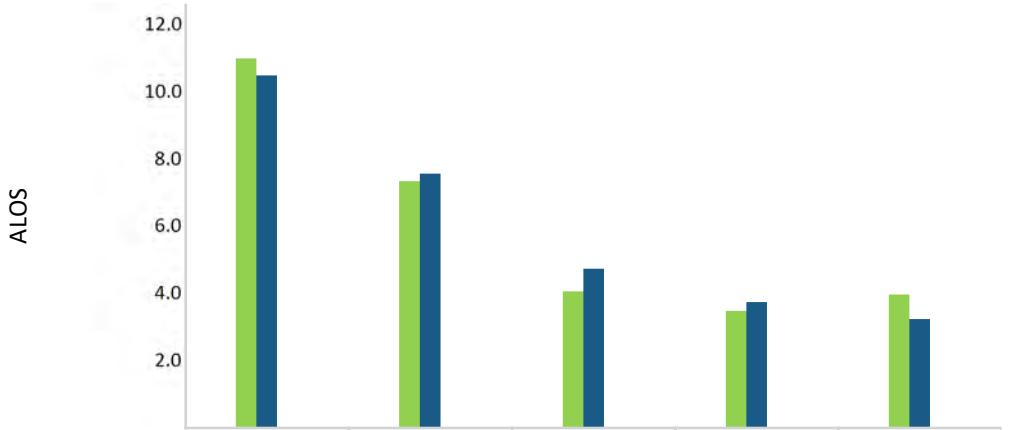
	Medical	Maternity	Surgical	Complex Newborns	Behavioral Health
Prior	17.1	14.8	8.7	8.1	7.3
Current	16.9	13.5	10.5	7.8	4.5
Benchmark	0.0		0.0	0.0	0.0

Inpatient Paid/Admission by Service Type



	Surgical	Medical	Post-Acute Care	Complex Newborns	Behavioral Health
Prior	$37,056	$14,313	$7,750	$54,473	$7,302
Current	$36,684	$22,745	$17,273	$16,895	$9,578
Benchmark	$0	$0	$0	$0	$0

Inpatient Average Length of Stay (ALOS) by Service Type



	Post-Acute Care	Behavioral Health	Surgical	Medical	Complex Newborns
Prior	11.9	7.9	4.4	3.8	4.3
Current	11.4	8.2	5.1	4.0	3.5
Benchmark	0.0	0.0	0.0	0.0	0.0

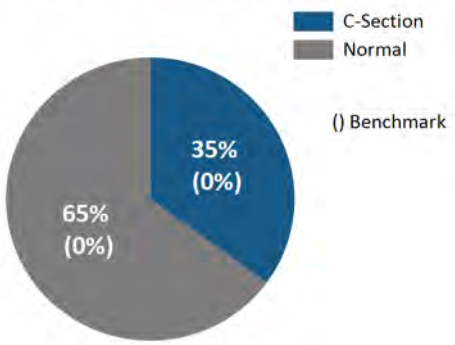
Inpatient Deliveries

BlueCross BlueShield of New Mexico

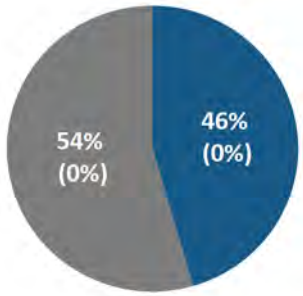
Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Paid	$1,112,971	$1,108,527	-0.4%		
Paid PMPM	**$8.90**	**$8.54**	**-4.0%**		**0.0%**
Admissions	148	137	-7.4%		
C-Section Delivery	37	48	29.7%		
Normal Delivery	111	89	-19.8%		
Admissions/1,000	14.2	12.7	-10.8%		0.0%
Days/1,000	38.2	35.9	-6.1%		0.0%
Average Length of Stay	2.7	2.8	5.3%	0.0	0.0%
C-Section Delivery	2.9	3.4	16.7%	0.0	0.0%
Normal Delivery	2.6	2.5	-3.8%	0.0	0.0%
Paid/Admission	$7,520	$8,091	7.6%	$0	0.0%
Average Mother Age	31.5	31.3	-0.8%		0.0%

The C-Section rate was **35%** which is above the benchmark (0%) .

Percent of Deliveries by Type

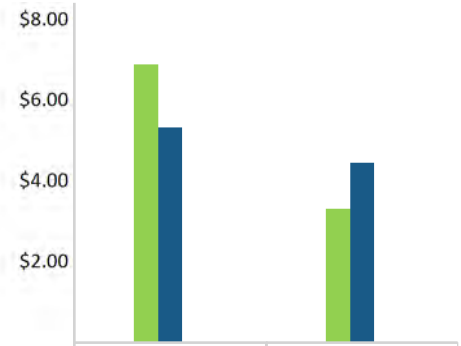


Percent of Delivery Costs by Type



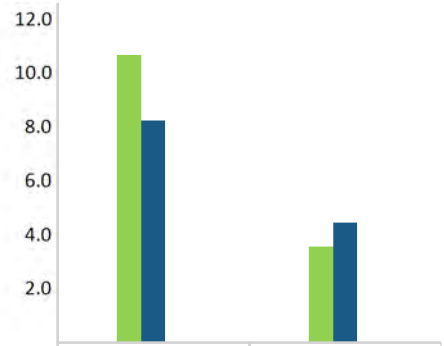
Normal Delivery and C-Section Overview:

Paid PMPM



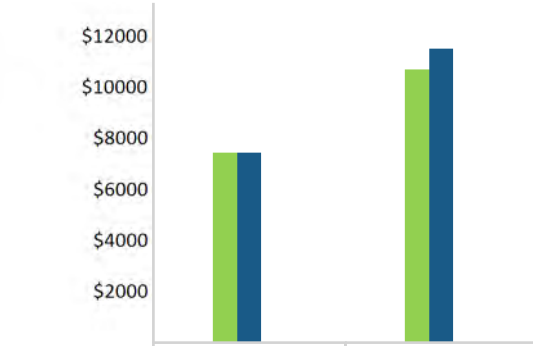
	Normal Delivery	C-Section Delivery
Prior	$6.02	$2.89
Current	$4.66	$3.89
Benchmark	$0.00	$0.00

Admissions/1,000



	Normal Delivery	C-Section Delivery
Prior	10.7	3.6
Current	8.2	4.4
Benchmark	0.0	0.0

Paid/Admission



	Normal Delivery	C-Section Delivery
Prior	$6,774	$9,758
Current	$6,786	$10,511
Benchmark	$0	$0

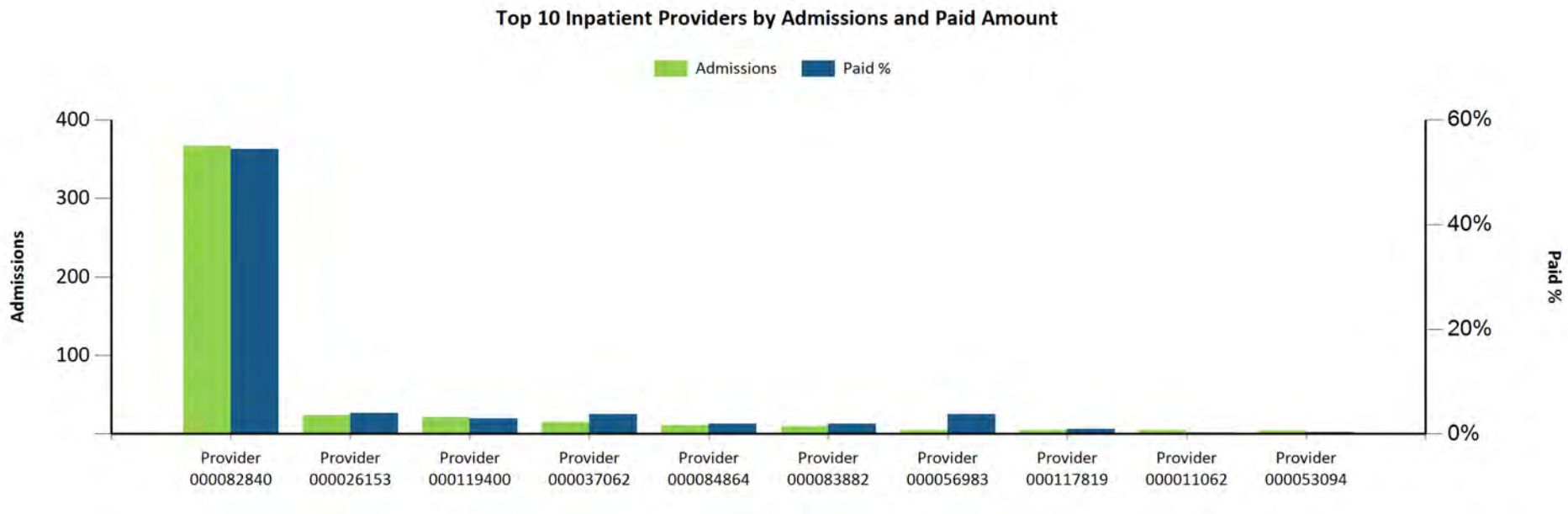
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Inpatient Provider Summary

Dec 2023 - Nov 2024

Top Inpatient Providers *by Admissions*	Provider State	Admissions	Paid	% of Total Paid	Paid/ Admission
Provider 000082840	NM	367	$6,403,731	54.5%	$17,448.86
Provider 000026153	NM	24	$472,942	4.0%	$19,705.92
Provider 000119400	NM	21	$348,579	3.0%	$16,599.01
Provider 000037062	NM	15	$449,278	3.8%	$29,951.85
Provider 000084864	NM	11	$226,667	1.9%	$20,606.08
Provider 000083882	FL	10	$235,733	2.0%	$23,573.31
Provider 000056983	CO	5	$442,384	3.8%	$88,476.80
Provider 000117819	NC	5	$113,900	1.0%	$22,779.92
Provider 000011062	NM	5	$25,677	0.2%	$5,135.44
Provider 000053094	AL	4	$37,752	0.3%	$9,438.03
All Other		123	$3,000,425	25.5%	$24,393.70
Summary		**590**	**$11,757,068**	**100.0%**	**$19,927.23**

- **Provider 000082840** was the most frequently utilized inpatient facility.
- **The top inpatient facility by paid amount was Provider 000082840**, which accounted for 54.5% of the total inpatient paid amount in the current reporting period.
- **The top 10 inpatient providers accounted for 74.5%** of the total inpatient spend in the current reporting period.

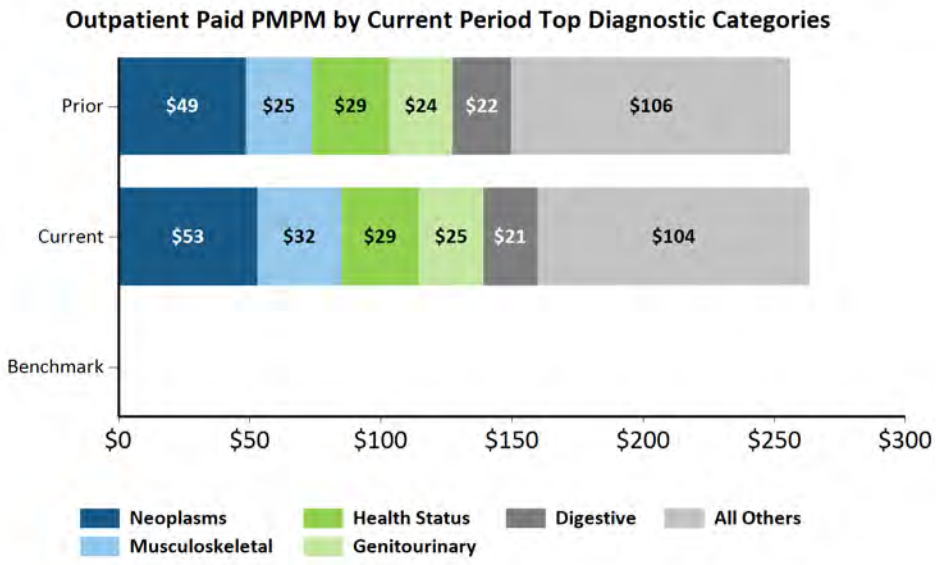


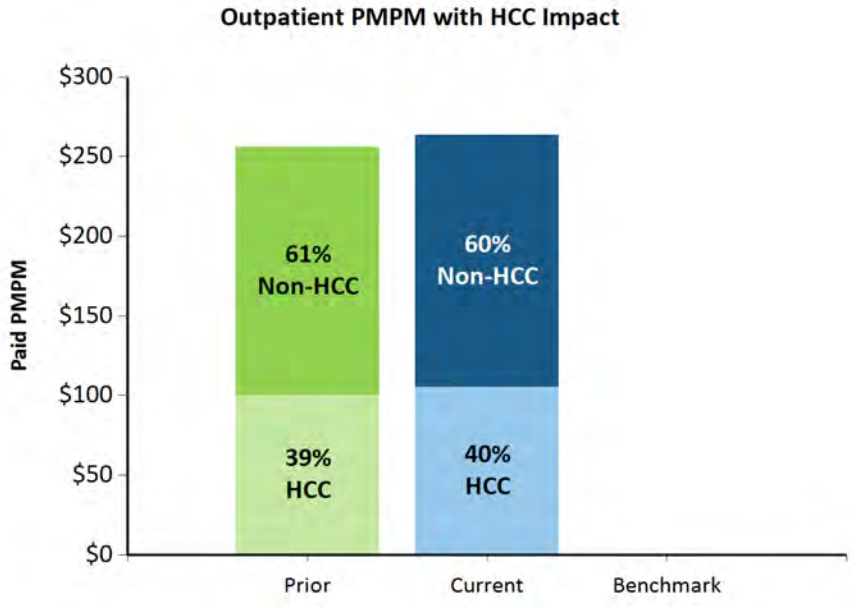
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Outpatient Facility Overview

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Allowed	$36,457,209	$38,562,937	5.8%		
Allowed PMPM	$291.67	$297.22	1.9%		0.0%
Paid	$32,029,725	$34,205,300	6.8%		
Paid PEPM	$372.70	$380.15	2.0%		0.0%
Paid PMPM	**$256.25**	**$263.63**	**2.9%**		**0.0%**
Non-High Cost	$156.25	$158.41	1.4%		0.0%
High Cost	$99.99	$105.22	5.2%		0.0%
Visits	44,542	44,870	0.7%		
Visits/1,000	4,276.2	4,150.0	-3.0%		0.0%
Paid/Visit	$719	$762	6.0%	$0	0.0%
In-Network Paid %	96.4%	98.6%		0.0%	
In-Network Visits %	98.1%	98.1%		0.0%	

- Outpatient paid PMPM **increased by 2.9%** between the two reporting periods and was **comparable to** the benchmark.
- High Cost Claimants accounted for **39.9% of total outpatient spend** compared to **39.0%** from the previous reporting period.
- **Neoplasms** was the most costly diagnostic category for outpatient services in the current reporting period. It **increased 9.1%** and was **>100% higher than** the benchmark.

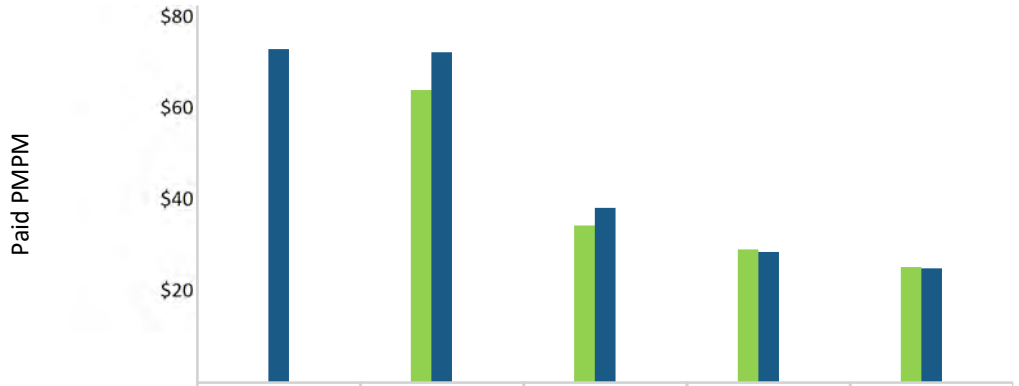




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Outpatient Facility - Details by Top 5 Service Types

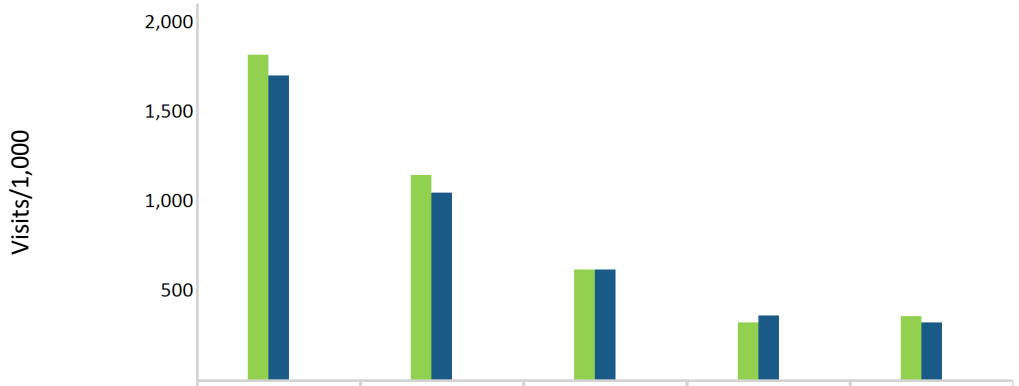
Outpatient Paid PMPM by Service Type



	Surgical	Pharmacy & IV Therapy	Radiology	ER	Pathology & Laboratory
Prior	$68.51	$60.64	$32.58	$27.60	$23.97
Current	$69.26	$68.55	$36.23	$27.05	$23.71
Benchmark	$0.00	$0.00	$0.00	$0.00	$0.00

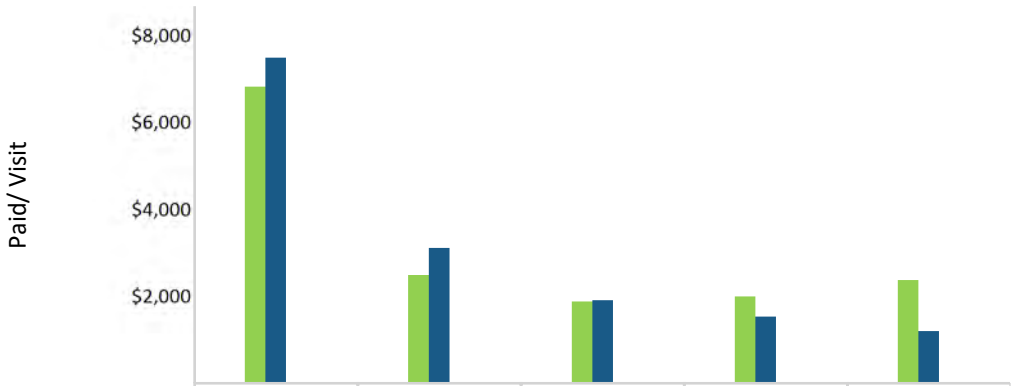
- **Surgical** was the service type with the highest paid PMPM for outpatient services in the current reporting period. Paid PMPM **increased** **1.1%** and was **comparable to** the benchmark.
- **Other Outpatient Services** had the highest rate of visits/1,000 in the current reporting period.
- **Surgical** had the highest amount paid per visit in the current reporting period.

Outpatient Visits/1,000 by Service Type



	Other Outpatient Services	Pathology & Laboratory	Radiology	PT/OT/ST	Pharmacy & IV Therapy
Prior	1,614.0	1,018.2	549.5	286.8	317.4
Current	1,510.3	931.0	547.8	320.7	288.3
Benchmark	0.0	0.0	0.0	0.0	0.0

Outpatient Paid/Visit by Service Type



	Surgical	Pharmacy & IV Therapy	ER	Dialysis	Observation
Prior	$6,265	$2,293	$1,735	$1,829	$2,175
Current	$6,880	$2,854	$1,753	$1,405	$1,101
Benchmark	$0	$0	$0	$0	$0

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Emergency Room Overview

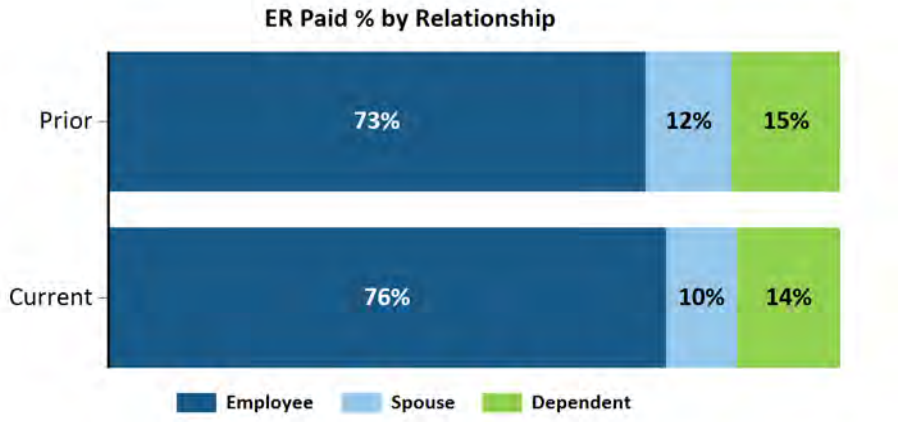
	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
ER Allowed	$4,475,449	$4,732,493	5.7%		
ER Paid	$3,708,673	$3,753,454	1.2%		
ER Allowed PMPM	$35.80	$36.48	1.9%		0.0%
ER Paid PMPM	**$29.67**	**$28.93**	**-2.5%**		**0.0%**
ER Visits	2,108	2,136	1.3%		
ER Visits/1,000	202.4	197.6	-2.4%		0.0%
ER Allowed/Visit	$2,123	$2,216	4.4%	$0	0.0%
ER Paid/Visit	$1,759	$1,757	-0.1%	$0	0.0%
% of ER Claimants with 3+ Visits	8.4%	8.2%		0.0%	
Total ER Allowed/Visit*	$2,422	$2,535	4.7%	$0	0.0%
Total ER Paid/Visit*	$2,004	$2,012	0.4%	$0	0.0%

*Includes physician charges

- ER paid PMPM **decreased by 2.5%** between the two reporting periods and was **0.0% comparable to** the benchmark.
- ER visits/1,000 **decreased 2.4%** between reporting periods and was **0.0% comparable to** the benchmark.
- **Employees** had the highest ER visits/1,000 rate in the current period.

ER Visits/1,000 by Relationship

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Employee	205.3	204.2	-0.5%		0.0%
Spouse	228.2	182.3	-20.1%		0.0%
Dependent	183.9	182.6	-0.7%		0.0%



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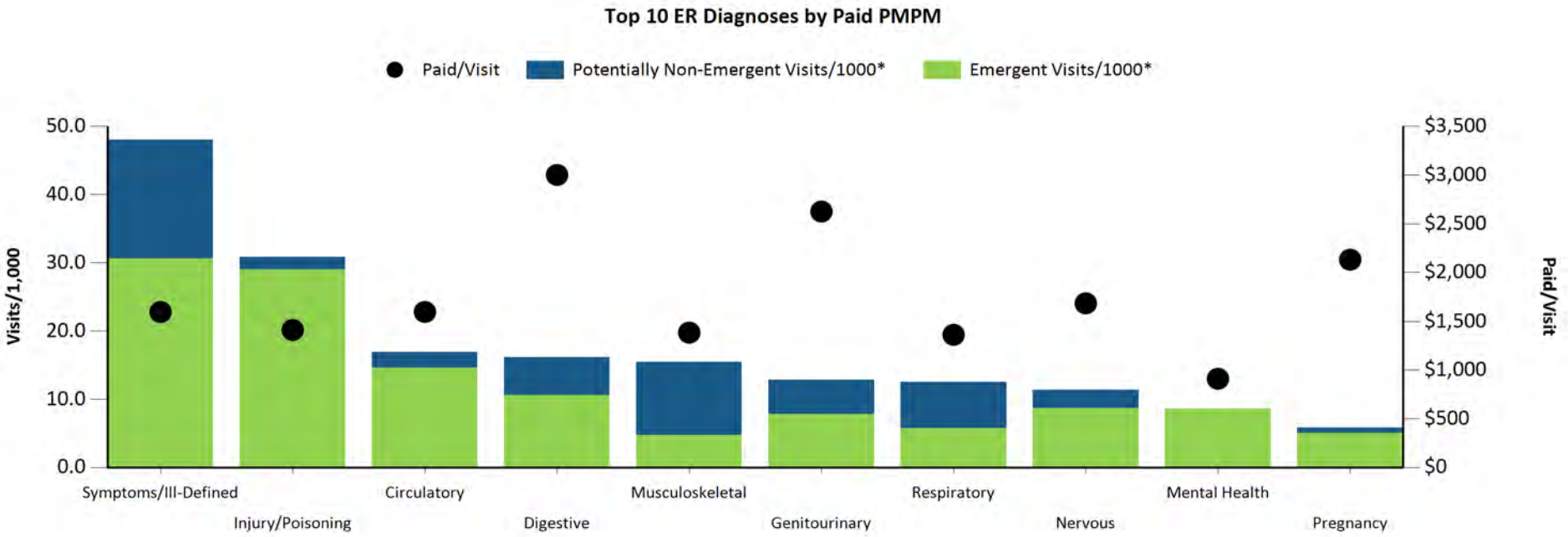
Emergency Room Leading Diagnoses

Top ER Diagnoses for Dec 2023 - Nov 2024

ER Diagnosis	Paid	Claimants	Visits	%Visits Potentially Non-Emergent *
Symptoms/Ill-Defined	$829,366	443	519	36.2%
Injury/Poisoning	$470,548	306	333	6.0%
Circulatory	$292,609	161	183	13.7%
Digestive	$525,318	157	175	34.3%
Musculoskeletal	$231,457	145	167	69.5%
Genitourinary	$364,921	125	139	38.8%
Respiratory	$185,492	121	136	54.4%
Nervous	$207,477	106	123	23.6%
Mental Health	$84,759	78	93	0.0%
Pregnancy	$134,229	39	63	12.7%
All Others	$427,279	293	332	22.3%
Summary	**$3,753,454**	**1,536**	**2,136**	**27.8%**

- **27.8% of ER visits** were potentially non-emergent in the current reporting period compared to **25.5%** in the prior reporting period and **0.0%** for the benchmark.
- The conditions with the highest volume of ER visits in the current reporting period were **Symptoms/Ill-Defined , Injury/Poisoning , and Circulatory**.

* Not reflective of benefit design



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Frequent Users Of The Emergency Room

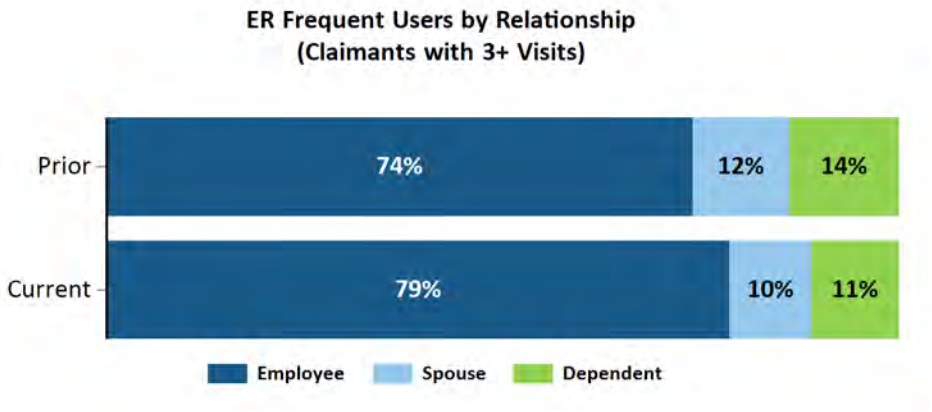
ER Utilization and Costs by Number of Visits for Dec 2023 - Nov 2024

ER Visits	Claimants	Claimants % of Total	ER Visits	ER Paid
1	1,168	76.0%	1,168	$1,840,093
2	242	15.8%	484	$1,015,802
3	72	4.7%	216	$355,413
4	32	2.1%	128	$255,823
5	13	0.9%	65	$124,981
6	2	0.1%	12	$20,812
7	2	0.1%	14	$24,684
8	3	0.2%	24	$46,210
9				
10+	2	0.1%	25	$69,636
Summary	**1,536**	**100%**	**2,136**	**$3,753,454**

Top Diagnoses of Claimants with 3+ ER Visits for Dec 2023 - Nov 2024

Diagnosis	ER Paid	ER Visits	Claimants
Symptoms/Ill-Defined	$175,678	114	71
Genitourinary	$106,897	34	23
Injury/Poisoning	$86,126	49	34
Circulatory	$82,262	43	27
Digestive	$74,989	37	27

- **8% of ER claimants** visited the ER three or more times in the current reporting period compared to **8%** in the prior reporting period and for the benchmark.
- Claimants with 3 or more ER visits accounted for **24% of the ER paid expenses** in the current reporting period compared to **29%** in the prior reporting period and for the benchmark.



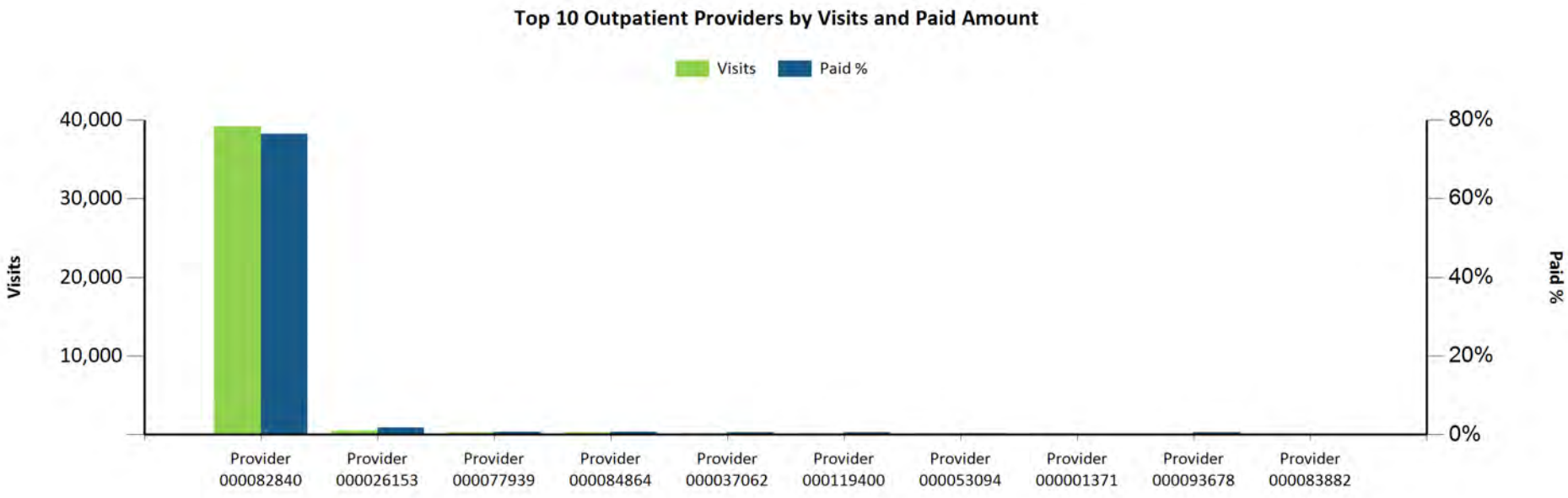
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Outpatient Provider Summary

Dec 2023 - Nov 2024

Top Outpatient Providers *by Visits*	Provider State	Visits	Paid	% of Total Paid	Paid/ Visit
Provider 000082840	NM	39,160	$26,145,043	76.4%	$667.65
Provider 000026153	NM	523	$637,638	1.9%	$1,219.19
Provider 000077939	NM	278	$247,638	0.7%	$890.78
Provider 000084864	NM	273	$253,684	0.7%	$929.25
Provider 000037062	NM	193	$189,703	0.6%	$982.91
Provider 000119400	NM	144	$191,228	0.6%	$1,327.98
Provider 000053094	AL	139	$99,763	0.3%	$717.72
Provider 000001371	IL	133	$81,279	0.2%	$611.12
Provider 000093678	NM	103	$221,887	0.7%	$2,154.24
Provider 000083882	FL	92	$69,382	0.2%	$754.15
All Other		3,832	$6,068,055	17.7%	$1,583.52
Summary		**44,870**	**$34,205,300**	**100.0%**	**$762.32**

- **Provider 000082840** was the most frequently utilized outpatient facility.
- **The top outpatient facility by paid amount was Provider 000082840**, which accounted for 76.4% of the total outpatient paid amount in the current reporting period.
- **The top 10 outpatient providers accounted for 82.3%** of the total outpatient spend in the current reporting period.



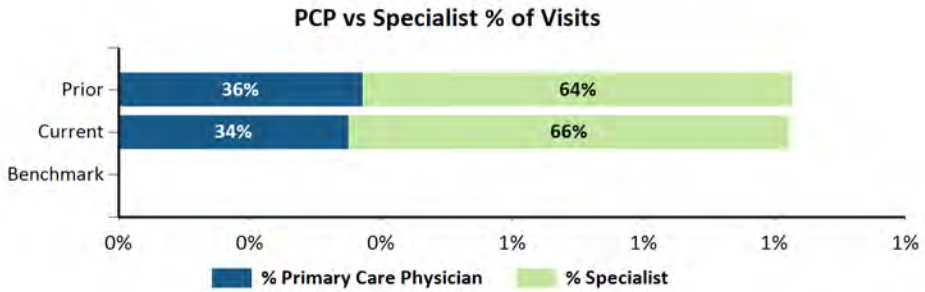
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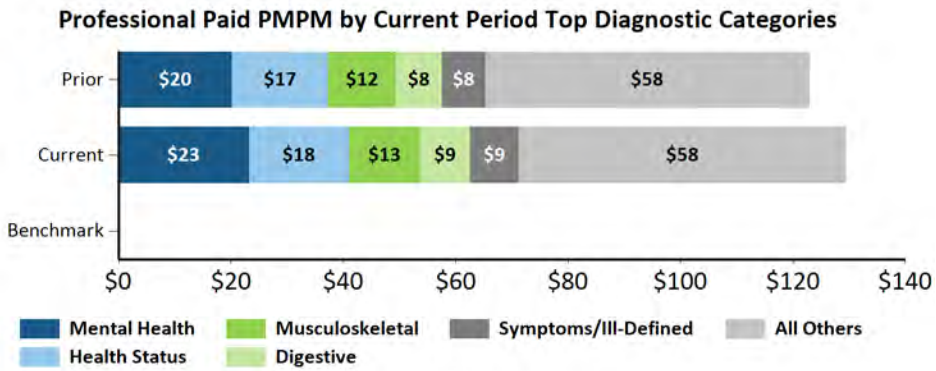
Professional Services Overview

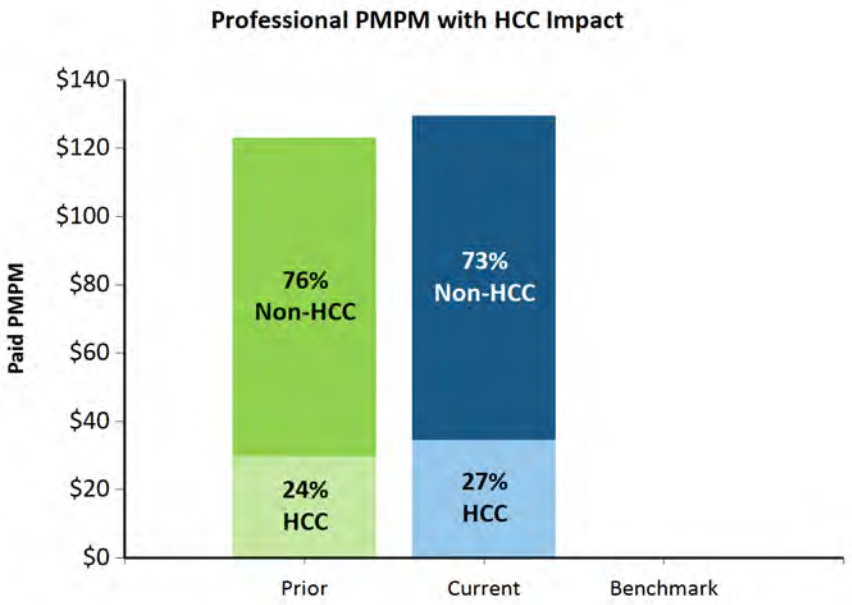
BlueCross BlueShield of New Mexico

Reporting Period	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Allowed	$19,890,603	$21,994,479	10.6%		
Allowed PMPM	$159.13	$169.52	6.5%		0.0%
Paid	$15,369,916	$16,795,777	9.3%		
Paid PEPM	$178.84	$186.67	4.4%		0.0%
Paid PMPM	**$122.96**	**$129.45**	**5.3%**		**0.0%**
Non-High Cost	$93.26	$94.97	1.8%		0.0%
High Cost	$29.71	$34.48	16.1%		0.0%
Visits/1,000	8,903.6	9,358.4	5.1%		0.0%
Services/1,000	15,257.0	16,245.3	6.5%		0.0%
Paid/Visit	$166	$166	0.2%	$0	0.0%
Paid/Service	$97	$96	-1.1%	$0	0.0%
In-Network Paid %	95.3%	95.8%		0.0%	
In-Network Visits %	93.3%	92.8%		0.0%	

- Professional paid PMPM **increased by 5.3%** between the two reporting periods and was **comparable to** the benchmark.
- High Cost Claimants accounted for **26.6% of total professional spend** compared to **24.2%** from the previous reporting period.
- **Mental Health** was the most costly diagnostic category for professional services in the current reporting period. It **increased 14.9%** and was **>100% higher than** the benchmark.
- Primary Care Physicians accounted for **35.1% of the total professional visits** in the current reporting period.



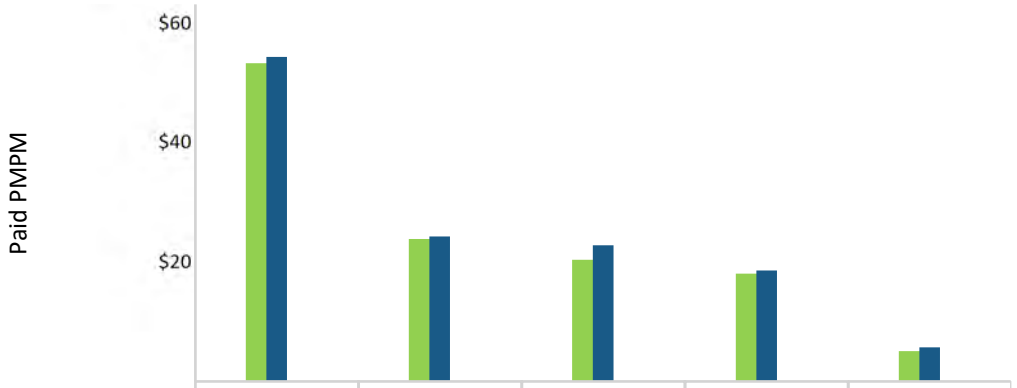




Professional - Details by Top 5 Service Types

BlueCross BlueShield of New Mexico

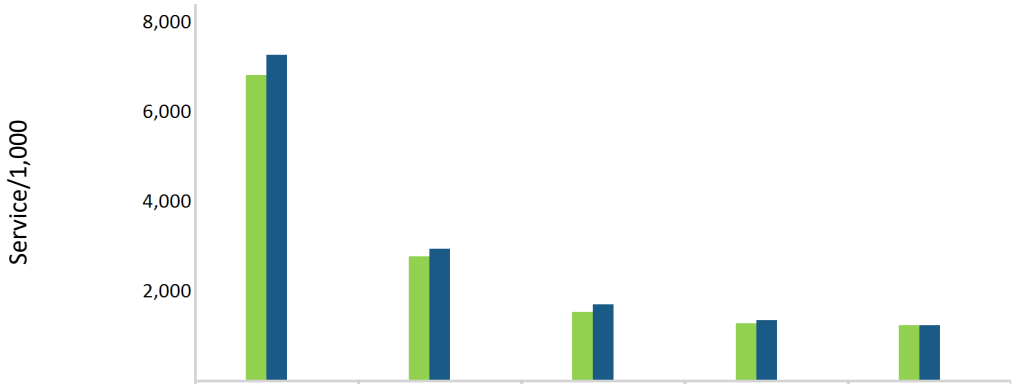
Professional Paid PMPM by Service Type



	Evaluation & Management	Surgical	Medical	Medical Services & Supplies (HCPCS II)	Radiology
Prior	$50.55	$22.62	$19.36	$17.10	$4.80
Current	$51.55	$23.00	$21.61	$17.61	$5.38
Benchmark	$0.00	$0.00	$0.00	$0.00	$0.00

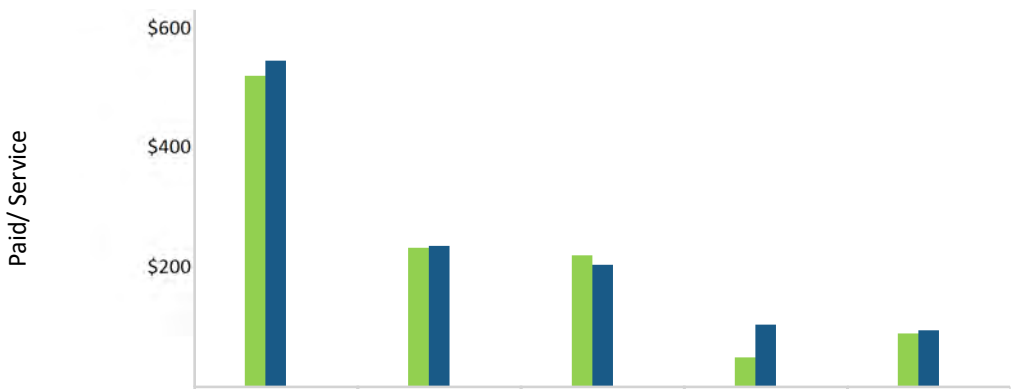
- **Evaluation & Management** was the service type with the highest paid PMPM for professional services in the current reporting period. Paid PMPM **increased 2.0%** and was **comparable to** the benchmark.
- **Evaluation & Management** had the highest rate of services/1,000 in the current reporting period.
- **Anesthesia** had the highest amount paid per service in the current reporting period.

Professional Services/1,000 by Service Type



	Evaluation & Management	Medical	Pathology & Laboratory	PT/OT/ST	Surgical
Prior	6,636.9	2,713.3	1,507.8	1,253.5	1,215.1
Current	7,086.1	2,883.0	1,671.8	1,323.6	1,217.0
Benchmark	0.0	0.0	0.0	0.0	0.0

Professional Paid/Service by Service Type

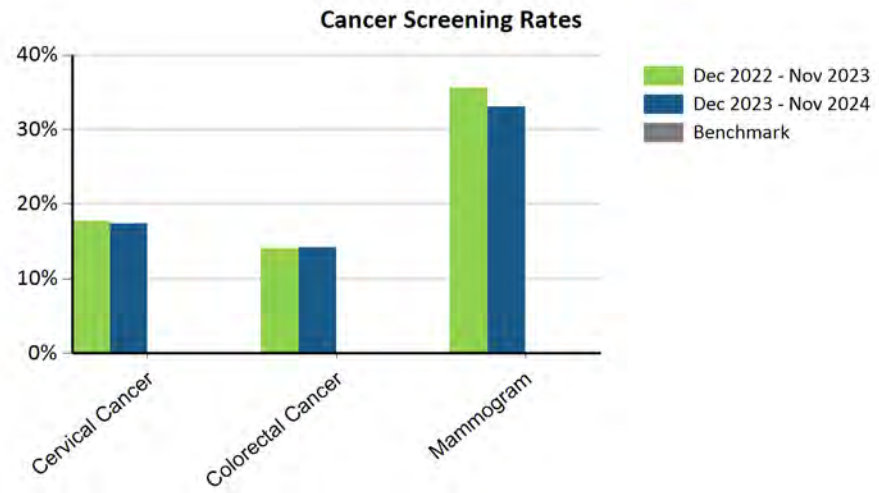


	Anesthesia	Surgical	Medical Services & Supplies (HCPCS II)	Other - Prof	Medical
Prior	$500	$223	$211	$47	$86
Current	$525	$227	$196	$100	$90
Benchmark	$0	$0	$0	$0	$0

Preventive Care

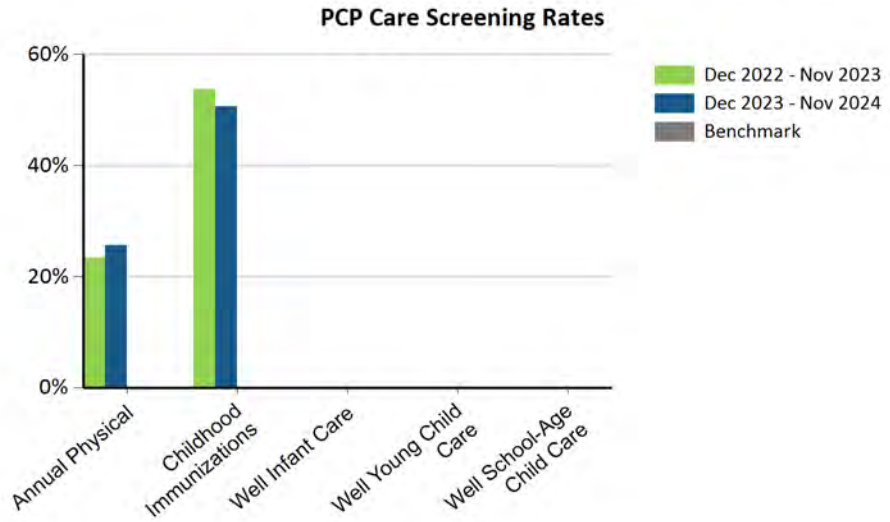
Cancer Screenings:

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	Benchmark
Cervical Cancer Screening	17.7%	17.3%	
Colorectal Cancer Screening	14.1%	14.1%	
Mammogram Screening	35.6%	33.1%	



PCP Care:

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	Benchmark
Annual Physical	23.3%	25.6%	
Childhood Immunizations	53.7%	50.6%	
Well Infant Care			
Well Young Child Care			
Well School-Age Child Care			

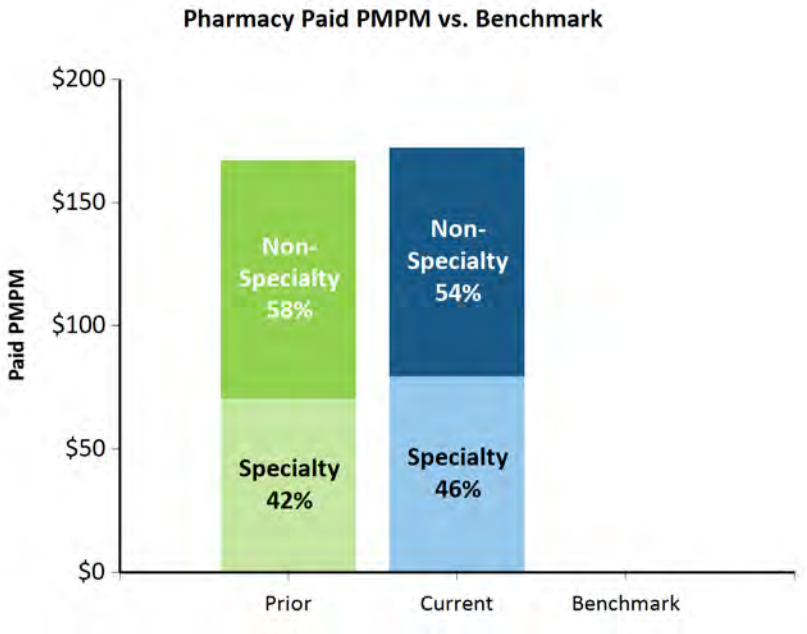


Percentages represent utilization of preventive services by those members for which the service is deemed appropriate.
Compliance rates for well infant care, well young child care,well school-age child care, and childhood immunizations are based on utilization for claimants (not members) for whom the service is deemed appropriate, in order to account for newborn children who have little to no enrollment data.

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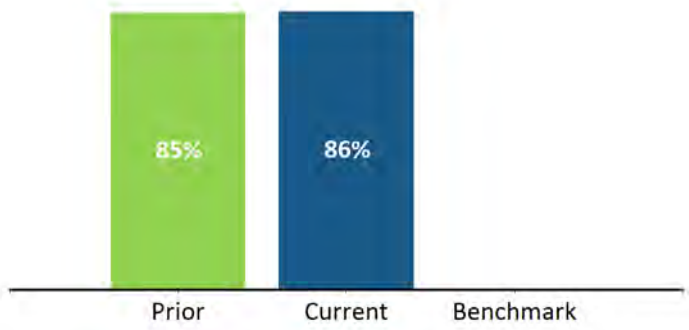
Pharmacy Overview

Metric	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Paid	$15,544,077	$16,127,370	3.8%		
Paid PMPM	$167.09	$172.10	3.0%		0.0%
Member Cost Share %	11.8%	10.5%		0.0%	
Paid/Claimant	$2,279.86	$2,386.76	4.7%		0.0%
Paid/Day	$5.05	$5.20	2.9%		0.0%
Prescriptions	119,276	119,974	0.6%		
Prescriptions/1000	15,385.7	15,362.9	-0.1%		0.0%
Claimants	6,818	6,757	-0.9%		
Claimants/1000	879.5	865.2	-1.6%	0.0	0.0%
Scripts/Claimant	17.5	17.8	1.5%		0.0%
Generic Dispensing Rate	85.3%	85.8%		0.0%	
Rx Retail as % of Prescriptions	94.3%	94.4%		0.0%	
Rx Mail Order as % of Prescriptions	5.7%	5.6%		0.0%	
Specialty % of Total Prescriptions	0.9%	1.1%		0.0%	
Specialty % of Pharmacy Cost	42.2%	46.2%		0.0%	



- **Pharmacy Paid PMPM** increased 3.0% and was in line with the benchmark in the current period.
- **Prescriptions/1000 decreased** 0.1% and was in line with the benchmark.
- The **Generic Dispensing Rate increased 0.5% to 85.8%** and was comparable to the benchmark.
- **Specialty Drugs accounted for 46.2% of the pharmacy spend in the current period** compared to 42.2% in the prior period and 0.0% in the benchmark.

Generic Dispensing Rate (GDR) vs. Benchmark



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Pharmacy: Top Therapeutic Drug Classes

BlueCross BlueShield of New Mexico

Top 10 Non-Specialty Drug Classes by Ingredient Cost: Current Period

Current/ Prior Rank		Plan Therapeutic Class	Prescriptions	Utilizing Members	Ingredient Cost	Avg. Ingredient Cost/ Prescription (Current)	Avg. Ingredient Cost/ Prescription (Prior)	% Generic	Rank by Volume
1	1	Incretin Mimetic Agents	2,981	442	$2,687,985	$901.71	$861.98		9
2	2	Calcitonin Gene-Related Peptide (CGRP) Receptor Antag	774	106	$815,596	$1,053.74	$1,047.62		39
3	4	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	1,127	150	$608,350	$539.80	$536.62		27
4	3	Insulin	1,653	180	$466,070	$281.95	$346.26		20
5	5	Sympathomimetics	2,811	1,059	$255,040	$90.73	$146.40	82.9%	10
6	7	Direct Factor Xa Inhibitors	476	63	$254,177	$533.99	$511.05		58
7	6	Viral Vaccines	2,466	1,628	$246,299	$99.88	$87.07		13
8	262	Antiviral Combinations	203	230	$217,772	$1,072.77	$0.02		92
9	11	Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	202	27	$105,643	$522.98	$510.04		93
10	10	Amphetamines	1,459	223	$88,900	$60.93	$115.78	94.8%	22
		All Other	104,485	6,386	$4,113,826	$39.37	$45.24	94.5%	
		Summary	**118,637**	**6,750**	**$9,859,660**	**$83.11**	**$86.89**	**86.3%**	

Top 10 Non-Specialty Drugs by Ingredient Cost: Current Period

Current/ Prior Rank		Brand Name	Plan Therapeutic Class	Prescriptions	Utilizing Members	Ingredient Cost	Avg. Ingredient Cost/ Prescription (Current)	Avg. Ingredient Cost/ Prescription (Prior)	Generic Indicator	Rank by Volume
1	3	OZEMPIC INJ 8MG/3ML	Incretin Mimetic Agents	500	94	$452,498	$905.00	$862.02	NO	9
2	2	OZEMPIC INJ 2MG/3ML	Incretin Mimetic Agents	547	145	$416,986	$762.31	$709.38	NO	4
3	1	OZEMPIC INJ 4MG/3ML	Incretin Mimetic Agents	463	112	$408,795	$882.93	$860.29	NO	11
4	5	NURTEC TAB 75MG ODT	Calcitonin Gene-Related Peptide (CGRP) Receptor	156	43	$242,151	$1,552.25	$1,592.27	NO	144
5	7	MOUNJARO INJ 5MG/0.5	Incretin Mimetic Agents	208	74	$208,808	$1,003.89	$968.87	NO	91
6		PAXLOVID TAB 300-100	Antiviral Combinations	152	166	$205,526	$1,352.15		NO	148
7	12	JARDIANCE TAB 25MG	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	348	48	$193,895	$557.17	$524.86	NO	30
8	9	ELIQUIS TAB 5MG	Direct Factor Xa Inhibitors	346	43	$187,022	$540.53	$517.68	NO	31
9	13	MOUNJARO INJ 7.5/0.5	Incretin Mimetic Agents	174	63	$173,218	$995.50	$965.74	NO	118
10	4	TRULICITY INJ 1.5/0.5	Incretin Mimetic Agents	166	38	$151,636	$913.47	$871.39	NO	125
		All Other		115,577	6,742	$7,219,125	$62.46	$70.93		
		Summary		**118,637**	**6,750**	**$9,859,660**	**$83.11**	**$86.89**		

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Pharmacy: Specialty Drug Analysis

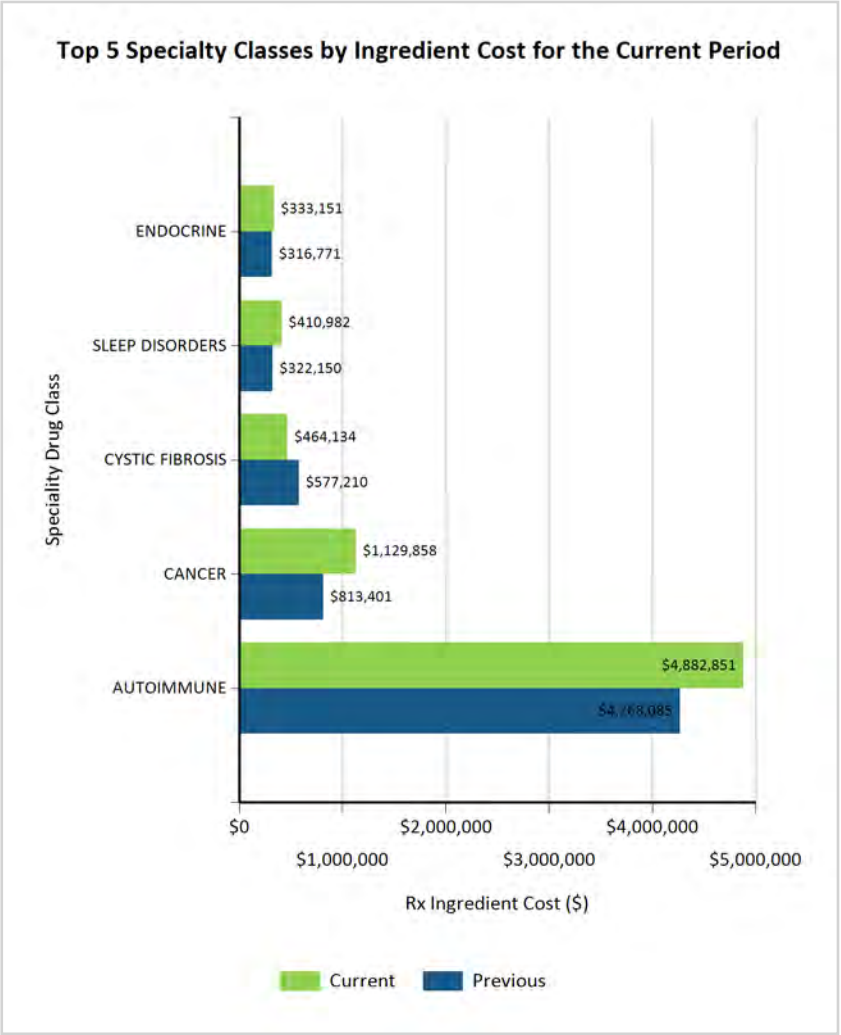
BlueCross BlueShield of New Mexico

Report Description: Specialty drugs generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies. This report provides a specialty drug analysis overview.

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change	Benchmark	Benchmark Variance
Unique Pharmacy Members	9,462	9,624	1.7%		
Claimants	195	215	10.3%		
Percent of Utilizing Members	2.1%	2.2%		0.0%	
Prescriptions	1,116	1,337	19.8%		
Specialty Percent of Total Paid	42.2%	46.2%		0.0%	
Percent of Total Prescriptions Paid	0.9%	1.1%		0.0%	
Paid	$6,561,167	$7,445,738	13.5%		
Paid PMPM	$70.53	$79.45	12.7%		0.0%
Average Ingredient Cost/Prescription	$6,497	$6,049	-6.9%		0.0%

Top 10 Specialty Drugs by Ingredient Cost for the Year to Date

Brand Name	Specialty Class	Ingredient Cost	Prescriptions	Avg. Ingredient Cost/ Prescription	Specialty Claimants
STELARA INJ 90MG/ML	AUTOIMMUNE	$872,935	32	$27,279.23	7
HUMIRA PEN INJ 40/0.4ML	AUTOIMMUNE	$745,640	104	$7,169.62	18
DUPIXENT INJ 300/2ML	AUTOIMMUNE	$395,364	98	$4,034.33	14
SKYRIZI PEN INJ 150MG/ML	AUTOIMMUNE	$327,643	16	$20,477.69	7
SOD OXYBATE SOL 500MG/ML	SLEEP DISORDERS	$294,135	15	$19,609.03	2
VERZENIO TAB 150MG	CANCER	$287,179	24	$11,965.78	2
SYMDEKO TAB 100-150	CYSTIC FIBROSIS	$285,378	11	$25,943.49	1
HUMIRA INJ 40/0.4ML	AUTOIMMUNE	$269,667	39	$6,914.55	5
SPRYCEL TAB 100MG	CANCER	$185,836	14	$13,273.97	1
JYNARQUE PAK 60-30MG	ENDOCRINE	$183,961	9	$20,440.06	1
All Other		$4,240,062	847	$5,005.98	168
Summary		**$8,087,801**	**1,209**	**$6,689.66**	**215**



Prior period is reflected only as it pertains to the Top 5 Speciality Classes of current period.

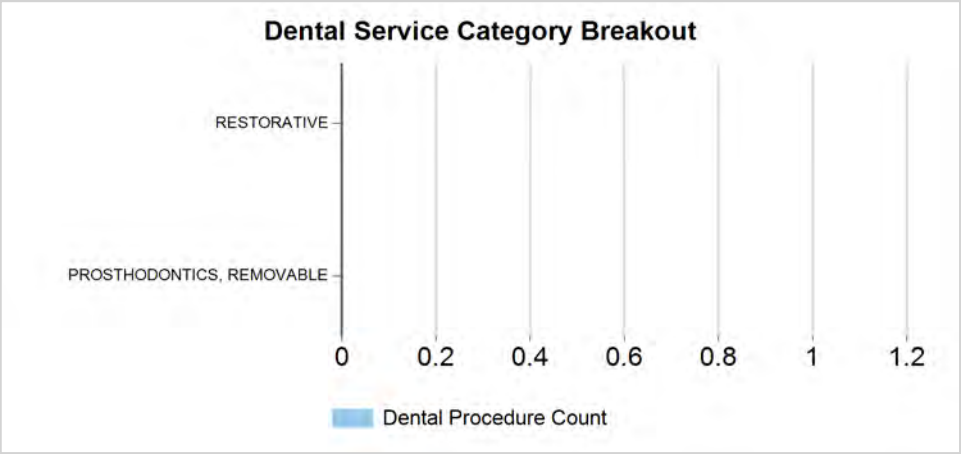
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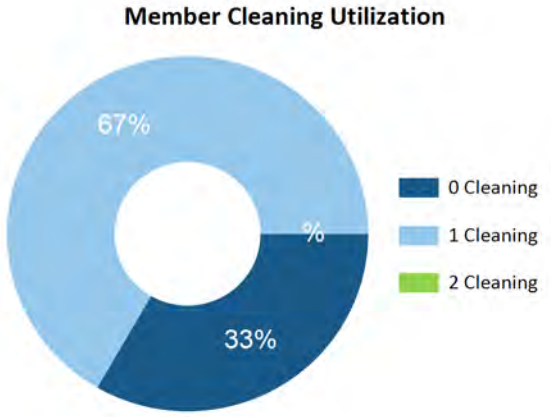
Dental Utilization Overview

Demographics

Members	Current Period	Prior Period	Number of Procedures/1000	Prior Year Number of Procedures/1000	% change	Benchmark	Variance
Employee					0.0%	0	0.0%
Spouse					0.0%	0	0.0%
Dependent					0.0%	0	0.0%
Totals							

- Membership **remained stable by 0.0%** from the previous reporting period, while the number of procedures **remained stable by 0.0%** for the same time period.
- of Total Members utilized their benefit during the current reporting period.
- **PROSTHODONTICS, REMOVABLE** procedures accounted for **0%** of the total procedures for the account. Compared to from the previous reporting period.

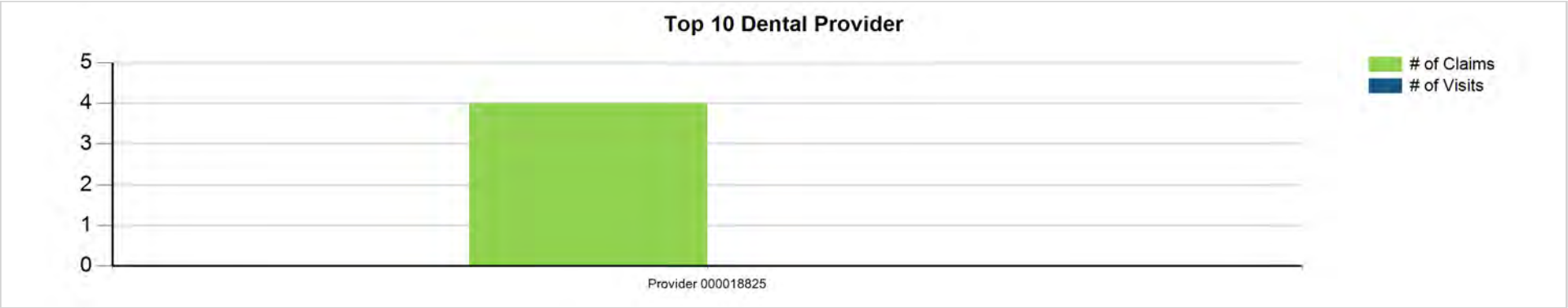






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Dental Utilization Overview



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Appendix: Financial Summary

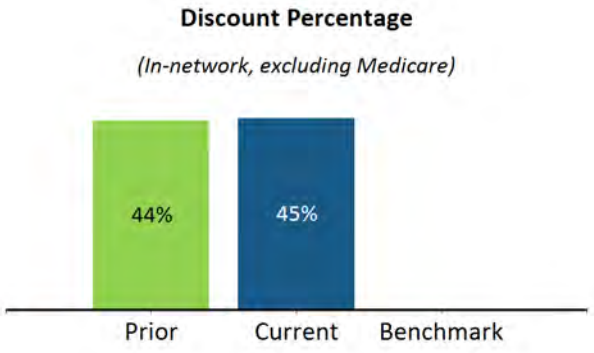
BlueCross BlueShield of New Mexico

Claims on paid basis

Financial Order of Reduction (including Pharmacy)

	Dec 2022 - Nov 2023	Dec 2023 - Nov 2024	% Change
Billed	$171,212,107	$219,379,274	28.1%
Not Covered	$17,976,551	$48,957,118	>100%
Covered	$153,235,556	$170,422,156	11.2%
Discount	$67,550,266	$76,834,449	13.7%
Allowed	$85,685,290	$93,587,707	9.2%
Out of Pocket	$10,991,616	$11,846,229	7.8%
COB	$493,201	$292,779	-40.6%
COB Medicare	$337,162	$4,681	-98.6%
Other Reductions	$110,599	$9,158	-91.7%
Other Adjustments	($61,820)	($59,172)	4.3%
Paid - Provider	$73,814,530	$81,494,034	10.4%
Other Payments	$71,746	$48,683	-32.1%
Total Paid	$73,886,276	$81,542,717	10.4%
Allowed PMPM	$733.70	$775.56	5.7%
Paid PMPM	$633.83	$677.26	6.9%
Plan Share	87.1%	87.3%	0.3%

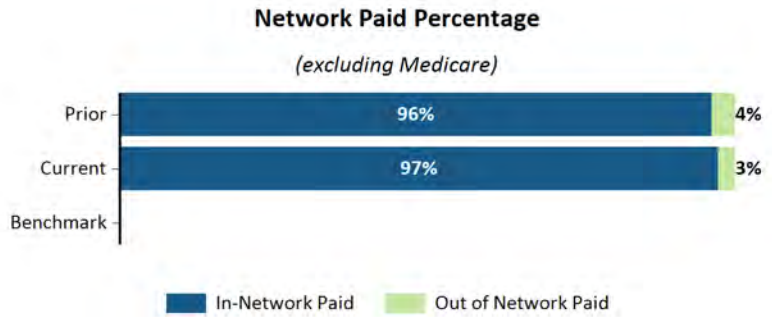
- The **total paid** amount **increased by 10.4%** between reporting periods.
- Total in-network **discounts** (excluding Medicare) were **$57,479,047 (44.6%)** for the current reporting period.
- The **in-network paid percentage** (excluding Medicare) was **97.2%** for the current reporting period.



Network Overview Dec 2023 - Nov 2024

Medicare Primary Indicator	Network Indicator	Covered	Discount	Discount %	Paid	% of Paid
No	In-Network	$128,858,852	$57,479,047	44.6%	$63,277,310	97.2%
	Out of Network	$8,273,257	$4,425,902	53.5%	$1,755,744	2.7%
Yes	In-Network	$238,081	$182,647		$49,244	0.1%
	Out of Network	$383	$60		$0	0.0%
Summary		**$137,370,573**	**$62,087,656**	**45.1%***	**$65,082,298**	**100.0%**

*Calculated discount percent excludes Medicare Primary.



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Appendix: Glossary

Admin Fees: The charge to an account for HCSC's operational cost of doing business.

Administrative Services Only (ASO): A contract between HCSC and a self-funded plan where HCSC performs administrative services only and does not assume any financial risk. Services usually include claims processing but may include other services such as actuarial analysis and utilization review.

Aggregate: Constituting or amounting to a whole. For example, an aggregate account report includes data for the entire account.

Aggregate Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Aggregate stop loss provides protection against the accumulation of total claims for a group as a whole exceeding a stated level.

Allowed: Amount considered eligible for payment by the plan

ASO Adjustments: An amount added or deducted from ASO (Administrative Services Only) fees. This includes Stop Loss Reimbursements.

Average Age: The difference between the claimant's year of enrollment and year of birth. Calculated using the measure Average Age divided by the members represented in the report.

Average Contract Size: The average number of members per subscriber. It is calculated as: Medical Members / Medical Subscribers

Average Dependents: Calculated using the measure Member Months (filtered on the Relationship = Dependents) divided by the number of months in the report.

Average Ingredient Cost: Represents the cost of the medication and is determined from the lowest submission of the pharmacy network rate, Usual & Customary amount, or Maximum Allowable Cost (MAC)

Average Members: Calculated using the measure Member Months divided by the number of months included in the report.

Average Subscribers: Calculated using the measure Subscriber Months divided by the number of months included in the report.

Billed: Amount submitted for payment by the provider

Billing and Accounts Receivable System (BARS): An HCSC financial system where all Administrative Services Only (ASO) customer bills are generated.

Blue Card Access Fee: Interplan Teleprocessing Services fee charged on out-of-state claims for accessing the local plan's provider network

Brand Formulary: Brand name medications that are listed on the formulary

Brand Non-Formulary: Brand name medications that are not listed on the formulary

Claimants: Number of individual members submitting a claim

Claim Lag: The amount of time between the date a claim is incurred and the date the claim payment is made.

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Appendix: Glossary

COB: Portion of amount considered eligible for payment that has been paid by another insurance company (Coordination of Benefits)

COB Medicare: Portion of amount considered eligible for payment that has been paid by Medicare

COBRA Members: Consolidated Omnibus Budget Reconciliation Act - A federal law which requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) when coverage under the plan would otherwise end.

Coinsurance: Portion of covered amount member is responsible to pay for the claim

Co-payment: Flat rate that the member is responsible to pay for the claim

Coverage Tier: Eligibility tiers which stratify enrollment data based on the employee and others enrolled under the employee's coverage. Varying benefits can be assigned to tiers.

Covered Amount: Amount eligible for payment based on the terms of the medical/dental benefits agreement.

DAW/1: Indicates that the physician has specified 'do not substitute' on the prescription.

DAW2: Indicates that the Physician has allowed a substitution, but the patient requested brand to be dispensed

Deductible: Portion of annual deductible amount member is responsible to pay applied to the claim.

Dental Loss Ratio: Calculated as the Dental Paid Claims Amount divided by the Billed Dental Premium Amount

Dental Paid Claims: An amount paid to cover the Health Plan's liability for dental services provided to members for claims that have been processed and approved for payment

Discount: Amount of reduction from billed amount that has been negotiated with the provider

Discount %: For medical claims, the discount percent is calculated as Discount / Covered

Dispensing Rate: The proportion of total drugs claims a certain drug or drug type is being dispensed

Drug Type: An indicator on each Rx claim that tells whether a prescription is single source brand, multi-source brand or generic item.

Effective Discount %: The effective discount percentage is calculated as: Discount / (Discount + Paid)

Fees and Credits: Includes all account-specific member and account level fees. Can include Specific Stop Loss, Aggregate Stop Loss, Administration, Access Fees, ASO Adjustments (either debits or credits), Rx Credits and other miscellaneous fees.

Females (20-44 years): The total number of members who are women between the ages of 20 and 44 years. The proportion of females (20-44 years) is calculated as: Member Months for Women between 20-44 years / Member Months

Formulary Compliance Rate: The percentage of drugs dispensed that were included in the formulary

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Appendix: Glossary

Generic Dispensing Rate: Proportion of potential generic prescriptions that were filled as generic (excludes COVID claims).

Generic Drugs: A medication for which the patent has expired, allowing any manufacturer to produce and distribute the product under the chemical name.

Generic Substitution Rate: The rate in which generics were dispensed when a generic was available (excludes COVID claims).

Group Liability: Total Claim Expense plus Fees and Credits

HCC: High Cost Claimant, a claimant with total paid amount over a specified threshold (e.g., $30,000 or $50,000) within the reporting period

IBNR: An acronym for 'incurred but not reported'. IBNR claims are that group which are incurred before the fund reserving date, but not reported until after that date.

Ingredient Cost: The cost of the drug including sales tax, excluding dispensing fees.

In-Network Paid %: Percent of total paid expenses for in-network claims. It is calculated as: In-Network Paid / Paid

Inpatient Facility: Refers to Facility Inpatient claims

International Classification of Diseases (ICD): An official list of categories of diseases, physical and mental, issued by the World Health Organization (WHO).

Leading ICD Diagnostic Category: For each patient, summarize total paid amount for each diagnosis and its corresponding MDC. The MDC with the greatest paid amount for the patient becomes the Leading ICD Diagnostic Category for the reporting period

MAC Program Savings: Savings achieved by using the MAC (maximum allowable cost) discount on generic medications

Medical Paid Claims: An amount paid to cover the Health Plan's liability for medical (healthcare) services provided to members for claims that have been processed and approved for payment

Medical/Pharmacy Loss Ratio: Calculated as the combined Medical and Pharmacy Paid Claims Amount divided by the total Billed Premium Amount for Medical and Pharmacy, where appropriate

Member Months: Count of months of eligibility for members

Multi-Source Brand: Brand name medications with a generic equivalent

Network Indicator: An indicator that shows whether the claim was processed as in-network (e.g., in the Preferred Provider Organization network) or out-of-network and paid accordingly

Network Savings Discount: The discount that is applied when a member receives services from a contract provider.

Not Covered: Amount considered not eligible for payment by the plan (excludes the discount amount)

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Appendix: Glossary

Other Adjustments: Minor payments or credits not captured in other specific expense measures

Other Payments: Combination of Blue Card access fees and surcharge expenses

Other Reductions: Combination of maximum reductions, penalties, workers compensation savings, and subrogation savings

Out of Pocket: Total amount that is the responsibility of the claimant. It is calculated as: (Copay + Deductible + Coinsurance)

Outpatient Facility: Refers to Facility Outpatient claims

Paid: Total amount paid by the plan, including access fees, adjustments, and surcharges

Paid + Recoveries: The total amount paid by the plan plus any amount recovered through subrogation.

Paid-Provider: Amount paid to the provider by the plan

Paid/Claimant: Amount paid to the provider by the plan per claimant. It is calculated as: Paid / Claimants

Paid/Service: Amount paid to the provider by the plan per admission (inpatient facility), per visit (outpatient facility and professional) or per script (prescription Rx). It is calculated as: Paid / Services

Paid PEPM: Amount paid to the provider by the plan per employee per month. It is calculated as: Paid / Subscriber Member Months

Paid PMPM: Amount paid to the provider by the plan per member per month. It is calculated as: Paid / Member Months

Penalty: Amount charged to the user of health care services for a non-approved contractual service

PEPM: Per employee per month

Pharmacy Discount %: For pharmacy claims, the discount percent is calculated as Discount / (Discount + Allowed)

Pharmacy Paid Claims: An amount paid to pharmacies (or members where applicable) to cover the Health Plan’s liability for pharmacy services provided to members for claims that have been processed and approved for payment. The calculation of “pharmacy paid claims” does not include pharmaceutical manufacturer rebates

Pharmacy Tier: An indicator on each Rx claim that tells whether a prescription is generic, preferred brand, non-preferred brand, specialty, or other

Plan Eligibility: Eligibility derived directly from the plan's enrollment system. It excludes eligibility created during data processing for claims without matching records in the enrollment system.

PMPM: Per member per month

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Appendix: Glossary

Premium: An agreed upon fee paid to the Health Plan for coverage of medical and/or dental benefits for an established benefit period and set intervals

Professional: Services provided by physicians or other professional providers

Recoveries: Subrogation and/or Reimbursements for claims that are included in BARS but not in HCSC's data warehouse (since some of the reimbursements could be for members or claims that are no longer in our data warehouse). Recoveries are loaded from the BARS System and included in Blue Insight for reconciliation purposes.

Rx Credit Fees: Drug rebates that are credited back to the account.

Rx Paid PEPM: Prescription drug paid amount per employee per month

Rx Paid PMPM: Prescription drug paid amount per member per month

Service Category: A classification based on claim type

Service Type: Classification based on principal diagnosis or ICD Procedure Code

Services: Number of admissions (inpatient facility), number of visits (outpatient facility), number of claim lines (professional), or number of scripts (prescription Rx)

Services/1000: Number of services per 1,000 members. It is calculated as: (Services / Member Months) * 1000 * 12

Single Source Brand: Brand name medications with no generic equivalent

Specialty Drugs: Medications that generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more costly than alternative drugs or therapies.

Specific Stop Loss: A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. Specific (or individual) stop loss limits the cost of eligible medical expenses for each covered individual.

Subrogation Savings: Portion of amount eligible for payment originally paid by the plan but that has since been recovered through a legal action

Surcharge: Amount charged as a tax by certain States on facility claims

Therapeutic Drug Class: Used to categorize or group prescription drugs which are considered similar by the disease they treat or by the effect they have on the body

Total Paid: The total amount of medical and pharmacy dollars paid to cover healthcare services provided to members for claims that have been processed and approved for payment

Workers Compensation Savings: Portion of amount eligible for payment that has been paid a third party Workers Compensation carrier

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BlueCross BlueShield of New Mexico

August 18, 2025

Reference: City of Albuquerque
Confidential and Proprietary Information

Dear Cassaundra Gomez:

The attached responses provided are not subject to production in response to an IPRA request as they qualify as trade secrets per the definition set forth in NMSA § 57-3A-2(D) and exempted from IPRA disclosure per NMSA § 14-2-1(F).

Maintaining the confidentiality of the documents marked "Confidential and Proprietary Information" is of utmost importance to employers, BCBSNM, and consumers in New Mexico because making the documents publicly available and otherwise permitting their disclosure hurts the competitive space that serves to improve services and provide for competitive fees. The attached documentation is marked and maintained by BCBSNM as confidential internally and not publicly disclosed. Our company privacy office identifies the information as Business Confidential Information (BCI) to include business strategy, discounts, financial data and product pricing information. BCBSNM's privacy office develops, implements and maintains company privacy policies and procedures and requires all areas to implement and maintain appropriate safeguards to protect the confidentiality of such information. Personnel violating our company policy relative to confidential information (including BCI) are subjected to corrective action, including termination. All employees are trained on an annual basis as to their obligations to protect confidential information including BCI. Disclosure of the confidential documents (developed using internal legal resources, access to confidential data and application of proprietary rate-development analyses) would result in competitive harm because the information is valuable to BCBSNM due to resources expended in collecting and evaluating claims administration data and formulating the relevant information, and disclosure of that information via IPRA constitutes disclosure of proprietary strategies applied to improve insurer performance. Release of the unredacted documents without prior written consent of BCBSNM is unfairly valuable to either competitors or potential customers who could attempt to leverage the proprietary information and attempt to improve strategic ideas developed by BCBSNM. On balance, the information qualifies for Trade Secret protection per NMSA § 57-3A-2(D) and is not subject to public inspection per NMSA § 14-2-1(F).

Respectfully submitted,

Attachments containing confidential information:

- Appendix B Dental Questionnaire
- Appendix F Technical Workbook
- Appendix G – 2024 Audited Financial Statement
- Appendix H Dental Cost Proposal (Performance Guarantees tab)
- Performance Guarantees Exhibits
- 2.1 Technical Proposal
- Access Analysis
- Disruption Summary
- References
- Account Team Biographies

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BlueCross BlueShield of New Mexico

Confidential Responses

Exhibit	Section/Question #	Question	Confidential Response
Appendix B – Dental Questionnaire	**General Information (All Offerors)** **#12 (Page 12)**	**Complete the following information about the individual who will be assigned as the OVERALL ACCOUNT MANAGER for the City:** **Name & Title:** **City/State:** **Length of Time in Current Position:**	Amanda Romero, Account Executive Albuquerque, New Mexico Three years.
Appendix B – Dental Questionnaire	**General Information (All Offerors)** **#13 (Page 12)**	**Complete the following information about the individual from your organization who will be assigned as the PRIMARY DAY TO DAY CONTACT for the City:** **Name & Title:** **City/State:** **Length of Time in Current Position:**	1. Amanda Romero, Account Executive 2. Regina Guion, Sr. Marketing Service Representative 3. Lisa Smith, Dental Account Executive 1. Albuquerque, New Mexico 2. Albuquerque, New Mexico 3. Lombard, IL 1. Three years. 2. 2.5 years. 3. 11 years

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Appendix B – Dental Questionnaire	**Customer Service Operations Dental #4 (Page 15)**	**What hours and days are live customer service representatives available (indicate using NM time)?**	Our Amarillo, Texas and Belleville, Illinois dental-only service centers handle claims processing and customer service. Both dental service centers support each other when call volumes are heavy and during emergencies. Their hours of operation are 7 a.m. to 5 p.m. Mountain time Monday to Friday (excluding major U.S. holidays).
Appendix B – Dental Questionnaire	**Customer Service Operations Dental #5 (Page 15)**	**Are your customer service representatives located in the continental US?**	Yes. Our dental-only call centers are located in Amarillo, Texas and Belleville, Illinois.
Appendix B – Dental Questionnaire	**Customer Service Operations Dental #7 (Page 16)**	**Please provide the following statistics for 2023 and 2024:** **Average speed to answer: ___% within 30 seconds** **Busy rate: ___ seconds** **Abandonment Rate : ___%**	We do not track average speed to answer by percentage. Our corporate standard is to answer all calls in less than 30 seconds. For 2023 our average answer speed was 19.7 seconds. For 2024 our average answer speed was 22.3 seconds. Given the capability of our automatic call distribution system, busy rates are not an issue. Therefore, we do not track them. Our abandoned call average for 2023 and 2024 was only 1.2%.
Appendix B – Dental Questionnaire	**Customer Service Operations Dental #14 (Page 22)**	**What methods does your organization use to measure customer satisfaction?**	We monitor and measure our customer service daily and continually strive to improve our services. For quality control, we record calls randomly throughout the week and conduct audits daily on both live and recorded phone calls. During the audit, supervisors assess the accuracy of information and the use of proper customer service skills. Our service centers in Amarillo, Texas and Belleville, Illinois, receive all calls to our toll-free number. Our corporate standard is

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			to answer all calls in less than 30 seconds, and for 2024 our average answer speed was 24.6 seconds. On rare occasions, members may abandon a call, but our abandoned call average for 2024 was only 1.2%. We take great pride in our dedicated dental service center, which provides personalized customer service and accurate, timely responses to inquiries. In most cases, our advocates resolve a member's question or concern during the first call. In 2024, our first-call resolution rate was 96.3%.
Appendix B – Dental Questionnaire	**Customer Service Operations Dental** **#15 (Page 23)**	Provide a copy of your most recent customer satisfaction survey statistics.	Our member satisfaction survey result was 91.4% in 2024. Surveys are not able to be shared externally at this time.
Appendix B – Dental Questionnaire	**Dental Network** **#6 a-c (Page 24-25)**	**a. General Dentists:** Access criteria: 2 providers within 10 miles of home zip code **b. Specialists (excluding orthodontists):** Access criteria: 2 providers within 10 miles of home zip code **c. Orthodontists:** Access criteria: 2 providers within 15 miles of home zip code	98.7% 94% 98.6%
Appendix B – Dental Questionnaire	**Dental Network** **#8 (Page 25)**	How many complaints per 1,000 visits do you receive on your network providers?	We do not track complaints per members or visits; however, for calendar year 2024, we had a total of 98 dental complaint cases.
Appendix B – Dental Questionnaire	**Dental PPO Claim Administration Services**	From what location would this policyholder's claims be processed?	Our Amarillo, Texas and Belleville, Illinois dental-only service centers handle claims processing and customer service. Both dental service centers support each other when call volumes are

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	#1 (Page 34)		heavy and during emergencies. Their hours of operation are 7 a.m. to 5 p.m. Mountain time Monday to Friday (excluding major U.S. holidays).
Appendix B – Dental Questionnaire	**Dental PPO Claim Administration Services** **#2 (Page 34)**	What is your company's claims processing turn-around time for dental claims not involving coordination of benefits?	Our average claim turnaround time is less than seven days. In 2024, our claim turnaround time was 3.4 days.
Appendix B – Dental Questionnaire	**Dental PPO Claim Administration Services** **#6a (Page 36)**	How are network claims processed?	In 2024, we received 91.43% of dental claims electronically. Electronic claims are received through Availity, BCBSNM's claim clearinghouse, and sent electronically to our claims processing system for adjudication. All paper claims, both in and out of network, are received by Conduent, our optical character recognition partner, located in Plano, Texas. Paper claims are sorted, imaged, verified for eligibility, converted to standard 837 transaction records, and electronically routed to our claim system for adjudication. Claims unable to auto-adjudicate are pended to a series of queues, where our processors review and complete all necessary steps, including claim pricing of both in- and out-of-network claims. If the claim is finalized, it automatically generates an explanation of benefits, which we can mail or deliver electronically. We update the member's claims history and, if required, issue a check or electronic payment. Electronic payments are only an option for payments issued to providers. If there are any discrepancies within the claim, we register an error and route the claim to an examiner, who will review, correct when possible, and resubmit the claim into the system. Unless additional information is required, the claim then completes the processing cycle.
Appendix B – Dental Questionnaire	**Dental PPO Plan Underwriting** **#7 (Page 39)**	**What were your historic 2023 and 2024 DPPO trends and anticipated 2025 trends for your proposed plan in the greater Albuquerque metropolitan area?**	

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<tr><td></td><td></td><td>a. 2023
b. 2024
c. Anticipated 2025</td><td>3-5%
4-6%
4-6.5%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>RFP Response Folder / 2.1 Technical Proposal</td><td>#2.1.2.1
Page 4</td><td>Current Experience. State relevant experience of the company and person(s) who will be actively engaged in the proposed project, including experience of subcontractors. Submit resumes for the individuals who will be performing the services for the City.</td><td><u>Experience of Subcontractors</u>
As of August 2025, we partner with the following vendors specific to this proposal offering:
<table>
<tr><th>Vendor</th><th>Headquarters</th><th>Description</th><th>Length of Experience</th></tr>
<tr><td>Dental Network of America, subsidiary of Health Care Corporation (HCSC)</td><td>701 East 22nd Street Lombard, IL 60148</td><td>Dental administration</td><td>45 years</td></tr>
<tr><td>Fiserv Solutions, Inc.</td><td>255 Fiserv Drive, Brookfield, WI 53045</td><td>Member Cards Manufacturer</td><td>38 years</td></tr>
<tr><td>MedeAnalytics, Inc.</td><td>501 W President George Bush Hwy Suite 250, Richardson, TX 75080</td><td>Client Reporting</td><td>28 years</td></tr>
<tr><td>R.R. Donnelley & Sons Company</td><td>35 West Wacker Drive, Chicago, IL 60601</td><td>Print enrollment materials</td><td>158 years</td></tr>
</table></td></tr>
</table>

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	#2.1.2.1 continued		**Key BCBSNM Staff Serving the City** Our local management team represents an extraordinary depth of health care and management experience and broad participation in New Mexico health care initiatives. We have provided full biographies of the account team in the Technical Proposal section of our proposal, which includes the following professionals: • **Maureen Sergel, Senior Manager of Account Management**, will provide oversight to the City's account administration. • **Marlene Baca, Sales Vice President,** oversees sales, account management, and marketing for New Mexico. • **Amanda Romero, Account Executive**, will serve as the City's main point of contact and lead the account management team. • **Regina Guion, Sr. Marketing Service Representative,** is responsible for supporting account executives in retaining, acquiring, and renewing business. • **Lisa A Smith, Dental Account Executive,** integrates communication between the broker, group administrators, internal sales managers, marketing representatives, and dental client services during the onboarding of new clients. She also provides dental-focused assistance at open enrollment and annual review meetings for clients, offering her dental expertise and experience to help improve their understanding of dental insurance and plan performance.
RFP Response Folder / 2.1 Technical Proposal	**2.1.13** **Page 9**	**Network Composition and Access: Provide comprehensive information on their provider networks. This information shall indicate where provider networks are directly contracted and where they are leased**	**Management and Operation of Network** We use Dental Network of America, LLC as our dental administrator for core services. Dental Network of America may coordinate services with various vendors for many of the products and services we offer to our members, employer groups, and providers but Dental Network of America remains responsible for the administration of those core services.

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		from another entity. Do not provide hard copy provider directories Provide the website address where such directories can be viewed. Where requested, geo-access and disruption analysis shall be included (refer to RFP Appendix F.) Further, the details on the management and operation of the network shall be included. Information on the expected provider and network membership shall be provided.	Core services include claim determinations, network management, utilization reviews, payment integrity, appeal determinations, and customer service involving any direct contact with members. Customer service means a call center staffed to answer members' claims, benefit, and network questions. Core services do not include work necessary to support the infrastructure for these functions, such as phone systems, computer, software, facilities, database or information management, quality services, or security services. Core services also do not include backroom operations, which are activities that do not involve direct contact with covered members.
	2.1.13 continued **Page 9**		**<u>Provider and Network Membership</u>** Our dental PPO network has over 151,000 unique providers, making us one of the largest dental networks in the U.S. in terms of unique providers. We are also one of the largest networks in New Mexico, with more than 1,200 unique providers. Broad access, combined with our PPO network awareness campaigns, results in higher in-network utilization, generating greater savings. Our persistent focus on network discounts has resulted in an average savings of 41.3% in the state of New Mexico alone. Our national gross discount is 42.7%. Refer to the geo access and disruption which has been included with this proposal.

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DISRUPTION SUMMARY

Prepared for:

City of Albuquerque

7/28/2025

DENTAL NETWORK COMPARISON

Number of Dentists Used By Employees	812	PERCENTAGE	OUT-OF-NETWORK
In-Network with BCBSNM - Currently ("Against Group")	717	88.2%	95
In-Network with BCBSNM - At Time of Claim ("Matching Group")	583	71.8%	229
NETWORK IMPROVEMENT	**134**	**16.4%**	

Amount of Billed Claims	$8,032,169	PERCENTAGE	OUT-OF-NETWORK
In-Network with BCBSNM - Currently ("Against Group")	$7,296,450	90.8%	$735,719
In-Network with BCBSNM - At Time of Claim ("Matching Group")	$6,899,652	85.9%	$1,132,517
FINANCIAL IMPROVEMENT	**$396798**	**4.9%**	

Please consult the Disruption Report for more information.

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BlueCross BlueShield of New Mexico

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Disruption Analysis Report

Created for...

City of Albuquerque

Created by...

Blue Cross and Blue Shield of New Mexico (BCBSNM)

July 28, 2025

Created with the Quest Analytics Suite

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BCBSNM Disclaimer Page

Disruption Report Disclaimer

This disruption analysis report is provided by Blue Cross and Blue Shield of New Mexico (BCBSNM) for informational purposes only. The report results should be considered a snapshot-in-time and used only as a guide for potential provider matching. Due to the many variables in provider network data, as supplied by Plans, matching results may be inexact and cannot be guaranteed. (i.e. Report results should not be used for other purposes, such as collating claims dollars or locating a participating provider from whom to obtain covered dental care services). Every effort is made to match providers utilizing the data elements, provided to BCBSNM, through multiple match methods that step from most stringent to least stringent.

For match results, BCBSNM will only utilize provider data that has been identified as part of a Plans' licensed service area.

Disruption Match Methodology

The methodology consists of 19 potential levels of matching. The matching levels start at the most stringent, utilizing the 6 data elements, and move towards a less stringent match that culminates in a single-element match for NPI or TIN. Name matches look for an exact match, then an approximate match to account for abbreviations or variations in spelling.

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Disruption Overview

July 28, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

DPPO - w/TIN Only and NPI Only

Matching...
Incumbent

Against...
Blue Stack With GRID Inc Non Pubs

Disruption Map
◆ Matched
● Not Matched

851.54 miles

Disruption Chart
Matched
Not Matched

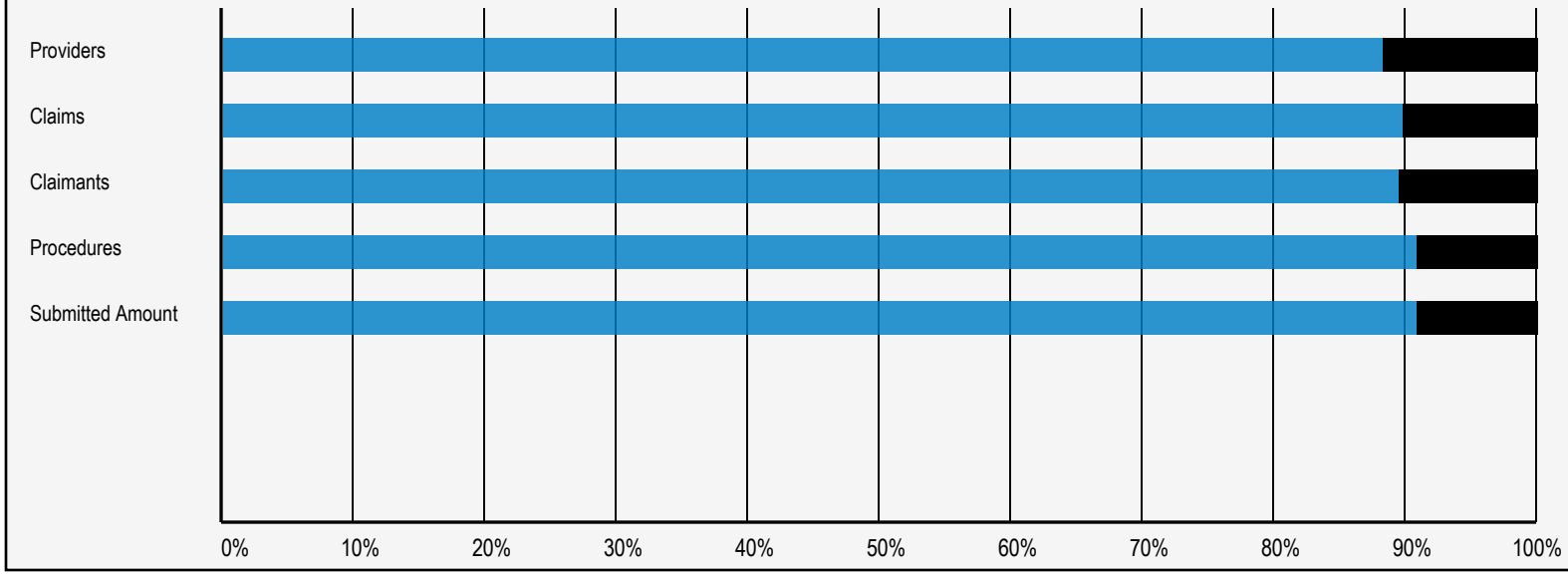
Overall Totals

Category	Matched	%	Not	%
Providers	717	88.2	95	11.8
Claims	18,131	89.7	2,058	10.3
Claimants	10,670	89.4	1,275	10.6
Procedures	52,482	90.8	5,189	9.2
Submitted Amount	$7,296,450	90.8	$735,719	9.2

Dentists Matched and Unmatched



Overall Percentages



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Disruption Network Overview

July 28, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

DPPO - w/TIN Only and NPI Only

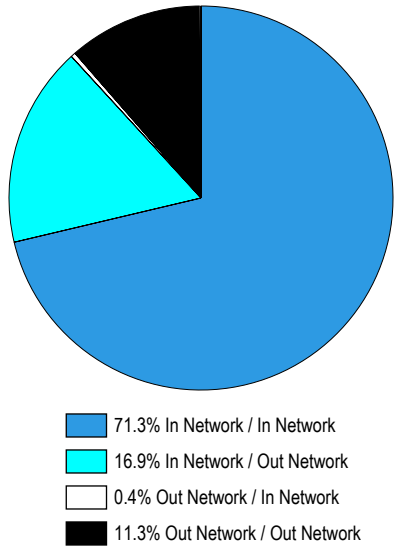
Matching...
Incumbent

Against...
Blue Stack With GRID Inc Non Pubs

Overall Totals

Category	Totals	Against Group		Matching Group	
		# Matched	% Matched	# In Network	% In Network
Providers	812	717	88.2	583	71.8
Claims	20,189	18,131	89.7	17,087	84.6
Claimants	11,945	10,670	89.4	10,022	83.9
Procedures	57,671	52,482	90.8	50,122	86.9
Submitted Amount	$8,032,169	$7,296,450	90.8	$6,899,652	85.9

Providers



Blue Stack With GRID Inc Non Pubs / Incumbent

Category	Totals	In Network / In Network		In Network / Out Network		Out Network / In Network		Out Network / Out Network	
		# Matched	% Matched	# Matched	% Matched	# Matched	% Matched	# Matched	% Matched
Providers	812	580	71.3	137	16.9	3	0.4	92	11.3
Claims	20,189	16,791	83.2	1,340	6.5	296	1.5	1,762	8.7
Claimants	11,945	9,802	82.1	868	7.3	220	1.8	1,055	8.8
Procedures	57,671	49,193	85.2	3,289	5.6	929	1.6	4,260	7.4
Submitted Amount	$8,032,169	$6,823,129	84.9	$473,321	5.9	$76,523	1.0	$659,196	8.2

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Disruption Summary By CBSA

July 28, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

DPPO - w/TIN Only and NPI Only

Matching...
Incumbent

Against...
Blue Stack With GRID Inc Non Pubs

Matching Passes:
1: TIN, Name, Facility, Location (Latitude & Longitude)
2: TIN, Name, Location (Latitude & Longitude)
3: TIN, NPI (Type1), Location (Latitude & Longitude)
4: Name, Facility, Location (Latitude & Longitude)
5: TIN, Facility, Location (Latitude & Longitude)
6: Name, Location (Latitude & Longitude)
7: NPI (Type 1), Location (Latitude & Longitude)
8: TIN, Location (Latitude & Longitude)
9: Name, Facility, ZIP
10: NPI (Type 1), Facility, ZIP
11: TIN, Facility, ZIP
12: TIN, Partial Name, ZIP
13: TIN, Partial Address, ZIP
14: Name, ZIP
15: Name, City, State
16: NPI (Type 1), ZIP
17: TIN, ZIP
18: TIN, NPI (Type 1)
19: NPI (Type 1) Only
20: TIN Only

Overall Results

Disruption Pass	Dentists Processed	Dentists				Submitted Amount			
		Matched	%	Not	%	Matched	%	Not	%
TIN, Name, Facility, Location (Latitude & Longitude)	812	607	74.8	205	25.2	$6,775,850	84.4	$1,256,319	15.6
TIN, Name, Location (Latitude & Longitude)	205	10	1.2	195	24.0	$57,165	0.7	$1,199,154	14.9
TIN, NPI (Type1), Location (Latitude & Longitude)	195	0	0.0	195	24.0	$0	0.0	$1,199,154	14.9
Name, Facility, Location (Latitude & Longitude)	195	1	0.1	194	23.9	$392	0.0	$1,198,762	14.9
TIN, Facility, Location (Latitude & Longitude)	194	69	8.5	125	15.4	$307,623	3.8	$891,139	11.1
Name, Location (Latitude & Longitude)	125	5	0.6	120	14.8	$12,802	0.2	$878,337	10.9
NPI (Type 1), Location (Latitude & Longitude)	120	0	0.0	120	14.8	$0	0.0	$878,337	10.9
TIN, Location (Latitude & Longitude)	120	0	0.0	120	14.8	$0	0.0	$878,337	10.9
Name, Facility, ZIP	120	1	0.1	119	14.7	$9,056	0.1	$869,281	10.8
NPI (Type 1), Facility, ZIP	119	0	0.0	119	14.7	$0	0.0	$869,281	10.8
TIN, Facility, ZIP	119	0	0.0	119	14.7	$0	0.0	$869,281	10.8
TIN, Partial Name, ZIP	119	2	0.2	117	14.4	$3,942	0.0	$865,339	10.8
TIN, Partial Address, ZIP	117	0	0.0	117	14.4	$0	0.0	$865,339	10.8
Name, ZIP	117	1	0.1	116	14.3	$1,410	0.0	$863,929	10.8
Name, City, State	116	17	2.1	99	12.2	$107,583	1.3	$756,346	9.4
NPI (Type 1), ZIP	99	0	0.0	99	12.2	$0	0.0	$756,346	9.4
TIN, ZIP	99	1	0.1	98	12.1	$4,945	0.1	$751,401	9.4
TIN, NPI (Type 1)	98	0	0.0	98	12.1	$0	0.0	$751,401	9.4
NPI (Type 1) Only	98	0	0.0	98	12.1	$0	0.0	$751,401	9.4
TIN Only	98	3	0.4	95	11.8	$15,682	0.2	$735,719	9.2
Totals	812	717	88.2	95	11.8	$7,296,450	90.8	$735,719	9.2

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Continued on next page...

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Disruption Summary By CBSA

July 28, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

DPPO - w/TIN Only and NPI Only

Matching...
Incumbent

Against...
Blue Stack With GRID Inc Non Pubs

Matching Passes:
1: TIN, Name, Facility, Location (Latitude & Longitude)
2: TIN, Name, Location (Latitude & Longitude)
3: TIN, NPI (Type1), Location (Latitude & Longitude)
4: Name, Facility, Location (Latitude & Longitude)
5: TIN, Facility, Location (Latitude & Longitude)
6: Name, Location (Latitude & Longitude)
7: NPI (Type 1), Location (Latitude & Longitude)
8: TIN, Location (Latitude & Longitude)
9: Name, Facility, ZIP
10: NPI (Type 1), Facility, ZIP
11: TIN, Facility, ZIP
12: TIN, Partial Name, ZIP
13: TIN, Partial Address, ZIP
14: Name, ZIP
15: Name, City, State
16: NPI (Type 1), ZIP
17: TIN, ZIP
18: TIN, NPI (Type 1)
19: NPI (Type 1) Only
20: TIN Only

Key Geographic Areas

	CBSA	Total Dentists	Dentists Matched	Dentists %	Dentists Not	Dentists %	Submitted Amount Matched	Submitted Amount %	Submitted Amount Not	Submitted Amount %
Key Areas Sorted by Matched	Albuquerque, NM MSA	683	617	90.3	66	9.7	$7,187,873	91.0	$709,651	9.0
	Santa Fe, NM MSA	29	22	75.9	7	24.1	$44,314	93.4	$3,126	6.6
	Las Cruces, NM MSA	9	8	88.9	1	11.1	$3,743	91.9	$332	8.1
	Washington-Arlington-Alexandria, DC-VA-MD-WV MSA	6	6	100.0	0	0.0	$6,146	100.0	$0	0.0
	{Not in CBSA}	7	6	85.7	1	14.3	$7,000	98.0	$140	2.0
	Phoenix-Mesa-Glendale, AZ MSA	8	6	75.0	2	25.0	$4,207	87.2	$617	12.8
	Farmington, NM MSA	4	4	100.0	0	0.0	$2,891	100.0	$0	0.0
	Punta Gorda, FL MSA	4	4	100.0	0	0.0	$2,272	100.0	$0	0.0
	Las Vegas-Paradise, NV MSA	5	4	80.0	1	20.0	$342	25.5	$1,000	74.5
	Espanola, NM	3	3	100.0	0	0.0	$3,479	100.0	$0	0.0
	Los Angeles-Long Beach-Santa Ana, CA MSA	3	3	100.0	0	0.0	$3,300	100.0	$0	0.0
	San Antonio-New Braunfels, TX MSA	3	3	100.0	0	0.0	$5,463	100.0	$0	0.0
	Taos, NM	3	3	100.0	0	0.0	$827	100.0	$0	0.0
	Grants, NM	4	3	75.0	1	25.0	$5,022	85.0	$889	15.0
	Boise City-Nampa, ID MSA	2	2	100.0	0	0.0	$1,625	100.0	$0	0.0
	Deming, NM	2	2	100.0	0	0.0	$559	100.0	$0	0.0
	Alamogordo, NM	1	1	100.0	0	0.0	$64	100.0	$0	0.0
	Boston-Cambridge-Quincy, MA-NH MSA	1	1	100.0	0	0.0	$1,120	100.0	$0	0.0
	Cincinnati-Middletown, OH-KY-IN MSA	1	1	100.0	0	0.0	$414	100.0	$0	0.0
	Denver-Aurora-Broomfield, CO MSA	1	1	100.0	0	0.0	$393	100.0	$0	0.0

	CBSA	Total Dentists	Dentists Matched	Dentists %	Dentists Not	Dentists %	Submitted Amount Matched	Submitted Amount %	Submitted Amount Not	Submitted Amount %
Key Areas Sorted by Not Matched	Albuquerque, NM MSA	683	617	90.3	66	9.7	$7,187,873	91.0	$709,651	9.0
	Santa Fe, NM MSA	29	22	75.9	7	24.1	$44,314	93.4	$3,126	6.6
	San Diego-Carlsbad-San Marcos, CA MSA	3	0	0.0	3	100.0	$0	0.0	$2,289	100.0
	Chicago-Joliet-Naperville, IL-IN-WI MSA	2	0	0.0	2	100.0	$0	0.0	$634	100.0
	Dallas-Fort Worth-Arlington, TX MSA	3	1	33.3	2	66.7	$857	17.4	$4,062	82.6
	Phoenix-Mesa-Glendale, AZ MSA	8	6	75.0	2	25.0	$4,207	87.2	$617	12.8
	Austin-Round Rock-San Marcos, TX MSA	1	0	0.0	1	100.0	$0	0.0	$3,355	100.0
	Boulder, CO MSA	1	0	0.0	1	100.0	$0	0.0	$1,216	100.0
	Brownsville-Harlingen, TX MSA	1	0	0.0	1	100.0	$0	0.0	$5,454	100.0
	Los Alamos, NM	1	0	0.0	1	100.0	$0	0.0	$434	100.0
	Stockton, CA MSA	1	0	0.0	1	100.0	$0	0.0	$508	100.0
	Colorado Springs, CO MSA	2	1	50.0	1	50.0	$1,308	49.9	$1,314	50.1
	Grand Junction, CO MSA	2	1	50.0	1	50.0	$912	61.0	$583	39.0
	Lubbock, TX MSA	2	1	50.0	1	50.0	$223	66.0	$115	34.0
	Milwaukee-Waukesha-West Allis, WI MSA	2	1	50.0	1	50.0	$485	100.0	$0	0.0
	Grants, NM	4	3	75.0	1	25.0	$5,022	85.0	$889	15.0
	Las Vegas-Paradise, NV MSA	5	4	80.0	1	20.0	$342	25.5	$1,000	74.5
	{Not in CBSA}	7	6	85.7	1	14.3	$7,000	98.0	$140	2.0
	Las Cruces, NM MSA	9	8	88.9	1	11.1	$3,743	91.9	$332	8.1

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BlueCross BlueShield of New Mexico

BlueCare Dental℠

GEO Access Report Summary

August 15, 2025

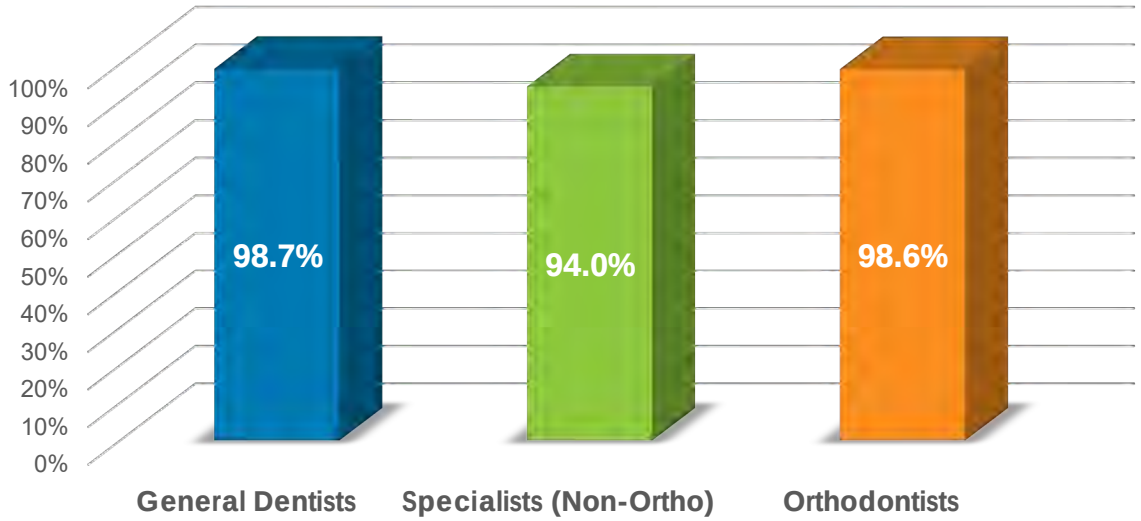
Network Used in Analysis: BlueCare Dental

Total Network Dentist Access Points: 810,668

Group: City of Albuquerque

Census Count: 7,742

Access Summary



Provider Description	Access Standard	Census Count	Members with Access	% With Access
General Dentists	2 providers within 10 miles	7,742	7,638	98.7%
Specialists*	2 providers within 10 miles	7,742	7,278	94%
Orthodontists	2 providers within 15 miles	7,742	7,633	98.6%

** Endodontist, Oral Surgeon, Pedodontist, Periodontist, Prosthodontist*

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BlueCross BlueShield of New Mexico

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Dental Accessibility Analysis

A report on the accessibility of the

Dental PPO Network

Created for...

City of Albuquerque

Created by...

Blue Cross and Blue Shield of New Mexico (BCBSNM)

August 15, 2025

Created with the Quest Analytics Suite

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Access Summary By Specialty

August 15, 2025

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City of Albuquerque

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Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

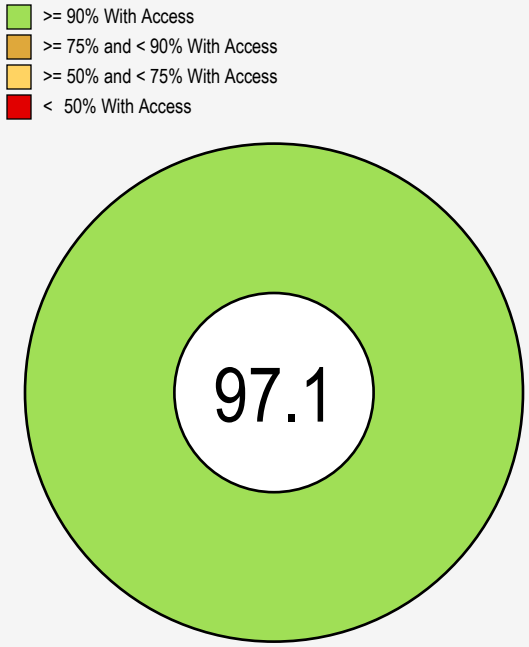
Distance Method
Estimated Driving Distance

Employee Group
All

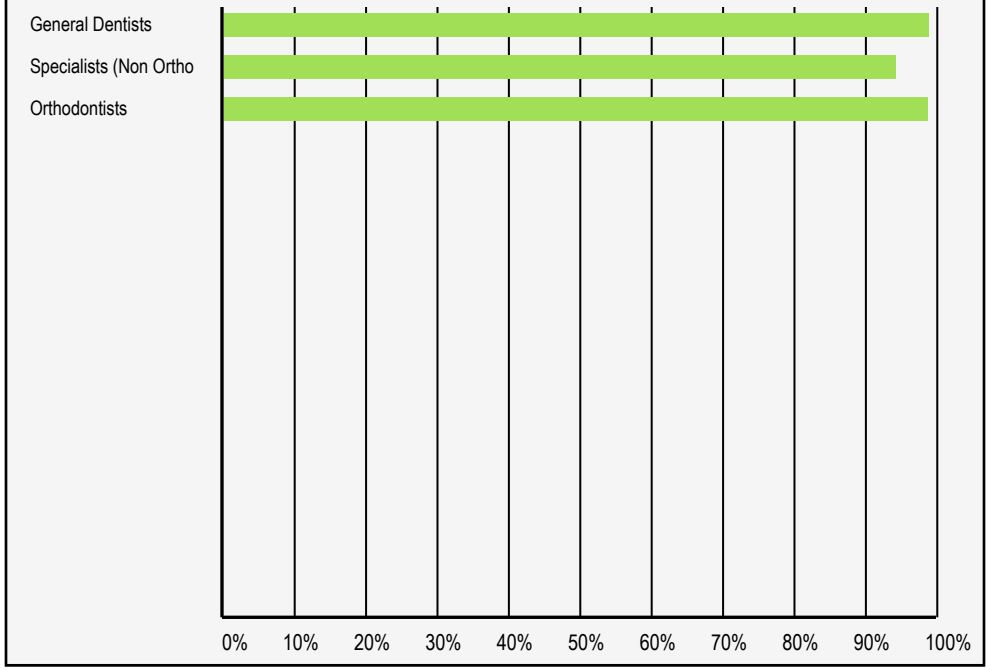
Provider Group
General Dentists
Specialists (Non Ortho)
Orthodontists

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

Overall Access



Overall Access by Provider



Access Summary By Specialty

Employee		Provider		With Access		Counts[1]			Average Distance				
Group	#	Group	Standard	#	%	#	P	L	1	2	3	4	5
All	7,742	General Dentists	2 in 10 miles	7,638	98.7	613,368	130,088	86,847	1.2	1.2	1.4	1.5	1.6
		Specialists (Non Ort…	2 in 10 miles	7,278	94.0	139,405	22,642	29,315	1.8	2.0	2.2	2.2	2.3
		Orthodontists	2 in 15 miles	7,633	98.6	57,895	8,042	17,158	2.2	2.4	2.5	2.7	2.9

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Access Summary By State - Employees With Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee Group
All

Provider Group
General Dentists
Specialists (Non Ortho)
Orthodontists

[1] Provider counts represent:
#: Provider access points
P: Unique providers
L: Unique provider locations

All Employees

Employee		Provider		With Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	P	L	1	2
All	7,742	General Dentists	2 in 10 miles	7,638	98.7	613,368	130,088	86,847	1.2	1.2
		Specialists (Non Ortho)	2 in 10 miles	7,278	94.0	139,405	22,642	29,315	1.8	2.0
		Orthodontists	2 in 15 miles	7,633	98.6	57,895	8,042	17,158	2.2	2.4

Key Geographic Areas

State Name	Employee	Provider		With Access		Average Distance	
	#	Group	Standard	#	%	1	2
New Mexico	7,740	General Dentists	2 in 10 miles	7,637	98.7	1.2	1.2
		Orthodontists	2 in 15 miles	7,632	98.6	2.2	2.4
		Specialists (Non Ortho)	2 in 10 miles	7,277	94.0	1.8	2.0
South Carolina	1	General Dentists	2 in 10 miles	1	100.0	1.1	1.1
		Orthodontists	2 in 15 miles	1	100.0	7.3	7.5
		Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.2	1.2

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Access Summary By State - Employees Without Access

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Access Analysis
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Distance Method
Estimated Driving Distance

Employee Group
All

Provider Group
General Dentists
Specialists (Non Ortho)
Orthodontists

[1] Provider counts represent:
#: Provider access points
P: Unique providers
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All Employees

Employee		Provider		Without Access		Counts[1]			Average Distance	
Group	#	Group	Standard	#	%	#	P	L	1	2
All	7,742	General Dentists	2 in 10 miles	104	1.3	613,368	130,088	86,847	16.7	17.2
		Specialists (Non Ortho)	2 in 10 miles	464	6.0	139,405	22,642	29,315	18.3	19.3
		Orthodontists	2 in 15 miles	109	1.4	57,895	8,042	17,158	25.2	26.3

Key Geographic Areas

State Name	Employee	Provider		Without Access		Average Distance	
	#	Group	Standard	#	%	1	2
New Mexico	7,740	Specialists (Non Ortho)	2 in 10 miles	463	6.0	18.2	19.2
		Orthodontists	2 in 15 miles	108	1.4	24.7	25.4
		General Dentists	2 in 10 miles	103	1.3	16.7	17.2
Montana	1	General Dentists	2 in 10 miles	1	100.0	15.0	15.0
		Orthodontists	2 in 15 miles	1	100.0	83.2	123.8
		Specialists (Non Ortho)	2 in 10 miles	1	100.0	70.3	74.4

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Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	Bernalillo	Albuquerque	87101	1	General Dentists	2 in 10 miles	1	100.0	0.7	0.7
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.6	2.5
					Orthodontists	2 in 15 miles	1	100.0	3.8	4.0
			87102	412	General Dentists	2 in 10 miles	412	100.0	0.5	0.7
					Specialists (Non Ortho)	2 in 10 miles	412	100.0	2.4	3.3
					Orthodontists	2 in 15 miles	412	100.0	3.5	3.5
			87103	4	General Dentists	2 in 10 miles	4	100.0	0.4	0.5
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	2.2	3.6
					Orthodontists	2 in 15 miles	4	100.0	3.6	3.6
			87104	129	General Dentists	2 in 10 miles	129	100.0	0.8	0.9
					Specialists (Non Ortho)	2 in 10 miles	129	100.0	2.0	2.1
					Orthodontists	2 in 15 miles	129	100.0	2.0	2.2
			87105	661	General Dentists	2 in 10 miles	661	100.0	1.3	1.3
					Specialists (Non Ortho)	2 in 10 miles	661	100.0	2.6	2.6
					Orthodontists	2 in 15 miles	661	100.0	2.0	2.0
			87106	163	General Dentists	2 in 10 miles	163	100.0	1.0	1.1
					Specialists (Non Ortho)	2 in 10 miles	163	100.0	1.4	2.3
					Orthodontists	2 in 15 miles	163	100.0	2.4	2.4
			87107	299	General Dentists	2 in 10 miles	299	100.0	0.8	0.9
					Specialists (Non Ortho)	2 in 10 miles	299	100.0	1.6	1.6
					Orthodontists	2 in 15 miles	299	100.0	2.6	2.8
			87108	174	General Dentists	2 in 10 miles	174	100.0	0.4	0.5
					Specialists (Non Ortho)	2 in 10 miles	174	100.0	1.1	1.1
					Orthodontists	2 in 15 miles	174	100.0	0.9	1.0
			87109	251	General Dentists	2 in 10 miles	251	100.0	0.5	0.6
					Specialists (Non Ortho)	2 in 10 miles	251	100.0	0.7	0.8
					Orthodontists	2 in 15 miles	251	100.0	0.8	1.0
			87110	324	General Dentists	2 in 10 miles	324	100.0	0.4	0.5
					Specialists (Non Ortho)	2 in 10 miles	324	100.0	0.7	0.7
					Orthodontists	2 in 15 miles	324	100.0	0.8	1.0
			87111	321	General Dentists	2 in 10 miles	321	100.0	0.5	0.6
					Specialists (Non Ortho)	2 in 10 miles	321	100.0	0.9	1.0
					Orthodontists	2 in 15 miles	321	100.0	1.4	1.5
			87112	295	General Dentists	2 in 10 miles	295	100.0	0.8	0.8
					Specialists (Non Ortho)	2 in 10 miles	295	100.0	1.6	1.6
					Orthodontists	2 in 15 miles	295	100.0	1.7	1.8
			87113	129	General Dentists	2 in 10 miles	129	100.0	1.1	1.1
					Specialists (Non Ortho)	2 in 10 miles	129	100.0	1.3	1.3
					Orthodontists	2 in 15 miles	129	100.0	1.5	1.7
			87114	714	General Dentists	2 in 10 miles	714	100.0	0.9	1.0

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Access Detail By Zip Code - Employees With Access

August 15, 2025

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City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	Bernalillo	Albuquerque	87114	714	Specialists (Non Ortho)	2 in 10 miles	714	100.0	1.8	2.1
					Orthodontists	2 in 15 miles	714	100.0	1.4	1.5
			87116	5	General Dentists	2 in 10 miles	5	100.0	1.1	1.1
					Specialists (Non Ortho)	2 in 10 miles	5	100.0	1.8	1.8
					Orthodontists	2 in 15 miles	5	100.0	1.6	1.7
			87119	1	General Dentists	2 in 10 miles	1	100.0	2.3	2.3
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	3.0	4.4
					Orthodontists	2 in 15 miles	1	100.0	4.0	4.0
			87120	769	General Dentists	2 in 10 miles	769	100.0	0.7	0.8
					Specialists (Non Ortho)	2 in 10 miles	769	100.0	1.2	1.4
					Orthodontists	2 in 15 miles	769	100.0	1.2	1.5
			87121	898	General Dentists	2 in 10 miles	898	100.0	1.5	1.5
					Specialists (Non Ortho)	2 in 10 miles	898	100.0	1.7	2.2
					Orthodontists	2 in 15 miles	898	100.0	1.6	2.1
			87122	71	General Dentists	2 in 10 miles	71	100.0	1.1	1.1
					Specialists (Non Ortho)	2 in 10 miles	71	100.0	2.0	2.1
					Orthodontists	2 in 15 miles	71	100.0	1.9	2.2
			87123	268	General Dentists	2 in 10 miles	268	100.0	0.9	0.9
					Specialists (Non Ortho)	2 in 10 miles	268	100.0	1.0	1.2
					Orthodontists	2 in 15 miles	268	100.0	1.1	2.0
			87125	7	General Dentists	2 in 10 miles	7	100.0	0.7	0.7
					Specialists (Non Ortho)	2 in 10 miles	7	100.0	1.6	2.5
					Orthodontists	2 in 15 miles	7	100.0	3.8	4.0
			87154	2	General Dentists	2 in 10 miles	2	100.0	0.2	0.2
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	0.2	0.2
					Orthodontists	2 in 15 miles	2	100.0	0.2	0.2
			87176	3	General Dentists	2 in 10 miles	3	100.0	0.3	0.3
					Specialists (Non Ortho)	2 in 10 miles	3	100.0	1.2	1.2
					Orthodontists	2 in 15 miles	3	100.0	0.6	0.6
			87184	6	General Dentists	2 in 10 miles	6	100.0	1.5	1.5
					Specialists (Non Ortho)	2 in 10 miles	6	100.0	2.5	2.5
					Orthodontists	2 in 15 miles	6	100.0	2.5	3.1
			87187	1	General Dentists	2 in 10 miles	1	100.0	0.2	0.2
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	0.3	0.3
					Orthodontists	2 in 15 miles	1	100.0	0.3	0.5
			87191	1	General Dentists	2 in 10 miles	1	100.0	0.2	0.2
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	0.2	0.2
					Orthodontists	2 in 15 miles	1	100.0	0.2	0.2
			87193	2	General Dentists	2 in 10 miles	2	100.0	0.7	0.7
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	0.7	0.7

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Access Detail By Zip Code - Employees With Access

August 15, 2025

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Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	Bernalillo	Albuquerque	87193	2	Orthodontists	2 in 15 miles	2	100.0	0.7	0.7
			87194	1	General Dentists	2 in 10 miles	1	100.0	0.7	0.7
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	2.7	2.7
					Orthodontists	2 in 15 miles	1	100.0	2.6	2.6
			87196	2	General Dentists	2 in 10 miles	2	100.0	0.6	0.6
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	0.6	2.0
					Orthodontists	2 in 15 miles	2	100.0	2.2	2.3
			87199	4	General Dentists	2 in 10 miles	4	100.0	0.3	0.3
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	1.0	1.1
					Orthodontists	2 in 15 miles	4	100.0	1.1	1.6
		Cedar Crest	87008	17	General Dentists	2 in 10 miles	17	100.0	2.7	2.7
					Specialists (Non Ortho)	2 in 10 miles	17	100.0	8.2	8.2
					Orthodontists	2 in 15 miles	17	100.0	9.6	9.6
		Edgewood	87015	15	General Dentists	2 in 10 miles	12	80.0	5.9	6.2
					Orthodontists	2 in 15 miles	15	100.0	7.5	7.5
		Isleta	87022	2	General Dentists	2 in 10 miles	2	100.0	1.4	1.4
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	6.8	8.9
					Orthodontists	2 in 15 miles	2	100.0	8.5	8.5
		Kirtland AFB	87117	2	General Dentists	2 in 10 miles	2	100.0	1.5	1.5
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	2.2	2.2
					Orthodontists	2 in 15 miles	2	100.0	1.8	2.2
		Sandia Park	87047	19	General Dentists	2 in 10 miles	19	100.0	3.2	3.2
					Orthodontists	2 in 15 miles	19	100.0	11.4	11.6
		Tijeras	87059	80	General Dentists	2 in 10 miles	64	80.0	3.9	4.0
					Specialists (Non Ortho)	2 in 10 miles	6	7.5	8.7	9.0
					Orthodontists	2 in 15 miles	79	98.8	9.2	9.2
	Cibola	Grants	87020	4	General Dentists	2 in 10 miles	4	100.0	2.0	2.0
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	2.0	2.0
					Orthodontists	2 in 15 miles	4	100.0	1.4	2.0
	Curry	Clovis	88101	2	General Dentists	2 in 10 miles	2	100.0	0.6	0.6
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	2.4	2.9
					Orthodontists	2 in 15 miles	2	100.0	1.9	1.9
	Dona Ana	Las Cruces	88011	1	General Dentists	2 in 10 miles	1	100.0	0.5	0.8
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	0.5	0.5
					Orthodontists	2 in 15 miles	1	100.0	0.8	0.8
	Grant	Silver City	88061	1	General Dentists	2 in 10 miles	1	100.0	0.3	0.3
	Guadalupe	Santa Rosa	88435	1	General Dentists	2 in 10 miles	1	100.0	0.8	0.8
	Los Alamos	Los Alamos	87544	1	General Dentists	2 in 10 miles	1	100.0	0.5	0.5
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	0.2	0.5
					Orthodontists	2 in 15 miles	1	100.0	0.2	0.4

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Access Analysis
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Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	McKinley	Gallup	87305	1	General Dentists	2 in 10 miles	1	100.0	0.8	0.8
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.1	1.1
					Orthodontists	2 in 15 miles	1	100.0	1.1	1.1
	Mora	Rainsville	87736	1	General Dentists	2 in 10 miles	1	100.0	6.1	6.1
	Rio Arriba	Espanola	87532	2	General Dentists	2 in 10 miles	2	100.0	1.9	1.9
					Orthodontists	2 in 15 miles	2	100.0	1.7	1.7
	San Juan	Farmington	87401	1	General Dentists	2 in 10 miles	1	100.0	0.6	0.7
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	2.1	2.2
					Orthodontists	2 in 15 miles	1	100.0	0.7	1.5
	San Miguel	Las Vegas	87701	2	General Dentists	2 in 10 miles	2	100.0	0.9	0.9
					Orthodontists	2 in 15 miles	2	100.0	1.9	1.9
	Sandoval	Algodones	87001	12	General Dentists	2 in 10 miles	11	91.7	1.0	3.3
					Specialists (Non Ortho)	2 in 10 miles	3	25.0	8.8	9.0
					Orthodontists	2 in 15 miles	11	91.7	10.5	10.5
		Bernalillo	87004	83	General Dentists	2 in 10 miles	83	100.0	0.8	0.8
					Specialists (Non Ortho)	2 in 10 miles	83	100.0	1.2	1.2
					Orthodontists	2 in 15 miles	83	100.0	0.9	1.5
		Cochiti Lake	87083	2	General Dentists	2 in 10 miles	2	100.0	1.3	5.8
		Corrales	87048	52	General Dentists	2 in 10 miles	52	100.0	2.0	2.0
					Specialists (Non Ortho)	2 in 10 miles	52	100.0	2.0	2.1
					Orthodontists	2 in 15 miles	52	100.0	2.0	2.2
		Cuba	87013	2	General Dentists	2 in 10 miles	2	100.0	3.8	3.8
		Pena Blanca	87041	5	General Dentists	2 in 10 miles	5	100.0	2.8	6.5
		Placitas	87043	12	General Dentists	2 in 10 miles	12	100.0	2.8	4.4
					Specialists (Non Ortho)	2 in 10 miles	11	91.7	5.2	5.2
					Orthodontists	2 in 15 miles	12	100.0	4.7	4.8
		Rio Rancho	87124	421	General Dentists	2 in 10 miles	421	100.0	1.0	1.0
					Specialists (Non Ortho)	2 in 10 miles	421	100.0	1.3	1.4
					Orthodontists	2 in 15 miles	421	100.0	1.3	1.7
			87144	335	General Dentists	2 in 10 miles	335	100.0	2.8	2.8
					Specialists (Non Ortho)	2 in 10 miles	335	100.0	3.6	3.7
					Orthodontists	2 in 15 miles	335	100.0	3.6	4.1
			87174	1	General Dentists	2 in 10 miles	1	100.0	0.6	0.6
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.0	1.0
					Orthodontists	2 in 15 miles	1	100.0	1.4	1.4
		Sandia Park	87047	9	General Dentists	2 in 10 miles	7	77.8	6.2	6.2
					Orthodontists	2 in 15 miles	5	55.6	13.6	13.9
		Santo Domingo P…	87052	1	General Dentists	2 in 10 miles	1	100.0	5.3	9.7
	Santa Fe	Edgewood	87015	89	General Dentists	2 in 10 miles	89	100.0	2.5	2.8
					Orthodontists	2 in 15 miles	89	100.0	3.5	3.8

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Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	Santa Fe	Espanola	87532	1	General Dentists	2 in 10 miles	1	100.0	1.2	1.2
					Orthodontists	2 in 15 miles	1	100.0	2.3	2.3
		Lamy	87540	1	Orthodontists	2 in 15 miles	1	100.0	13.5	13.5
		Moriarty	87035	2	General Dentists	2 in 10 miles	2	100.0	7.0	7.9
					Orthodontists	2 in 15 miles	2	100.0	7.0	7.9
		Sandia Park	87047	4	General Dentists	2 in 10 miles	3	75.0	8.7	8.7
					Orthodontists	2 in 15 miles	4	100.0	11.2	11.2
		Santa Fe	87501	4	General Dentists	2 in 10 miles	4	100.0	1.7	1.7
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	3.2	3.2
					Orthodontists	2 in 15 miles	4	100.0	2.5	2.5
			87505	5	General Dentists	2 in 10 miles	5	100.0	0.7	0.7
					Specialists (Non Ortho)	2 in 10 miles	5	100.0	0.7	0.7
					Orthodontists	2 in 15 miles	5	100.0	0.7	0.8
			87506	2	General Dentists	2 in 10 miles	2	100.0	6.4	6.4
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	7.9	7.9
					Orthodontists	2 in 15 miles	2	100.0	7.5	7.7
			87507	9	General Dentists	2 in 10 miles	9	100.0	1.5	1.5
					Specialists (Non Ortho)	2 in 10 miles	9	100.0	1.4	1.4
					Orthodontists	2 in 15 miles	9	100.0	1.6	1.6
			87509	1	General Dentists	2 in 10 miles	1	100.0	0.4	0.4
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	0.6	0.6
					Orthodontists	2 in 15 miles	1	100.0	0.1	0.2
		Stanley	87056	4	General Dentists	2 in 10 miles	1	25.0	9.3	9.3
					Orthodontists	2 in 15 miles	3	75.0	11.7	12.3
	Sierra	Truth or Consequ...	87901	1	General Dentists	2 in 10 miles	1	100.0	0.4	1.5
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.5	1.5
	Socorro	Lemitar	87823	1	General Dentists	2 in 10 miles	1	100.0	7.9	7.9
					Orthodontists	2 in 15 miles	1	100.0	8.5	8.5
		Socorro	87801	4	General Dentists	2 in 10 miles	4	100.0	1.0	1.3
					Orthodontists	2 in 15 miles	4	100.0	1.8	1.8
	Taos	Chamisal	87521	1	General Dentists	2 in 10 miles	1	100.0	0.4	0.4
	Torrance	Edgewood	87015	23	General Dentists	2 in 10 miles	23	100.0	3.3	3.9
					Orthodontists	2 in 15 miles	23	100.0	3.3	3.7
		Estancia	87016	16	General Dentists	2 in 10 miles	8	50.0	6.6	6.6
					Orthodontists	2 in 15 miles	1	6.2	14.3	14.3
		McIntosh	87032	1	General Dentists	2 in 10 miles	1	100.0	7.1	7.1
		Moriarty	87035	18	General Dentists	2 in 10 miles	3	16.7	7.2	8.2
					Orthodontists	2 in 15 miles	13	72.2	11.0	11.9
	Valencia	Belen	87002	120	General Dentists	2 in 10 miles	117	97.5	1.9	2.1
					Specialists (Non Ortho)	2 in 10 miles	28	23.3	8.1	8.2

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Access Detail By Zip Code - Employees With Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees With Access

State Abbr	County	City	Zip Code	Employee #	Provider Group	Provider Standard	With Access #	With Access %	Average Distance 1	Average Distance 2
NM	Valencia	Belen	87002	120	Orthodontists	2 in 15 miles	108	90.0	11.0	11.0
		Bosque Farms	87068	55	General Dentists	2 in 10 miles	55	100.0	1.0	1.0
					Specialists (Non Ortho)	2 in 10 miles	55	100.0	3.2	5.4
					Orthodontists	2 in 15 miles	55	100.0	5.1	5.1
		Jarales	87023	5	General Dentists	2 in 10 miles	3	60.0	4.7	4.7
					Orthodontists	2 in 15 miles	2	40.0	14.6	14.6
		Laguna	87026	4	General Dentists	2 in 10 miles	2	50.0	9.8	9.8
		Los Lunas	87031	287	General Dentists	2 in 10 miles	287	100.0	2.7	2.7
					Specialists (Non Ortho)	2 in 10 miles	280	97.6	3.3	3.4
					Orthodontists	2 in 15 miles	287	100.0	3.3	3.3
		Peralta	87042	30	General Dentists	2 in 10 miles	30	100.0	1.0	1.8
					Specialists (Non Ortho)	2 in 10 miles	30	100.0	3.2	4.3
					Orthodontists	2 in 15 miles	30	100.0	4.0	4.0
		Tome	87060	1	General Dentists	2 in 10 miles	1	100.0	4.0	4.0
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	4.4	4.4
					Orthodontists	2 in 15 miles	1	100.0	4.4	4.4
SC	Lexington	West Columbia	29169	1	General Dentists	2 in 10 miles	1	100.0	1.1	1.1
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.2	1.2
					Orthodontists	2 in 15 miles	1	100.0	7.3	7.5
Grand T…				7,694	General Dentists	2 in 10 miles	7,638	99.3	1.2	1.2
				7,461	Specialists (Non Ortho)	2 in 10 miles	7,278	97.5	1.8	2.0
				7,675	Orthodontists	2 in 15 miles	7,633	99.5	2.2	2.4

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Access Detail By Zip Code - Employees Without Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees Without Access

State Abbr	County	City	Zip Code	Employee	Provider		Without Access		Average Distance	
				#	Group	Standard	#	%	1	2
MT	Flathead	Lakeside	59922	1	General Dentists	2 in 10 miles	1	100.0	15.0	15.0
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	70.3	74.4
					Orthodontists	2 in 15 miles	1	100.0	83.2	123.8
NM	Bernalillo	Edgewood	87015	15	General Dentists	2 in 10 miles	3	20.0	10.0	10.4
					Specialists (Non Ortho)	2 in 10 miles	15	100.0	16.6	16.7
		Sandia Park	87047	19	Specialists (Non Ortho)	2 in 10 miles	19	100.0	12.7	12.7
		Tijeras	87059	80	General Dentists	2 in 10 miles	16	20.0	12.0	12.1
					Specialists (Non Ortho)	2 in 10 miles	74	92.5	14.1	14.3
					Orthodontists	2 in 15 miles	1	1.2	15.3	15.3
	Cibola	Casa Blanca	87007	1	General Dentists	2 in 10 miles	1	100.0	22.1	22.1
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	25.9	25.9
					Orthodontists	2 in 15 miles	1	100.0	25.5	25.9
		Cubero	87014	2	General Dentists	2 in 10 miles	2	100.0	18.4	18.4
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	18.4	18.4
					Orthodontists	2 in 15 miles	2	100.0	17.9	18.4
		Laguna	87026	1	General Dentists	2 in 10 miles	1	100.0	36.1	36.1
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	36.1	36.1
					Orthodontists	2 in 15 miles	1	100.0	35.9	36.1
		New Laguna	87038	1	General Dentists	2 in 10 miles	1	100.0	18.9	18.9
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	27.8	27.8
					Orthodontists	2 in 15 miles	1	100.0	27.5	27.8
		Paguate	87040	1	General Dentists	2 in 10 miles	1	100.0	20.8	20.8
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	26.1	26.1
					Orthodontists	2 in 15 miles	1	100.0	26.1	26.1
		Pueblo of Acoma	87034	4	General Dentists	2 in 10 miles	4	100.0	20.6	20.6
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	20.6	20.6
					Orthodontists	2 in 15 miles	4	100.0	20.1	20.6
	Grant	Silver City	88061	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	1.0	57.1
					Orthodontists	2 in 15 miles	1	100.0	1.0	57.1
	Guadalupe	Santa Rosa	88435	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	92.9	93.8
					Orthodontists	2 in 15 miles	1	100.0	63.0	63.0
	McKinley	Prewitt	87045	1	General Dentists	2 in 10 miles	1	100.0	19.8	26.6
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	26.9	26.9
					Orthodontists	2 in 15 miles	1	100.0	26.6	26.9
		Thoreau	87323	1	General Dentists	2 in 10 miles	1	100.0	18.4	26.5
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	26.8	26.8
					Orthodontists	2 in 15 miles	1	100.0	26.5	26.8
		Zuni	87327	1	General Dentists	2 in 10 miles	1	100.0	29.0	32.1
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	32.3	32.3
					Orthodontists	2 in 15 miles	1	100.0	32.3	32.3

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Access Detail By Zip Code - Employees Without Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees Without Access

State Abbr	County	City	Zip Code	Employee	Provider		Without Access		Average Distance	
				#	Group	Standard	#	%	1	2
NM	Mora	Rainsville	87736	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	40.7	48.7
					Orthodontists	2 in 15 miles	1	100.0	27.7	27.7
	Rio Arriba	Espanola	87532	2	Specialists (Non Ortho)	2 in 10 miles	2	100.0	2.9	18.6
	San Miguel	Las Vegas	87701	2	Specialists (Non Ortho)	2 in 10 miles	2	100.0	41.6	41.7
		Ribera	87560	1	General Dentists	2 in 10 miles	1	100.0	27.6	27.6
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	45.4	45.4
					Orthodontists	2 in 15 miles	1	100.0	28.5	28.5
	Sandoval	Algodones	87001	12	General Dentists	2 in 10 miles	1	8.3	11.1	11.1
					Specialists (Non Ortho)	2 in 10 miles	9	75.0	14.0	14.1
					Orthodontists	2 in 15 miles	1	8.3	20.8	20.8
		Cochiti Lake	87083	2	Specialists (Non Ortho)	2 in 10 miles	2	100.0	17.1	17.1
					Orthodontists	2 in 15 miles	2	100.0	17.0	17.0
		Cuba	87013	2	Specialists (Non Ortho)	2 in 10 miles	2	100.0	51.9	52.1
					Orthodontists	2 in 15 miles	2	100.0	51.7	51.7
		Jemez Pueblo	87024	5	General Dentists	2 in 10 miles	5	100.0	23.9	24.9
					Specialists (Non Ortho)	2 in 10 miles	5	100.0	27.2	27.3
					Orthodontists	2 in 15 miles	5	100.0	27.2	27.2
		Jemez Springs	87025	4	General Dentists	2 in 10 miles	4	100.0	23.5	24.4
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	24.4	24.5
					Orthodontists	2 in 15 miles	4	100.0	24.2	24.2
		Pena Blanca	87041	5	Specialists (Non Ortho)	2 in 10 miles	5	100.0	18.9	18.9
					Orthodontists	2 in 15 miles	5	100.0	19.7	19.7
		Placitas	87043	12	Specialists (Non Ortho)	2 in 10 miles	1	8.3	10.3	10.5
		Ponderosa	87044	2	General Dentists	2 in 10 miles	2	100.0	20.1	22.8
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	25.7	25.9
					Orthodontists	2 in 15 miles	2	100.0	25.7	25.7
		San Ysidro	87053	2	General Dentists	2 in 10 miles	2	100.0	17.6	17.6
					Specialists (Non Ortho)	2 in 10 miles	2	100.0	19.0	19.0
					Orthodontists	2 in 15 miles	2	100.0	19.0	19.3
		Sandia Park	87047	9	General Dentists	2 in 10 miles	2	22.2	10.4	10.4
					Specialists (Non Ortho)	2 in 10 miles	9	100.0	16.4	16.4
					Orthodontists	2 in 15 miles	4	44.4	15.4	15.6
		Santo Domingo…	87052	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	22.2	22.2
					Orthodontists	2 in 15 miles	1	100.0	23.8	23.8
	Santa Fe	Edgewood	87015	89	Specialists (Non Ortho)	2 in 10 miles	89	100.0	17.7	17.9
		Espanola	87532	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	2.3	20.8
		Lamy	87540	1	General Dentists	2 in 10 miles	1	100.0	12.2	12.2
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	13.5	13.5
		Moriarty	87035	2	Specialists (Non Ortho)	2 in 10 miles	2	100.0	24.3	24.8
		Sandia Park	87047	4	General Dentists	2 in 10 miles	1	25.0	10.9	10.9

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Access Detail By Zip Code - Employees Without Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees Without Access

State Abbr	County	City	Zip Code	Employee	Provider		Without Access		Average Distance	
				#	Group	Standard	#	%	1	2
NM	Santa Fe	Sandia Park	87047	4	Specialists (Non Ortho)	2 in 10 miles	4	100.0	21.0	21.0
		Stanley	87056	4	General Dentists	2 in 10 miles	3	75.0	12.0	12.4
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	27.3	27.5
					Orthodontists	2 in 15 miles	1	25.0	14.9	15.3
	Sierra	Truth or Conseq...	87901	1	Orthodontists	2 in 15 miles	1	100.0	66.8	66.8
	Socorro	Bosque	87006	7	General Dentists	2 in 10 miles	7	100.0	16.4	17.4
					Specialists (Non Ortho)	2 in 10 miles	7	100.0	27.7	28.1
					Orthodontists	2 in 15 miles	7	100.0	27.8	27.8
		La Joya	87028	1	General Dentists	2 in 10 miles	1	100.0	21.4	21.4
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	22.6	34.0
					Orthodontists	2 in 15 miles	1	100.0	22.6	22.6
		Lemitar	87823	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	8.5	47.7
		Socorro	87801	4	Specialists (Non Ortho)	2 in 10 miles	4	100.0	1.8	53.9
	Taos	Chamisal	87521	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	21.2	28.4
					Orthodontists	2 in 15 miles	1	100.0	19.1	19.1
	Torrance	Edgewood	87015	23	Specialists (Non Ortho)	2 in 10 miles	23	100.0	18.6	19.0
		Estancia	87016	16	General Dentists	2 in 10 miles	8	50.0	13.0	13.0
					Specialists (Non Ortho)	2 in 10 miles	16	100.0	32.7	32.8
					Orthodontists	2 in 15 miles	15	93.8	22.6	23.1
		McIntosh	87032	1	Specialists (Non Ortho)	2 in 10 miles	1	100.0	34.7	34.8
					Orthodontists	2 in 15 miles	1	100.0	20.0	20.9
		Moriarty	87035	18	General Dentists	2 in 10 miles	15	83.3	12.6	13.4
					Specialists (Non Ortho)	2 in 10 miles	18	100.0	28.2	28.5
					Orthodontists	2 in 15 miles	5	27.8	16.4	17.3
		Mountainair	87036	10	General Dentists	2 in 10 miles	10	100.0	26.6	26.6
					Specialists (Non Ortho)	2 in 10 miles	10	100.0	40.3	40.3
					Orthodontists	2 in 15 miles	10	100.0	38.1	38.2
		Willard	87063	1	General Dentists	2 in 10 miles	1	100.0	12.8	12.8
					Specialists (Non Ortho)	2 in 10 miles	1	100.0	46.7	46.7
					Orthodontists	2 in 15 miles	1	100.0	36.5	37.2
	Valencia	Belen	87002	120	General Dentists	2 in 10 miles	3	2.5	13.8	13.8
					Specialists (Non Ortho)	2 in 10 miles	92	76.7	12.7	12.7
					Orthodontists	2 in 15 miles	12	10.0	17.7	17.7
		Jarales	87023	5	General Dentists	2 in 10 miles	2	40.0	15.7	15.7
					Specialists (Non Ortho)	2 in 10 miles	5	100.0	15.4	15.5
					Orthodontists	2 in 15 miles	3	60.0	16.2	16.2
		Laguna	87026	4	General Dentists	2 in 10 miles	2	50.0	12.0	12.0
					Specialists (Non Ortho)	2 in 10 miles	4	100.0	28.3	28.3
					Orthodontists	2 in 15 miles	4	100.0	28.3	28.3
		Los Lunas	87031	287	Specialists (Non Ortho)	2 in 10 miles	7	2.4	10.7	10.7

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Access Detail By Zip Code - Employees Without Access

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Access Analysis
Multiple Access Standards (All Employees - General Dentists, Orthodontists and Specialists)

Distance Method
Estimated Driving Distance

Employee / Provider Groups
All
General Dentists
Specialists (Non Ortho)
Orthodontists

All Employees Without Access

State Abbr	County	City	Zip Code	Employee	Provider		Without Access		Average Distance	
				#	Group	Standard	#	%	1	2
Grand T…				335	General Dentists	2 in 10 miles	104	31.0	16.7	17.2
				792	Specialists (Non Ortho)	2 in 10 miles	464	58.6	18.3	19.3
				331	Orthodontists	2 in 15 miles	109	32.9	25.2	26.3

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Provider Count By 3-Digit Zip Code

August 15, 2025

Created for...
City of Albuquerque

Created by...
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Provider Group
General Dentists
Orthodontists
Specialists (Non Ortho)

[1] Provider counts represent:
P: Unique Providers
L: Unique Locations

All Providers			
3-Digit Zip Code	Provider Group	Counts P	Counts L
870	General Dentists	244	49
	Orthodontists	32	11
	Specialists (Non Ortho)	28	8
871	General Dentists	591	205
	Orthodontists	53	58
	Specialists (Non Ortho)	78	71
873	General Dentists	85	14
	Orthodontists	16	3
	Specialists (Non Ortho)	15	3
Grand Totals	General Dentists	920	268
	Orthodontists	101	72
	Specialists (Non Ortho)	121	82

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BlueCross BlueShield of New Mexico

References

Describe a minimum of three (3) projects of similar scope and size, which are now complete; state for whom the work was performed, year completed, and a letter of reference for each regarding the work. References must be for work performed in the past three to five (3 to 5) years. DO NOT use City employees or any City elected officials as a reference. The City will not contact and will not assign any evaluation points for references from City employees or elected officials. State relevant experience with other municipalities or government entities.

Company Name:	City of Farmington
Address:	800 N Municipal Dr, Farmington, NM 87401
Contact Person:	Jamie Wagoner, Deputy HR Director
Contact Phone:	(505) 599-1265
Type of Services / Dates Provided:	Dental (fully insured), Medical administration, Stop Loss, Rx, Vision, Life & Disability. Since 2012

Company Name:	Texas Association of Counties (TAC)
Address:	1210 San Antonio St, Austin, TX 78701
Contact Person:	Brian Naiser, Financial Manager
Contact Phone:	(512) 615-8961
Type of Services / Dates Provided:	Medical since 2001, Dental since 2021, Vision since 2021

Company Name:	Summit Electric Supply
Address:	2900 Stanford NE Albuquerque, NM 87107
Contact Person:	Candace Burton, Benefits Administrator
Contact Phone:	(505) 389-1404
Type of Services / Dates Provided:	Medical, Dental, Stop Loss. Since 2017

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BlueCross BlueShield of New Mexico

Account Team Biographies

Marlene Baca
Vice President of Sales
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Marlene is responsible for the overall strategic direction of sales, retention and membership growth, performance of the sales division, and will oversee all commercial lines of business.

Marlene has more than 30 years of experience in the health care industry, mainly as a senior administrator with responsibilities in sales, marketing, product implementation, and program oversight for commercial, Affordable Care Act, Medicare, and Medicaid lines of business. She has also owned and operated a consulting firm, which provided strategic and marketing guidance to health care and health plans.

Before joining BCBSNM, Marlene served as chief programs officer, chief sales and service officer, and vice president of public programs at Lovelace Health Plan. She was also CEO for New Mexico Health Connections and vice president of marketing and strategy planning at Consumer Direct Insurance Services, for New Mexico, Illinois, Oklahoma, and Texas.

Marlene is an active member of the community and is a board member for APS Education Foundation and New Mexico Coalition for Healthcare Value. She has also served on United Way Hispano Philanthropy and as president of Silver Horizons board of directors.

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Maureen Sergel
Senior Manager of Account Management
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Maureen will provide oversight to the City's account administration. She joined Blue Cross and Blue Shield of New Mexico (BCBSNM) in 2018 and is based in our Albuquerque, New Mexico office. As a senior manager, Maureen is responsible for oversight of the mid-market and large group account management team. Her team manages the relationships and contract renewal processes for over 370 employer groups ranging in membership size from one subscriber to over 25,000.

Before joining BCBSNM, Maureen worked for 14 years in the pharmaceutical and medical supply distribution industry. In this time, she served as a contracts and pricing manager, a customer advocate, and as an account executive. She gained extensive experience in contract administration, distribution operations and Lean Six Sigma practices.

Maureen attended the University of New Mexico, where she studied physics and education. She also studied business at Central New Mexico Community College.

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Amanda Romero, MBA
Account Executive III
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Amanda Romero is an Account Executive III at BCBSNM in the Albuquerque Office. Amanda is responsible for overall retention and satisfaction of accounts in her assigned book of business. Amanda oversees the preparation and implementation of all transactions, paperwork, and internal processing for assigned accounts. Amanda has a wide range of experience in customer service, leadership skills and management skills.

Amanda joined BCBSNM February of 2022 and has seven years of large group consulting experience. She attended the University of New Mexico and the New Mexico Highlands University.

Amanda can be reached via email at amanda_romero@bcbsnm.com.

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Regina Guion
Sr. Marketing Service Representative
Blue Cross and Blue Shield of New Mexico (BCBSNM)

Regina Guion joined BlueCross and BlueShield of New Mexico in 2018. She dedicated five years working in Turquoise Care Medicaid as a Customer Advocate I-II and she was promoted to a Claims Technician. Regina attained the position of Marketing Service Representative for Large Group in 2023 and was promoted to Sr. Marketing Service Representative for Large Group in 2025. As a Sr. Marketing Service Representative Regina supports Account Management and serves as a day-to-day contact for the group and broker. Regina's responsibilities include assisting the Account Executive with contract review and ensuring the internal renewal process and updates are completed. Regina assists with Benefit Booklet review, prepares, and delivers reports. Regina is responsible for organizing and attending Open Enrollment meetings.

Regina can be reached via email at Regina_Guion@bcbsnm.com.

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Lisa Smith
Dental Account Executive
Blue Cross and Blue Shield of Illinois

Lisa Smith joined BCBSIL in 2010. As a dental account executive, she provides customer support to our internal and external clients, serving as their direct contact to address any needs that arise. Committed to providing the best service possible, Lisa designs a customized service strategy for each of her clients, ensures plan rules and parameters are followed and supports the retention of our existing customers. In addition, she negotiates renewals and ensures satisfaction with existing customers.

Lisa has 35 years of experience in the insurance industry, giving her expertise in all aspects of Dental Operations, including claim management, customer service, and implementation. Lisa uses her past experiences to help companies overcome day-to-day obstacles and identify solutions to reduce cost and streamline benefits to align with what is best for clients.

Lisa can be reached via email at lasmith@bcbsil.com.

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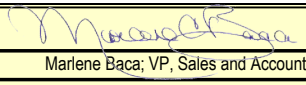
THE CITY OF ALBUQUERQUE

City of Albuquerque
DENTAL PPO COST PROPOSAL FORM
Appendix H

This form must be completed in its entirety. Please do not alter, add or delete rows. Multi-year rates and rate caps will be considered more favorably. Failure to complete this form in its entirety may deem your submission as non-responsive.

REQUESTED AND/OR PROPOSED PLAN DESIGN RATES					
Dental PPO Cost Form		**Current Plan Design**			
		7/1/2025 - 6/30/2026	**7/1/2026 - 6/30/2027**	**7/1/2027- 6/30/2028**	**07/01/2028-6/30/2029**
Enrollment Assumptions					
Employee Only		3,175	3,175	3,175	3,175
Employee + Spouse		1,152	1,152	1,152	1,152
Employee + Child(ren)		825	825	825	825
Employee + Family		1,999	1,999	1,999	1,999
Total		7,151	7,151	7,151	7,151
Monthly Fully Insured Premium Rates	***Rate Tiers***				
Employee Only		$31.30	$31.30	$31.30	$31.30
Employee + Spouse		$63.30	$63.30	$63.30	$63.30
Employee + Child(ren)		$69.55	$69.55	$69.55	$69.55
Employee + Family		$94.15	$94.15	$94.15	$94.15
Total Monthly Premium		$417,884	$417,884	$417,884	$417,884
Total Annual Premium		$5,014,604	$5,014,604	$5,014,604	$5,014,604
Are there any additional costs not included in your rates? If so, please identify.		n/a	n/a	n/a	n/a
Rate Guarantees					
Rate Guaranteed?		YES	YES	YES	YES
Implementation/Communication/Tech Credits					
Indicate if any credits are included in your proposal.		NO	NO	NO	NO
Participation					
Minimum Participation Requirements		If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.	If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.	If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.	If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.

Comments
BCBSNM Propose an option 1) Total Replacement- (Required Minimum 90% of current enrollment) Premium rates are guaranteed for 3 yrs 7/1/2026- 6/30/2029. **BCBSNM propose an option 2) Slice Option_ See Slice rate exhibit for band pricing.**

Authorized Signature		
Authorized Name		Marlene Baca; VP, Sales and Account Management
Vendor Name		Blue Cross and Blue Shield of New Mexico
Date		18-Aug-25
Contact Phone Number		505-900-4021

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

THE CITY OF ALBUQUERQUE

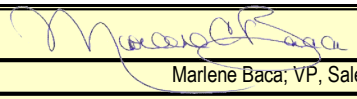
City of Albuquerque
SELF FUNDED DENTAL ADMINISTRATION
Appendix H

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REQUESTED AND/OR PROPOSED PLAN DESIGN RATES

Dental PPO Cost Form		Current Plan Design			
		7/1/2025 - 6/30/2026	7/1/2026 - 6/30/2027	7/1/2027- 6/30/2028	07/01/2028-6/30/2029
Enrollment Assumptions					
Employee Only		3,175	3,175	3,175	3,175
Employee + Spouse		1,152	1,152	1,152	1,152
Employee + Child(ren)		825	825	825	825
Employee + Family		1,999	1,999	1,999	1,999
Total		7,151	7,151	7,151	7,151
Monthly Self Insured Administration (PEPM)		N/A	$2.44	$2.44	$2.44
Total Annual Self Insured Administative Cost		#VALUE!	$29.28	$29.28	$29.28
Are there any additional costs not included in your rates? If so, please identify.		N/A	N/A	N/A	N/A
Rate Guarantees					
Rate Guaranteed?		NO	YES	YES	YES
Implementation/Communication/Tech Credits					
Indicate if any credits are included in your proposal.		NO	NO	NO	NO
Participation					
Minimum Participation Requirements			If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.	If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.	If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.

Comments
BCBSNM Propose an option 1) Total Replacement- (Required Minimum 90% of current enrollment) Premium rates are guaranteed for 3 yrs 7/1/2026- 6/30/2029. **BCBSNM propose an option 2) Slice Option-See Slice rate exhibit for band pricing.**

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City of Albuquerque
COST PROPOSAL - PERFORMANCE GUARANTEES
Appendix H

For the following categories, provide the performance standard you are willing to offer, the financial penalty (maximum dollar amount or % of administrative fees) you will agree to pay if the standard is not met, and the method of measuring the penalty.

Confidential and Proprietary

PERFORMANCE GUARANTEES	VENDOR RESPONSE
1. **Vendor attendance at the Client meetings** Attendance by vendor representatives when requested at meetings scheduled by the Client during the contract period and implementation phase.	We propose a composite score of 3.0 out of 5.0 for NM Account Management which means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Report Card or through a web-based survey. Performance will be measured in the following areas: 1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner. Measured semi-annually by joint meeting City of Albuquerque and Contractor no later than 45 days following the end of the semi-annual period. Measured semi-annually by Account Management Survey sent via e-mail no later than 45 days following the end of the semi-annual period. ASO= 2% at risk; FI= $2,000 at risk.
2. **Vendor call (or e-mail) return timeliness** The Client or designated consultant's calls (or e-mails) to vendor are returned within 48 business hours.	We propose Vendor Call (or e-mail) Return Timeliness - City of Albuquerque or designated consultant's (calls or emails) to vendor are returned within 48 business hours.Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.
3. **Processing monthly eligibility updates** All updates to eligibility or enrollment records will be made within 3 business days after the information is received by the vendor.	We propose Eligibility Processing defined as processing updates within an average of 3 business days from receipt of complete and accurate electronic information. Note: Open enrollment activities are excluded from this measure. Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.
4. **Telephone call availability & answering speed** 90% of all calls are answered within 30 seconds, and telephone service is available between 8:00 am and 4:30 pm MST on business days.	We propose 30 seconds or less Average Speed to Answer, calculated over the complete workday, defined as the time a caller spends on hold until a service representative becomes available. Standard is measured by determining the average number of seconds the caller spends waiting for a service representative. Standard is measured using participant calls on an Employer specific basis. Measured and settled annually. ASO= 2% at risk; FI= $3,000 at risk.
5. **Telephone call on-hold (in-queue) time** An average of less than 2 minute(s) on hold before a **human being** answers.	Not available as a performance guarantee. See #4 above.
6. **Telephone Abandonment Rate** An abandonment rate of less than 3% is maintained during standard business hours.	We propose 2.0% Abandoned calls defined as calls, calculated over the complete workday, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a service representative becomes available. Any calls abandoned or terminated by the caller prior to the Average Speed to Answer number of seconds standard will not be counted as Abandoned Calls. Standard is measured using participant calls on an Employer specific basis. Measured and settled annually. ASO= 2% at risk; FI= $3,000 at risk.
7. **Claims Processing Accuracy** 99% of claims dollars submitted for payment will be accurately processed and paid. Regardless of whether or not these standards of performance are satisfied, the vendor must reimburse the Client for all overpayments that are not recovered from the recipient within 60 days after the overpayment is discovered. The Client will assign its right to any recover such overpayments to the vendor.	We propose 99.0% Processing Accuracy defined as the percent of claims processed accurately. The level of performance is based on an audit of Employer-specific Claims.Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.
8. **Turnaround Time on Claims Payments** 97% of all claims received will be completely processed (paid, denied, or pended for additional information) within 14 calendar days after they are received. 100% of claims will be processed within 30 calendar days of receipt.	We propose 95.0% Claim Turnaround Time - Turnaround time is defined as the number of days it takes to process a claim, beginning with the date the claim is received to the check/EOB date on participant filed claims or to the date the claim passes all edits on provider filed claims. The standard is measured as a percent of process-ready claims finalized within 14 calendar days on an Employer specific basis. Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.
9. **Timeliness of Claim Reports** Each report the vendor will supply the Client will be provided within a mutually agreed upon timeframe.	We propose Timeliness of Claim Reports- Reports will be provided to the client within a mutually agreed upon timeframe. Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.
10. **Claims Coding** 99% of all claims will be coded with no errors.	Not available as a performance guarantee. We propose the following alternative guarantee (ASO Only): 98.0% Financial Accuracy defined as the percent of dollars paid accurately. The level of performance is based on the results from a random sample audit of all claims processed on an Employer specific basis. Measured and settled annually. ASO= 2% at risk; FI= Not available as a performance guarantee.
11. **Implementation** Successful implementation as defined by key milestones. Include measurable milestones in your proposal.	Not applicable as a performance guarantee as we are the incumbent carrier.
12. **Data Exchange** Receive and transmit data with vendors based on a frequency defined by the business needs of the Client.	Not available as a performance guarantee. We propose the following alternative guarantee: 95.0% Inquiry Resolution - Inquiry resolution is defined as the number of days it takes to resolve a participant inquiry, beginning with the date the inquiry is received to the resolution date. All written and telephone inquiries will be measured. The standard is measured as a percent processed within 14 calendar days on an Employer-specific basis. Measured and settled annually. ASO= 2% at risk; FI= $2,000 at risk.

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2027

Presented by:

BCBS of New Mexico

08/12/2025

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2027

CLAIM EXPERIENCE SUMMARY

DPPO

Current Month	Dental Claims	Dental Enrollment
Jul-24		7,138
Aug-24	$307,160.25	7,134
Sep-24	$285,621.37	7,182
Oct-24	$149,504.68	7,104
Nov-24	$530,679.39	7,103
Dec-24	$318,192.27	7,097
Jan-25	$322,841.64	7,053
Feb-25	$332,343.64	7,045
Mar-25	$349,629.35	7,027
Apr-25	$341,442.05	7,026
May-25	$350,142.25	7,046
Jun-25	$321,204.22	7,052
Jul-25	$396,995.42	
Total	**$4,005,756.53**	**85,007**
Cost PEPM	$47.12	

Prior Month	Dental Claims	Dental Enrollment
Jul-24	$194,523.39	
Total	**$194,523.39**	**0**
Cost PEPM		

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2027

CLAIM PROJECTION

	DPPO	DENTAL	
		Prior 08/23-07/24	Current 08/24-07/25
A	Net Paid Claims	$194,523	$4,005,757
D	Exposures	0	85,007
E	Average Claim Value (ACV) Per Employee Per Month (PEPM): E = C / D	$0.00	$47.12
	Annual Trend Rate	5.3%	5.2%
	Trend Months (midpoint method)	35.0	23.0
F	Trend Factor	16.2%	10.2%
G	Trended ACV PEPM: G = E * (1 + F)	$0.00	$51.93
H	Historical Plan Change Adjustment	0.00%	0.00%
I	Enrollment Shift Adjustment	0.00%	0.00%
J	Demographic Adjustment	0.00%	0.00%
M	Projected ACV PEPM by Period: M = G * (1 + H) * (1 + I) * (1 + J)	$0.00	$51.93
N	Experience Period Weighting	0%	100%
O	Blended Experience ACV PEPM		$51.93
Q	Credibility		100%
R	Total Projected ACV PEPM: R = O * Q + P * (1 - Q)		$51.93
S	Projected Plan Change Adjustment		0.00%
T	Total Projected ACV PEPM with Adjustments: T = R * (1 + S)		$51.93
U	Stop Loss Alternate Level Adjustment		1.0000
V	Adjusted Projected ACV PEPM: V = T * U		$51.93
W	Projected Enrollment		7,151
X	Number of Months in Policy Period		12
Y	Projected Net Paid Claims: Y = V * W * X		$4,456,217

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2027

TOTAL PROJECTED COST

RENEWAL	DPPO
Projected Enrollment	7,151
Total Projected Net Claims	$4,456,217
Risk	$160,424
Total Benefit Charges	$4,616,641
Desired Loss Ratio (DLR)	92.04%
Preliminary Premium	$5,015,816
Required Premium	$5,015,816
Premium at Current Rates	$5,014,604
Required Premium/Premium at Current Rates	0.0%

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2029

RATE DEVELOPMENT (Total Replacement)

Plan Name	DPPO
HCSC Primary (Enrollment)	
Single	3,175
Single + Spouse	1,152
Single + Child(ren)	825
Family	1,999
HCSC Total	7,151
	Current / **Renewal**
HCSC Primary	
Single	$31.30 / $31.30
Single + Spouse	$63.30 / $63.30
Single + Child(ren)	$69.55 / $69.55
Family	$94.15 / $94.15
Premium at Current Rates	**$5,014,604**
Requested Premium at Renewal Rates	**$5,014,604**

Premium Rate is quoted Net of Commission
Premium Rate is guaranteed for 3 years (36 months)

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2028

RATE DEVELOPMENT- TIER STRUCTURE (Slice Option)

Plan Name	DPPO	
Network	BlueCare Dental PPO	BlueCare Dental PPO
7000 + Subscribers	**Current**	**Renewal**
Single	$31.30	$31.30
Single + Spouse	$63.30	$63.30
Single + Child(ren)	$69.55	$69.55
Family	$94.15	$94.15
6000 - 6999 Subscribers	**Current**	**Proposed**
Single	$31.30	$32.24
Single + Spouse	$63.30	$65.20
Single + Child(ren)	$69.55	$71.64
Family	$94.15	$96.97
5000 - 5999 Subscribers	**Current**	**Proposed**
Single	$31.30	$33.37
Single + Spouse	$63.30	$67.48
Single + Child(ren)	$69.55	$74.14
Family	$94.15	$100.37
4000 - 4999 Subscribers	**Current**	**Proposed**
Single	$31.30	$34.70
Single + Spouse	$63.30	$70.18
Single + Child(ren)	$69.55	$77.11
Family	$94.15	$104.38
3000 - 3999 Subscribers	**Current**	**Proposed**
Single	$31.30	$36.26
Single + Spouse	$63.30	$73.34
Single + Child(ren)	$69.55	$80.58
Family	$94.15	$109.08
0000 - 2999 Subscribers	**Current**	**Proposed**
Single	$31.30	$38.08
Single + Spouse	$63.30	$77.01
Single + Child(ren)	$69.55	$84.61
Family	$94.15	$114.53

Premium Rate is quoted Net of Commission
Premium Rate is guaranteed for 3 years (36 months)

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BlueCross BlueShield of New Mexico

City Of Albuquerque

Prospective Premium Projection for the period of

July 1, 2026 - June 30, 2027

CONDITIONS AND CAVEATS

Notwithstanding anything in the renewal or proposal to the contrary, BCBSNM reserves the right to revise or withdraw any term herein or to change our charge for the cost of coverage (premium, fees or other amounts) at any time before or during the contract period if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSNM to pay, submit or forward, on its own behalf or on the Employer Group's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts). BCBSNM also reserves the right to change the premium rates it charges the Employer Group at any time before or during the contract period to the extent that any local, state or federal legislation, regulation, rule or guidance (or amendments or clarifications thereto) is enacted or becomes effective/implemented which results in increased projected claim costs or an increase to BCBSNM's expenses or cost of plan administration.

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

After the initial benefit plan design(s) is quoted, HCSC will not be providing a Minimum Value determination for any requested alternative benefit plan design(s). After you have notified HCSC of your final benefit plan design selection(s) for the upcoming policy year or renewal period, a statement indicating whether each selected benefit plan design meets/does not meet Minimum Value standards will be included in the corresponding Summary of Benefits and Coverage document(s) provided by HCSC.

Rates/fees are projected to be effective for the 12-month period beginning on the effective date indicated.

Offer assumes the contract situs will be New Mexico.

Insured benefits must comply with applicable state mandates.

Unless otherwise indicated, proposal offers assume standard HCSC administration practices/contract provisions/reports/materials and renewal offers assume existing administration practices/contract provisions/reports/materials.

We reserve the right to revise or withdraw our offer if, at any time during the projected coverage period:
- The actual number of enrolled contracts (in total, by product, or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies by +/- 10% from our projections.
- The information upon which our projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate.

Commissions are excluded from the quoted rates/fees. Upon inquiry from employer groups, HCSC will provide information to the employer group regarding commissions and other compensation paid to the employer's agent by HCSC in connection with the employer's policy or contract with HCSC.

Employer will contribute a minimum of 25% toward the cost of coverage.

A minimum of 75% of eligible employees excluding waivers, or a minimum of 50% of eligible employees including waivers, enroll for coverage.

Offer is contingent upon Underwriting approval of any changes to the plan's eligibility definitions.

This offer expires as of the effective date indicated above.

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BlueCross BlueShield of New Mexico

City Of Albuquerque

ASO Projection for the period of

July 1, 2026 - June 30, 2027

Presented by:

BCBS of New Mexico

08/08/2025

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BlueCross BlueShield of New Mexico

City Of Albuquerque

ASO Projection for the period of

July 1, 2026 - June 30, 2029

7/1/2026 ASO Dental Proposal

MULTI-YEAR FEE GUARANTEE (Total Replacement)

DPPO		Number of Employee	7,151
Projected Periods	**Year 1 (07/01/2026)**	**Year 2 (07/01/2027)**	**Year 3 (07/01/2028)**
Guaranteed Administrative Fee (PEPM)	$2.44	$2.44	$2.44
Admin Commissions (PEPM)	$0.00	$0.00	$0.00
Total Administration (PEPM)	$2.44	$2.44	$2.44
Monthly Administration cost	$17,448.44	$17,448.44	$17,448.44
Annual Administration cost	$209,381.28	$209,381.28	$209,381.28

** ASO fee is quoted with net of commission.*
** ASO fee is guaranteed for 3 years effective 7/1/2025- 12/31/2029.*
** If final enrollment varies by +/- 10% (or more) in total, tier, or plan at time of implementation BCBSNM reserves the right to rerate.*

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BlueCross BlueShield of New Mexico

City Of Albuquerque

ASO Projection for the period of

July 1, 2026 - June 30, 2029

7/1/2026 ASO Dental Proposal

ADMINISTRATION FEE TIER STRUCTURE (Slice Option)

	Subscriber Enrollment	Fee
	7000 + Subscribers	$2.44
	6000 - 6999 Subscribers	$2.49
	5000 - 5999 Subscribers	$2.51
	4000 - 4999 Subscribers	$2.58
	3000 - 3999 Subscribers	$2.64
	0000 - 2999 Subscribers	$2.68

ASO fee is quoted Net of Commission.
ASO fee is quoted is guaranteed for 36 months effective 7/1/2026-6/30/2029.
We reserve the right to revise or withdraw our offer if enrollment drops below the minimum tier at any time during the period.

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City Of Albuquerque

ASO Projection for the period of
July 1, 2026 - June 30, 2027

CONDITIONS AND CAVEATS

Notwithstanding anything in the renewal or proposal to the contrary, BCBSNM reserves the right to revise or withdraw any term herein or to change our charge for the cost of coverage (premium, fees or other amounts) at any time before or during the contract period if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSNM to pay, submit or forward, on its own behalf or on the Employer Group's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts). BCBSNM also reserves the right to change the administrative fees it charges the Employer Group at any time before or during the contract period to the extent that any local, state or federal legislation, regulation, rule or guidance (or amendments or clarifications thereto) is enacted or becomes effective/implemented which results in increased projected claim costs or an increase to BCBSNM's expenses or cost of plan administration.

As part of the pre-sale, sales, negotiation and implementation processes, Blue Cross and Blue Shield of New Mexico will perform a review of the employer's health benefits strategies. Included in this review will be assessments of whether the employer's strategy requires any customization that may lead to additional fees and charges.

Throughout this process, items may be discovered that warrant review in more detail when assessing the full scope of the employer's benefits strategies. With that in mind, there are specific services that may require the employer pay additional fees and charges, depending on the level of customization. These services include, but are not limited to: custom plan designs and benefits, third party vendor arrangements, file transfers for import or export of data, ad hoc reporting and analytics and custom processes, adjudication workflows and services.

Rates/fees are projected to be effective for the 12-month period beginning on the effective date indicated.

Offer assumes the contract situs will be New Mexico.

Quoted products include DPPO.

Offer assumes benefit levels during the coverage period will be [comparable to the current levels / comparable to the requested levels / different from the current and requested levels as outlined elsewhere in our proposal].

Unless otherwise indicated, proposal offers assume standard HCSC administration practices/contract provisions/reports/materials and renewal offers assume existing administration practices/contract provisions/reports/materials.

We reserve the right to revise or withdraw our offer if, at any time during the projected coverage period:
- The actual number of enrolled contracts (in total, by product, or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies by +/- 10% from our projections.
- The information upon which our projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate.

Commissions are excluded from the quoted rates/fees. Upon inquiry from employer groups, HCSC will provide information to the employer group regarding commissions and other compensation paid to the employer's agent by HCSC in connection with the employer's policy or contract with HCSC.

Proposals for new or add-on business cover only those claims incurred on or after the projection effective date. Processing and funding claims incurred prior to the effective date will remain the responsibility of the prior carrier and/or the employer/plan sponsor.

Employer will contribute a minimum of 25% toward the cost of coverage.

A minimum of 75% of eligible employees excluding waivers, or a minimum of 50% of eligible employees including waivers, enroll for coverage.

If HCSC will be offered as an option alongside another carrier, employee contributions shall differ solely on the basis of significant differences in plan benefit levels and minimum participation requirements may be met by the combined total of enrollees in all carriers' plans.

Offer is contingent upon Underwriting approval of any changes to the plan's eligibility definitions.

Offer may be contingent upon receipt and Underwriting approval of a completed Controlled Affiliate Letter; details will be provided by Sales/Account representative if applicable.

If provided, premium equivalent rates reflect employer's total projected liability to HCSC for claims, administration fees, and stop loss premiums if applicable. They do not include any changes in the amount of reserves to be held by the employer.

This offer expires as of the effective date indicated above.

If a non-preferred vendor is selected for automated eligibility processing, an additional charge will apply.

BCBSNM retains the right to recoup monetary credits provided, any remaining implementation costs, shared savings or PG incentive fees from the plan sponsor in the event of early termination of the proposed coverage or contract, either in its entirety or with respect to certain custom services or programs included in this offer.

Administration Fee assumes Weekly claim funding.

Proprietary and Confidential Information of BCBSNM
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BlueCare Dental℠
PPO Plan

BlueCross BlueShield of New Mexico

City of Albuquerque

Effective: 7/1/2026

The following is a listing of common services available through your BlueCare Dental PPO℠ plan. The member's share of the cost is determined by whether care is received from a contracted or non-contracted provider. Your plan allows you to see any licensed dentist, but using an in-network provider may minimize your out-of-pocket expenses and prevent you from being subject to balance billing.

Summary of Dental Benefits

PROGRAM BASICS	In-Network Dentist	Out-of-Network Dentist
Benefit Period Maximum: Calendar Year	$1,500	$1,500
Deductible: Calendar Year	$50.00 Individual $150.00 Family	$50.00 Individual $150.00 Family
Reimbursement Level:	Contracted Fee Schedule	Maximum Allowable Charge (MAC) **
COVERED SERVICES		
Class 1: Preventive Services ***(Deductible does not apply)*** Periodic Oral Evaluations Problem Focused Oral Evaluations Comprehensive Oral Evaluations Prophylaxis/routine cleanings X-rays Full-Mouth, Pano, Bitewing, Periapical Sealants Topical Fluoride Space maintainers Perio Maintenance Palliative Treatment (emergency care to relieve pain)	100%	80%
Class 2: Basic Restorative Services Amalgam & Composite Fillings Non-surgical Extractions Full Mouth Debridement Scaling & Root Planning Denture Reline/Rebase Repairs – Crown & Bridge Oral Surgery & Surgical Extractions Endodontics (root canal) Major Periodontics	85%	85%
Class 3: Major Restorative Services Repairs – Crown and Bridge Crowns, Inlays, Onlays Denture Reline/Rebase Bridges and Dentures Implants	50%	50%
Class 4: Orthodontics ***(Deductible does not apply)*** Orthodontic Diagnostic Procedures and Treatment Coverage for Adults and Dependent Children (to age 26) **Lifetime Maximum Ortho Benefit per Participant**	50% **$1,250**	50% **$1,250**

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BlueCare Dental℠

BlueCross BlueShield of New Mexico

Benefit Limitations & Frequencies:	
Oral Evaluations	2 per year
Comprehensive Evaluations	2 per 12 months
Prophy/Cleanings	2 per year
Fluoride Application	2 per year for children up to age 19
X-rays Full Mouth Panoramic	1 per 60 months
X-rays: Bitewings	2 per year
Sealants (per tooth)	1 per lifetime up to age 16
Space Maintainers	1 per lifetime up to age 14
Amalgam and Composite Fillings	1 per tooth per 12 months
Periodontal Maintenance	2 per year
Crowns/Dentures/Bridges/Implants	Replacement every 5 years
Denture Reline/Rebase	1 per 36 months

Included Plan Features:

Missing Tooth Exclusion: This plan covers replacement of tooth/teeth missing prior to your effective date under this policy.

No Benefit Waiting Period: There is no required period of time a member must be covered under the plan before receiving coverage for dental procedures.

Three-Month Deductible Carryover: Any covered dental expenses incurred **in the final three months of the plan year** and applied toward satisfaction of the deductible for that plan year will also be applied toward satisfaction of the deductible for the following plan year.

Enhanced Dental Benefit: Participants diagnosed and receiving active medical care for cardiovascular disease, diabetes, prediabetes or pregnancy qualify for one of the following enhanced dental benefits after standard benefits are exhausted: one additional cleaning, periodontal scaling and root planing or periodontal maintenance. Enhanced benefit services will apply toward your individual annual maximum.

****Please note that your benefit plan reimburses services rendered by non-contracted dentists according to the Maximum Allowable Charge. This is the maximum reimbursement that BlueCare Dental allows for Out-of-Network providers, which will ultimately subject you to balance billing for all charges that exceed this threshold.**

Predetermination of benefits is recommended, but not required, for services in excess of $300.

This summary is intended to highlight the most common services and frequencies under the dental plan. For complete and detailed descriptions of services, limitations and exclusions, please refer to the Certificate of Coverage.

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BlueCross BlueShield of New Mexico

Performance Guarantees

Per the RFP instructions, this file is considered confidential and has been segregated. Please refer to the Legally Confidential folder located in the Cost Proposal section for details on the dental performance guarantees we are offering.

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FULLY INSURED DENTAL EXHIBIT-PG
EMPLOYER NAME: CITY OF ALBUQUERQUE
Employer Account Number: 324605
Employer Group Number: TBD
Effective for the Settlement Period beginning July 1, 2026, and ending June 30, 2027
Effective for the Settlement Period beginning July 1, 2027, and ending June 30, 2028
Effective for the Settlement Period beginning July 1, 2028, and ending June 30, 2029

Performance guarantees are contingent upon maintaining an enrollment in the Plan dental benefit coverage administered by Claim Administrator of not less than **6,441** Covered Employees, based on a total of **7,157** contracts. Performance measurement will begin **July 1, 2026**. Performance Guarantees are measured and settled annually.

SERVICE – Dental	Defined Performance Guarantees	Performance Guarantee	Dollars at Risk
Account Management	**NM Account Management** means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Report Card or through a web-based survey. Performance will be measured in the following areas: 1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner. Measured semi-annually by joint meeting City of Albuquerque and Contractor no later than 45 days following the end of the semi-annual period. Measured semi-annually by Account Management Survey sent via e-mail no later than 45 days following the end of the semi-annual period.	Composite Score 3.0 - 5.0 0 - 2.9	 $0 $2,000
Claim Turnaround Time	**Claim Turnaround Time** - Turnaround time is defined as the number of days it takes to process a claim, beginning with the date the claim is received to the check/EOB date on participant filed claims or to the date the claim passes all edits on provider filed claims. The standard is measured as a percent of process-ready claims finalized within 14 calendar days on an Employer-specific basis.	95.0%-100% 0%-94.9%	$0 $2,000
Claim Processing Accuracy	**Processing Accuracy** is defined as the percent of claims processed accurately. The level of performance is based on an audit of Employer-specific Claims.	99.0% - 100% 0% - 98.9%	$0 $2,000

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SERVICE – Dental	Defined Performance Guarantees	Performance Guarantee	Dollars at Risk
Inquiry Resolution	**Inquiry Resolution** - Inquiry resolution is defined as the number of days it takes to resolve a participant inquiry, beginning with the date the inquiry is received to the resolution date. All written and telephone inquiries will be measured. The standard is measured as a percent processed within 14 calendar days on an Employer-specific basis.	95.0% - 100% 0% - 94.9%	$0 $2,000
Abandoned Calls	**Abandoned calls** are defined as calls, calculated over the complete workday, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a service representative becomes available. Any calls abandoned or terminated by the caller prior to the Average Speed to Answer number of seconds standard will not be counted as Abandoned Calls. Standard is measured using participant calls on an Employer-specific basis.	0%-2.0% 2.1%-100%	$0 $3,000
Average Speed to Answer	**Average Speed to Answer**, calculated over the complete workday, is defined as the time a caller spends on hold until a service representative becomes available. Standard is measured by determining the average number of seconds the caller spends waiting for a service representative. Standard is measured using participant calls on an Employer-specific basis.	0 - 30 seconds 31 seconds or more	$0 $3,000
Eligibility	**Eligibility Processing** is defined as processing updates within an average of 3 business days from receipt of complete and accurate electronic information. Note: Open enrollment activities are excluded from this measure.	Average 0-3 Business Days = Met Average >3 Business Days = Not Met	$0 $2,000
Vendor Call (or e-mail) Return Timeliness	**Vendor Call (or e-mail) Return Timeliness -** City of Albuquerque or designated consultant's (calls or emails) to vendor are returned within 48 business hours.	Met Not Met	$0 $2,000
Timeliness of Claim Reports	**Timeliness of Claim Reports-** Reports will be provided to the client within a mutually agreed upon timeframe.	Met Not Met	$0 $2,000
Total Dental			**$20,000**

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BlueCross BlueShield of New Mexico

PPO PERFORMANCE GUARANTEE AGREEMENT

This Agreement made as of _____ between **Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the "Plan") and _____ (hereinafter referred to as the "Policyholder"), Account Number(s) _____, WITNESSETH AS FOLLOWS:

WHEREAS, the Benefit Program Application accepted by the Plan establishes the Group Number(s) of the Policyholder under the Policy, the effective date of the Policy, and the payment method under the Policy; and

WHEREAS, the Policyholder desires that performance standards be established with respect to the health care benefit programs being administered by the Plan at the Plan's full service unit(s) assigned to administer the Policyholder's health care benefit program; and

WHEREAS, the Plan agrees to guarantee a level of service performance satisfactory to the Policyholder, as described in this Agreement;

NOW, THEREFORE, in consideration of these premises and mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiently of which are hereby acknowledged, the Policyholder and Plan hereby agree as follows:

(I) DEFINITIONS

The following definitions apply to this Agreement:

A. **Claim** means a properly completed notification in a form acceptable to the Plan, including but not limited to, form and content required by applicable law, that a service has been rendered or furnished to a Covered Person in accordance with the provisions of the health care benefit program specified in the Policy in effect on the date a service is rendered or furnished. This notification must set forth in full the details of such service including, but not limited to, the covered person's name, age, sex and identification number, the name and address of the provider of service, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes) and the fee for such service.

B. **Claim Payment** means the benefit payment made by the Plan, upon submission of a Claim, in accordance with the health care benefit program provisions specified in the Policy in effect on the date a service is rendered.

C. **Policy** means the Group Administration Document between the Plan and the Policyholder, including any addenda attached thereto, the Certificate Booklet, the Benefit Program Application or other appropriate document; the benefit program and premium notification letter, if any; the Benefit Program Application Change Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Covered Persons.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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(II) TIMING

A. The period for which the Plan's performance will be measured and for which Policyholder may receive a penalty payment is referred to as the Settlement Period and is indicated on the most current Exhibit-PG PPO attached hereto.

B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG PPO provided that accurate and complete membership information has been received and loaded onto the Plan's claims processing system.

(III) DETERMINATION

A. The Plan agrees to guarantee performance levels as indicated on the most current Exhibit-PG PPO. In the event that the Plan's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG PPO during a Settlement Period for which the Plan's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Plan's normal business operation, the Plan will be responsible for paying the dollars at risk described in the most current Exhibit-PG PPO to Policyholder.

B. The Plan will measure Performance Guarantees and report the measurement results to Policyholder, and any dollars at risk due if applicable, in accordance with this Agreement within 120 days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

C. The Plan will not be obligated to measure Performance Guarantees and will not be obligated to pay Policyholder based thereon until this Agreement has been executed and is on file with the Plan by the close of the applicable Settlement Period.

D. The Plan will not be obligated to measure Performance Guarantees and will not be obligated to pay dollars at risk if applicable to Policyholder based thereon for any portion of the Settlement Period in which the Policyholder:

1. Fails to provide the Plan with timely changes in enrollment or membership information or any information as may be necessary for the Plan to perform its duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or

2. Fails to pay premium charges in accordance with the terms of the Policy or comply with all established transfer payment procedures as outlined in the Policy.

E. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Plan, Medicare payment systems, or if the enrollment of the Policyholder's benefit coverage administered by the Plan falls below number of enrolled Covered Employees as indicated in the most current Exhibit-PG PPO attached to and made a part of this Agreement during any Settlement Period, the Plan reserves the right to re-evaluate and renegotiate the level of performance and/or the dollars at risk in this Agreement or terminate this Agreement.

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(IV) REMEDIES

This Agreement does not in any way limit other remedies which Policyholder may have available to it in the event that Plan fails to perform or does not meet a performance guarantee(s).

(V) TERM AND TERMINATION

A. This Agreement shall continue in full force and effect during the settlement period(s) indicated in the Exhibit-PG PPO. If for any reason the Policy issued to the Policyholder by the Plan is terminated prior to the end of the Settlement Period, this Agreement will automatically terminate.

B. If for any reason this Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and Policyholder will not receive dollars at risk as applicable, based on that part of the Settlement Period in which this Agreement was in effect.

C. Any of the rights and obligations of the Plan under this Agreement may be assumed by any subsidiary or affiliate company of the Plan (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written consent by the Policyholder. Any reference in this Agreement to the Plan shall include its directors, officers and employees, as well as the directors, officers and employees of any of its subsidiaries or affiliate companies (including any successor corporations, whether by merger, consolidation or reorganization) and the Plan or its successor corporation shall be responsible and liable for all rights and obligations in connection with this Agreement.

The Effective Date of this Agreement is _____.

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DENTAL EXHIBIT-PG
EMPLOYER NAME: CITY OF ALBUQUERQUE
Employer Account Number: 324605
Employer Group Number(s): TBD
Effective for the Settlement Period beginning July 1, 2026, and ending June 30, 2027
Effective for the Settlement Period beginning July 1, 2027, and ending June 30, 2028
Effective for the Settlement Period beginning July 1, 2028, and ending June 30, 2029

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan dental benefit coverage administered by Claim Administrator of not less than **6,441** Covered Employees, based on a total of **7,157** contracts. Performance measurement will begin **July 1, 2026.** Performance Guarantees are measured and settled annually.

SERVICE - Dental	Defined Performance Guarantees	Performance Guarantee	Percentage of the Dental Administrative Charge at Risk
Account Management	**NM Account Management** means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Report Card or through a web-based survey. Performance will be measured in the following areas: 1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner. Measured semi-annually by joint meeting City of Albuquerque and Contractor no later than 45 days following the end of the semi-annual period. Measured semi-annually by Account Management Survey sent via e-mail no later than 45 days following the end of the semi-annual period.	Composite Score 3.0 - 5.0 0 - 2.9	 0% 2%
Claim Turnaround Time	**Claim Turnaround Time** - Turnaround time is defined as the number of days it takes to process a claim, beginning with the date the claim is received to the check/EOB date on participant filed claims or to the date the claim passes all edits on provider filed claims. The standard is measured as a percent of process-ready claims finalized within 14 calendar days on an Employer specific basis.	95.0%-100% 0%-94.9%	0% 2%

Proprietary Information
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SERVICE - Dental	Defined Performance Guarantees	Performance Guarantee	Percentage of the Dental Administrative Charge at Risk
Claim Processing Accuracy	**Processing Accuracy** is defined as the percent of claims processed accurately. The level of performance is based on the results from a random sample audit of all claims processed on an Employer specific basis.	99.0% - 100% 0% - 98.9%	0% 2%
Claim Financial Accuracy	**Financial Accuracy** is defined as the percent of dollars paid accurately. The level of performance is based on the results from a random sample audit of all claims processed on an Employer specific basis.	98.0%-100% 0%-97.9%	0% 2%
Inquiry Resolution	**Inquiry Resolution** - Inquiry resolution is defined as the number of days it takes to resolve a participant inquiry, beginning with the date the inquiry is received to the resolution date. All written and telephone inquiries will be measured. The standard is measured as a percent processed within 14 calendar days on an Employer specific basis.	95.0%-100% 0%-94.9%	0% 2%
Abandoned Calls	**Abandoned calls** are defined as calls, calculated over the complete workday, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a service representative becomes available. Any calls abandoned or terminated by the caller prior to the Average Speed to Answer number of seconds standard will not be counted as Abandoned Calls. Standard is measured using participant calls on an Employer specific basis.	0%-2.0% 2.1%-100%	0% 2%
Average Speed to Answer	**Average Speed to Answer**, calculated over the complete workday, is defined as the time a caller spends on hold until a service representative becomes available. Standard is measured by determining the average number of seconds the caller spends waiting for a service representative. Standard is measured using participant calls on an Employer specific basis.	0-30 seconds 31 seconds or more	0% 2%
Eligibility	**Eligibility Processing** is defined as processing updates within an average of 3 business days from receipt of complete and accurate electronic information. Note: Open enrollment activities are excluded from this measure.	Average 0-3 Business Days = Met Average >3 Business Days = Not Met	0% 2%

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SERVICE - Dental	Defined Performance Guarantees	Performance Guarantee	Percentage of the Dental Administrative Charge at Risk
Vendor Call (or e-mail) Return Timeliness	**Vendor Call (or e-mail) Return Timeliness -** City of Albuquerque or designated consultant's (calls or emails) to vendor are returned within 48 business hours.	Met Not Met	0% 2%
Timeliness of Claim Reports	**Timeliness of Claim Reports-** Reports will be provided to the client within a mutually agreed upon timeframe.	Met Not Met	0% 2%
Total Dental			**20%**

RFP

Proprietary Information
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ADDENDUM PG
PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Administrative Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current Fee Schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current Fee Schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and its most current Exhibit-PG.

SECTION I
TIMING

A. The period for which the Claim Administrator's performance will be measured and for which Employer may receive a refund is referred to as the Settlement Period and is indicated on the most current Exhibit-PG.

B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG provided all of the requirements listed below are completed. The requirements are as follows:

1. Benefit information and claims administrative procedures have been provided by Employer to the Claim Administrator,

2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto the Claim Administrator's claims processing system,

3. Accurate and complete membership information has been received and loaded onto the Claim Administrator's claims processing system, and

4. Transfer Payment procedures have been established in accordance with the Agreement.

SECTION II
DETERMINATION

A. The Claim Administrator agrees to guarantee performance levels as indicated on the most current Exhibit-PG. In the event that the Claim Administrator's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG during a Settlement Period for which the Claim Administrator's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Claim Administrator's normal business operation, the Claim Administrator will be responsible for reimbursing Employer a portion of the Administrative Charge.

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

B. The Claim Administrator will measure Performance Guarantees and report the measurement results to Employer, and any refund amounts due in accordance with this Addendum PG within 120 days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

C. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon until the Administrative Services Agreement (including the most current Exhibit-PG) has been executed and is on file with the Claim Administrator by the close of the applicable Settlement Period.

D. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon for any portion of the Settlement Period in which the Employer:

1. Fails to provide the Claim Administrator with Timely changes in enrollment or membership information or any other reports or information as may be necessary for the Claim Administrator to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or

2. Fails to pay Administrative Charges in accordance with the terms of the Agreement or comply with all established Transfer Payment procedures.

E. The Claim Administrator will not be obligated to measure any Performance Guarantee impacted by changes requested in writing by Employer during the time period required to modify the Claim Administrator's system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to the Claim Administrator in accordance with the Agreement.

F. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Claim Administrator, Medicare payment systems, or if the enrollment of the Plan's benefit coverage administered by the Claim Administrator varies in number of enrolled Covered Employees as indicated in the most current Exhibit-PG attached to and made a part of this Addendum during any Settlement Period, the Claim Administrator reserves the right to re-evaluate and renegotiate the level of performance and/or the Administrative Charges at risk in this Addendum PG and the attached Exhibit-PG.

G. If for any reason the Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and Employer will not receive any refund, based on that part of the Settlement Period in which the Administrative Services Agreement was in effect.

H. If (i) changes to the formula, methodology or manner in which a third-party benchmark (such as AWP) is calculated or reported take effect, or (ii) such third party ceases to publish such benchmark, then the performance guarantees and/or standards based on such benchmark in this Agreement, if any, shall be re-evaluated and adjusted or converted to an alternative benchmark by Claim Administrator or its designee at the time of such change to return the parties to their respective economic positions with respect to such guarantees and/or standards as they existed under the Agreement immediately prior to such change.

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

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Financial Statements and Supplementary Information – Statutory Basis

Health Care Service Corporation,
a Mutual Legal Reserve Company
Years Ended December 31, 2024 and 2023
With Report of Independent Auditors

The better the question.
The better the answer.
The better the world works.

Shape the future
with confidence

Docusign Envelope ID: 92A19913-26B7-4B0B-BB4F-A91ADC78FE22

Health Care Service Corporation,
a Mutual Legal Reserve Company

Financial Statements and Supplementary Information – Statutory Basis

Years Ended December 31, 2024 and 2023

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Statements of Revenues and Expenses – Statutory Basis 6
Statements of Changes in Policyholders' Surplus – Statutory Basis 7
Statements of Cash Flow – Statutory Basis 8
Notes to Financial Statements – Statutory Basis 9

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Shape the future
with confidence

Ernst & Young LLP
155 North Wacker Drive
Chicago, IL 60606-1787

Tel: +1 312 879 2000
Fax: +1 312 879 4000
ey.com

Report of Independent Auditors

The Board of Directors
Health Care Service Corporation,
a Mutual Legal Reserve Company

Opinion

We have audited the statutory basis financial statements of Health Care Service Corporation, a Mutual Legal Reserve Company (the Company), which comprise the balance sheets as of December 31, 2024 and 2023, and the related statements of revenues and expenses, changes in policyholders' surplus and cash flow for the years then ended, and the related notes to the financial statements (collectively referred to as the "financial statements").

Unmodified Opinion on Statutory Basis of Accounting

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2024 and 2023, and the results of its operations and its cash flows for the years then ended, on the basis of accounting described in Note 2.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the significance of the matter described in the Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles section of our report, the financial statements do not present fairly, in accordance with accounting principles generally accepted in the United States of America, the financial position of the Company at December 31, 2024 and 2023, or the results of its operations or its cash flows for the years then ended.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

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Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 2 to the financial statements, the Company prepared these financial statements using accounting practices prescribed or permitted by the Illinois Department of Insurance, which is a basis of accounting other than accounting principles generally accepted in the United States of America. The effects on the financial statements of the variances between these statutory accounting practices described in Note 2 and accounting principles generally accepted in the United States of America, although not reasonably determinable, are presumed to be material and pervasive.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the accounting practices prescribed or permitted by the Illinois Department of Insurance. Management is also responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for one year after the date that the financial statements are issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

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In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Ernst & Young LLP

May 9, 2025

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Health Care Service Corporation,
a Mutual Legal Reserve Company

Balance Sheets – Statutory Basis
(In Millions of Dollars)

	December 31 2024	2023
Admitted assets		
Cash, cash equivalents, and short-term investments	**$ 4,675.4**	$ 167.3
Bonds	**18,823.3**	20,238.6
Preferred stocks:		
Nonaffiliate	**93.8**	52.9
Affiliate	**268.6**	224.7
Common stocks:		
Nonaffiliate	**1,354.1**	1,402.2
Affiliate	**2,015.7**	1,976.5
Real estate	**761.0**	725.3
Other invested assets	**1,379.2**	926.8
Total cash and invested assets	**29,371.1**	25,714.3
Amounts receivable related to self-funded groups	**6,255.0**	6,110.3
Health care receivables	**1,574.7**	1,975.3
Accrued retrospective premiums	**1,271.2**	1,643.7
Deferred premiums	**1,181.3**	1,106.3
Receivables from subsidiaries	**1,050.5**	559.8
Uncollected premiums	**840.9**	708.8
Net deferred tax asset	**–**	313.3
Other admitted assets	**610.0**	433.1
Total admitted assets	**$ 42,154.7**	$ 38,564.9

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	December 31 2024	2023
Liabilities and policyholders' surplus		
Liabilities:		
Policy and contract liabilities:		
Claims unpaid	**$ 5,441.8**	$ 4,373.7
Accrued medical incentives	**189.7**	294.1
Unpaid claims adjustment liability	**203.2**	180.9
Accident and health policy reserves	**815.2**	915.8
Premiums received in advance	**962.4**	778.6
Total policy and contract liabilities	**7,612.3**	6,543.1
General expenses due and accrued	**2,310.0**	2,499.8
Borrowed funds, including interest payable	**4,480.1**	1,992.2
Remittances and items not allocated	**965.4**	871.4
Liabilities related to uninsured plans	**625.3**	608.2
Amounts withheld or retained for the account of others	**380.1**	297.4
Federal income tax payable	**119.4**	614.9
Other liabilities	**778.2**	833.5
Total liabilities	**17,270.8**	14,260.5
Policyholders' surplus:		
Unassigned surplus	**24,883.9**	24,304.4
Total liabilities and policyholders' surplus	**$ 42,154.7**	$ 38,564.9

See accompanying notes.

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Health Care Service Corporation,
a Mutual Legal Reserve Company

Statements of Revenues and Expenses – Statutory Basis
(In Millions of Dollars)

	Year Ended December 31	
	2024	**2023**
Premium revenues	**$ 62,823.6**	$ 54,748.6
Benefit expenses	**56,961.7**	48,027.5
	5,861.9	6,721.1
Claims adjustment expenses including cost containment expenses	**1,843.5**	1,544.0
General and administrative expenses	**4,590.5**	4,169.7
Decrease in contract reserves	**(0.3)**	(0.1)
	6,433.7	5,713.6
Net underwriting (loss) gain	**(571.8)**	1,007.5
Net investment income	**1,085.3**	926.0
Net realized investment losses net of capital gains tax expense (benefit) of $6.5 and $(11.5) in 2024 and 2023, respectively	**(129.8)**	(148.1)
Other income (expenses), net	**26.1**	(32.0)
	981.6	745.9
Gain before federal income tax (benefit) expense	**409.8**	1,753.4
Federal income tax (benefit) expense	**(249.2)**	308.1
Net income	**$ 659.0**	$ 1,445.3

See accompanying notes.

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Health Care Service Corporation,
a Mutual Legal Reserve Company

Statements of Changes in Policyholders' Surplus – Statutory Basis
(In Millions of Dollars)

	Year Ended December 31	
	2024	**2023**
Policyholders' surplus, beginning of year	**$ 24,304.4**	$ 23,352.8
Net income	**659.0**	1,445.3
Net change in unrealized capital gains and losses (including investment in unconsolidated subsidiaries)	**128.9**	311.1
Increase in nonadmitted assets	**(306.7)**	(531.5)
Increase (decrease) in net deferred income taxes	**21.0**	(361.8)
Change in benefit plans and other	**77.3**	88.5
Change in policyholders' surplus	**579.5**	951.6
Policyholders' surplus, end of year	**$ 24,883.9**	$ 24,304.4

See accompanying notes.

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Health Care Service Corporation,
a Mutual Legal Reserve Company

Statements of Cash Flow – Statutory Basis
(In Millions of Dollars)

	Year Ended December 31	
	2024	**2023**
Operating activities		
Premiums collected	**$ 62,966.4**	$ 54,740.7
Claims paid	**(55,834.7)**	(48,785.6)
Commissions and expenses paid	**(6,566.4)**	(5,485.4)
Investment income received, net	**1,153.1**	920.1
Federal income tax paid	**(252.8)**	(4.0)
Net cash provided by operating activities	**1,465.6**	1,385.8
Investing activities		
Proceeds from investments sold, matured or repaid:		
Bonds	**5,654.1**	4,126.7
Common and preferred stocks	**483.6**	378.7
Other invested assets	**34.3**	36.9
Total investment proceeds	**6,172.0**	4,542.3
Cost of investments acquired:		
Bonds	**4,420.2**	3,719.7
Common and preferred stocks	**514.2**	572.8
Real estate	**68.2**	23.6
Other invested assets	**344.3**	388.8
Total investments acquired	**5,346.9**	4,704.9
Net cash provided by (used in) investing activities	**825.1**	(162.6)
Financing and miscellaneous activities		
Borrowed funds and interest paid on debt, net	**2,359.3**	(56.2)
Other cash used in financing and miscellaneous activities	**(141.9)**	(306.2)
Net cash provided by (used in) financing and miscellaneous activities	**2,217.4**	(362.4)
Net increase in cash, cash equivalents and short-term investments	**4,508.1**	860.8
Cash, cash equivalents and short-term investments:		
Beginning of year	**167.3**	(693.5)
End of year	**$ 4,675.4**	$ 167.3
Supplemental disclosure of cash flow information for non-cash transactions		
Other invested asset received as return of capital from subsidiary	**$ 9.7**	$ –
Other invested asset contributed to subsidiary	**$ 9.7**	$ –

See accompanying notes.

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Health Care Service Corporation,
a Mutual Legal Reserve Company

Notes to Financial Statements – Statutory Basis
(In Millions of Dollars)

December 31, 2024 and 2023

1. Organization

Health Care Service Corporation, a Mutual Legal Reserve Company (the Company), operates as a mutual insurance company in Illinois. The Company is an independent licensee of the Blue Cross Blue Shield Association (the Association) and does business as Blue Cross Blue Shield of Illinois (BCBSIL), Blue Cross Blue Shield of Montana (BCBSMT), Blue Cross Blue Shield of New Mexico (BCBSNM), Blue Cross Blue Shield of Oklahoma (BCBSOK), and Blue Cross Blue Shield of Texas (BCBSTX).

The Company underwrites and administers medical and dental insurance business through its operating divisions in the states of Illinois, Montana, New Mexico, Oklahoma, and Texas. The Company provides group and individual indemnity health insurance and managed health care products such as health maintenance organizations, participating provider/preferred provider options, point-of-service plans, and consumer-driven health plans. In addition, the Company also sells other products such as Medicare supplemental coverage, Medicaid, stand-alone Medicare Part D (Part D), Medicare Advantage and Prescription Drug insurance coverage (MAPD), Medicare/Medicaid dual eligible, managed behavioral health, prescription drug, vision coverages, and administrative services contracts (ASCs) for self-funded groups.

Affordable Care Act (ACA)

The ACA created significant changes to health care coverage in the U.S., and subsequent regulatory actions and challenges to the ACA similarly had significant impact to the health care coverage market.

Generally, the ACA imposes medical loss ratio (MLR) standards for insurers of 85% for the large group market and 80% for the individual, small group, and student health markets, which may require insurers to issue MLR rebates to employers and/or members on an annual basis. In addition, the ACA imposes MLR standards of 85% for the Medicaid, Part D, MAPD, and Medicare/Medicaid dual eligible products that the Company offers, which may require insurers to issue MLR rebates on an annual basis. The ACA also requires that insurers guarantee issuance of coverage to all eligible individuals, regardless of health status, and defines how individual and small group health insurance is rated. The ACA risk adjustment program transfers funds from individual and small group market issuers who enroll a comparably lower risk population (based on health status and other qualities) to those who have enrolled a comparable higher risk population to account for the likelihood of increased claims and health management exposure.

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1. Organization (continued)

The ACA also provides for premium subsidies for individual health insurance to eligible persons through public exchanges and expanded Medicaid eligibility. The ACA also imposes an annual fee on health insurance companies to (in part) fund the Patient Centered Outcomes Research Institute (PCORI). The PCORI fee has been extended to policy years ending on or before September 30, 2029.

2. Accounting Policies

Basis of Presentation

The accompanying statutory basis financial statements have been prepared in accordance with the National Association of Insurance Commissioners' (NAIC) *Accounting Practices and Procedures Manual*, subject to any deviations prescribed or permitted by the Illinois Department of Insurance (DOI). The Company did not have any permitted practice exceptions in 2024 or 2023. These practices differ from U.S. generally accepted accounting principles (GAAP).

The more significant variances from GAAP are as follows:

Nonadmitted assets: Certain assets designated as "nonadmitted assets" are excluded from the accompanying balance sheets and are charged directly to policyholders' surplus. Nonadmitted assets consist principally of certain receivables, deferred tax assets, furniture and equipment, prepaid pension assets, leasehold improvements, and nonoperating system software. Under GAAP, these assets are included in the balance sheets, net of valuation allowances, if necessary.

Subsidiaries: Changes in equity of unconsolidated subsidiaries are reported as a direct addition or reduction to policyholders' surplus. The accounts and operations of the Company's subsidiaries are not consolidated with the accounts and operations of the Company as would be required under GAAP.

Leases: All leases are classified as operating leases. For GAAP, certain leases are classified as financing leases. GAAP also requires a lessee to record assets and liabilities arising from its lease obligations.

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2. Accounting Policies (continued)

Deferred income taxes: Deferred income taxes are provided for differences between the financial statement and the tax bases of assets and liabilities. Changes in deferred tax assets and liabilities are recorded as an addition or a reduction to policyholders' surplus. Deferred taxes do not include amounts for state taxes. The application of Statement of Statutory Accounting Principles (SSAP) No. 101, *Income Taxes,* requires a company to evaluate the recoverability of deferred tax assets and to establish a valuation allowance, if necessary, to reduce the deferred tax asset to an amount that is more likely than not to be realized. The admissibility of deferred tax assets is limited to (1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse within three years of the balance sheet date; plus (2) the lesser of the remaining gross deferred tax assets expected to be realized within three years of the balance sheet date, or an amount that is no greater than the applicable percentage of policyholders' surplus as required to be shown in the statutory balance sheet of the reporting entity for the current reporting period's statement filed with the domiciliary state commissioner, adjusted to exclude any net deferred tax assets, electronic data processing equipment and operating system software, and any net positive goodwill; plus (3) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are nonadmitted. Under GAAP, excluding the tax impact of other comprehensive income, the change in deferred income taxes is recorded in the statements of revenues and expenses. State income taxes are considered in the computation of deferred taxes.

Investments: Certain investments are stated at values prescribed or permitted by the NAIC and, therefore, are not stated in accordance with GAAP. GAAP requires that such securities be classified as held to maturity, trading, or available for sale. For GAAP, securities classified as held to maturity are carried at cost or amortized cost, while securities classified as trading or available for sale are carried at fair value, with unrealized gains and losses reported in income for all equity securities and for those fixed-income securities classified as trading and as accumulated other comprehensive income for fixed-income securities classified as available for sale. The NAIC did not adopt the GAAP guidance requiring income recognition for the unrealized gains and losses for equity securities and continues to require reporting of the unrealized gains and losses from equity securities directly as a component of unassigned surplus.

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2. Accounting Policies (continued)

Real estate: Real estate used for operational purposes is included in invested assets, whereas under GAAP, real estate is included in property and equipment. Also, under statutory accounting practices, insurance companies are required to include both imputed rental income and rental expense for owner-occupied real estate in its statements of revenues and expenses.

Statements of cash flow: The statements of cash flow are prepared in conformity with statutory accounting practices and, therefore, are not in accordance with GAAP. Cash, bank overdrafts, cash equivalents, and short-term investments in the statements of cash flow represent cash, cash equivalents, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities.

Self-funded groups: In accordance with statutory accounting practices, claim payments and their subsequent reimbursements are excluded from the Company's statements of revenues and expenses. Administrative fees earned are deducted from claims adjustment expenses and general and administrative expenses. For GAAP, these administrative fees are reported as revenue in the statements of revenues and expenses.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known, which could affect the amounts reported and disclosed therein such that actual results differ from management's estimates.

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2. Accounting Policies (continued)

Premium Revenues

Insurance premiums are recorded on the accrual basis of accounting and are recognized as income during the period of coverage.

Self-Funded Groups

The Company charges self-funded groups an administrative fee, which is usually calculated on a per subscriber basis, for processing claims and administering the plan. Administrative fee revenue is shown as a reduction of claims adjustment expenses and general and administrative expenses in the statements of revenues and expenses, while the claims processed and associated claims reimbursements received from self-funded groups are excluded from the statements of revenues and expenses. The primary type of self-funded group contracts for which the Company receives an administrative fee for providing services is ASC. ASC includes business where the Company pays benefits on behalf of employers using the Company's funds.

Federal Employee Program (FEP)

The FEP is a national contract between Blue Cross Blue Shield plans (participating plans) and the U.S. Office of Personnel Management under which participating plans provide health coverage to U.S. government employees. The contract is underwritten on an insured basis by the participating plans. The Company provides insurance coverage for FEP members in Illinois, Montana, New Mexico, Oklahoma, and Texas. The Association acts as the agent for the various participating plans. In its capacity as agent, the Association coordinates billing, claims processing, and investment activity, and reports the financial results to each participating plan. The Company reports revenues, expenses, assets, and liabilities related to its share of the contract in its financial statements.

Deferred FEP premiums, which are reported in the balance sheets as deferred premiums and accident and health policy reserves, represent funds being held in a letter of credit account maintained specifically for FEP benefits. As claim payments clear its bank account, the Company reimburses itself by drawing funds from the FEP letter of credit account.

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2. Accounting Policies (continued)

Claims Unpaid, Unpaid Claims Adjustment Liability, and Accident and Health Policy Reserves

Claims unpaid and unpaid claims adjustment liabilities on insured policies represent management's best estimate of the ultimate net cost to process and pay all reported and unreported claims incurred through December 31. The Company does not discount unpaid claims and claims adjustment liabilities. Although such amounts are based on estimates, management believes that the reserves are reasonable and adequate.

These estimates are continually reviewed, and, as adjustments to these liabilities become necessary, such adjustments are reflected in current operations. Changes in assumptions for such items as medical cost, as well as changes in actual experience, could cause these estimates to change in the near term. Reserves for unearned premium income (including deferred FEP premiums), liabilities for experience rating refunds, premium deficiency reserves (PDRs), risk adjustment payables, and the accrual for customer rebates pursuant to the Public Health Service Act are shown as accident and health policy reserves in the balance sheets.

An estimate of future claim payments is not recorded for self-funded claims.

PDR: The Company assesses the underwriting results of contracts providing insurance coverage to members, further examining segments of business where current operating results and forecasts indicate probable future losses. The Company establishes a PDR in current operations to the extent that the sum of expected future claims and incurred costs, including claims adjustment expenses and administration costs, exceeds the sum of related future premiums and anticipated investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method in which the Company manages, prices, and markets such contracts. Estimates are continually reviewed, with any necessary adjustments reflected in current operations. Changes in assumptions for such items as medical cost, as well as changes in actual experience, could cause these estimates to change in the near term.

As of December 31, 2024 and 2023, the Company had no liabilities related to PDRs. The need for PDR recognition was analyzed for policies the Company was committed to for 2025 and 2024, respectively. The Company did consider anticipated investment income when calculating PDRs. See Note 2 – Change in Accounting Policy for additional details.

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2. Accounting Policies (continued)

Health Care Receivables

Health care receivables, generally representing amounts due from contracted medical providers, are recorded when incurred. The portion of these receivables related to insured plans is reported as health care receivables, while the portion related to self-funded groups is reported in the Company's balance sheets as amounts receivable related to self-funded groups. Balances are classified as admitted assets to the extent that the Company has a payable with the same provider and will collect the receivable under the guidance included in SSAP No. 84, *Health Care and Government Insured Plan Receivables*, for the portion of these receivables related to insured plans, while portions related to self-funded groups are classified as admitted assets to the extent that they are not over 90 days past due.

Pharmacy Rebate Receivables

The Company contracts mainly with Prime Therapeutics, LLC (Prime), an affiliated Pharmacy Benefit Manager (PBM), for the administration of pharmaceutical drug claims.

Pharmacy rebate receivables are based on the PBM's estimate of the actual amounts due to the Company and an estimated amount calculated by the Company. The Company's estimated amount is based on the claims processed by the PBM in the current quarter multiplied by a contractual rate based on utilization. Pharmacy rebate receivables are included in amounts receivable related to self-funded groups and health care receivables in the balance sheets depending on the type of business.

Electronic Data Processing Equipment and Software

The Company capitalizes the cost of electronic data processing equipment, including operating system software. At December 31, 2024 and 2023, electronic data processing equipment had an admitted asset balance of $24.5 and $49.8, respectively. Electronic data processing equipment is depreciated on a straight-line basis over the lesser of three years or its remaining useful life.

Nonoperating system software is depreciated on a straight-line basis over the lesser of five years or its remaining useful life, with the remaining undepreciated balance being nonadmitted.

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2. Accounting Policies (continued)

The Company capitalizes internally developed software, which is all nonoperating system software. Development costs for internally developed software are capitalized if the total capitalizable internal and external development costs are expected to exceed the predetermined threshold. In the second quarter of 2024, the Company increased its capitalization threshold to $10.0 per project effective as of January 1, 2024 to better align with the size of the Company. Once operational, internally developed software is depreciated on a straight-line basis over the lesser of five years or its remaining useful life, with the remaining undepreciated balance being nonadmitted. As of December 31, 2024 and 2023, the net capitalized internally developed software balance was $132.7 and $58.7, respectively, with the net carrying amounts being nonadmitted.

Depreciation expense for electronic data processing equipment, nonoperating system software, and operating system software was $52.7 and $71.2 for 2024 and 2023, respectively, and is reported as claims adjustment expenses and general and administrative expenses in the statement of revenues and expenses. Accumulated depreciation was $857.2 and $810.2 at December 31, 2024 and 2023, respectively.

Furniture, Equipment, and Leasehold Improvements

The Company capitalizes the cost of furniture and equipment and depreciates these assets on a straight-line basis generally over a five-year life. The capitalization threshold for furniture and equipment is five thousand dollars per item.

The Company also capitalizes the cost of leasehold improvements and amortizes that cost on a straight-line basis over the shorter of the life of the lease or the economic useful life of the leasehold improvements. Net carrying amounts of furniture, equipment, and leasehold improvements are nonadmitted.

Investments

Investments are stated at values prescribed or permitted by the NAIC as follows:

Cash equivalents, including money market mutual funds, are investments with original maturities of three months or less. Cash equivalents are principally stated at amortized cost, which approximates fair value. All money market mutual funds are stated at net asset value (NAV) as a

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2. Accounting Policies (continued)

practical expedient for the measurement of fair value. Short-term investments are those investments that, when purchased, have a maturity between three months and one year and are stated at amortized cost, except for short-term bonds with an NAIC 3-6 designation, which are carried at the lower of amortized cost or fair value.

Bonds not backed by other loans are stated at amortized cost using the interest rate method, except for those bonds with an NAIC 3-6 designation, which are carried at the lower of amortized cost or fair value. Fair values are calculated based on the market prices provided by the custodian. If there are no market prices provided by the custodian, the fair value is calculated by the Company in conjunction with its investment advisors. All NAIC Securities Valuation Office (SVO) identified bond exchange-traded funds (ETFs) held by the Company are reported at fair value.

Loan-backed securities are carried at amortized cost, except for those loan-backed securities with an initial NAIC 3-6 designation, which are carried at the lower of amortized cost or fair value.

Prepayment assumptions for loan-backed securities are obtained from Mortgage Industry Advisor Corporation Mortgage Industry Medians, Moody's Analytics, and Reuters, and the retrospective adjustment method is used. Once a loan-backed security has recognized an other-than-temporary impairment (OTTI), the security is prospectively accreted over its remaining life to the undiscounted estimate of principal recovery.

Common stocks of nonaffiliates are stated at fair value, except for Federal Home Loan Bank (FHLB), which is stated at par. Mutual funds are stated at NAV as a practical expedient for the measurement of fair value. Fair values are based on market prices provided by the custodian, which also provides the NAV for mutual fund holdings. If there is not a market price or NAV provided by the custodian, the fair value is calculated based on market prices provided by third-party pricing services.

Preferred stocks, including preferred stocks of affiliates, are stated at cost, except for preferred stocks with an NAIC 3-6 designation, which are carried at the lower of cost or fair value. Fair values are calculated based on market prices provided by the custodian. If there are no market prices provided by the custodian, the fair value is calculated by the Company in conjunction with its investment advisors.

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2. Accounting Policies (continued)

Investments in limited liability companies (LLCs) and limited partnerships (LPs) are initially recorded at cost on the funding date. Carrying value of these investments will be equal to cost plus subsequent capital contributions to the investee, plus the Company's proportional share of audited GAAP basis earnings or losses of the investee after the date of acquisition adjusted for any distributions received.

The net unrealized capital gains (losses) on investments carried at fair value are reported in policyholders' surplus and are not recognized in income, unless there is deemed to be an OTTI, in which case the loss is charged to income. Realized gains and losses are determined on a specific lot identification basis. Security transactions are accounted for on a trade-date basis, with any unsettled transactions recorded as due to or due from investment broker and included in other invested assets and other liabilities in the balance sheets.

Impairments are recognized for investments where the decline in fair value is determined to be other than temporary. Investments in bonds not backed by other loans, common stocks, or preferred stocks are written down to fair value as the new cost basis. Investments in bonds backed by other loans are written down to the present value of cash flows expected to be collected, discounted at the loan-backed securities' effective yield immediately preceding the OTTI determination. In all cases, the amount of the write-down is accounted for as a realized loss in the Company's statements of revenues and expenses. In addition, unrealized losses would be considered realized for interest-related declines in fair value should the Company lack the intent and ability to hold these securities.

Investments in the Company's unconsolidated insurance subsidiaries are reported in the accompanying balance sheets as affiliate common stocks based on their underlying statutory capital and surplus. Investments in the Company's unconsolidated noninsurance subsidiaries are reported in the accompanying balance sheets based on their underlying GAAP equity, with certain statutory valuation adjustments. Changes in the valuation of investments in unconsolidated subsidiaries are recorded as a direct addition or reduction to net change in unrealized capital gains and losses within policyholders' surplus. Investments in the Company's LLC and LP subsidiaries are reported as other invested assets.

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2. Accounting Policies (continued)

The Company recognizes an impairment loss when the fair value of an investment in subsidiary declines and it is deemed to be other than temporary; that is, the Company does not believe future estimated earnings would be sufficient to recover prior unrealized losses in an estimable period of time. The impairment loss is recognized in the statements of revenues and expenses during the period in which the loss occurs, and the new cost basis of the investment equals its fair value. An impairment loss is first applied to the nonadmitted portion of the investment, if any. The Company does not increase the cost basis for its investment in subsidiaries for subsequent increases in fair value.

Dividends received or declared from unconsolidated subsidiaries are recorded as investment income in the statements of revenues and expenses.

Real Estate

The Company's real estate primarily consists of its headquarters and corporate data center buildings. All the real estate is categorized as properties occupied by the Company and is carried at depreciated cost. There are no mortgages. The buildings and building components are being depreciated over their useful lives, which range from 5 to 40 years.

Under statutory accounting practices, insurance companies are required to include both imputed rental income and rental expense for owner-occupied real estate. The method for calculating imputed rental income and expense is based on estimated current market value per square foot multiplied by rentable square feet. These imputed amounts are reported as net investment income, and claims adjustment expenses and general and administrative expenses in the statements of revenues and expenses as if the Company had paid itself rent of $110.4 and $110.0 in 2024 and 2023, respectively.

Pension and Postretirement Benefit Benefits

The Company measures the pension liability using the projected benefit obligation (PBO) and the postretirement benefits liability using the accumulated postretirement benefit obligation (APBO).

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2. Accounting Policies (continued)

The valuation for pension benefit obligation excludes not-yet-eligible individuals and includes non-fully vested individuals while the postretirement benefit obligations includes covered not-yet-fully-eligible employees. In addition, the differences between the APBO and the fair value of plan assets for the postretirement benefits plan, and the PBO and the fair value of plan assets for the pension plans, are recorded as an asset or a liability, with the corresponding change recorded as a direct addition or reduction to policyholders' surplus.

Accounting for the Risk Adjustment Program of the ACA

The permanent risk adjustment program transfers funds from qualified individual and small group insurance plans with lower risk to those respective plans with higher risk in the same risk pool within a state. Based on the risk of the Company's qualified plan members compared with the risk of members of other qualified plans in comparable markets, the Company estimates its risk adjustment receivable or payable and reports the year-to-date impact as an adjustment to premium revenues. The risk adjustment receivable and payable are reported in accrued retrospective premiums and accident and health policy reserves, respectively.

The process for deriving receivables and payables related to the risk adjustment program requires management to make estimates and assumptions, which could change in the future as more information becomes known. In developing its estimates, management uses experience-to-date information, and establishes a valuation allowance or nonadmits risk adjustment receivables based on marketplace activity and any significant uncertainties. These estimates and assumptions could affect the amounts reported and disclosed. The Company will perform a final reconciliation with HHS of the current year risk adjustment program in the subsequent year. Estimated receivables and payables for the risk adjustment are recorded in the balance sheet as they are due from the federal government program.

Based on the information currently available, the Company adjusted its risk adjustment balance to reflect the expected outcome of the Risk Adjustment Data Validation Audit (RADV) program. The Company records the impacts of the RADV program to premium revenues. The related risk adjustment receivable and payable are reported in accrued retrospective premiums and accident and health policy reserves, respectively.

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2. Accounting Policies (continued)

The impact of risk sharing provisions of the ACA on admitted assets, liabilities, revenue, and expenses for the current year is outlined in Note 9 – Retrospectively Rated Contracts and ACA Risk Sharing Provisions.

Medicare MAPD and Part D Contracts

The Company offers stand-alone Part D prescription drug and MAPD insurance coverage under contracts with CMS. These contracts consist of an insurance component where the insurance company assumes the risk for individuals in exchange for a fixed premium that is paid in part by CMS and in part by the covered individual. This activity is reported as insurance premiums and claims. After the end of each calendar year, for the stand-alone Part D and the Part D portion of the MAPD contract, the net gain or loss on each Part D contract is calculated and a settlement amount is determined. Based on the agreed-upon formula, a portion of any gains in excess of the target are returned to CMS and are reported as a reduction to premium revenues. Any losses outside the agreed-upon target result in an additional premium payment from CMS to the Company and are reported as an increase to premium revenues.

CMS also pays 80% of all Part D net claim costs in excess of a predetermined threshold per person, per year. Amounts received from CMS are reported as deposits and are not included in the statements of revenues and expenses. Instead, they are reported as uninsured payments pursuant to SSAP No. 47, *Uninsured Plans*, which pertains to accounting for self-funded business. The claim amounts over the threshold are reported as receivables due from CMS, and payments received from CMS are reported as collection of the receivable. Lastly, for certain low-income members, CMS is responsible for part or all of the members' cost-sharing amounts, such as deductibles. This program is known as Low Income Member Cost Share. CMS pays the Company each month an amount that is expected to cover these cost sharing amounts. The Company pays these claims on behalf of CMS and then settles with CMS based on actual experience after the end of the contract year. Revenues and claims under this arrangement are reported as deposits and, as such, are excluded from the statements of revenues and expenses. The Company had claims and claim reimbursements related to the uninsured portion of the MAPD and Part D business of $164.7 and $169.1 in 2024 and 2023, respectively. No gain or loss was recorded.

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2. Accounting Policies (continued)

In addition, CMS implemented the Coverage GAP Discount Program, in which drug manufacturers provide a 50% discount on brand drugs to Part D members in the coverage gap.

CMS pays monthly cash advances to the Company and then on a quarterly basis, after the manufacturers have reimbursed the Company for the actual cost of the 50% discount, nets the actual cost against the next advance. Revenues and claims under this arrangement are reported as deposits and, as such, are excluded from the statements of revenues and expenses.

ACA Advance Premium Tax Credit (APTC)

CMS pays some portion of the member's monthly premiums to the Company on the member's behalf for qualifying low-income members who purchased Qualified Health Plans. The Company accounts for these APTCs as premium revenues because the Company assumes the insurance risk for these members, which are recognized as income during the period of coverage. The Company recognized $10,340.8 and $5,864.6 of APTCs for the years ended December 31, 2024 and 2023, respectively. Under the ACA, these members have a three-month grace period to pay their member share of premiums. During the first month of the grace period, insurers are entitled to keep the APTC and must pay for the member's claims.

Change in Accounting Policy

During 2024, the Company implemented a change in accounting principle to include anticipated investment income in its calculation of PDR. This approach allows for a more holistic view of the Company's forecasted operating results. The cumulative effect of this change in accounting had no material impact on the Company's financial position or operating results.

Effect of New Accounting Pronouncements

SSAP No. 94, *Transferable and Non-Transferable State Tax Credits*, was updated to include both purchased state and federal tax credits. The revised guidance is effective as of January 1, 2025, with an option to early adopt. The Company early adopted the guidance in Q1 2024, which had an immaterial impact to the Company's financial position.

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2. Accounting Policies (continued)

SSAP No. 26, *Bonds*, SSAP No. 43 *Loan-Backed and Structured Securities*, and other related SSAPs were updated as part of the NAIC's principle-based bond definition project. Under the new bond definition, bonds are classified as either an "issuer credit obligation" or an "asset-backed security" and must establish a creditor relationship. Securities that exhibit equity-like features will transition to a new accounting and reporting standards under SSAP No. 21, *Other Admitted Assets*. The revisions were effective January 1, 2025. The adoption of this guidance will not have a material impact on the Company's financial position and results of operations.

3. Fair Values of Financial Instruments

The Company's financial assets and liabilities carried at fair value have been classified, for disclosure purposes, based on a hierarchy that gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest ranking to fair values determined using methodologies and models with unobservable inputs (Level 3). An asset's or a liability's classification is based on the lowest-level input that is significant to its measurement. For example, a Level 3 fair value measurement may include inputs that are both observable (Levels 1 and 2) and unobservable (Level 3). There were no changes in valuation techniques from the prior period.

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3. Fair Values of Financial Instruments (continued)

The levels of the fair value hierarchy, as defined by SSAP No. 100, *Fair Value*, are as follows:

Level Input	Input Definition
Level 1	Inputs are unadjusted quoted prices for identical assets and liabilities in active markets accessible at the measurement date.
Level 2	Inputs include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the instrument. Such inputs include market interest rates and volatilities, spreads, and yield curves.
Level 3	Certain inputs are unobservable (supported by little or no market activity) and significant to the fair value measurement. Unobservable inputs reflect the Company's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.
NAV	NAV per share is the amount of net assets attributable to each share of capital stock (other than senior equity securities, that is, preferred stock) outstanding at the close of the period. It excludes the effects of assuming conversion of outstanding convertible securities, whether or not their conversion would have a diluting effect.

In order to be classified as Level 1, unadjusted quoted market prices for identical assets or liabilities in active markets must be available. Fair values based on quoted prices for similar assets in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the instrument (e.g., market interest rates and volatilities, spreads, yield curves, reported trades, broker/dealer quotes, bids, and offers) are classified as Level 2. Fair values not determined using the methods applicable to Levels 1 and 2, such as using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality (matrix pricing) or other methods, models, and assumptions that management believes market participants would use to determine a current transaction price, are assigned to Level 3.

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3. Fair Values of Financial Instruments (continued)

The Company's invested assets subject to this disclosure are priced principally through independent pricing services that obtain prices from reputable pricing vendors in the marketplace. Through contracted custodians and software vendors, the Company obtains prices for all securities and continually monitors and reviews the external pricing sources while actively attempting to resolve any pricing issues that may arise. These service providers use a market approach to find pricing of similar financial instruments.

These valuation techniques involve some level of management estimation and judgment, which become significant with increasingly complex instruments or pricing models. Where appropriate, adjustments are included to reflect the risk inherent in a particular methodology, model, or input used.

Included in common stocks in the balance sheets are certain financial instruments carried at fair value. Other financial instruments are periodically measured at fair value, such as when impaired, or for certain bonds, when carried at the lower of amortized cost or fair value.

The following tables summarize fair value measurements by level at December 31 for assets carried at fair value on a recurring basis:

	Level 1	Level 2	Level 3	NAV	Total
2024					
Bonds	**$ 424.2**	**$ 766.9**	**$ –**	**$ –**	**$ 1,191.1**
Short-term investments	**–**	**0.7**	**–**	**–**	**0.7**
Nonaffiliate preferred stocks	**–**	**18.7**	**–**	**–**	**18.7**
Nonaffiliate common stocks	**95.7**	**1.7**	**28.6**	**1,223.1**	**1,349.1**
Money market mutual funds	**–**	**–**	**–**	**4,647.3**	**4,647.3**
	$ 519.9	**$ 788.0**	**$ 28.6**	**$ 5,870.4**	**$ 7,206.9**
2023					
Bonds	$ 431.2	$ 892.2	$ –	$ –	$ 1,323.4
Short-term investments	–	0.3	–	–	0.3
Nonaffiliate common stocks	74.9	–	24.2	1,298.1	1,397.2
Money market mutual funds	–	–	–	1,919.7	1,919.7
	$ 506.1	$ 892.5	$ 24.2	$ 3,217.8	$ 4,640.6

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3. Fair Values of Financial Instruments (continued)

It is the Company's policy to recognize transfers between fair value hierarchy levels at the end of the reporting period. There were no transfers between levels during 2024 or 2023.

The following table provides the aggregate fair value for all financial instruments, excluding those accounted for under the equity method, by fair value hierarchy level as of December 31:

Type of Financial Instrument	Aggregate Fair Value	Carrying Value	Level 1	Level 2	Level 3	NAV
2024						
Assets:						
Bonds	**$ 17,542.4**	**$ 18,823.3**	**$ 425.3**	**$ 17,117.1**	**$ –**	**$ –**
Cash equivalents	**750.6**	**750.6**	**–**	**750.6**	**–**	**–**
Short-term investments	**4.4**	**3.2**	**–**	**4.4**	**–**	**–**
Money market mutual funds	**4,647.3**	**4,647.3**	**–**	**–**	**–**	**4,647.3**
Nonaffiliate common stocks	**1,354.1**	**1,354.1**	**95.7**	**6.7**	**28.6**	**1,223.1**
Affiliate preferred stocks	**268.6**	**268.6**	**–**	**–**	**268.6**	**–**
Nonaffiliate preferred stocks	**93.8**	**93.8**	**–**	**18.7**	**75.1**	**–**
Other invested assets	**0.4**	**0.4**	**–**	**0.4**	**–**	**–**
Total assets at fair value	**$ 24,661.6**	**$ 25,941.3**	**$ 521.0**	**$ 17,897.9**	**$ 372.3**	**$ 5,870.4**
Liabilities:						
Notes	**$ 4,089.9**	**$ 4,480.1**	**$ –**	**$ 4,089.9**	**$ –**	**$ –**
Total liabilities at fair value	**$ 4,089.9**	**$ 4,480.1**	**$ –**	**$ 4,089.9**	**$ –**	**$ –**
2023						
Assets:						
Bonds	$ 18,819.9	$ 20,238.6	$ 431.2	$ 18,388.7	$ –	$ –
Cash equivalents	5.0	5.0	–	5.0	–	–
Short-term investments	1.6	1.5	–	1.6	–	–
Money market mutual funds	1,919.7	1,919.7	–	–	–	1,919.7
Nonaffiliate common stocks	1,402.2	1,402.2	74.9	5.0	24.2	1,298.1
Affiliate preferred stocks	224.7	224.7	–	–	224.7	–
Nonaffiliate preferred stocks	52.9	52.9	–	–	52.9	–
Other invested assets	0.4	0.5	–	0.4	–	–
Total assets at fair value	$ 22,426.4	$ 23,845.1	$ 506.1	$ 18,400.7	$ 301.8	$ 3,217.8
Liabilities:						
Notes	$ 1,643.1	$ 1,992.2	$ –	$ 1,643.1	$ –	$ –
Total liabilities at fair value	$ 1,643.1	$ 1,992.2	$ –	$ 1,643.1	$ –	$ –

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4. Investments

The cost or carrying value and fair value of investments in long-term bonds and stocks held by the Company at December 31 are as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
2024				
U.S. government and agency securities	**$ 1,585.8**	**$ 0.4**	**$ (174.8)**	**$ 1,411.4**
Corporate bonds	**10,103.8**	**80.5**	**(659.4)**	**9,524.9**
ETF as identified by the SVO	**450.0**	**–**	**(25.8)**	**424.2**
Loan-backed and structured securities	**6,748.5**	**17.4**	**(585.1)**	**6,180.8**
Certificates of Deposit	**1.1**	**–**	**–**	**1.1**
Total bonds	**18,889.2**	**98.3**	**(1,445.1)**	**17,542.4**
Affiliate preferred stocks	**268.6**	**–**	**–**	**268.6**
Nonaffiliate preferred stocks	**93.9**	**0.1**	**(0.2)**	**93.8**
Affiliate common stocks	**2,123.6**	**183.2**	**(284.9)**	**2,021.9**
Nonaffiliate common stocks	**675.1**	**685.9**	**(6.9)**	**1,354.1**
Total stocks	**3,161.2**	**869.2**	**(292.0)**	**3,738.4**
	$ 22,050.4	**$ 967.5**	**$ (1,737.1)**	**$ 21,280.8**
2023				
U.S. government and agency securities	$ 1,986.0	$ 8.9	$ (176.8)	$ 1,818.1
Corporate bonds	10,933.1	94.1	(826.0)	10,201.2
ETF as identified by the SVO	460.0	0.5	(29.3)	431.2
Loan-backed and structured securities	6,955.4	23.8	(609.8)	6,369.4
Total bonds	20,334.5	127.3	(1,641.9)	18,819.9
Affiliate preferred stocks	224.7	–	–	224.7
Nonaffiliate preferred stocks	52.9	–	–	52.9
Affiliate common stocks	2,059.2	183.9	(260.7)	1,982.4
Nonaffiliate common stocks	708.5	700.8	(7.1)	1,402.2
Total stocks	3,045.3	884.7	(267.8)	3,662.2
	$ 23,379.8	$ 1,012.0	$ (1,909.7)	$ 22,482.1

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4. Investments (continued)

Cost for bond categories included in the table above is different from the bond value included in the balance sheet by $65.9 and $95.9 in 2024 and 2023, respectively, resulting from certain bonds being carried at fair value.

The portion of unassigned surplus represented by net unrealized gains totaled $591.6 and $437.0 as of December 31, 2024 and 2023, respectively.

The Company believes that all unrealized losses on individual securities are the result of normal price fluctuations due to market conditions and are not an indication of OTTI. Market conditions include interest rate fluctuations, credit quality, supply, and demand.

In 2024, the Company recognized OTTI losses of $19.9 on bonds, $2.8 on nonaffiliate preferred stocks and $2.6 on nonaffiliate common stocks. In 2023, the Company recognized OTTI losses of $49.3 on bonds and $4.3 on nonaffiliate preferred stocks. The Company recognized OTTI losses of $3.1 and $19.1 on loan-backed securities in 2024 and 2023, respectively. See Note 5 – Investments in Unconsolidated Subsidiaries for disclosure of OTTI related to investments in subsidiaries.

The following table illustrates the fair value and gross unrealized losses, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position, at December 31:

	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Loss	Fair Value	Unrealized Loss	Fair Value	Unrealized Loss
2024						
U.S. government and agency securities	**$ 366.1**	**$ (9.2)**	**$ 1,045.3**	**$ (165.6)**	**$ 1,411.4**	**$ (174.8)**
Corporate bonds	**4,073.1**	**(37.5)**	**5,451.8**	**(621.9)**	**9,524.9**	**(659.4)**
ETF as identified by the SVO	**–**	**–**	**424.2**	**(25.8)**	**424.2**	**(25.8)**
Loan-backed and structured securities	**2,315.7**	**(22.8)**	**3,865.1**	**(562.3)**	**6,180.8**	**(585.1)**
Affiliate preferred stocks	**268.6**	**–**	**–**	**–**	**268.6**	**–**
Nonaffiliate preferred stocks	**79.1**	**–**	**14.7**	**(0.2)**	**93.8**	**(0.2)**
Affiliate common stocks	**588.0**	**(41.2)**	**1,433.9**	**(243.7)**	**2,021.9**	**(284.9)**
Nonaffiliate common stocks	**1,347.3**	**(3.6)**	**6.8**	**(3.3)**	**1,354.1**	**(6.9)**
	$ 9,037.9	**$ (114.3)**	**$ 12,241.8**	**$ (1,622.8)**	**$ 21,279.7**	**$ (1,737.1)**

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4. Investments (continued)

	Less Than 12 Months		12 Months or More		Total	
	Fair Value	Unrealized Loss	Fair Value	Unrealized Loss	Fair Value	Unrealized Loss
2023						
U.S. government and agency securities	$ 409.8	$ (5.7)	$ 1,408.3	$ (171.1)	$ 1,818.1	$ (176.8)
Corporate bonds	2,596.0	(8.9)	7,605.2	(817.1)	10,201.2	(826.0)
ETF as identified by the SVO	10.5	–	420.7	(29.3)	431.2	(29.3)
Loan-backed and structured securities	1,257.3	(5.3)	5,112.1	(604.5)	6,369.4	(609.8)
Affiliate common stocks	597.1	(44.4)	1,385.3	(216.3)	1,982.4	(260.7)
Nonaffiliate common stocks	1,370.4	(1.8)	31.8	(5.3)	1,402.2	(7.1)
	$ 6,241.1	$ (66.1)	$ 15,963.4	$ (1,843.6)	$ 22,204.5	$ (1,909.7)

Management regularly reviews the fair value of the Company's investments. If the fair value of any investment falls below its cost basis, the decline is analyzed to determine whether it is an other-than-temporary decline in value. The analysis considers the following:

- The length of time and the extent to which the fair value has been below cost
- The financial condition and near-term prospects of the issuer of the security, including any specific events that may affect its operations or earning potential
- Management's intent and ability to hold the security long enough for it to recover its value

Using the results of this analysis, management makes a judgment as to whether the loss is other than temporary. If management determines the loss is other-than-temporary, an impairment charge is recorded as a net realized investment loss in the statements of revenues and expenses in the period the determination is made.

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4. Investments (continued)

A summary of the carrying value and fair value of the Company's investments in bonds at December 31, 2024, by contractual maturity, is shown below. Expected maturities may differ from contractual maturities because certain borrowers may have the right to adjust, call, or prepay obligations with or without prepayment penalties.

	Carrying Value	Fair Value
Due in one year or less	$ 427.9	$ 426.9
Due after one year through five years	5,340.2	5,192.4
Due after five years through ten years	3,938.7	3,687.7
Due after ten years	1,943.9	1,630.4
ETF as identified by the SVO	424.2	424.2
Loan-backed and structured securities	6,748.4	6,180.8
	$ 18,823.3	$ 17,542.4

The number of securities not rated by the NAIC (5GI securities) held by the Company, by investment type, and the carrying value and fair value at December 31 are as follows:

	Number of Securities		Carrying Value		Fair Value	
	2024	**2023**	**2024**	**2023**	**2024**	**2023**
Bonds	**7**	4	**$ 2.6**	$ 2.5	**$ 2.6**	$ 2.6
Preferred stock	**6**	2	**343.6**	52.8	**343.6**	52.8
	13	6	**$ 346.2**	$ 55.3	**$ 346.2**	$ 55.4

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4. Investments (continued)

The proceeds from disposals of securities that resulted in realized gains or losses for the years ended December 31 are as follows:

	Cost or Amortized Cost	Realized Gains	Realized Losses	Proceeds From Sales
2024				
U.S. government and agency securities	**$ 928.9**	**$ 7.4**	**$ (33.6)**	**$ 902.7**
Corporate and other bonds	**2,302.4**	**29.6**	**(174.4)**	**2,157.6**
ETF as identified by the SVO	**1,150.0**	**0.4**	**(2.0)**	**1,148.4**
Nonaffiliate common stocks	**91.1**	**222.3**	**(0.5)**	**312.9**
Cash equivalents and short-term investments	**4,012.8**	**0.2**	**(0.1)**	**4,012.9**
Other invested assets	**0.4**	**–**	**–**	**0.4**
	$ 8,485.6	**$ 259.9**	**$ (210.6)**	**$ 8,534.9**
2023				
U.S. government and agency securities	$ 140.3	$ 0.9	$ (4.5)	$ 136.7
Corporate and other bonds	1,381.4	9.7	(96.6)	1,294.5
ETF as identified by the SVO	1,458.7	0.2	(87.2)	1,371.7
Nonaffiliate common stocks	64.5	168.4	(0.2)	232.7
Cash equivalents and short- term investments	457.2	0.1	–	457.3
Other invested assets	0.4	–	–	0.4
	$ 3,502.5	$ 179.3	$ (188.5)	$ 3,493.3

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4. Investments (continued)

Net investment income earned for the years ended December 31 is as follows:

	2024	2023
U.S. government bonds	**$ 45.5**	$ 38.9
Other bonds (unaffiliated)	**745.9**	712.0
Preferred stock and common stock (unaffiliated)	**29.6**	28.8
Preferred stock and common stock (affiliated)	**100.0**	40.0
Real estate	**123.5**	123.1
Other invested assets	**81.1**	35.2
FEP and other	**44.7**	44.1
Cash, cash equivalents, and short-term investments	**148.4**	64.8
Gross investment income	**1,318.7**	1,086.9
Less investment expenses	**(233.4)**	(160.9)
Net investment income	**$ 1,085.3**	$ 926.0

Investment expense for 2024 and 2023 is composed of real estate taxes and expenses of $54.6 and $55.3, respectively; other investment expense of $51.2 and $56.1, respectively; and interest expense of $127.6 and $49.5, respectively. All investment income due and accrued of $153.0 and $154.7 was admitted and included in policyholders' surplus at December 31, 2024 and 2023, respectively.

The Company does not engage in any off-balance sheet, material derivative, or hedging activities. There are no significant industries or other concentrations.

Restricted Assets

Starting in 2023, the Company is required to maintain amounts in dedicated bank accounts pursuant to the requirements of the New Mexico Medicaid (NM Medicaid) contract and the Texas Employee Retirement System (TERS) contract. At December 31, 2024 the Company held bonds and cash equivalents with a carrying value of $182.4 and $7.7, respectively, pursuant to the NM Medicaid contract and cash with a carrying value of $104.6 pursuant to the TERS contract, all of which was admitted.

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5. Investments in Unconsolidated Subsidiaries

Below is a listing of directly or indirectly owned subsidiaries as of December 31, 2024 (the percentage of ownership is 100% unless otherwise stated):

505 Insurance Company (NM PPO)
Alacura Holdings, Inc. (30.9%)
Availity, LLC (19.5%) (Availity)
Avalon Health Services, LLC, d/b/a Avalon Healthcare Solutions (18.0%)
Blue Cross Blue Shield Venture Partners, L.P. (21.6%)
Blue Cross Blue Shield Ventures, Inc. (21.6%)
CMH Technology Subsidiary, LLC (CMH)
Cogitativo, Inc. (11.9%)
Collective Health, Inc. (14.5%) (CollectiveHealth)
Dearborn Life Insurance Company (DLIC)
Dearborn National Life Insurance Company of New York (DNLNY)
Dental Network of America, LLC (DNoA)
Dental Solutions, Inc.
DenteMax, LLC
Essential Health Partners, LLC (40.0%)
Genovista Health, LLC (49.0%)
GHS General Insurance Agency, Inc.
GHS Health Maintenance Organization Inc., d/b/a BlueLincs HMO (BlueLincs)
GHS Insurance Company (GHSIC)
GSI Health, LLC
HCSC Insurance Services Company (HISC)
HCSC Investments, LLC (HCINV)
HCSC ITC, LLC
HCSC Medicare Holdings Inc.
HCSC Medicare Inc.
HCSC Purchasing, LLC
HCSC Ventures, Inc. (HCSCV)
Health Intelligence Company, LLC, d/b/a Blue Health Intelligence (10.6%)
Healthbox Chicago III, LLC (36.3%)
Illinois Blue Cross Blue Shield Insurance Company (IL PPO)
Innovista Health Partners, LLC
Innovista Medical Center Texas, LLC (d/b/a Innovista Medical Center
Innovista, LLC (Innovista)
Luminare Health Benefits, Inc. (Luminare Health)
Medecision, Inc. (Medecision)
Prime (39.0%)
Silver Cross MSO, LLC (13.3%)
Solera Health, Inc (28.8%)
South Water Insurance Company (SOWIC)
Texas Blue Cross Blue Shield Insurance Company (TX PPO)
Triwest Alliance Inc. (15.6%) (TriWest)

The Company may make capital contributions or loans to its subsidiaries from time to time to fund subsidiary growth or meet regulatory requirements. Those transactions considered significant for the years ended December 31, 2024 and 2023, are discussed below.

The Company made cash capital contributions of $114.9 to HCSCV and received as return of capital of $115.2 from HCSCV in 2024. The Company made cash capital contributions of $116.1 to HCSCV and received as return of capital of $12.1 from HCSCV in 2023. The Company also made cash capital contributions of $284.0 to HCINV and received as return of capital of $14.0 from HCINV in 2024. The Company made cash capital contributions of $368.0 to HCINV and received as return of capital of $15.0 from HCINV in 2023. HCINV paid the Company cash

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5. Investments in Unconsolidated Subsidiaries (continued)

dividends of $45.9 and $14.9 in 2024 and 2023, respectively. The contributions are reflected in the statutory carrying value of the subsidiaries and the dividends were reported in net investment income.

The Company recognized net realized investment losses within the statement of revenues and expenses on the following wholly owned subsidiary investments for the years ended December 31:

	2024	2023
GHSIC	**$ 65.7**	$ 62.5
HISC	**58.7**	3.4
Innovista	**26.4**	19.7
Medecision	**14.9**	10.0
IL PPO	**0.4**	1.1
	$ 166.1	$ 96.7

These net realized investment losses were recognized as the future estimated earnings of these subsidiaries were not expected to be sufficient to cover prior unrealized losses in a reasonable period of time. There was no impact on policyholders' surplus from the recognition of these unrealized losses.

The Company utilizes the look through approach in valuing its investment in HCSCV, a non-insurance holding company, and HCINV, a non-insurance LLC, which had carrying values of $801.6 and $1,163.6 as of December 31, 2024, respectively and $757.2 and $833.3 as of December 31, 2023, respectively. HCSCV and HCINV's financial statements are not audited, so the Company limited the value of its investment in HCSCV and HCINV to the underlying GAAP equity, with certain statutory valuation adjustments, of the audited Subsidiary, Controlled, and Affiliated (SCA) entities and the audited non-SCA entities owned by HCSCV and HCINV as defined by SSAP No. 48, *Joint Ventures, Partnerships and Limited Liability Companies*.

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5. Investments in Unconsolidated Subsidiaries (continued)

The Company has guaranteed, to the full extent of its assets, all the contractual and financial obligations to the customers of its six wholly owned health insurance subsidiaries (BlueLincs, GHSIC, HISC, IL PPO, NM PPO, and TX PPO) and its wholly owned life insurance subsidiary (DLIC) for liabilities arising while they are licensed under the Association. The Company has not recorded any liabilities to cover these types of agreements or commitments.

The balance sheet values, admitted and nonadmitted, of the Company's investments in SCA entities per SSAP No. 97, *Investments in Subsidiary, Controlled and Affiliated Entities*, except investments in insurance SCA entities as of December 31, 2024, are as follows:

SCA Investment	Gross SCA Value	Nonadmitted	Admitted
HCINV	$ 1,163.6	$ –	$ 1,163.6
HCSCV	812.0	10.4	801.6
Prime	563.7	430.6	133.1
Luminare Health	360.4	–	360.4
SOWIC	107.5	–	107.5
TriWest	69.7	–	69.7
DNoA	60.1	33.7	26.4
Availity	44.5	54.8	(10.3)
Innovista	33.1	–	33.1
Blue Health Intelligence	9.0	–	9.0
GHS General Insurance Agency, Inc.	3.1	3.1	–
Solera Health, Inc.	3.0	–	3.0
HCSC Purchasing, LLC	0.6	0.6	–
Medecision	(4.9)	36.3	(41.2)
Total	$ 3,225.4	$ 569.5	$ 2,655.9

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5. Investments in Unconsolidated Subsidiaries (continued)

The required SCA filings per SSAP No. 97 with the NAIC are summarized below:

SCA Investment – SCA Filing with NAIC	Type of Filing (a)	Date of Filing		Valuation Amount for the SCA Entity	Response Received	Resubmission Required
a. SSAP No. 97 8a Entities:						
Total SSAP No. 97 8a Entities	N/A	N/A	$	–	N/A	N/A
b. SSAP No. 97 8b(ii) Entities:						
Availity	N/A	–	$	–	–	–
DNoA	N/A	–		–	–	–
Medecision	S2	8/22/2024		–	Y	N
Prime	N/A	–		–	–	–
Total SSAP No. 97 8b(ii) Entities	N/A	N/A	$	–	N/A	N/A
c. SSAP No. 97 8b(iii) Entities:						
GHS General Insurance Agency, Inc.	N/A	–	$	–	–	–
HCINV	N/A	–		–	–	–
HCSC Purchasing, LLC	N/A	–		–	–	–
HCSCV	S2	1/22/2025		763.2	Y	N
Blue Health Intelligence	N/A	–		–	–	–
Innovista	N/A	–		–	–	–
SOWIC	S2	8/22/2024		91.6	Y	N
Solera Health, Inc.	S1	2/5/2025		–	Y	N
TriWest	S2	8/22/2024		47.0	Y	N
Luminare Health	S2	1/14/2025		408.3	Y	N
Total SSAP No. 97 8b(iii) Entities	N/A	N/A	$	1,310.1	N/A	N/A
d. SSAP No. 97b(iv) Entities						
Total SSAP No. 97 8b(iv) Entities	N/A	N/A	$	–	N/A	N/A
e. Total SSAP No. 97 8b Entities (except 8bi entities) (b+c+d)	N/A	N/A	$	1,310.1	N/A	N/A
f. Aggregate Total (a+e)	N/A	N/A	$	1,310.1	N/A	N/A

(a) Filing not required for investments marked N/A

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6. Receivables

Pharmacy Rebate Receivable

The total pharmacy rebate receivable at December 31, 2024, 2023, and 2022, was $2,548.4, $3,178.0, and $2,264.3, respectively. Of these amounts, $716.7, $657.7, and $372.9 were nonadmitted for 2024, 2023, and 2022, respectively. The net admitted assets of $1,831.7, $2,520.3, and $1,891.4 at December 31, 2024, 2023, and 2022, respectively, are included in amounts receivable related to self-funded groups and health care receivables in the balance sheets depending on the type of business. The billed or confirmed pharmacy rebates owed to the Company in 2024, 2023, and 2022 were $4,731.1, $5,354.0, and $3,753.7, respectively.

In 2024, 2023, and 2022, the Company collected pharmacy rebates of $7,138.5, $4,429.6, and $3,272.8, respectively. The chart below contains further detail regarding pharmacy rebate receivables and collections, by quarter, for 2022–2024:

	Estimated Pharmacy Rebates as Reported on Financial Statements	**Pharmacy Rebates as Billed or Otherwise Confirmed**	**Actual Rebates Received Within 90 Days of Billing**	**Actual Rebates Received Within 91 to 180 Days of Billing**	**Actual Rebates Received More Than 180 Days After Billing**
12/31/2024	**$ 1,789.4**	**$ 2.0**	**$ –**	**$ –**	**$ –**
9/30/2024	**1,759.8**	**1,694.7**	**1,437.3**	**–**	**–**
6/30/2024	**1,801.7**	**1,582.1**	**1,537.1**	**(21.0)**	**–**
3/31/2024	**1,437.0**	**1,452.3**	**1,284.1**	**33.1**	**0.8**
12/31/2023	$ 1,557.9	$ 1,483.6	$ 1,414.6	$ 19.1	$ 5.8
9/30/2023	1,365.2	1,259.7	1,382.9	56.8	(26.8)
6/30/2023	1,487.6	1,487.4	1,266.1	7.9	2.8
3/31/2023	1,131.5	1,123.3	1,103.1	47.0	(33.9)
12/31/2022	$ 1,062.5	$ 1,069.8	$ 1,057.5	$ (4.2)	$ (4.8)
9/30/2022	1,143.7	1,029.0	981.5	30.4	(37.7)
6/30/2022	952.6	880.7	910.5	29.2	(0.9)
3/31/2022	845.4	774.2	752.4	70.0	13.2

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6. Receivables (continued)

ACA Cost-Sharing

The ACA created a system of reduced cost-sharing in certain defined plans sold to eligible lower income persons available through the ACA marketplaces. Such reduced cost-sharing was subsidized through direct reimbursements from the Federal government to the issuers of such policies. CMS paid the Company such cost sharing reimbursements (CSRs) for benefit years 2014 through part of the 2017 benefit year. However, in October 2017, an executive order immediately discontinued federal funding of these CSR reimbursements to issuers. In August 2020, Federal Courts ruled that the Federal Government must pay CSR reimbursements to insurers but left undecided to what extent any payments would be reduced to account for adjustments payors made to their premiums after CSR payments stopped. Consequently, at the time of the ruling, the net receivable amounts were not readily known. In 2024, the Company established the bases for the receivable of $254.6, net of legal fees. In February of 2025, the Company received the settlement. This amount is reported as other admitted assets in the balance sheets and as a reduction to benefit expenses on the statements of revenue and expenses.

7. Self-Funded Groups

The Company provides certain claim processing and administration services for self-funded groups.

The net gain from operations related to ASCs for 2024 and 2023 is shown below:

	2024	2023
Gross reimbursement for medical cost incurred	**$ 89,376.2**	$ 82,703.4
Gross administrative fees earned	**4,264.3**	4,274.0
Gross expenses incurred (claims and administrative)	**(93,234.5)**	(86,583.3)
Net gain from operations	**$ 406.0**	$ 394.1

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8. Claims Unpaid and Unpaid Claims Adjustment Liability

The following table provides a reconciliation of the beginning and ending balances of unpaid claims liability as of December 31, which includes claims unpaid, accrued medical incentives, and unpaid claims adjustment liability:

	2024	2023
Claims unpaid, at beginning of year	**$ 4,848.7**	$ 5,113.4
Incurred expenses related to:		
Current year	**59,181.2**	50,590.5
Prior years	**(4.6)**	(586.5)
Total incurred	**59,176.6**	50,004.0
Paid expenses related to:		
Current year	**53,467.9**	45,940.4
Prior years	**4,722.7**	4,328.3
Total paid	**58,190.6**	50,268.7
Claims unpaid, at end of year	**$ 5,834.7**	$ 4,848.7

Reserves for incurred claims and claim adjustment expenses attributable to insured events of prior years are periodically updated. These updates are generally the result of ongoing analysis of recent loss development trends. Original estimates are increased or decreased as additional information becomes known regarding individual claims. In calendar years 2024 and 2023, the favorable development reported for incurred expenses related to prior years resulted from claims being settled for amounts less than originally estimated. In both 2024 and 2023, this decrease is primarily attributable to actual medical cost experience being more favorable than that assumed at the time the liability was established.

The Company considered estimated anticipated salvage and subrogation in its determination of the net liability for unpaid claims and reduced such liability by $1,090.7 and $891.5 as of December 31, 2024 and 2023, respectively.

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9. Retrospectively Rated Contracts and ACA Risk Sharing Provisions

The Company estimates accrued retrospective premium adjustments for certain contracts such as MAPD, Medicaid, ACA in the individual and student health plans market, and group health insurance business with experience-rated contracts through using various mathematical approaches, including, where allowed, an algorithm of the Company's underwriting rules and experience rating practices.

The ACA risk adjustment, the Part D portion of its MAPD contract and the stand-alone Part D are subject to "risk share settlement" with CMS, which is settled subsequent to the end of the plan year.

The retrospective premium and accrued risk share settlements are recorded as an adjustment to premium earned once estimable and in the period the determination is made.

The amount of net premiums written by the Company at December 31, 2024 and 2023, that are subject to retrospective rating features was $58,385.8 and $50,419.7, respectively, which are primarily related to premiums subject to minimum MLR rebates, and risk adjustment pursuant to the ACA, MAPD, and Medicaid premiums. This represented 93% of the total net premiums written in both 2024 and 2023.

Premium income was decreased by $3.5 and increased by $36.5 related to MLR rebates pursuant to the Public Health Service Act that were incurred for the years ended December 31, 2024 and 2023, respectively. The following table details MLR rebates pursuant to the Public Health Service Act that were accrued but not paid as of December 31, 2024:

	Individual	Other Categories With Rebates	Total
Rebates unpaid, at January 1, 2023	$ 36.8	$ –	$ 36.8
Rebates incurred	(36.8)	0.3	(36.5)
Rebates paid	–	–	–
Rebates unpaid, at December 31, 2023	–	0.3	0.3
Rebates incurred	**–**	**3.5**	**3.5**
Rebates paid	**–**	**–**	**–**
Rebates unpaid, at December 31, 2024	**$ –**	**$ 3.8**	**$ 3.8**

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9. Retrospectively Rated Contracts and ACA Risk Sharing Provisions (continued)

The Company did not owe ACA MLR rebates in the Small Group or Large Group Employer rebate-eligible segments.

The impact of risk sharing provisions of the ACA on the Company's admitted assets, liabilities, revenues, and expenses as of December 31 is as follows:

	2024	2023
Permanent ACA Risk Adjustment Program		
Assets:		
Risk adjustment receivable	**$ 1,124.8**	$ 1,579.3
Liabilities:		
Risk adjustment user fees payable	**7.3**	5.6
Risk adjustment payable	**112.0**	86.3
Revenues and expenses:		
Premium revenues	**816.1**	1,227.2
Risk adjustment user fees	**7.4**	5.7

The below table is a rollforward of prior year ACA risk sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 – 3)	Prior Year Accrued Less Payments (Col 2 – 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 – 3 +7)	Cumulative Balance from Prior Years (Col 2 – 4 +8)
	1	2	3	4	5	6	7	8		9	10
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref*	Receivable	(Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustments receivable	$ 1,579.3	$ –	$ 1,262.8	$ –	$ 316.5	$ –	$ (207.2)	$ –	A	$ 109.3	$ –
2. Premium adjustments (payable)	–	(86.3)	–	(73.9)	–	(12.3)	–	12.2	A	–	(0.2)
3. Subtotal ACA Permanent Risk Adjustment Program	$ 1,579.3	$ (86.3)	$ 1,262.8	$ (73.9)	$ 316.5	$ (12.3)	$ (207.2)	$ 12.2		$ 109.3	$ (0.2)

*Explanations of Adjustments

A. Adjustments were made to reflect risk adjustment data provided by CMS beginning in July of 2024 through August 6, 2024 and insolvency risk of other market participants.

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10. Borrowed Funds

On June 10, 2024, the Company issued $2,500.0 aggregate principal amount of notes pursuant to Rule 144A under the Securities Act of 1933. The notes were issued in three separate tranches consisting of $750.0 aggregate principal amount of 5.200% notes maturing on June 15, 2029, $750.0 aggregate principal amount of 5.450% notes maturing on June 15, 2034 and $1,000.0 aggregate principal amount of 5.875% notes maturing on June 15, 2054. Interest for all tranches is payable on June 15 and December 15 of each year. All of the aforementioned notes may be redeemed prior to maturity for an amount calculated to preserve the purchase yield of the holders for the duration of the notes. Through December 31, 2024, $71.2 in interest has been paid on these notes. As of December 31, 2024, the carrying value of the debt obligations, including discount accretion was $2,494.5. The Company has remained in compliance with all debt covenants since date of issue.

On June 1, 2020, the Company issued $2,000.0 aggregate principal amount of notes pursuant to Rule 144A under the Securities Act of 1933. The notes were issued in three tranches consisting of $500.0 aggregate principal amount of 1.50% notes maturing on June 1, 2025, $750.0 aggregate principal amount of 2.20% notes maturing June 1, 2030, and $750.0 aggregate principal amount of 3.20% notes maturing on June 1, 2050. Interest for all tranches is payable on June and December 1 of each year. All of the aforementioned notes may be redeemed prior to maturity for an amount calculated to preserve the purchase yield of the holders for the duration of the notes. The Company has remained in compliance with all debt covenants since date of issue. The Company paid $48.0 in interest in both 2024 and 2023. At December 31, 2024 and 2023, the carrying value of the debt obligation, including discount accretion, was $1,992.1 and $1,991.4, respectively.

On July 26, 2021, the Company entered into a five-year, $1,000.0 senior unsecured revolving credit facility with a group of 11 U.S. banks. The effective interest rate on this credit facility is a floating rate and determined at time of borrowing. The facility will mature on July 24, 2026. As of December 31, 2024 and 2023, no funds have been drawn on this facility.

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10. Borrowed Funds (continued)

Federal Home Loan Bank Agreements

The Company is a member of the FHLB. Through its membership, the Company has immediate access to short-term and long-term credit products on a secured basis. It is part of the Company's strategy to utilize these funds as a source of liquidity. All borrowings with the FHLB are fully secured and must be sufficiently over collateralized per FHLB collateral guidelines in place at the time of borrowing. Per the FHLB requirements, the Company's borrowing capacity can be no greater than 25% of admitted assets, provided the Company continues to meet the FHLB underwriting guidelines. As of both December 31, 2024 and 2023, the Company had the authority to borrow up to $1,750.0 from the FHLB as determined by the Company.

The Company had no borrowings outstanding as of December 31, 2024 and 2023. Overnight borrowings have a variable rate of interest that changes each day based on a daily rate published by the FHLB. The overnight borrowing rate in effect on December 31, 2024 and 2023, was 4.460% and 5.450%, respectively. Interest is paid daily. For the years ended December 31, 2024 and 2023, the Company paid interest of $1.0 and $7.6, respectively.

FHLB Capital Stock aggregate totals as of December 31 are as follows:

	2024	2023
Membership stock – Class B	**$ 5.0**	$ 5.0
Activity stock	**–**	–
Excess stock	**–**	–
Aggregate total	**$ 5.0**	$ 5.0
Actual or estimated borrowing capacity as determined by the Company	**$ 1,750.0**	$ 1,750.0

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10. Borrowed Funds (continued)

The $5.0 of Class B membership stock was not eligible for redemption as of both December 31, 2024 and 2023.

The maximum amounts of collateral pledged during the years ended December 31 are as follows:

	Fair Value	Carrying Value	Amount Borrowed at Time of Maximum Collateral
2024 – Total maximum collateral pledged	**$ 514.3**	**$ 588.5**	**$ 500.0**
2023 – Total maximum collateral pledged	1,281.5	1,428.3	1,250.0

As of December 31, 2024 and 2023, the Company held bonds with a carrying value of $1,783.8 and $1,989.5, respectively, in restricted accounts related to its borrowing arrangement with FHLB, all of which was admitted.

11. Pension Plans and Other Employee Benefits

The Company sponsors a qualified noncontributory defined benefit pension plan; a qualified defined contribution plan, including an employer match; and a postretirement benefit-retiree health and life plan, including retiree cost sharing.

Noncontributory Defined Benefit Pension Plan

The Company sponsors a qualified defined benefit pension plan, covering the majority of eligible employees during 2024 and 2023 (including certain Chicago-based union employees as well as employees of certain wholly owned subsidiaries).

Pension benefits are primarily a function of a Cash Balance formula based on periodic pay based benefit credit varying by age and accumulated balance interest credit. The current provisions of the plan require one year of service for eligibility and three years of service for vesting.

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11. Pension Plans and Other Employee Benefits (continued)

The Company's policy is to fund the plans as needed on a current basis to the extent that the contribution is deductible under existing federal tax law. The Company met regulatory (limited to required minimum contribution under Internal Revenue Service (IRS) rules) pension contribution requirements for 2024 and 2023, which were zero for both years. The Company made additional contributions for the HCSC Employees Pension Plan (Pension Plan) during 2024 and 2023 totaling $60.0 and $120.0, respectively. The Company (unless subject to maximum deductible limits) expects to contribute an estimated range of zero to $120.0 to the plan during 2025, which would cover any minimum required and maintain target funded ratios of 100% or greater, but may contribute amounts less than or in excess of that.

Other Benefits – Retiree Health and Life Benefit Plan

The Company provides certain health care benefits (including prescription drug coverage meeting the qualifications under the Medicare Act) for eligible retired employees and term life insurance benefits for certain eligible retired employees of the Company (including certain eligible retired employees of certain wholly owned subsidiaries).

The majority of the Company's active employees (including a limited number among certain Chicago-based union employees) as well as employees of certain wholly owned subsidiaries are eligible for postretirement benefits if they are at least 55 years old and have at least 10 years of service when they terminate employment. The ongoing health coverage offerings are comprised of commercial group insured Medicare related MAPD and Plan F/Plan D offerings, or similar variations only as over age 65 options and Health Savings Account (HSA) type high deductible PPO based options for retirees under age 65. The coverages are annually adjusted and renewed based on actual retiree group experience (which process then limits the annual increase the Company will absorb). Retired covered employees pay a percentage of the cost of their own health and pharmacy benefit coverage, a higher percentage of their covered dependent's health and pharmacy benefit coverage based on a schedule of age and years of service prior to retirement, and if covered, pay 100% of the cost of any dental benefit offering elected.

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11. Pension Plans and Other Employee Benefits (continued)

The Company pays the cost of varying levels of term life insurance coverage provided to existing retirees as of December 31, 2015, and future retiring employees who were active, eligible, and at least 55 years old and had at least 10 years of service as of December 31, 2015. Otherwise no term life coverage is provided.

There is no pre-funding requirement for the postretirement benefits plan and the Company expects to contribute approximately $35.0 considering subsidies, retiree contributions or reimbursements on a pay-as-you-go basis to pay benefits under the HCSC Postretirement Benefit Plan during 2025. The Company did not make a direct contribution directly to a Voluntary Employees' Beneficiary Association Trust, including the Retired Employees Welfare Benefit Trust (WBT) in 2024 or 2023. The Company paid the current cost of retiree health claims and life premiums (net of any retiree contributions) directly from corporate assets during 2024 and 2023. The Company intends to pay a portion of the current cost of retiree health claims and life premiums (net of any retiree contributions) directly from corporate assets during 2025. The Company may elect to reimburse retiree health claim costs or life premiums (net of any retiree or subsidy contributions) from trust assets for previous, current or future periods during any current or future period.

Estimates and Assumptions Used to Determine Benefit Obligations and Costs

The preparation of financial statements in conformity with accounting practices prescribed or permitted by the DOI requires various estimates and assumptions that affect the reporting of net periodic benefit cost, plan assets, and plan obligations at the date of the financial statements. Significant estimates that relate to the calculation of benefit plan obligations are listed below. The discount rate used to determine the present value of the plan benefit obligations as of December 31 is based upon published investment-grade, long-term corporate bond yields. The expected long-term rate of return on the plan assets is based on an analysis of expected plan assets and recent economic conditions with a longer-term view.

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11. Pension Plans and Other Employee Benefits (continued)

The following actuarial assumptions were used at December 31 in determining the reported plan benefit obligations and net periodic benefit costs for the majority of employees:

	Pension Benefits		Other Benefits	
	2024	**2023**	**2024**	**2023**
Discount rate for current year expense	**5.40%**	5.70%	**5.40%**	5.70%
Discount rate for end-of-year obligations	**5.80**	5.40	**5.80**	5.40
Rate of compensation increase for current year expense	**4.45**	4.41	**4.56**	4.56
Rate of compensation increase for end-of-year obligations	**4.45**	4.41	**4.42**	4.41
Expected long-term rate of return on plan assets	**6.00**	5.00	**5.00**	5.00
Interest crediting rates (for cash balance plans and other plans with promised interest crediting rates)	**4.51**	4.26	**N/A**	N/A

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11. Pension Plans and Other Employee Benefits (continued)

The following tables provide a reconciliation of the changes in the plans' benefit obligations and fair market value of the plans' assets and a statement of the plans' funded status as of December 31:

	Pension Benefits (Overfunded)		Other Benefits[(a)] (Underfunded)	
	2024	**2023**	**2024**	**2023**
Reconciliation of benefit obligation				
Obligation at beginning of year	**$ 1,516.7**	$ 1,419.9	**$ 376.0**	$ 353.3
Service cost	**93.3**	80.0	**10.2**	8.9
Interest cost	**76.7**	74.6	**20.1**	20.7
Contribution by plan participants	**–**	–	**7.2**	7.7
Actuarial (gain) loss	**(8.5)**	29.2	**(6.9)**	19.2
Benefits paid	**(85.2)**	(87.0)	**(41.2)**	(34.6)
Loss recognized due to a settlement or curtailment	**–**	–	**0.7**	0.8
Obligation at December 31	**$ 1,593.0**	$ 1,516.7	**$ 366.1**	$ 376.0

[(a)] There is no "funding requirement" for the Post Retirement Benefit plan (retiree health and life plan). Any contribution remains the sole discretion of the Company – Sponsor/Employer.

	Pension Benefits		Other Benefits	
	2024	**2023**	**2024**	**2023**
Reconciliation of fair value of plan assets				
Fair value of plan assets at beginning of year	**$ 2,364.8**	$ 2,085.5	**$ 246.8**	$ 216.9
Actual return on plan assets	**196.8**	246.3	**25.6**	29.9
Employer contributions	**60.0**	120.0	**34.4**	26.9
Contribution by plan participants	**–**	–	**6.8**	7.7
Benefit payments	**(85.2)**	(87.0)	**(41.2)**	(34.6)
Fair value of plan assets at December 31	**$ 2,536.4**	$ 2,364.8	**$ 272.4**	$ 246.8

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11. Pension Plans and Other Employee Benefits (continued)

	2024	2023
Funded status		
Pension benefits:		
Prepaid benefit costs	**$ 947.4**	$ 920.6
Overfunded plan assets	**(4.0)**	(72.5)
Nonadmitted assets	**$ 943.4**	$ 848.1
Other benefits:		
Accrued benefit costs	**$ (144.9)**	$ (156.6)
Liability for other benefits	**51.2**	27.3
Total liabilities recognized	**$ (93.7)**	$ (129.3)

Amounts in unassigned surplus to be recognized as components of net periodic benefit cost are as follows:

	Pension Benefits		Other Benefits	
	2024	2023	2024	2023
Items not yet recognized as a component of net periodic benefit cost – prior year	**$ 72.5**	$ 188.2	**$ (27.3)**	$ (24.0)
Net prior service cost recognized	**–**	–	**(1.5)**	(1.5)
Net (gain) loss arising during the period	**(68.5)**	(115.7)	**(22.4)**	(1.8)
Items not yet recognized as a component of net periodic benefit cost – current year	**$ 4.0**	$ 72.5	**$ (51.2)**	$ (27.3)

The amount of the accumulated benefit obligation for defined benefit pension plans was $1,504.0 and $1,421.1 at December 31, 2024 and 2023, respectively. The relative embedded values underlying other benefits represented as APBO for not yet fully eligible actives was $121.4 and $117.5 for 2024 and 2023, respectively.

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11. Pension Plans and Other Employee Benefits (continued)

Amounts in unassigned surplus that have not yet been recognized as components of net periodic benefit cost are as follows:

	Pension Benefits		Other Benefits	
	2024	**2023**	**2024**	**2023**
Net prior service cost	**$ –**	$ –	**$ 6.5**	$ 8.0
Net recognized losses	**4.0**	72.5	**(57.7)**	(35.3)

The following table provides the components of net periodic benefit cost for the plans for 2024 and 2023:

	Pension Benefits		Other Benefits	
	2024	**2023**	**2024**	**2023**
Year ended December 31				
Service cost	**$ 93.3**	$ 80.0	**$ 10.2**	$ 8.9
Interest cost	**76.7**	74.6	**20.1**	20.7
Expected return on plan assets	**(136.7)**	(101.4)	**(10.3)**	(8.8)
Amortization of prior service cost	**–**	–	**1.5**	1.5
Loss recognized due to a settlement or curtailment	**–**	–	**0.7**	0.8
Net periodic benefit cost	**$ 33.3**	$ 53.2	**$ 22.2**	$ 23.1

Net periodic pension costs of $33.3 and $53.2 in 2024 and 2023, respectively, include allocations to certain wholly owned subsidiaries of $1.3 and $2.0 in 2024 and 2023, respectively.

Net periodic postretirement benefit retiree health and life costs of $22.2 and $23.1 in 2024 and 2023, respectively, include allocations to certain wholly owned subsidiaries of $0.9 and $1.1 in 2024 and 2023, respectively.

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11. Pension Plans and Other Employee Benefits (continued)

For retiree health, prior service costs are amortized over the average future lifetime of participating employees expected to receive benefits under the plan. Gains and losses are amortized to the extent they exceed 10% of the APBO over the average remaining service period of participating employees expected to receive benefits under the plan. For measurement purposes the following annual rates of increase in the per capita cost of covered health care benefits were assumed:

- Pre-65 – 7.00% for 2025, 6.50% for 2026, then grading down each year by 0.25% until reaching 5.00% in 2032 thereafter

- Post-65 – 3.50% for 2025, then grading up each year by 0.25% until reaching 5.00% in 2031 thereafter

Expected retiree health care benefit payments (net of the Medicare subsidy) during 2025 are projected to be $23.0, during 2026–2029 are projected to be within a range from $22.6 to $23.2 per year, and for the five-year period ending 2034 are projected to average $25.4 per year. The Medicare subsidy is estimated to be $0.4 for 2025, during 2026 may range from $0.0 to $0.4, and from 2027 forward is expected to be $0.0 per year.

Expected future pension plan benefit payments during 2025 are projected to be $186.5, during 2026–2029 are projected to be within a range from $168.3 to $175.4 per year, and for the five-year period ending 2034 are projected to average $171.2 per year.

Investment Policies

The investment policy of the HCSC Master Pension Trust's (the Master Trust) is to employ a suitable combination of investment risk and rate of return to support the Pension Plan's emerging obligations. The Master Trust uses a long-term approach to obtain a stable level of return based upon a diversified portfolio.

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11. Pension Plans and Other Employee Benefits (continued)

At December 31, 2024, the Company's Pension Plan assets held in the Master Trust were invested approximately 63% in Return Seeking category vehicles designed to produce a competitive risk-adjusted return, and 37% in Liability Hedging category vehicles designed to first hedge known liabilities with high-quality fixed-income investments, then deploy any remaining plan assets in asset classes earning returns higher than high-quality fixed-income investments. Effective 2018 and as refined through 2023, the pure public equity commitment allocation has a reduced target range but is combined with a target of 10% Higher Risk Fixed Income and 20% Alternatives, such as private equity, real estate or infrastructure funds, equating to a combined target of 60% referred to as Return Seeking with the remaining target commitment to traditional fixed income, including traditional forms of debt at 40%. During periods of relative market volatility, equity commitments may fall outside this range and during periods of investment selection, calls and distributions may fall outside this range. For 2024 and 2023 reporting, the target allocation range reflects the Master Trust's longer-term investment strategy referred to as "liability hedging" and "return seeking". The 2024 and 2023 ending periods do not yet precisely reflect the fully invested longer-term investment strategy of the Master Trust.

Fair Value

All investment information disclosed in the below table of assets held at December 31, 2024 and 2023, represents holdings within the separate Master Trust or WBT and is as reported or derived from information supplied to the plan administrator, certified as complete and accurate by the Trustee consistent with Employee Retirement Income Security Act of 1974 (ERISA) reporting requirements.

Investments held in both the Master Trust and WBT are stated at fair value. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date (an exit price).

To measure fair value, a hierarchy has been established that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs. As such, the hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3).

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11. Pension Plans and Other Employee Benefits (continued)

Common stocks are valued at the closing market prices of the principal market on which the stocks are traded. Corporate debt instruments and U.S. Government securities are valued at the last quoted bid price. Shares of registered investment companies are valued based on published market prices, which represent the NAV of shares held by the Master Trust and the WBT at year-end. Investments in common/collective trusts and pooled separated accounts have been valued using the NAV per share, as determined by the issuer. Investments in partnerships/joint ventures are accounted for using the cost methodology where transactions are recorded based on the date of receipt of wires (settlement date). These transactions are processed based on statements provided by the fund company. These investments are valued at the NAV practical expedient.

The following tables present the fair value of the Pension Plan's Master Trust assets as of December 31:

Investment Type	Level 1	Level 2	Level 3	NAV	Total *
2024					
Corporate debt instruments	**$ –**	**$ 158.3**	**$ –**	**$ –**	**$ 158.3**
State and local government bonds	**–**	**5.8**	**–**	**–**	**5.8**
U.S. government securities	**–**	**125.9**	**–**	**–**	**125.9**
Registered investment companies	**204.3**	**–**	**–**	**–**	**204.3**
Partnership/joint venture interest[(a)]	**–**	**–**	**–**	**581.1**	**581.1**
Common/collective trusts[(b)]	**–**	**1,447.4**	**–**	**–**	**1,447.4**
Pooled separated accounts[(c)]	**–**	**10.3**	**–**	**–**	**10.3**
Total assets	**$ 204.3**	**$ 1,747.7**	**$ –**	**$ 581.1**	**$ 2,533.1**

*Excludes $3.3 of accrued income and trade settlements.

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11. Pension Plans and Other Employee Benefits (continued)

Investment Type	Level 1	Level 2	Level 3	NAV	Total *
2023					
Corporate debt instruments	$ –	$ 162.2	$ –	$ –	$ 162.2
State and local government bonds	–	6.8	–	–	6.8
U.S. government securities	–	127.3	–	–	127.3
Registered investment companies	192.9	–	–	–	192.9
Partnership/joint venture interest[(a)]	–	–	–	526.8	526.8
Common/collective trusts[(b)]	–	1,321.2	–	–	1,321.2
Pooled separated accounts[(c)]	–	25.1	–	–	25.1
Total assets	$ 192.9	$ 1,642.6	$ –	$ 526.8	$ 2,362.3

*Excludes $2.5 of accrued income and trade settlements.

(a) May consist of **Higher Risk Fixed Income (High Yield and Bank Loans)**: These funds offer a process of robust credit analysis to identify opportunities in predominately below investment-grade bank loans and high yield fixed income. At their sole discretion, the fund may restrict withdrawals (e.g., requiring advance written notification and/or imposing dollar limits on the maximum amount allowed to be withdrawn). Investments are predominately priced using a pricing matrix or the closing price on an exchange. If unavailable, investments will be priced at the midpoint of an independent broker-dealer two-sided quotation, and in specific cases, an independent valuation firm. **Private Assets (Core Real Estate)**: These funds are core fully-specific open-end commingled equity real estate investment funds diversified by property type and geographic location across the U.S. Full or partial withdrawals may be requested from these funds on a quarterly basis with advanced written request of withdrawal. At their sole discretion, the funds may restrict withdrawals subject to cash availability. **Private Assets (Primary/Secondary Private Equity/Infrastructure)**: investments of this type of fund represent an interest in non-redeemable, closed-end private investment partnerships that do not trade in an active market and represent illiquid long-term investments that generally require future capital commitments. These funds primarily invest in secondary interests of pooled private equity investment vehicles, focusing on mature, high quality leveraged buyout vehicles with mezzanine, venture capital, distressed securities, fund of funds and other strategies also considered. Redemptions from the underlying funds are generally not permitted and the liquidity provided by the underlying funds is principally dependent upon the ability of the investee funds to realize transactions through their respective portfolios. Capital

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11. Pension Plans and Other Employee Benefits (continued)

is typically committed for periods of at least five to 10 years, extendable at the discretion of the general partner. General partner's valuation of limited partnerships is generally equal to or based upon the reported capital account or net asset value of the underlying investee funds as of the prior quarter, net of current quarter cash activity, since the general partner will not have the required information to present fair value as of current quarter.

(b) These funds offer a range of risk/return characteristics and performance goals are to consistently outperform benchmarks, other funds, or certain indexes. The fund reserves the right to restrict contributions and withdrawals (e.g., imposing dollar limits to avoid any limitations or impact across the fund as a result of market conditions). For 2024 and 2023 it includes a Higher Risk Fixed Income (Emerging Market Debt) Fund which seeks to take advantage of investment opportunities across the emerging markets fixed income spectrum, including hard and local currency-denominated sovereign, quasi-sovereign, and corporate debt, and their derivatives where holdings may deviate considerably from the benchmark based on analysis of fundamental, valuation, and other technical considerations (which securities and other instruments are generally valued on the basis of valuations furnished by authorized third-party pricing services).

(c) Investments in this category seek to add +150 basis points of annualized excess return over a broad U.S. bond market index over a full market cycle (three to five years) by emphasizing relative value based sector allocation, research-based security selection, and modest duration and yield curve positioning. Full or partial withdrawals require written request of withdrawal. At their sole discretion, the funds in this category may restrict withdrawals (e.g., requiring advance written notification and/or imposing dollar limits on the maximum amount allowed to be withdrawn).

The following tables present the fair value of the WBT assets as of December 31:

Investment Type	Level 1	Level 2	Level 3	NAV	Total*
2024					
Corporate debt instruments	**$ –**	**$ 36.6**	**$ –**	**$ –**	**$ 36.6**
Registered investment companies	**169.3**	**–**	**–**	**–**	**169.3**
U.S. government securities	**–**	**11.0**	**–**	**–**	**11.0**
State and local government securities	**–**	**48.6**	**–**	**–**	**48.6**
Common /collective trusts	**–**	**5.8**	**–**	**–**	**5.8**
Total assets	**$ 169.3**	**$ 102.0**	**$ –**	**$ –**	**$ 271.3**

*Excludes $1.1 of accrued income and trade settlements.

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11. Pension Plans and Other Employee Benefits (continued)

Investment Type	Level 1	Level 2	Level 3	NAV	Total*
2023					
Corporate debt instruments	$ –	$ 33.2	$ –	$ –	$ 33.2
Registered investment companies	145.0	–	–	–	145.0
U.S. government securities	–	10.8	–	–	10.8
State and local government bonds	–	49.4	–	–	49.4
Common/collective trusts	–	7.4	–	–	7.4
Total assets	$ 145.0	$ 100.8	$ –	$ –	$ 245.8

*Excludes $1.0 of accrued income and trade settlements.

Impact of Medicare Modernization Act of Postretirement Benefits

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act) was signed into law in December 2003. The Act expanded Medicare to include coverage for prescription drugs. This change can affect the measurement of the APBO and the net periodic postretirement cost for the plan because this legislation will reduce the Company's costs for some of the benefit programs it sponsors. The Company has been initially approved to claim a subsidy from the federal government for 2024 and 2023, having received $0.4 and $0.5, respectively. This amount is included as a reduction to 2024 and 2023 net periodic benefit costs and is included in the plan participant contribution line item. The accrued cost result without the Medicare savings is estimated to have been $200.0 and $216.0 as of December 31, 2024 and 2023, respectively.

Defined Contribution Plans

The Company sponsors a qualified defined contribution 401(k) plan, covering the majority of eligible employees during 2024 and 2023 (including certain Chicago based union employees and employees of certain wholly owned subsidiaries). The 401(k) plan provides immediate eligibility and an automatic enrollment feature. Participants may elect to contribute a portion of their salary, which will be matched, in part, by the Company. The total expense incurred by the Company related to matching employee contributions was $77.7 and $70.9 in 2024 and 2023, respectively. At December 31, 2024 and 2023, the fair value of 401(k) plan assets was $3,837.2 and $3,372.1, respectively, excluding participant account loans of $78.8 and $67.6, respectively.

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11. Pension Plans and Other Employee Benefits (continued)

The Company also provides a nonqualified deferred compensation plan for a select group of employees and a nonqualified excess benefit plan (nonqualified pension benefit restoration plan) for certain highly compensated employees limited in their qualified defined benefit by the IRS rules. The Company continues to administer any benefits in pay status assumed as a liability for smaller closed nonqualified benefit restoration type plans resulting from mergers or acquisitions in the past.

12. Leases

Leases are primarily for electronic data processing equipment with lease terms of one to five years and for office space with lease terms of one to fifteen years. Rental expense for 2024 and 2023 was $132.5 and $135.2, respectively.

Certain rental commitments have renewal options, with some of these renewals being subject to adjustments in future periods.

Future minimum lease payments as of December 31, 2024, are as follows:

2025	$	46.8
2026		45.2
2027		30.8
2028		15.6
2029		15.6
Subsequent to 2029		47.7
Total minimum lease payments	$	201.7

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13. Income Taxes

The Company files a consolidated federal income tax return with the following subsidiaries:

NM PPO	HCSC Medicare Holdings Inc.
BlueLincs	HCSC Medicare Inc.
CMH	HCSC Purchasing, LLC
DLIC	HCSCV
DNLNY	IL PPO
DNoA	Innovista
Dental Solutions	Innovista Health Partners
DenteMax, LLC	Innovista Medical Center Texas
GHS General Insurance Agency, Inc.	Medecision
GHSIC	SOWIC
GSI Health	TX PPO
HISC	Luminare Health
HCSC ITC, LLC	USB HTC Fund 2017-2, LLC
HCINV	USB RETC Fund 2017-2, LLC

The method of allocation between the companies is subject to a written agreement, approved by the Company's Board of Directors, whereby allocation is made primarily on a separate return basis, with a current credit for net operating losses or other items utilized in the consolidated return. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Further pursuant to the agreement, if the consolidated group incurs a corporate alternative minimum tax (CAMT), the Company may be allocated a portion of that consolidated liability. If allocated a portion of the consolidated CAMT liability, the Company would be allocated a corresponding amount of CAMT credit carryforward.

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13. Income Taxes (continued)

The components of the net deferred tax asset (liability) as of December 31 are as follows:

	Ordinary	Capital	Total
2024			
Total of all gross deferred tax assets	**$ 1,643.9**	**$ 158.8**	**$ 1,802.7**
Less valuation allowance	**938.0**	**26.4**	**964.4**
Total adjusted gross deferred tax assets	**705.9**	**132.4**	**838.3**
Deferred tax assets nonadmitted	**478.9**	**–**	**478.9**
Net admitted deferred tax assets	**227.0**	**132.4**	**359.4**
Total of all deferred tax liabilities	**227.0**	**132.4**	**359.4**
Total net admitted deferred tax assets	**$ –**	**$ –**	**$ –**

	Ordinary	Capital	Total
2023			
Total of all gross deferred tax assets	$ 1,529.8	$ 151.8	$ 1,681.6
Less valuation allowance	826.5	21.4	847.9
Total adjusted gross deferred tax assets	703.3	130.4	833.7
Deferred tax assets nonadmitted	182.1	–	182.1
Net admitted deferred tax assets	521.2	130.4	651.6
Total of all deferred tax liabilities	213.0	125.3	338.3
Total net admitted deferred tax assets	$ 308.2	$ 5.1	$ 313.3

The change in the components of the net deferred tax asset (liability) is as follows:

	Change During 2024		
	Ordinary	Capital	Total
Total of all gross deferred tax assets	$ 114.1	$ 7.0	$ 121.1
Less valuation allowance	111.5	5.0	116.5
Total adjusted gross deferred tax assets	2.6	2.0	4.6
Deferred tax assets nonadmitted	296.8	–	296.8
Net admitted deferred tax assets	(294.2)	2.0	(292.2)
Total of all deferred tax liabilities	14.0	7.1	21.1
Total net admitted deferred tax (liability) assets	$ (308.2)	$ (5.1)	$ (313.3)

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13. Income Taxes (continued)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, as of December 31, 2024, is as follows:

	Ordinary	Capital	Total
Admitted gross deferred tax assets 11.a.	**$ –**	**$ –**	**$ –**
Admitted gross deferred tax assets 11.b. Lesser of 11.b.i. and 11.b.ii.	**–**	**–**	**–**
Admitted gross deferred tax assets expected to be realized following the balance sheet date 11b.i.	**–**	**–**	**–**
Admitted gross deferred tax assets allowed per limitation threshold 11b.ii.	**N/A**	**N/A**	**3,728.5**
Admitted gross deferred tax assets 11.c.	**227.0**	**132.4**	**359.4**
Total admitted gross deferred tax assets	**$ 227.0**	**$ 132.4**	**$ 359.4**

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, as of December 31, 2023, is as follows:

	Ordinary	Capital	Total
Admitted gross deferred tax assets 11.a.	$ 35.9	$ 5.1	$ 41.0
Admitted gross deferred tax assets 11.b. Lesser of 11.b.i. and 11.b.ii.	272.3	–	272.3
Admitted gross deferred tax assets expected to be realized following the balance sheet date 11b.i.	272.3	–	272.3
Admitted gross deferred tax assets allowed per limitation threshold 11b.ii.	N/A	N/A	3,590.5
Admitted gross deferred tax assets 11.c.	213.0	125.3	338.3
Total admitted gross deferred tax assets	$ 521.2	$ 130.4	$ 651.6

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13. Income Taxes (continued)

The change in the amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 during 2024 is as follows:

	Change During 2024		
	Ordinary	**Capital**	**Total**
Admitted gross deferred tax assets 11.a.	$ (35.9)	$ (5.1)	$ (41.0)
Admitted gross deferred tax assets 11.b. Lesser of 11.b.i. and 11.b.ii.	(272.3)	–	(272.3)
Admitted gross deferred tax assets expected to be realized following the balance sheet date 11b.i.	(272.3)	–	(272.3)
Admitted gross deferred tax assets allowed per limitation threshold 11b.ii.	N/A	N/A	138.0
Admitted gross deferred tax assets 11.c.	14.0	7.1	21.1
Total admitted gross deferred tax assets (liabilities)	$ (294.2)	$ 2.0	$ (292.2)

The following table provides the authorized control level risk-based capital ratio percentage and the amount of adjusted policyholders' surplus, excluding deferred tax assets, used to determine the recovery period and threshold limitation amounts under SSAP No. 101, paragraphs 11.b.i. and 11.b.ii. as of December 31:

	2024	**2023**
Ratio percentage used to determine recovery period and threshold limitation amount	**1,032%**	1,138%
Amount of adjusted capital and policyholders' surplus used to determine recovery period and threshold limitation	**$ 24,901.8**	$ 24,010.2

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13. Income Taxes (continued)

The Company did not rely on tax planning strategies to admit deferred tax assets during 2024 or 2023.

At December 31, 2024 and 2023, the Company had no unrecognized deferred tax liabilities.

Current income taxes incurred consist of the following major components:

	2024	2023	Change
Federal income tax expense (benefit)	**$ (249.2)**	$ 308.1	$ (557.3)
Federal income tax expense (benefit) on net capital gains	**6.5**	(11.5)	18.0
Federal income tax expense (benefit) incurred	**$ (242.7)**	$ 296.6	$ (539.3)

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13. Income Taxes (continued)

The tax effects of the temporary differences that give rise to significant portions of the deferred tax assets and deferred tax liabilities are as follows:

	2024	2023	Change
Deferred tax assets:			
Ordinary:			
Policyholder reserves	**$ 22.0**	$ 17.3	$ 4.7
Compensation and benefits accrual	**99.6**	104.6	(5.0)
Receivables – nonadmitted	**121.3**	99.7	21.6
Contingent liabilities	**174.8**	211.8	(37.0)
Salvage and subrogation recoverable	**318.5**	316.4	2.1
Benefit plans	**–**	12.9	(12.9)
Intangible assets	**63.2**	66.8	(3.6)
Prepaid expense – nonadmitted	**52.8**	45.5	7.3
Prepaid pension – nonadmitted	**198.1**	178.1	20.0
Fixed assets	**134.2**	113.0	21.2
Allowance for doubtful accounts	**84.5**	–	84.5
CAMT	**317.0**	270.2	46.8
Other	**57.9**	93.5	(35.6)
Total gross deferred tax assets – ordinary	**1,643.9**	1,529.8	114.1
Statutory valuation allowance adjustment	**938.0**	826.5	111.5
Nonadmitted deferred tax assets – ordinary	**478.9**	182.1	296.8
Admitted ordinary deferred tax assets	**227.0**	521.2	(294.2)
Capital:			
Investments	**158.8**	151.8	7.0
Total gross deferred tax assets – capital	**158.8**	151.8	7.0
Statutory valuation allowance adjustment	**26.4**	21.4	5.0
Admitted capital deferred tax assets	**132.4**	130.4	2.0
Admitted deferred tax assets	**$ 359.4**	$ 651.6	$ (292.2)

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13. Income Taxes (continued)

	2024	2023	Change
Deferred tax liabilities:			
Ordinary:			
Investments	**$ 14.7**	$ –	$ 14.7
Pension	**198.9**	193.3	5.6
Other	**13.4**	19.7	(6.3)
Total gross deferred tax liability – ordinary	**227.0**	213.0	14.0
Capital:			
Investments	**132.4**	125.3	7.1
Total gross deferred tax liability – capital	**132.4**	125.3	7.1
Deferred tax liabilities	**359.4**	338.3	21.1
Net deferred tax assets	**$ –**	$ 313.3	$ (313.3)

At December 31, 2024, the Company had $317.0 of CAMT credits which can be carried forward indefinitely. As of December 31, 2024 the Company had no net operating loss carryforwards.

The change in net deferred income taxes is composed of the following:

	2024	2023	Change
Total adjusted deferred tax assets	**$ 838.3**	$ 833.7	$ 4.6
Total deferred tax liabilities	**359.4**	338.3	21.1
Net adjusted deferred tax asset	**$ 478.9**	$ 495.4	(16.5)
Change in unrealized capital gain and benefit plans			37.5
Change in net adjusted deferred income taxes			$ 21.0

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13. Income Taxes (continued)

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The significant items causing this difference for 2024 are as follows:

	Effective Tax Rate	
	Amount	**Percentage**
Provision computed at statutory rate	$ 87.4	21.0%
Special deduction	(271.4)	(65.2)
Prior year true-up special deduction	(244.7)	(58.8)
Change in valuation allowance	126.6	30.4
Change in nonadmitted assets	(2.1)	(0.5)
Nondeductible §162(m)(6) expense	52.1	12.5
Change in accrued interest	(29.7)	(7.1)
Other	18.1	4.4
Total	$ (263.7)	(63.3)%
Federal income tax benefit incurred	$ (242.7)	(58.3)
Change in net deferred income taxes	(21.0)	(5.0)
Total statutory income tax benefit	$ (263.7)	(63.3)%

The Company had no federal income taxes incurred in the current year or the two preceding years that are available for recoupment in the event of future net losses.

The Company had no protective tax deposits under Internal Revenue Code §6603 that it reasonably expects to recover in a subsequent period.

The Company classifies all interest and penalties related to unrecognized tax positions as income tax expense. There is $4.1 of interest and penalties recognized in the statutory basis balance sheet as of December 31, 2024. For the year ended December 31, 2024, $38.3 of prior years' interest expense was released and recognized as income in the statement of revenues and expenses, respectively. As of December 31, 2024, there were no material positions for which management believes it is reasonably possible that the total amounts of unrecognized tax positions will

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13. Income Taxes (continued)

significantly increase within 12 months of the reporting date. At December 31, 2024, management considers the Company's open tax years to include returns filed for 2019 through 2023, and the return that will be filed for 2024.

The Inflation Reduction Act (IRA) was enacted on August 16, 2022, and includes a 15% corporate alternative minimum tax (CAMT) for applicable corporations, which is effective for tax years beginning after 2022. The Company is the parent of a tax-controlled group of corporations and has determined it is an applicable reporting entity for purposes of the CAMT. The Company is subject to and liable for CAMT in 2023 and 2024, and has incurred $270.2 and $74.2, respectively, of CAMT within current federal income taxes.

The Company has made an accounting policy election to disregard CAMT when evaluating the need for a valuation allowance for its non-CAMT deferred tax assets.

14. Contingencies and Commitments

Litigation

The Company is frequently made party to a variety of legal proceedings, investigations, audits, and claims, including the specific matters described below. These legal proceedings include claims of or relating to bad faith claims processing, noncompliance with state and federal regulatory regimes, failure to timely or appropriately pay or administer claims and benefits, rescission of insurance coverage, anticompetitive practices, general contractual matters, intellectual property litigation, and employment litigation. Some of these legal proceedings are or are purported to be class actions or derivative claims. The Company is defending itself against the claims brought in these matters.

Where available information indicates that it is probable that a loss has been incurred, and said loss can be reasonably estimated, the Company accrues for the estimated loss by a charge to operations. However, it is not always possible to determine whether a loss is probable and estimable. Furthermore, due to the uncertainties regarding these matters, there is no guarantee that the final resolutions will not exceed the accrued amounts. As of December 31, 2024, the Company has appropriately considered the impact of these matters within its financial statements.

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14. Contingencies and Commitments (continued)

Blue Cross and Blue Shield (BCBS) Antitrust Litigation

The Company was a defendant in two nationwide purported class actions originally filed in 2012: one brought by BCBS subscribers and the other brought by health care providers. Dozens of underlying complaints were consolidated into a multi-district proceeding in the U.S. District Court for the Northern District of Alabama. A related case, *Piercy, Deborah et al. v. HCSC*, remained in Union County, Illinois. Generally, the proposed plaintiff classes alleged that the Company and the other BCBS Plans (the Defendants) conspire not to compete in each other's allocated geographical markets through license agreements, best efforts rules that cap the percentage of each plan's non-Blue revenue, and other arrangements in violation of the Sherman Antitrust Act and related state laws. Plaintiffs also allege that the plans use the Association to promulgate rules and policies to uphold and enforce the alleged conspiracy.

On April 5, 2018, the Court granted Plaintiffs' motion for summary judgment and concluded that certain aspects of the Blue system in the aggregate will be reviewed under the per se standard of review, while the BlueCard program and other alleged Sherman Act violations will be analyzed under the Rule of Reason standard. The Court declined to rule on whether Defendants operate as a single entity with regard to their enforcement of the BCBS trademarks.

The Defendants reached a settlement of the claims brought by the Subscribers, which the Company's Board approved on September 21, 2020. The Court entered an order approving the settlement on August 9, 2022, which was affirmed by the Eleventh Circuit on October 25, 2023. The settlement became final on June 24, 2024 when the Supreme Court of the United States declined review. Under the settlement, Defendants paid $2,670.0, including attorneys' fees. The settlement also contains nonmonetary terms, including (i) eliminating the "national best efforts" standard in the Association Guidelines to Administer Membership Standards (which limited the percentage of non-Blue revenue permitted for each Blue plan) and (ii) allowing for some large national employers with self-funded benefit plans to be able to request a bid for healthcare coverage from a second Blue plan in addition to the local Blue plan. Pursuant to the settlement, the claims brought by Subscribers and the *Piercy* case have been dismissed with prejudice. Certain subscribers who opted out of the settlement have commenced individual lawsuits against Defendants, including the Company. The Company has been named as a defendant in the following opt-out cases: *Alaska Air Group Inc. v. Anthem Inc*., *Jet Blue Airways Corporation v. Anthem Inc*., and *Bed Bath & Beyond Inc. v. Anthem Inc*. (all pending before the U.S. District

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14. Contingencies and Commitments (continued)

Court for the Northern District of Alabama); *Hoover v. BCBSA* (pending before the U.S. District Court for the Southern District of Florida); and *VHS v. Blue Cross of California* (pending before the California Superior Court of Alameda County). With the exception of *Hoover*, all of the opt out cases are in fact discovery. The VHS case has been set for trial on August 24, 2026. No other trial dates have been set.

The Defendants also have reached a settlement of the claims brought by Providers. On October 14, 2024, Providers filed a motion for preliminary approval of the settlement, which was granted on December 4, 2024. If the settlement is approved and becomes final, Defendants will pay $2,800.0, including attorneys' fees, and agree to certain non-monetary relief including improvements to the BlueCard program. The Court has set a final approval hearing for July 29, 2025. Certain providers who opted out of the settlement have commenced individual lawsuits against Defendants, including the Company. The Company has been named as a defendant in the following opt-out-cases: *Alta Los Angeles Hospitals v. Blue Cross of California*, *Chinese Hospitals Association v. Blue Cross of California*, *Cottage Clinical Associates v. Blue Cross of California*, *Fresno Community Hospital & Medical Center v. Blue Cross of California*, *John Muir Health v. Blue Cross of California*, *Orange County Global Medical Center v. Blue Cross of California*, *Stanford Health Care v. Blue Cross of California*, *WHC Liquidating Trust v. Blue Cross of California* (all pending before the California Superior Court of Alameda County); *Regents of the University of California v. Blue Cross Blue Shield Association* (pending before the California Superior Court of San Francisco County); *Bon Secours Mercy Health v. Blue Cross Blue Shield Association* (pending before the U.S. District Court for the Northern District of California); *IES Central Texas PLLC v. Blue Cross and Blue Shield of Alabama*, *AmeriTeam Services, LLC v. Blue Cross and Blue Shield of Alabama*, *CommonSpirit Health v. Blue Cross and Blue Shield of Alabama*, *Adventist Health System Sunbelt Healthcare Corp. v. Blue Cross Blue Shield Association*, *Duke University Health System v. Blue Cross Blue Shield Association* (all pending before the U.S. District Court for the Northern District of Illinois); *LHHealth, LLC v. Blue Cross Blue Shield Association*, *Temple University Health System, Inc. v. Blue Cross Blue Shield Association* (all pending before the U.S. District Court for the Eastern District of Pennsylvania); and *Phoebe Putney Memorial Hospital v. Blue Cross Blue Shield Association* (pending before the U.S. District Court for the Middle District of Georgia).

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14. Contingencies and Commitments (continued)

Texas Out-of-Network Freestanding Emergency Facility Litigation

The Company is named as a defendant in several lawsuits arising out of its practices related to the payment of claims for services rendered to its members and members of other Blue Cross and Blue Shield Plans by Texas freestanding emergency facility providers, and physician associations that staff such facilities, with whom the Company does not have a contract (out-of-network providers). These lawsuits allege in common that the Company paid too little to out-of-network providers for these services in violation of Texas and federal laws. These out-of-network provider plaintiffs allege violations of ERISA payment obligations, breach of contract, bad faith insurance practices, negligent misrepresentation, and other Texas common law and statutory causes of action. In some cases, the plaintiff providers also seek declaratory judgments determining their right to reimbursement for future services.

Provider & Member Litigation

The Company is named as a defendant in purported class actions and individual lawsuits arising out of its practices related to the coverage and/or payment of claims for services rendered to its members by health care providers with which the Company has a contract (network or participating providers) and with which the Company does not have a contract (out-of-network providers). Among other things, these lawsuits allege that the Company paid too little to its health plan members and/or providers for these services and/or otherwise allege that the Company failed to timely or appropriately pay or administer claims and benefits. Certain of these lawsuits also allege that the Company's refusal to pay claims of certain health care providers for services rendered by other providers (also known as pass-through billing) was wrongful.

Government Investigations, Audits, and Reviews

The Company has been involved or is currently involved in various routine, regular, and special investigations, audits, and reviews by CMS, state insurance departments, state attorneys general, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Labor, and other governmental authorities. Certain of the Company's business practices have been reviewed or are currently under review, including the payment of pharmacy rebates, certain claims processing practices, and compliance with various state unclaimed property laws, among other matters.

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14. Contingencies and Commitments (continued)

The outcome of any current or future litigation or governmental investigations, audits, and reviews, including the matters described above, cannot be accurately predicted, nor can the Company predict any resulting judgments, penalties, fines, or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or because of actions by third parties. The Company believes that any liability that may result from any of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

Other Contingencies and Commitments

Assessments

Certain Consumer Operated and Oriented Plan (Co-Op) programs and Long-Term Care (LTC) insurance companies in various states have established premiums that may be insufficient to cover the cost of care and administrative expenses for their members, which may result in increased insolvencies covered by state insolvency or guaranty association laws. In that event, the Company may experience increased guaranty association assessments, the amount and timing of which are uncertain. Given this uncertainty around whether, and to what extent, there may be an increase in Co-Op or LTC insolvencies, and if so, the amount and timing of any associated future guaranty fund assessments and the availability and amount of any potential premium tax credits and other offsets, the Company currently cannot estimate its net exposure, if any, to potential liquidations of Co-Op programs or LTC in various states. At the time of a formal order of liquidation being entered, the Company will assess the need to record an estimated liability and expense for the applicable reporting period, which could be material to the Company's operating results. As of December 31, 2024 and 2023, no material amounts have been recorded related to this matter.

Guarantees

In acquisitions (through merger or otherwise), the Company has or may have agreed to pay or guarantee the obligations of the acquired entity to (a) maintain existing indemnification rights for a period of time to the current or former officers, directors, or employees of the acquired entity for liabilities for acts or omissions occurring at or prior to the date of the acquisition and (b) purchase "tail" insurance coverage on behalf of the acquired entity's officers and directors with an extended reporting period of claims from the date of acquisition. Some of these commitments may continue to be in effect, and the potential for future payments is unknown. The Company has not recorded any liabilities to cover these types of agreements or commitments.

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14. Contingencies and Commitments (continued)

Under various vendor contracts, the vendor provides products or services to the Company and certain subsidiaries and affiliates, and the Company may explicitly or implicitly guarantee the obligations of these subsidiaries and affiliates. The Company has not recorded any liabilities to cover these types of agreements or commitments.

Under certain ASC agreements (and a small number of agreements related to insured contracts), the Company has provided guarantees related to its operational and financial performance. The Company's primary responsibilities relate to customer service, claims processing, provider discounts and trend guarantees. The maximum potential amount of future payments is limited to the amount of administrative fees for the contract year. The Company recorded an estimated liability of $69.2 and $66.0 for this guarantee as of December 31, 2024 and 2023, respectively.

Tax Credit Commitments

The Company has commitments to purchase transferable Low Income Housing premium tax credits in the State of Oklahoma annually in the amount of $4.2 for the years 2025-2026. The Company has commitments to purchase various transferable federal energy tax credits under the IRA. The transferable federal tax credit commitments for 2025 are $161.9. The Company has annual transferable federal tax credit commitments averaging $73.3 for the years 2026-2035.

RADV Adjustments

On January 20, 2022 and September 15, 2022 CMS reissued RADV adjustment calculations for the 2018, 2019 and 2020 years, respectively. The reissued 2019 and 2020 results indicate that the RADV methodology was revised to align with the RADV formula and methodological changes established in the 2019 Notice of Benefit and Payment Parameters. As a result of these recalculations, the value of RADV adjustments received by the Company in 2022 was reduced in states that had a measurable impact due to the adjustments. The Company has appealed and requested a reconsideration of the design and application of the methodological changes applied by CMS. The timing of a final resolution of this dispute is not clear. No amounts pending appeal have been accrued on the Company's financial statements.

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15. Related-Party Transactions

The Company has administrative agreements with many of its subsidiaries whereby the Company may provide any combination of management, administrative, marketing, or claims processing services. Amounts billed by the Company to the subsidiaries under these agreements, based on actual costs incurred, were $164.2 and $188.6 in 2024 and 2023, respectively. The Company also has administrative agreements with certain subsidiaries for various services that the Company may receive from its subsidiaries, such as claims processing. Amounts billed by the subsidiaries to the Company under these agreements, based on actual costs incurred, were $445.4 and $358.9 in 2024 and 2023, respectively. These amounts are included in claims adjustment expenses and general and administrative expenses in the Company's statements of revenues and expenses. At December 31, 2024 and 2023, the Company had admitted receivables from subsidiaries of $1,050.5 and $559.8, respectively, and payables to subsidiaries of $45.2 and $38.4, respectively.

Affiliated amounts due to or from are typically settled within 90 days pursuant to the intercompany agreements, or they are nonadmitted.

In March 2024 and subsequently approved in April 2024, the Company and its wholly-owned subsidiary HISC filed forms with CMS requesting to novate HISC's standalone Medicare Part D contract to the Company effective January 1, 2025. In addition, in March 2024 and subsequently approved in May 2024, the Company and HISC filed form D with the Illinois Department of Insurance requesting approval of an assumption reinsurance agreement between the Company and HISC effective January 1, 2025. HISC has issued various standalone Medicare Part D policies pursuant to its standalone Medicare Part D contract with CMS, which under the assumption reinsurance agreement, HISC as the "ceding company" would transfer all rights and liabilities of its standalone Medicare Part D policies and contracts issued under the CMS contract. Accordingly, associated admitted assets of $312.1 and liabilities of $63.3 totaling net admitted assets of $248.8 were transferred to the Company on January 1, 2025. There was no statutory gain or loss on the transfer.

16. Risk Based Capital (RBC)

The Company, like all licensed life and health insurance entities, is subject to RBC requirements. The RBC calculation serves as a metric for the assessment of a life and health insurance entity's solvency by state insurance regulators. At December 31, 2024, the Company's total adjusted capital was in compliance with applicable regulatory RBC requirements.

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17. Business Combinations and Goodwill

On October 5, 2022, the Company acquired Luminare Health for $404.2 paid in cash and potential future additional payments related to a three-year earnout provision. Luminare Health is a third-party administrator that has developed innovative solutions and built vendor relationships to help clients and brokers design personalized self-funded health benefit plans. The acquisition resulted in goodwill of $508.2 under the statutory purchase method, all of which was fully admitted. Luminare Health is carried at its audited GAAP equity in accordance with SSAP No. 97. The goodwill amortization was $58.0 in both 2024 and 2023. As of December 31, 2024, $378.4 of the goodwill was admitted, which represents 105.0% of Luminare Health's book adjusted carrying value.

The December 31, 2024 admitted goodwill of $381.0 was 1.5% of prior period adjusted capital and surplus of $24,855.4, which was adjusted for goodwill, EDP equipment & operating system software and deferred taxes.

18. Subsequent Events

Management of the Company has evaluated all events occurring after December 31, 2024 through May 9, 2025, the date the statutory basis financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. Based on this evaluation, no significant subsequent events occurred other than the below and those disclosed in the financial statements.

On March 19, 2025, the Company completed its acquisition of The Cigna Group's (Cigna) Medicare Advantage, Medicare Supplemental Benefits, Medicare Part D and CareAllies businesses. The original purchase price was $3,300.0, with standard purchase price adjustments to be completed in accordance with the purchase agreement. The business was acquired primarily via the purchase of all issued and outstanding shares and other equity interest of several Cigna subsidiaries. Management expects the transaction to enhance the Company's capabilities and reach, particularly in the growing Medicare segment.

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Questionnaire Instructions to Offerors:

*****DO NOT ALTER THE QUESTIONS OR QUESTION NUMBERING***.**

- Provide answers to the questionnaires in MS Word format.
- Provide an answer to each question even if the answer is “not applicable” or “unknown.”
- Answer the question as directly as possible.
  - If the questions asks “How many…” provide a number.
  - If the question asks “Do you…” Grisindicate Yes or No **first**, followed by your additional narrative explanation.
- Lengthy responses may be truncated when displayed. Be concise in your response. Use bullet points as appropriate. Reconsider how to word any response that exceeds 250 words in length so that the response contains the most important points you want displayed. Responses longer than the 250 words will be truncated in review.
- Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments.
- Offeror will be held accountable for accuracy/validity of all answers.
- Remember, RFP responses will become part of the contract between the awarded Offeror and The City of Albuquerque.
- Any references to “Client” in the questionnaire refer the The City of Albuquerque. Other abbreviations include CITY for the City of Albuquerque.

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MINIMUM CONTRACTUAL REQUIREMENTS

ALL OFFERORS

Indicate "Yes" or "No" as to your organization's ability to meet the minimum requirements. **Failure to complete this form and include it with your response may result in elimination from consideration**.

A "Yes" response shall result in the provision being adopted in the final contract. No deviations will be accepted for "YES" answers in this section.

MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
1. Proposal, Interview, and Best and Final Responses Become Part of Contract: Do you agree that your written response to this RFP, written information provided as part of an interview and written responses provided during a Best and Final negotiation become part of the contract between your organization and The City of Albuquerque?		X
2. Agree that your proposal and pricing are **not** contingent on acceptance of other coverages or services outside the scope of this RFP.	X	
3. Are each of the coverage lines included in your response free-standing and not contingent upon the CITY selecting the entire package of services being offered?	X	
4. Effective Date of Offer: Proposal terms are guaranteed for at least 180 days from the proposal due date.	X	
5. You agree that the Contract has a length of four (4) years.		X
6. Variance Provision: Any provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote must be clearly noted in the financial section of the questionnaire.	X	
7. Any changes in **financial strength** rating agencies (downgrades or upgrades) shall be disclosed to the City of Albuquerque within 30 days of the effective date of the award.	X	
8. Proper Licensure: Do you agree to maintain proper licensure as required by any state law where it relates to the services that you will be performing for The City of Albuquerque?	X	
9. Prior Notice of Major Operational Changes: Do you agree to provide no less than 30 day notice to the City of Albuquerque for any changes involving the sale, merger, data breaches, layoffs, participating provider facility terminations, consolidation or outsourcing of services to foreign countries that will impact The City of Albuquerque?	X	
10. Subcontracting: Unless otherwise explained in this RFP, do you agree that you will disclose all subcontractor arrangements.	X	
11. HIPAA Compliance: OFFEROR attests to meeting all applicable HIPAA EDI, Privacy, Security, and HITECH requirements and agrees to hold the City of Albuquerque harmless for breaches that are the result of OFFEROR actions.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
12. The successful OFFEROR's proposal must contain provisions reserving these rights to City of Albuquerque: **No-Loss, No-Gain:** Current participants in any of City of Albuquerque's sponsored PPO dental will be provided coverage on a "no-loss, no-gain" basis.	X	
13. Eligibility Rules and Uncertain Claimant Eligibility Situations: The OFFEROR agrees to the specified eligibility rules established by City of Albuquerque. The OFFEROR(s) must communicate directly with City of Albuquerque regarding any uncertain claimant eligibility situations before notifying the claimant of ineligibility.	X	
14. No Member Communication Without Client Consent: The OFFEROR will not automatically enroll City of Albuquerque in any programs that involve any type of communication with members, without express written consent from City of Albuquerque.	X	
15. Rights to Claims Data: Selling of the City of Albuquerque's data to outside entities must be disclosed and approved in writing in advance by the City of Albuquerque.	X	
16. Right to Audit: City of Albuquerque reserves the right to review and audit the PPO dental files and financial accounting data to assure that claims subject to each proposed coverage are evaluated in accordance with the plan provisions. Additionally, the OFFEROR agrees to allow for no less than one claim audit per year at no cost to City of Albuquerque using the auditor of City of Albuquerque's choice (so long as the auditor is not a competitor or involved in any legal proceedings with the OFFEROR). The OFFEROR will cooperate with any outside auditor the City of Albuquerque selects to perform the audit. This provision shall survive the termination of the agreement between the parties for a period of two (2) years.		X
17. Maintenance, Ownership, and Transfer of Records: a) The OFFEROR will be required to maintain all pertinent records for seven years. b) The OFFEROR will be charged with the safekeeping of plan experience information; and c) In the event of contract termination, and related to contract termination, the OFFEROR will be required to cooperate with City of Albuquerque, or their representative, in the prompt, accurate, and orderly transfer of City of Albuquerque's plan experience, claims and utilization information to City of Albuquerque or its designated succeeding dental carrier at **no added fee**.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
18. Renewal Notification: The OFFEROR must provide any rate changes in writing with full justification **by January 1 of the Calendar year for a July 1 effective date in that Calendar Year. (For example, January 1, 2026 is the deadline for rate actions effective July 1, 2026)**. Additionally, the OFFEROR must provide the following with each renewal package: a. Any contract language changes requested b. Specific justification of rate/fee changes, including the Rate Development/Underwriting Worksheet. c. Current enrollment by rate class d. Additional options for consideration e. All underwriting caveats f. Any proposed plan design or benefit changes	X	
19. Assignment or Transfer of Rights: Do you agree that you will not assign or transfer the rights or obligations of the contract or any portion thereof, without the prior written approval of City of Albuquerque?	X	
20. Scope of Services: Are you able to provide the services outlined in the Scope of Services?	X	
21. Commissions: The City contracts with McGriff, a Marsh McLennan Agency as the City's benefits consultant. The City does not seek to add another consultant or general agent through this RFP. a) Proposal submitted must be net of commissions. Confirm.	X	

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MINIMUM CONTRACTUAL REQUIREMENTS	YES	NO
If you answered “No” to any of the questions above, please provide an explanation below:		

Requirement No.	**Explanation**
1	**Fully Insured** The RFP and our responses themselves, in their entirety, shall not be incorporated into any subsequent contract. In case of conflict, the mutually agreed-upon terms and/or conditions of a contract drafted after our selection as the administrator shall take precedence over anything contained in this proposal. Unless specifically stated otherwise in our response, our bid is conditioned on City of Albuquerque's agreement to the terms and conditions of our Group Administration Document (GAD). While state regulations and legislation do not allow us to modify the GAD, we can modify our contract offerings in other ways. We define the contract to include the GAD; the benefit booklets; the benefit program application; and any other applications, schedules of coverage, riders, enclosures, addenda, exhibits, and amendments. A sample of our current GAD is included in the Technical Proposal section of our submission. Some of the City of Albuquerque's terms and conditions may be similar to those in our GAD. We encourage you to review our GAD, and we look forward to being selected as the winning bidder. **Self-Funded** The RFP and our responses themselves, in their entirety, shall not be incorporated into any subsequent contract, and, in case of conflict, the mutually agreed-upon terms and/or conditions of a contract drafted after our selection as the administrator shall take precedence over anything contained in this proposal. Unless specifically stated otherwise in our response, our bid is conditioned on City of Albuquerque’s agreement to the terms and conditions of our ASA. A sample of our current ASA is included in the Technical Proposal section of our submission. Some of City of Albuquerque’s terms and conditions may be similar to those in our ASA. We encourage you to review our ASA, and we look forward to being selected as the winning bidder.
5	Our fully insured and self-funded proposals include a three-year rate/fee guarantee.

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MINIMUM CONTRACTUAL REQUIREMENTS		YES	NO
16	Fully insured group clients may not perform an external audit, as the risk is all ours for fully insured business. For ASO clients, Dental claim audits are performed in conjunction with the DOL ERISA 5500 Financial Audit. These audits are performed by external auditors to assist the City with their 5500 annual filings. Our internal audit department works closely with the dental claims team to obtain the necessary information required by the auditors to confirm proper payment of the dental claims. Clients are welcome to perform an audit limited to a sampling of not more than 300 claims (dental and medical combined) under the program processed for the group for the agreed-upon audit period, up to 180 days following termination of the business relationship, and according to the administrative services agreement. All audits are subject to our external audit policy and procedures. We do not allow or support contingency-fee audits and limit the audit period to the current and previous contract year, with no more than one audit per 12 consecutive months. We also do not grant auditors access to the system.		

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate	
	Month and Year of Rating	
1. Indicate your firm's most recent ratings by all of the following agencies:	**Rating**	**Date**
A.M. Best	A+ (Superior)	10/31/2024
Standard and Poor's (S&P)	A+ (Very Strong)	3/20/2025
Fitch	HCSC is not rated by Fitch.	N/A
Moody's	A3 (Good)	3/24/2025
Weiss	The financial strength rating of Health Care Service Corporation (HCSC) as of June 2024 is B-. HCSC does not have a rating agency relationship with Weiss. Weiss completes its rating assessment using publicly available information.	6/2024
2. Organization background:		
a. Organization's name.	Blue Cross and Blue Shield of New Mexico	
b. Corporate headquarters address.	5701 Balloon Fiesta Parkway NE, Albuquerque, New Mexico 87113	
c. City & State that will service the City's account.	Albuquerque, New Mexico	
d. Does your firm have a local office?	Yes BCBSNM 5701 Balloon Fiesta Parkway NE Albuquerque, New Mexico 87113	
e. Date your firm became operational.	1936.	
f. Date your firm became operational for the services requested in this RFP.(Specify dental and/or vision separately.)	We implemented the BlueCare Dental PPO program in 2002. We have provided dental benefits to New Mexico employers since 1977.	
g. Ownership of your firm.	BCBSNM is the New Mexico-based division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company established and licensed in 1936.	

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
3. Is your company "affiliated" with another company? If so, describe the "affiliate relationship." "Affiliated" means owned by another company, owned by a common controlling shareholder or interest, or inter-tied by contract so as to be under the dominion or influence of another.	Yes. Blue Cross and Blue Shield of Illinois (BCBSIL), Blue Cross and Blue Shield of Montana (BCBSMT), Blue Cross and Blue Shield of New Mexico (BCBSNM), Blue Cross and Blue Shield of Oklahoma (BCBSOK), and Blue Cross and Blue Shield of Texas (BCBSTX) are operating divisions of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC).
4. If your firm is not a corporation, please advise who each of the partners, proprietors or other owners are and whether they have interest in any dental services provider firms.	Not applicable.
5. Is your firm involved in any current litigation against or from the Client? If yes, please describe.	Yes. At any given time, there are multiple lawsuits filed in which HCSC and/or its subsidiaries and officers are named as a defendant(s) involving various matters. The litigation against HCSC that was deemed to be material for purposes of disclosure in HCSC's 2020, 2021, 2022, 2023, and 2024 financial statements can be found here. In the statements, refer to section 14, Contingencies and Commitments. In the ordinary course of business, HCSC is also involved in other litigation not disclosed in its financial statements. Additional information is available upon request.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
6. Have you been involved in litigation within the last five years arising out of your performance in the administration of a Group Dental or Vision plan? Exclude routine matters involving participants that do not reflect on your performance under the contract with your Client. If the answer is yes, explain fully.	Yes. At any given time, there are multiple lawsuits filed in which HCSC and/or its subsidiaries and officers are named as a defendant(s) involving various matters. The litigation against HCSC that was deemed to be material for purposes of disclosure in HCSC's 2020, 2021, 2022, 2023, and 2024 financial statements can be found here. In the statements, refer to section 14, Contingencies and Commitments. In the ordinary course of business, HCSC is also involved in other litigation not disclosed in its financial statements. Additional information is available upon request.
7. a. Has your organization **acquired, been acquired by, or merged with** another organization in the past 24 months?	Yes. • In March 2025, HCSC purchased The Cigna Group's Medicare Advantage, Medicare Supplemental Benefits, Medicare Part D, and CareAllies businesses. The acquisition benefits HCSC's current and future members by enhancing the company's capabilities and reach, particularly in the growing Medicare segment. • In November 2023, Trustmark Health Benefits became Luminare Health Benefits Inc. In October 2022, HCSC acquired Health Benefits from Trustco Holdings, Inc. (Trustmark). The third-party administrator designs and offers custom plans for self-funded customers that help manage costs through innovative solutions, data transparency, and member-centric support. This provides HCSC additional capabilities to serve customers seeking customizable and flexible health benefit solutions.
b. Is your firm **anticipating restructuring or reorganizing** in the next two years? (Include any major staff relocations or office closings.)	No. We do not anticipate any restructuring or reorganizing in the next 24 months. We will inform you of any changes.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
c. What is your plan for continuance of principles in the event of a reorganization or restructuring?	BCBSNM occasionally explores business opportunities, including mergers and acquisitions, that allow the organization to grow or would otherwise benefit the company. Before pursuing such opportunities, we carefully assess the impact they might have on our networks, claims processing systems, member service functions, care management services, provider relationships, and other business relationships. In exploring such business opportunities, we typically enter into confidentiality requirements that prohibit disclosures to third parties. As an organization, BCBSNM invests in opportunities that fall into three categories: • Investments that strengthen our core business. These investments must support and grow our core infrastructure, such as technology advancements, claims processing upgrades, and opportunities to further strengthen our data security. • Investments that transform the health insurance experience. These investments leverage our nine decades of experience to better serve organizations by creating new delivery options and lending our name to initiatives that make health care more accessible to both current and future members. • Investments that address social determinants of health. We actively build programs and seek partners that enable us to better serve underserved communities and close gaps in care. BCBSNM continually seeks out new options to enhance your coverage by providing programs that strengthen our core business, transform the health insurance experience for you and your members, and address the determinants of health that affect our entire society.
8. Do you understand that you are prohibited from using the IIHI for any purpose other than as required by law and further agree to promptly destroy such data if you are NOT the successful bidder?	Yes.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
9. Do you agree to attend the Annual Open Enrollment meeting at the City's desired location (up to 10 meetings over the course of 3 weeks) at no additional cost?	Yes.
10. Implementation: a. What is the minimum implementation lead-time needed to initiate the proposed services?	Not applicable as we are the incumbent carrier on your dental plan.
b. List any transition issues the City should consider.	Not applicable as we are the incumbent carrier on your dental plan.
c. List any specific administrative procedures or information your firm will need from the City in order to implement your services?	Not applicable as we are the incumbent carrier on your dental plan.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
11. If your company is awarded this business, how soon after notification of the award would you be able to have a draft of the:	
a. Master Policy?	Typically, BCBSNM will produce an initial draft of the policy within 45 days from the date the Benefit Program Application (BPA) is signed. The actual drafting time will vary depending on many factors, such as the employer's effective date, degree of customization, and time of year.
b. Certificate booklet?	Typically, we produce draft benefits booklets within 90 days of the employer's approval of the finalized benefit plans and our confirmation that we can administer the benefits. The exact time varies depending on the employer's effective date, benefit design, time of year, and other factors.
c. ID Cards	We mail member ID cards as quickly and efficiently as possible—generally in less than 10 business days for new groups and renewals. Electronic ID cards will be available in the mobile app, Blue Access for Members, and/or Blue Access for Employers site within 48 hours.
12. Complete the following information about the individual who will be assigned as the OVERALL ACCOUNT MANAGER for the City: Name & Title:	This response is considered confidential. Please refer to the Legally Confidential folder for details.
City/State:	
Length of Time in Current Position:	
13. Complete the following information about the individual from your organization who will be assigned as the PRIMARY DAY TO DAY CONTACT for the City: Name & Title:	This response is considered confidential. Please refer to the Legally Confidential folder for details.
City/State:	
Length of Time in Current Position:	

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
14. The master contract is to reflect the elimination of the actively-at-work restrictions or deferred effective date for employees and dependents eligible on the effective date of the contract. This provision however, does not remove the liability of the prior carrier for expenses incurred with respect to the extension of benefits provisions of their contract. Indicate your agreement to this stipulation.	Not applicable as we are the incumbent carrier on your dental plan.
15. Identify any services under any subsequent contract that may be awarded as part of this RFP that are currently or planned to be performed outside the borders of the United States.	No services are performed offshore.
16. Do you agree to provide the City a clear path (representative phone number or email, etc.) for employees to register complaints?	Yes.

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GENERAL INFORMATION (All OFFERORs)	OFFEROR RESPONSE If your response varies based on line of coverage, please clearly indicate
17. All sample forms and communication materials should be provided for approval to the City in advance of distribution (ID cards, claim forms, enrollment forms, booklets, brochures, flyers, mailers, etc.). Do you agree to this requirement?	Yes. We offer various communication materials to inform members about their dental benefits. We distribute printed enrollment guides and benefit highlight summaries during annual enrollment meetings and fairs. Using Blue Access for Members, we email members who elect to receive news and updates. We provide standard enrollment guides in both English and Spanish. Contract booklets that highlight plan benefits and explain dental procedures, patient/provider responsibilities, and appeals are available in English after enrollment. We will be happy to share our communications package with the City for review and approval prior to distribution among the City employees. Upon approval, we will ship to the City for distribution to employees. We also offer wellness outreach emails to educate members on the importance of seeking routine oral health care. This includes emails specific to members with conditions that may impact their oral health such as diabetes, cardiovascular disease, and pregnancy.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
1. Will there be a designated team of customer service representatives for the City?	Yes. Our dental services are structured so that dental claims and customer service functions are handled in dedicated dental service centers. While we are not designating member service resources specifically for the City, our dental-only service centers have dedicated member services staff, defined as handling only dental benefits. All customer advocates are trained to respond to a wide variety of questions from members, providers, groups, and agents. In addition, each unit has a technician who is responsible for fielding more advanced/complex inquiries or adjustments. Using this approach for all accounts further enables our exemplary service and customer satisfaction levels.
2. Will you provide a toll-free customer service number for claim and benefit inquiries?	Yes.
3. Are questions regarding provider billing, benefits, or member grievances covered by the same phone number? If not, please explain.	Yes.
4. What hours and days are live customer service representatives available (indicate using NM time)?	This response is considered confidential. Please refer to the Legally Confidential folder for details.
5. Are your customer service representatives located in the continental US?	This response is considered confidential. Please refer to the Legally Confidential folder for details.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
6. What alternative services do you provide? (i.e., Assistance for the hearing impaired, 24-hour toll-free automated benefits and eligibility, bilingual option, customer service accessible via the internet, etc.).	We offer our members an interactive voice response system with access to additional customer service 24/7. Our system, which is both touch-tone and voice responsive, allows callers to: • Access plan design/benefit information. • Review eligibility status. • Receive status of submitted claims. • Access the return fax feature (receive and respond to inquiries by fax; this feature is available only for providers). Members also may access our website (www.bcbsnm.com) to view a claim, browse dental product information, access frequently asked questions, locate a provider, download a claim form, nominate a provider for inclusion in our network, and contact customer service. Through our online Dental Wellness Center, members can: • Ask dentists questions through “Ask a Dentist.” • Locate an in-network dentist or specialist with Provider Finder. • Research information with the Dental Dictionary. • Determine approximate dental fees in the marketplace with the Dental Cost Advisor. • Read monthly news articles. To better serve our non-English-speaking members, we implemented LanguageLine Solutions. The LanguageLine provides over-the-phone interpretation between English and more than 200 languages including Spanish, Mandarin, Cantonese, Hindi, Arabic, Korean, Vietnamese, Japanese, Thai, and Polish.
7. Please provide the following statistics for 2023 and 2024: Average speed to answer: ___% within 30 seconds	This response is considered confidential. Please refer to the Legally Confidential folder for details.
Busy rate: ___ seconds	Given the capability of our automatic call distribution system, busy rates are not an issue. Therefore, we do not track them.
Abandonment Rate : ___%	This response is considered confidential. Please refer to the Legally Confidential folder for details.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
8. Will the City have online access to address additions, terminations, and status changes?	Yes. Our employer portal features downloadable forms as well as information and links on products, services, and legislative issues. Employers may use an interactive map to locate our closest sales office for more information or sales assistance. **Blue Access for Employers** Our website features an employer portal with various self-service account functions, including: • Viewing bills. • Obtaining detailed dental coverage information on employees. • Updating members' names and addresses. • Adding, canceling, and reinstating members. • Reviewing eligibility and benefit selection. • Viewing online activity associated with a member's record. • Requesting ID cards. • Viewing pending activities. • Making category transfers. • Accessing reports. Blue Access for Employers is available 24/7 for most functions; however, employee enrollment and maintenance transactions are unavailable from midnight to 5:30 a.m.
9. Are plan participants able to access a web portal for:	
a. Status of claims	Yes.
b. Benefit brochure	Yes.
c. ID cards	Yes.
d. Cost estimator of common services	Yes.
e. Cost of services by a specific provider	Our cost advisor tool provides a cost range based on location and procedure, not by a specific provider. This allows the member to see an estimated range of what the cost of any procedure could be.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
f. Network Provider Quality	Yes. Members can locate a dentist through our online Provider Finder. We update this tool weekly and allow members to personalize directories based on provider specialty, location, or secondary language. Members can also access the Provider Finder by calling the toll-free customer service number. For dentists in our BlueCare Dental network, members see a score that compares them to other dentists within the same specialty and geographic area. The rating system, called DentaQual, compares dentists with their peers using composite scores based on treatment outcomes, commitment to best practices, cost effectiveness, patient retention, and treatment recommendations.
g. Deductible/benefit maximum accumulator	Yes.
10. Can the City and their designated Consultant access eligibility and reporting through a secure website?	Yes.

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11. What kind of reports can the City and/or their designated Consultant retrieve online?	We have three dental reporting packages available to all clients, the Dental Client Report, the Monthly Financial Report and the Blue Insight Utilization Analysis Report. **Dental Client Report** The Dental Client Report package includes dental utilization, claim experience, top dental procedures, top dental providers (in and out of network), claims savings, and claim dollar utilization. This package highlights key analysis criteria show fiscal status, focusing on what drives costs. The report includes utilization information on experience, utilization by category, and in-network versus out-of-network savings. Incurred year-over-year utilization data is shown. This report is available from your account executive twice a year. **Monthly Financial Report & The Blue Insight Utilization Analysis Report** The Monthly Financial Report and the Blue Insight Utilization Analysis Report contain similar information that includes a dental financial analysis chart, service type analysis information, dental loss ratio, and an enrollment overview section. Employers access the Monthly Financial Report and the Blue Insight Utilization Analysis Report through Blue Access for Employers. These reports are also available through Blue Insight reporting, and groups receive our monthly financial and utilization dental reports as a PDF. Our standard reporting package is comprehensive and should meet most financial and utilization reporting needs. Blue Insight reports are available 12 days after the close of the reporting period. The monthly report presents financial and utilization components for the current reporting month, as well as renewal year-to-date. It is also available each month through Blue Access for Employers. We provide the following information in these reports: • Customized reports to include your logo. • Standard executive summary reports. • Drill-down and reach through functionality. • Benchmarking data against our book of business.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
	• Monthly data loads with rolling 38 months of data. Please refer to the Monthly Financial Report sample and the Blue Insight Utilization Analysis Report sample, for examples of this reporting package.

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12. What other kinds of information can the City obtain through your website?	Blue Access for Employers is our secure employer site. The City can access group-specific product, membership, billing, and other account information to manage employee health care coverage. Blue Access for Employers enables the City to streamline various employee eligibility transactions. This gives employers the opportunity to go back to what they do best—managing their business. Additionally, Blue Access for Employers features downloadable forms, information on products and services, news and updates, and important legislative issues. The City can quickly and easily: • Add or cancel an employee/dependent. • Check current and historical member eligibility/coverage. • Reinstate an employee/dependent. • Update plan coverage. • Request ID cards, print temporary ID cards, and email temporary ID cards to employees. • Change employee/dependent information. • View pending activities. • Make category and classification transfers. • View and pay bills online. • Access reports. • Access the summary of benefits and coverage tool. **Viewing and Paying Your Bill** Paperless billing and online bill payment are also available for most accounts. Benefits to online bill payment include: • Simple and secure—the fastest way to review and make payments. • No lost or delayed paperwork—email alerts notify you when the bill is ready. • Quick, accurate payment processing—credits post to account in two business days or less. • Payment status activity for current and past payments. • Credits post to account in two business days or less.

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CUSTOMER SERVICE OPERATIONS DENTAL	OFFEROR RESPONSE
	• Total control when scheduling payments. Employers can view their fully insured payment status activity for current and past payments but cannot access an individual employee's claim details/status. **Hours** Blue Access for Employers is available 24/7 for most functions. Employee enrollment and maintenance transactions are not available midnight to 4:30 a.m. Mountain time.
13. Please provide a temporary login/password so the Client can evaluate your tools. (If Available)	As the incumbent carrier on your dental plan, the City currently has access to our secure employer site, Blue Access for Employers.
14. What methods does your organization use to measure customer satisfaction?	This response is considered confidential. Please refer to the Legally Confidential folder for details.

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15. Provide a copy of your most recent customer satisfaction survey statistics.	This response is considered confidential. Please refer to the Legally Confidential folder for details.
16. How do your providers recognize a patient as a participant in your program – voucher, ID card, electronic connection to your eligibility database, etc.? Please explain.	Providers can identify members that belong to our plan by the branding on the ID cards (both hard copy and electronic copies are available to the member) and if that is not available, providers can utilize DNoA Connect (https://www.dnoaconnect.com), a self-service tool for dental offices to conveniently connect to patient information for BlueCare Dental members. DNoA Connect reduces expenses in our call centers, helping drive not only convenience, but also diminishing overall costs for members. Building on feedback and input from our existing dental providers, we designed the following features: • Benefits and eligibility. Easily access benefit and eligibility information, including plan maximums, deductibles, and frequencies at a summary or detailed level. • Procedure code lookup. Instantly look up code-specific information as well as utilization history and view related codes. • Procedure history. Review patient service history since initial date of eligibility, with an option to export data. • Claims status. View status of submitted claims, including payment status, benefit determination, and payment detail and view remaining maximums and deductibles for benefit period. • Enhanced Print Functionality. Print a summary or detailed benefit information. • Resource Library. Answers to commonly asked questions and claim guidelines.

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DENTAL NETWORK	OFFEROR RESPONSE
1. Do you contract with individual dentists, dental group facilities, or both?	We contract with both individual dentists and dental group facilities to provide a robust dental network.
2. Do you wholly own and operate the network you are proposing for the City?	Our network is made up of a combination of our proprietary network and strategic leased networks, which allows us to create the largest network with the best overall gross discount nationally.
3. Indicate the marketing name of the network you are proposing.	BlueCare Dental PPO National Network.
4. Provide the number of network providers that terminated in the City's service area during the past 12 months: a. By your organization	In 2024, 58 providers have terminated. We do not track whether this was by organization or provider.
b. By the provider	In 2024, 58 providers have terminated. We do not track whether this was by organization or provider.
5. What changes do you anticipate to your network over the next two years?	We are committed to continuously investing in the growth of our priority network and are focused on investing in resources to grow the depth of our dental network overall, providing additional access and savings. We continually monitor our leased networks according to contract requirements and evaluate new network opportunities as they arise.
6. Please provide Geo Access reports using the following access standards: For the census provided, provide a GeoAccess report to determine the following (6,900 employees must be used in each determination): Reports should reflect city, state, zip code, and number of **unique** dental providers by zip, number of employees with desired access (as defined below) for each category AND **locations (Zip Code and County) where access standards are not met** including the number of employees without desired access.	Confirmed. Please refer to the geo access report included under the Technical Proposal section for details.
a. **General Dentists:** Access criteria: 2 providers within 10 miles of home zip code	This response is considered confidential. Please refer to the Legally Confidential folder for details.
b. **Specialists (excluding orthodontists):** Access criteria: 2 providers within 10 miles of home zip code	This response is considered confidential. Please refer to the Legally Confidential folder for details.

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DENTAL NETWORK	OFFEROR RESPONSE
c. **Orthodontists:** Access criteria: 2 providers within 15 miles of home zip code	This response is considered confidential. Please refer to the Legally Confidential folder for details.
7. How does your organization measure the quality of care provided by the providers in your network?	We expect providers to deliver reliable, quality care based on sound clinical judgment and applicable scientific evidence. We measure provider quality through site visits or ongoing discussions with the provider relations staff. We also determine provider quality through the following methods: • Utilization review. • Member satisfaction surveys. • Grievance procedures. • Provider credentialing. • Structural review of the dental office. • Assessment of the patient care process. • Availability of a reasonable appointment schedule. • Access to emergency care. • Documentation in patient files. Each of these quality activities has its own unique reporting mechanism and predetermined level of acceptance. If the provider fails to perform at acceptable levels, our provider service agreement allows the opportunity to remedy any deficiencies. If the provider fails to remedy identified deficiencies, we give notice to terminate the agreement and remove the provider from the network.
8. How many complaints per 1,000 visits do you receive on your network providers?	This response is considered confidential. Please refer to the Legally Confidential folder for details.

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DENTAL NETWORK	OFFEROR RESPONSE
9. Do any network providers include night or weekend hours?	Yes; however, office hours are not tracked as they are attached to the location and not the provider. In case of a medical or dental emergency, members should seek immediate care from the nearest facility or professional provider. Contractually, DPPO providers must maintain emergency care hours and respond to a member's request for help within 24 hours. We also reimburse according to the benefit plan for any emergency services members seek while traveling outside the service area. Non-network providers are not held to the same protocol as network providers. Additionally, through Teledentistry.com, members can access a network of dentists 24/7, to get an evaluation, receive a prescription, if needed, and even get help finding a local dentist for follow-up care.
10. Do network providers pay a membership fee to your organization?	No. There is no cost for providers to join the BCBSNM dental network.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
1. Are you able to match the requested PPO Dental plan (Current & Alternates)	Yes, as we are the incumbent carrier on your dental plan.
2. a. Does your proposed plan include any exclusions or limitations that are more restrictive than the current plan?	Not applicable as we are the incumbent carrier on your dental plan.
b. Does your proposed plan include any services that are paid in a different benefit class than the existing plan design?	Not applicable as we are the incumbent carrier on your dental plan.
c. Does your proposal include any pre-existing condition limitations?	Preexisting conditions do not apply to dental. We reference prior claim history, but not based on preexisting conditions.
d. If yes to 'a', 'b', or 'c' above, identify any differences in the Deviations Exhibit A. Do not merely refer the reader to your proposal but specifically detail in the exhibit.	Not applicable as we are the incumbent carrier on your dental plan.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
3. Describe any exclusions or limitations on your orthodontia benefits.	Orthodontic procedures and treatment include examination, records, tooth guidance repositioning (straightening), and retention of the teeth for Participants covered for orthodontics as shown on your Dental Schedule of Coverage. Covered services include: Special Provisions Regarding Orthodontic Services: • Orthodontic services are paid over the Course of Treatment, up to the maximum orthodontic benefit, as shown on your Dental Schedule of Coverage. Benefits cease when the Participant is no longer covered, whether or not the entire benefit has been paid. • Orthodontic treatment is started on the date the bands or appliances are inserted. • Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic benefit and subject to the maximum benefit, as shown on your Dental Schedule of Coverage for orthodontic services. • If orthodontic treatment is terminated for any reason before completion, benefits will cease on the date of termination. • If the Participant's coverage is terminated prior to the completion of the orthodontic treatment plan, the Participant is responsible for the remaining balance of treatment costs. • Recementations of an orthodontic appliance by the same Dentist who placed the appliance and/or who is responsible for the ongoing care of the Participant is not covered. • Benefits are not available for replacement or repair of an orthodontic appliance. • For services in progress on the Effective Date, benefits will be reduced based on the benefits paid prior to this coverage beginning. Please refer to our limitations and exclusions in the Technical Proposal section of this proposal.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
4. Describe how treatment in progress (at initial takeover) will be covered. 5. How will orthodontic claims be adjudicated? 6. What portion of claim expenses will be honored?	Not applicable as we are the incumbent carrier on your dental plan. We pay orthodontic claims over the course of treatment and base payment on a percentage of the total case fee, up to the lifetime maximum. Providers submit claims monthly or quarterly.
7. Describe how treatment in progress will be covered if your plan is terminated during an episode of treatment.	When leaving the network, a dentist is contractually obligated to complete all covered dental treatment started before termination. The provider must complete services within a reasonable time at the charge, if any, established under the program. We handle in-progress orthodontia treatment case by case, according to the duration of remaining treatment.
8. What services (i.e., root canal, crowns, etc.) are covered and for what amounts?	Please refer to the included dental highlight sheets for details.
9. Describe any missing tooth limits your plan may have for new participants.	Our quotes do not include a missing tooth exclusion.
10. Describe how you would handle a late entrant.	We follow the eligibility and enrollment rules established by the City.
11. Are implants covered under the dental plan?	Yes, implants are covered.
12. How does your plan handle a resin composite filling on teeth that traditionally would be treated with an amalgam?	We cover posterior composite restorations under our group contract.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
13. If benefits under the City's plan are exhausted or not covered, can members take advantage of your negotiated pricing? If not, please explain.	Yes. Most participating dentists agree to accept our maximum allowable amount and not to balance bill patients. Occasionally, out-of-network dentists may balance bill for any services over the allowed amount, any deductibles, and any noncovered services. The provider may bill a patient directly for any portion of the services provided under the following circumstances: • When the plan lists a patient copayment/coinsurance for a covered service. • When a service is not a covered procedure on the member's plan. • When a member exceeds their annual maximum. • When it is determined the member was not eligible at the time of service. • When the cost of a customized course of care is associated with a covered service.
14. How will your plan pay benefits for students who reside outside of the state?	This is not applicable to our traditional dental program, as it is not a network-driven program. Our dental PPO program includes providers throughout the U.S. Because the dental PPO program does not feature a gatekeeper, members can access dental providers when living or traveling outside their service area. Choosing an out-of-network dentist may lower the benefit level and lead to a greater out-of-pocket expense. Members can search for a network dentist by using our online dental Provider Finder.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
15. Describe how your pretreatment review system operates and the current turnaround time.	There are no services requiring prior authorization by the dental director; however, we recommend submitting a predetermination for the following procedures: • Inlays/onlays. • Crowns (single restoration). • Partial dentures. • Fixed bridges. • Removable bridges. • Periodontal surgery and treatment. • Any service with a cost greater than $300. Predeterminations are treated the same as an original entry claim. The process begins with a system-adjudicated screening of pre-estimate submissions and ends with two levels of in-depth reviews of complex and expensive treatments. Effectively applying plan provisions based on plan design, benefit exclusions, and various other frequency limitations is efficient and generates savings. We systematically identify any predeterminations that are not auto adjudicated for individual review under the alternate benefit provision and sent through the utilization review process. We suspend any delayed pre-estimates the examiner or technician cannot immediately complete and route the claim for professional review. Our consultant team ensures timely and appropriate review of all submissions requiring a clinical opinion. Our average claim turnaround time is less than seven days.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
16. What additional benefits do you offer to pregnant women?	Multiple studies show that dental disease can cause complications for people who are pregnant or have health issues such as heart disease or diabetes. Through our dental wellness program, BlueCare Dental Connection, we are committed to promoting our members' total health and wellness. Integration with our medical plans allows us to focus on a member's overall health, potentially reducing health care costs by lowering the incidence of more serious complications. We offer wellness outreach emails to educate members on the importance of routine oral health care. This includes emails specific to members with conditions that may impact their oral health, such as diabetes, cardiovascular disease, and pregnancy. We also administer an enhanced benefit for members who require additional dental care because of high-risk medical conditions, whom we identify through medical claims. This benefit, which is supported by evidence-based studies, complements our wellness program by covering additional dental services.
17. Does your plan allow nitrous oxide analgesia? If so, please indicate any additional costs.	Our standard contract does not cover nitrous oxide analgesia; however, it can be considered for an additional cost.

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DENTAL PPO BENEFIT ADMINISTRATION	OFFEROR RESPONSE
18. What types of sedatives do you cover and what are the coverage limitations?	Our dental plan covers the following sedatives: • Deep Sedation/General Anesthesia (First 15 minutes) - Occurrence limit of 1 in 1 day has been reached for procedures with codes 9222 based on paid claims. • Deep Sedation/General Anesthesia (Each Subsequent 15 Minute Increment) - Occurrence limit of 3 in 1 day has been reached for procedures with codes 9223 based on paid claims. • Intravenous Moderate (Conscious) Sedation/Analgesia (First 15 Minutes) - Occurrence limit of 1 in 1 day has been reached for procedures with codes 9239 based on paid claims. • Intravenous Moderate (Conscious) Sedation/Analgesia (Each Subsequent 15 Minute Increment) - Occurrence limit of 3 in 1 day has been reached for procedures with codes 9243 based on paid claims. • Non-Intravenous Conscious Sedation.
19. Do you cover temporary fillings?	Yes, Our plan covers preventative resin restoration (D1352) and protective restorations (D2940) which is placed to relieve pain, promote healing, or prevent further deterioration of the tooth.
20. Up to what age do you cover fluoride treatments and how often?	2 per year for children up to age 19.
21. Up to what age do you cover sealants and how often?	1 per lifetime up to age 16.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
1. From what location would this policyholder's claims be processed?	This response is considered confidential. Please refer to the Legally Confidential folder for details.
2. What is your company's claims processing turn-around time for dental claims not involving coordination of benefits?	This response is considered confidential. Please refer to the Legally Confidential folder for details.
3. Does your claim system have any protections against fraud by:	
a. Providers	Yes.
b. Members	Yes.
c. Employees	Yes.
4. Does your claim system have any protections against unbundling and/or upgrading claims? If so, describe in detail.	Yes. The claims processing system has a specific procedure code to identify unbundling. If the provider submits a procedure code with other procedures that our dental consultants identify as including the primary procedure, the system will deny the claim and issue an EOB. These rules also apply to periodontal procedures, major restorative procedures, and some oral surgery procedures.

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5. a. What cost containment/management programs are available to City of Albuquerque (i.e., precertification, utilization review, etc.)?	Before, during, and after processing claims, we use the following methods to evaluate the appropriateness of charges and treatment: **Predetermination of Benefits** To determine appropriateness of treatment and charges prospectively, we recommend predetermination of benefits in all instances when the cost will be greater than $300. **Professional Review** We have a dental director, two dental hygienists, and seven part-time dental consultants to conduct professional reviews. We systematically delay about 2.5% of all dental claims for review or referral. Additionally, the system automatically selects the following claim categories for professional review: • Provider (if we suspect fraud). • Procedure code such as crowns, bridges, inlays, and onlays. • Any service that requires pretreatment radiographs. • Claims that are high cost, very complex, or have the potential for alternative treatment. • Questionable treatment planning. **Utilization Review** The utilization management process begins with an automatic screening of claims submissions and ends with a two-level, in-depth review of complex and expensive treatments. In most cases, savings result from effectively applying plan provisions based on plan design, benefit exclusions, and other frequency limitations. We systematically identify pretreatments that are not auto-adjudicated for individual consideration or review under the alternate benefit provision and send them through the utilization review process. In this process, our examiners or technicians pend any pretreatments they are unable to process immediately and route them for timely, professional review. **Claims Data** We evaluate each dentist's practice patterns by comparing paid claims utilization to related statistics and peer practices. This review ensures dental services are medically necessary,

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
	appropriate, of acceptable quality, and within the scope of a group contract. Throughout the utilization review process, dental consultants provide professional advice and answer clinical questions. We thoroughly train our dental consultants on contractual plan provisions and appropriateness of care. Using applicable criteria to review and evaluate oral health care services, we reduce the impact of high-cost claims while still providing benefits for appropriate dental care. Major restorative care, periodontal treatment, and oral surgery are three important types of care we continually evaluate.
b. Are these programs included in your quoted premium or are they an additional cost? If an additional cost, list the cost for each individual program.	Yes, included.
6. a. How are network claims processed?	This response is considered confidential. Please refer to the Legally Confidential folder for details.
b. Are any authorization forms necessary or ID cards required?	No.
c. Do members pay up-front and submit claims for reimbursement or are members responsible for only plan copays, deductibles and coinsurance?	Members are responsible for plan copays, deductibles, and coinsurance. The provider, if in-network, submits the claim on behalf of the member.
e. Are there any time limits for submitting claims?	Standard timely filing is one year; however we follow any state and regulatory criteria that apply or group contracted stipulations.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
7. How are non-network claims processed?	As the incumbent carrier, your current out of network dental plan includes a maximum allowable cost (MAC) plan. MAC programs use PPO-level fees, whether delivered by a network provider or a non-network provider. These programs produce the lowest premiums but result in higher out-of-pocket expenses for members who visit non-network providers.
b. How do you determine Usual, Customary, and Reasonable (UCR) for non-network dental benefits (e.g., own data, percentile of HIAA data, relative value scale, Fair Health)?	R&C plans pay out-of-network claims using the provider's actual billed charges, up to a pre-established maximum allowable. Our standard maximum allowable is the 90th percentile for the given geographic area, as determined using a database of fees provided by FAIR Health, Inc.
8. Does your plan use maximum allowable cost for limiting non-network allowances?	Yes.
9. What UCR level have you used for non-network claims?	Not applicable.
10. Explain how maximum allowable charges are determined geographically:	For MAC, the fees are determined based on the average in-network fee for each service code in each zip code. For R&C, FairHealth data is used to get the different percentiles.
11. a. By the location of the employer, or the provider of dental services? Other? Please explain. b. How are specific areas delineated *(e.g.,* 5 digit zip, 3 digit zip, county)? c. How often is data updated?	The specific areas are delineated by three-digit ZIP code based on the location of where the provider is located. The specific areas are delineated by three-digit ZIP code based on the location of where the provider is located. We review our contracted fees annually and the chief dental actuary makes updates as needed. Updates may not include all procedures in all areas. We maintain and apply historical values on the date of service. Adjustments are typically effective January 1.
12. What steps are taken if the maximum allowable charge is un-coded?	We update our codes annually, but if there is a charge that is uncoded, we would review manually and apply the most appropriate available code.

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DENTAL PPO CLAIM ADMINISTRATION SERVICES	OFFEROR RESPONSE
13. How are the client and plan participants supported in their resistance to charges in excess of the maximum allowable charge?	Most participating dentists agree to accept our maximum allowable amount and not to balance bill patients. Occasionally, out-of-network dentists may balance bill for any services over the allowed amount, any deductibles, and any noncovered services. The provider may bill a patient directly for any portion of the services provided under the following circumstances: • When the plan lists a patient copayment/coinsurance for a covered service. • When a service is not a covered procedure on the member's plan. • When a member exceeds their annual maximum. • When it is determined the member was not eligible at the time of service. • When the cost of a customized course of care is associated with a covered service.
14. How can a claimant find out what the maximum allowable charge is for a particular procedure in advance of having the procedure performed?	Members can request a predetermination. Predeterminations are included in average cycle time, as they are considered claims, but we do not impose a turnaround time specifically for predeterminations.
15. With respect to dental surgery, do you ever reimburse assistant surgeons? 16. What is the basis for such a determination 17. How is the allowance for the assistant surgeon, if any, calculated?	We do not reimburse assistant surgeons. The only time an assistant surgeon would be involved is when performing complex surgical cases. These types of cases are not a benefit under dental, usually medical. Medical has their own formula for reimbursing assistant surgeons. Not applicable.
18. When you are COB secondary payor, do you use your UCR profiles or those of the primary carrier to determine your level of reimbursement?	When a member has coverage under two or more dental plans, the provider coordinates coverage from those plans to ensure the member receives the maximum allowable benefit from each plan. The total payment to the provider from all plans cannot exceed the total charges. We reimburse up to the negotiated fee whether we are the primary or secondary coverage.

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DENTAL PPO PLAN UNDERWRITING	OFFEROR RESPONSE
1. What experience period will be used for the first renewal (e.g., first 6 months)? What period will be used in subsequent renewals?	We use the most recent 12 months experience for first and each subsequent renewal.
2. How much would the group have to change in size before the credibility percentages above would vary by more than 10 percent?	We reserve the right to re-rate if the number of covered members increases or decreases by 10% or more.
3. What credibility do you anticipate assigning to the Client's experience at: First Renewal?	100% fully credible.
Subsequent?	100% fully credible.
4. How will projected incurred claims be estimated?	We will use a blend of trend and exposures.
5. a. Do you agree to use client specific lag to determine paid to incurred adjustments for renewal calculations?	Not applicable.
b. If no, describe how you adjust paid claims to incurred claims? What standard reserve factor would you use?	We use paid claims for renewal calculation
6. Is retention calculated as a percentage of claims, a percentage of premium, or a per capita basis?	It is calculated by percentage of claims.
7. What were your historic 2023 and 2024 DPPO trends and anticipated 2025 trends for your proposed plan in the greater Albuquerque metropolitan area? a. 2023	These responses (a, b and c) are considered confidential. Please refer to the Legally Confidential folder for details.
b. 2024	
c. Anticipated 2025	
FINANCIAL	

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DENTAL PPO PLAN UNDERWRITING	OFFEROR RESPONSE
1. Please list all provisions relating to reevaluation of proposed rates due to variation in enrollment or other contingencies of the quote.	We reserve the right to recalculate our quoted rates mid-contract if any of the following occur: • The covered members' demographic composition changes. • The number of covered members increases or decreases by 10% or more. • The benefit plan changes. • Any local, state, or federal legislation, regulation, rule, or guidance (or amendments or clarifications thereto) is enacted or becomes effective/implemented which results in increased projected claim costs or an increase to our expenses or cost of plan administration. Refer to the conditions and caveats section of our proposal for a complete overview of applicable caveats or surcharges.

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DENTAL BILLING PROCESS	OFFEROR RESPONSE
1. When is premium due and when is it considered delinquent?	**Fully Insured** We consider clients delinquent, putting them at risk for claims delay and cancellation, if we do not receive payment within 30 days of the due date. We generate billing 15 days before the premium due date and payment is due on the first day of coverage. Our delinquency process follows the standard 30-day grace period: • Stage 1: 20 days after the payment was due, we send a courtesy letter to let the group know there could be a claims lock if we do not receive payment within 10 days. • Stage 2: 30 days after the payment was due, we send a letter stating claims will be delayed, and we will initiate cancellation if we do not receive payment within 30 days. • Stage 3: 60 days after the payment was due, we send a letter stating we have canceled the account. There are situations when we send a partial letter stating we have received a partial payment and the balance due. **Self-Funded** Accommodating the City's banking needs is a priority for us. There are two payment options: standard pay as billed and self-billing. Standard payment is billed with the City's choice of weekly or monthly frequency. Weekly billed accounts are due in 48 hours. Monthly billed accounts are due in 30 days. We offer a self-bill arrangement to allow the City to track and maintain their own membership records. Roster and matching payment are due per the standard billing due dates. The billing due date is the tenth of the billed month; for example, January premiums are due February 10th. We compare your roster to our membership data and will notify you of any discrepancies. We require a resolution of discrepancies on the next month's roster and payment. All eligibility changes and/or updates will need to be sent to BCBS membership team to update membership records to prevent or resolve administration billing discrepancies.

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DENTAL BILLING PROCESS	OFFEROR RESPONSE
2. How do you handle reconciliation of billing and enrollment issues?	**Fully Insured** We do not assume responsibility for bank reconciliation for fully insured accounts. We do provide a monthly list of member charges. All the information needed to perform a reconciliation can be obtained through Blue Access for Employers. **Self-Funded** We provide a weekly/monthly (depending on group's funding type) claim detail listing report. All the information needed to perform a reconciliation can be obtained through the reports available in Blue Access for Employers.
3. How often would you audit the City of Albuquerque for eligibility discrepancies?	If we need to clarify eligibility or enrollment information, we will contact the group through Blue Access for Employer's membership message center, and in some cases by email, within five days of receiving the information. We identify errors in several ways: • When we receive an electronic eligibility file, we check it against the information in our existing files. • If there is a discrepancy, we examine the files further to determine any missing, incomplete, or inaccurate information. • If we are unable to resolve the discrepancy, we contact the group and issue a discrepancy report. If a group or member identifies an error, the group can send corrections by making updates or sending an inquiry in Blue Access for Employers, a change request form, or updating values on their electronic feed. We will enter corrections into our eligibility and membership system, and the updates will be immediately available.
4. The City of Albuquerque would prefer at a minimum current month plus 60 days for retroactive terminations. What is your timeframe allowed for retroactive terminations? Is this negotiable?	Your current fully insured plan allows for 90 days retroactive terminations unless there is a paid claim. We allow 365 days for ASO.

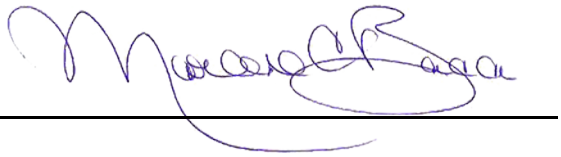
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REPORTING						
1. Based on the attached required structure, do you agree to provide the following reports as identified in the table below? Please indicate if your report is available online to City of Albuquerque (and/or their consulting firm). Please include sample reports.						
REPORTING – ALL OFFERORS						
Coverage Line	**Month**	**Quarter**	**Annual**	**OFFEROR Response (Y or N)**	**Online Access (Y or N)**	**Excel (Y or N)**
Dental						
Enrollment (subscriber/member) by coverage tier and active/cobra.	X			Y	Y	Y
Premiums paid	X			Y	Y	Y
Claims paid by Status (active/cobra) and in-network vs out of network	X			Y	Y	Y
Utilization report		X		Y	Y	Y
Lag report			X	Y	Y	Y
Ad Hoc Reporting Capabilities						
Ability for the City to generate Ad Hoc Reports	Determined by the City.			Y	Y	Y

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DEVIATIONS

Offeror Name: **Blue Cross and Blue Shield of New Mexico**

Signature: 

Date: **August 18, 2025**

Deviations	
Reference in RFP	**Deviation**
Terms and Conditions Review	**Fully Insured** Blue Cross and Blue Shield of New Mexico (BCBSNM) has developed a standard Group Administration Document (GAD) that describes the administrative services and the roles and responsibilities of BCBSNM and a group customer client. BCBSNM's bid is conditioned upon the group's agreement to the terms and conditions of BCBSNM's GAD. While we are unable to modify the GAD and the Benefit Program Application (BPA), due to state regulations and legislation, we are able to modify the benefit booklet(s) and any other applications, schedule(s) or coverage, riders, enclosures, addenda, exhibits and amendment to any of them, and our contract offerings in other ways in order to incorporate mutually agreed upon benefits and services requested to meet City of Albuquerque's needs and expectations. Please note these additional terms and conditions may be subject to approval by the New Mexico Office of the Superintendent of Insurance.

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Deviations	
	Self-Funded Blue Cross and Blue Shield of New Mexico ("BCBSNM") values its relationship with the City of Albuquerque, which includes the contract negotiations that culminated in an executed Administrative Services Agreement, it's exhibits, and all modifications or revisions made in accordance with its terms, unless otherwise specified ("Agreement"). For the proposed business for the City of Albuquerque, BCBSNM is open to incorporating mutually agreed-upon modifications to the Agreement. BCBSNM looks forward to working with the City of Albuquerque to negotiate those contract terms during the contracting phase after we have more information about the City of Albuquerque's specific needs and the actual services we will be delivering to the City of Albuquerque.
Part 1 – Instructions to Offerors: 1.5.5	We agree to the requirements in the insurance section (1.23) of the RFP except as noted below. HCSC procures and maintains the insurance policies specified in this section. For compliance purposes, some of the language may need to be modified in order to meet the New Mexico Office of Superintendent of Insurance (OSI) and carrier requirements. Any changes would be subject to discussion and agreed-upon terms would be included in the ASA.
Part 1 – Instructions to Offerors: 1.5.9, 1.5.10	Not applicable to our proposed offering.
Part 1 – Instructions to Offerors: 1.23.1	Certificates of insurance are issued in compliance with rules using ACORD forms. Special language for notice of cancellation is not allowed as worded. Our insurance policies are confidential and proprietary. Policies, in whole or in part, are not released to third parties. Additional insured status and primary positioning on the Commercial General Liability policy do not appear to be applicable to this engagement. During the contract phase, we can discuss this further and work out the appropriate terms that are suitable for this type of engagement.
Part 1 – Instructions to Offerors: 1.23.2	We assume responsibility for our subcontractors. Subcontractors may have

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Deviations	
	different insurance requirements based on the type of service they are performing.
Part 1 – Instructions to Offerors: 1.23.3.1	Our commercial general liability policy includes contractual liability coverage; however, it cannot be tied to the hold harmless provisions as worded. The hold harmless provisions should be separate from the insurance provisions. Our limits are currently $2 million per occurrence and policy aggregate.
Part 1 – Instructions to Offerors: 1.23.4, 1.23.5	During the life of the contract, HCSC will consider an increase in limits. Any agreed to changes or increases must be added to the ASA by way of a signed addendum. A discussion is always welcomed.

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STATE OF NEW MEXICO

TAXATION AND REVENUE DEPARTMENT

RESIDENT BUSINESS CERTIFICATE

Issued to: **HEALTH CARE SERVICE CORPORATION**

DBA: **BLUE CROSS AND BLUE SHIELD OF NEW MEXICO**
1001 E LOOKOUT DR
RICHARDSON, TX 75082-4144

Expires: **01-Sep-2025**

Certificate Number:

L0013013104

Stephanie Schardin Clarke
Cabinet Secretary

THIS CERTIFICATE IS NOT TRANSFERABLE

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City of Albuquerque
DPPO PROVIDER DISRUPTION
Appendix F

Confidential and Proprietary

Vendor Name	Blue Cross and Blue Shield of New Mexico	
Contact Name	Amanda Romero	
Contact Number	505-900-4021	

If the dental provider is included in your network, indicate Yes in column J. Do not add, delete or re-sort rows.

Row Number	TIN	PROVIDER NPI	Provider Name	Facility	Address 1	Address 2	City	State	ZIP	Network Status (In or Out)	Claims	Claimants	Procedures
1	043487228	1871881193	VICTORIA KAPLAN	SUDBURY FAMILY DENTAL CARE	370 BOSTON POST RD		SUDBURY	MA	01776	IN	3	1	5
2	200290040	1639185820	DANIEL MARTINEZ	DANIEL L MARTINEZ DDS	7930 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	64	31	183
3	201489022	1255347332	TERRY GOMEZ KROETER	TERRY GOMEZ DDS PC	6830 MONTGOMERY BLVD NE	STE F	ALBUQUERQUE	NM	87109	IN	98	58	246
4	201688195	1639132715	MICHAEL GALLEGOS	MICHAEL H GALLEGOS, DDS	490B W ZIA RD	STE 2	SANTA FE	NM	87505	OON	3	2	7
5	201781522	1346498722	CRAIG STEICHEN	CRAIG T STEICHEN DDS	7131 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	54	26	138
6	201781522	1003496316	CHUNWOO KANG	PRECISION DENTAL CARE	6301 INDIAN SCHOOL RD NE	STE 100	ALBUQUERQUE	NM	87110	IN	19	13	58
7	202029146	1760401830	DOUGLAS GIBBONS	DOUGLAS B GIBBONS DDS PC	1101 MEDICAL ARTS AVE NE	BLDG 1	ALBUQUERQUE	NM	87102	OON	62	39	160
8	202075729	1770655623	ROSS MOHR	ROSS I MOHR DMD PC	7500 HOLLY AVE NE	STE 2	ALBUQUERQUE	NM	87113	IN	17	13	33
9	202218437	1124096995	CARLOS TORREBIARTE	TORREBIARTE CARLOS E DDS	3730 ELLISON RD NW	STE B	ALBUQUERQUE	NM	87114	OON	8	4	14
10	202260167	1154405819	CHRISTINA BACHICHA	STERBA PATRICK M DDS	606 ENCINO PL NE		ALBUQUERQUE	NM	87102	IN	34	21	82
11	202260167	1245314921	PATRICK STERBA	STERBA PATRICK M DDS	606 ENCINO PL NE		ALBUQUERQUE	NM	87102	IN	50	33	127
12	202396315	1578553111	SCOTT BINGHAM	BINGHAM SCOTT DMD	7711 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	38	28	190
13	202804808	1073964730	TIMOTHY NGO	KIDS CHOICE DENTAL	6211 4TH ST NW	STE 13	ALBUQUERQUE	NM	87107	IN	1	1	6
14	202804808	1194307520	GENNA VEGH	KIDS CHOICE DENTAL	120 98TH ST NW	STE C3	ALBUQUERQUE	NM	87121	IN	4	4	11
15	202804808	1346724234	GREGORY WELLS	KIDS CHOICE DENTAL	120 98TH ST NW	STE C3	ALBUQUERQUE	NM	87121	IN	4	4	15
16	202804808	1528086188	JOHN NOYES	KIDS CHOICE DENTAL	120 98TH ST NW	STE C3	ALBUQUERQUE	NM	87121	IN	67	30	261
17	202828519	1871753343	KIRK MACGILLIVRAY	KIRK W MACGILLIVRAY DDS	1496 S SAINT FRANCIS DR		SANTA FE	NM	87505	IN	2	1	5
18	202954524	1659351955	DAVID MARTINEZ	DAVID J MARTINEZ DDS PC	7500 HOLLY AVE NE	STE 1	ALBUQUERQUE	NM	87113	OON	261	194	850
19	202954524	1659351955	DAVID MARTINEZ	DAVID J MARTINEZ DDS PC	7500 HOLLY AVE NE	STE 1	ALBUQUERQUE	NM	87113	OON	171	46	510
20	202970185		DENTA QUEST	DENTAQUEST	11100 W LIBERTY DR	SUBROGATION CLAIMS	MILWAUKEE	WI	53224	OON	1	1	0
21	203502859	1558597013	NEAL BAUGH	COMFORT DENTAL OF BRENTWOOD HI	2010 JUAN TABO BLVD NE		ALBUQUERQUE	NM	87112	IN	51	25	109
22	204056199		DENTAQUEST NEW MEXICO	DENTAQUEST NEW MEXI	PO BOX 678118		DALLAS	TX	75267	OON	9	9	37
23	204222481	1134215122	DAVID OCHENRIDER	PERFECT TEETH	10250 COTTONWOOD PARK NW	STE B	ALBUQUERQUE	NM	87114	IN	58	38	162
24	204222481	1679771976	MARTHA HOLLIDAY	PERFECT TEETH	10250 COTTONWOOD PARK NW	STE B	ALBUQUERQUE	NM	87114	IN	2	2	2
25	204263713	1831241645	MICHAEL SPARKS	MICHAEL SPARKS DDS	4216 LOUISIANA BLVD NE		ALBUQUERQUE	NM	87109	OON	19	14	32
26	204691758	1285696724	JOHN HARMON	WESTSIDE ENDODONTICS	2320 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	5	5	13
27	204691758	1821218702	MELISSA HARMON	WESTSIDE ENDODONTICS	2320 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	14	12	35
28	205153997	1093786618	MARIFER MARTINEZ LUJAN	MARIFER MARTINEZ LUJAN DDS PC	8400 OSUNA RD NE	STE 4C	ALBUQUERQUE	NM	87111	IN	5	4	12
29	205292736	1922084201	RACHAEL TINGEN	PLACITAS DENTAL PC	3 HOMESTEADS RD	STE B	PLACITAS	NM	87043	OON	3	1	6
30	205384003	1629630538	RUBEN VALENCIA JR	PROMENADE DENTAL GROUP	2755 S 99TH AVE	STE 105	TOLLESON	AZ	85353	IN	2	1	5
31	205443404		GARY HERRON	AFFORDABLE DENTURES	4821 ALEXANDER BLVD NE		ALBUQUERQUE	NM	87109	IN	1	1	2
32	205610119	1073695961	NAZARIO YOUNG TRUJILLO	NAZARIO YOUNG TRUJILLO DDS INC	312 UNSER BLVD NE		RIO RANCHO	NM	87124	IN	30	25	102
33	205610119	1538804919	CHRISTOPHER GRAHAM	NAZARIO YOUNG TRUJILLO DDS INC	312 UNSER BLVD NE		RIO RANCHO	NM	87124	IN	1	1	4
34	205610119	1740419100	MELISSA IVERS	NAZARIO YOUNG TRUJILLO DDS INC	312 UNSER BLVD NE		RIO RANCHO	NM	87124	IN	50	34	184
35	205611176	1619289238	CHRISTIAN PECK	CHRISTIAN PECK DDS	106 MAIN ST NE		LOS LUNAS	NM	87031	IN	1	1	10
36	205980338	1851306591	HALEY RITCHEY	ELDORADO DENTAL	2100 CALLE DE LA VUELTA	STE D105	SANTA FE	NM	87505	IN	1	1	3
37	205980338	1851306591	HALEY RITCHEY	HALEY RITCHEY	1 CALIENTE RD	STE E	SANTA FE	NM	87508	IN	2	1	2
38	208114933	1659427318	TIMOTHY KELLY	TIMOTHY M KELLY DMD PA	1441 CARLISLE BLVD NE	STE D	ALBUQUERQUE	NM	87110	IN	25	15	49
39	208488778	1043585730	BLAKE GUTIERREZ	UNM MEDICAL GROUP INC	1801 CAMINO DE SALUD NE	STE 1100 AND 1200	ALBUQUERQUE	NM	87102	IN	18	11	32
40	208488778	1043585730	BLAKE GUTIERREZ	UNM MEDICAL GROUP INC	900 YALE BLVD		ALBUQUERQUE	NM	87131	IN	16	12	27
41	208488778	1720085749	GARY CUTTRELL	UNM MEDICAL GROUP INC	1801 CAMINO DE SALUD NE	STE 1100 AND 1200	ALBUQUERQUE	NM	87102	IN	1	1	2

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42	208488778	1972782472	ERIK WATSON	UNM MEDICAL GROUP INC	1801 CAMINO DE SALUD NE	STE 1100 AND 1200	ALBUQUERQUE	NM	87102	IN	1	1	1
43	208735417		JACOB COLLINS	DESERT HILL DENTAL CARE LLC	2525 E 30TH ST		FARMINGTON	NM	87401	IN	1	1	1
44	208735417	1326350356	CLARISSA BURGESS	DESERT HILL DENTAL CARE LLC	2525 E 30TH ST		FARMINGTON	NM	87401	IN	6	3	18
45	260233336	1588879225	JAMES KU	JAMES H KU DDS INC	9316 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87111	IN	28	12	76
46	260476550	1639167828	DANIA PELLERANO	DMM FAMILY DENTAL CARE	8400 OSUNA RD NE	STE 5B	ALBUQUERQUE	NM	87111	IN	48	20	109
47	260725685	1336111319	STEPHEN JENKINS	JENKINS STEPHEN D DDS	10151 MONTGOMERY BLVD NE	STE 2B	ALBUQUERQUE	NM	87111	OON	7	6	9
48	260849508	1285626564	HONG MORRISON	CABEZON DENTAL LLC	2401 CABEZON BLVD SE	STE 101 A	RIO RANCHO	NM	87124	IN	108	70	236
49	260849508	1972655405	JEREMY MORRISON	CABEZON DENTAL LLC	2401 CABEZON BLVD SE	STE 101 A	RIO RANCHO	NM	87124	IN	65	49	161
50	261349865	1881906394	MICHAEL MILLBURN	COMFORT DENTAL OF CORONADO	5820 MENAUL BLVD NE		ALBUQUERQUE	NM	87110	IN	19	9	57
51	261349865	1982869756	NATHAN HORTON	COMFORT DENTAL OF CORONADO	5820 MENAUL BLVD NE		ALBUQUERQUE	NM	87110	IN	14	8	37
52	261349865	1992297410	CHAZ GIBBONS	COMFORT DENTAL OF CORONADO	5820 MENAUL BLVD NE		ALBUQUERQUE	NM	87110	IN	20	15	66
53	262008926	1427122548	GREGORY POHL	KENTUCKY DNT PROFESSIONALS PSC	618 BUTTERMILK PIKE		CRESCENT SPGS	KY	41017	IN	1	1	3
54	262619724	1689751067	CASEY ALLMAN	CASEY C ALLMAN DMD	5740 NIGHT WHISPER RD NW	STE 100	ALBUQUERQUE	NM	87114	IN	102	58	334
55	262810477	1750340147	CHRISTOPHER BUTTNER	CHRISTOPHER A BUTTNER DDS	6800 MONTGOMERY BLVD NE	STE O	ALBUQUERQUE	NM	87109	OON	28	20	60
56	262979248	1316556962	BAHRAM BARZEGARI	UPTOWN DENTAL ASSOCIATES LLC	7101 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	62	47	166
57	262979248	1326722919	ALYSSA CANDELARIA	UPTOWN DENTAL ASSOCIATES LLC	7101 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	42	38	113
58	262979248	1326722919	ALYSSA CANDELARIA	UPTOWN DENTAL ASSOCIATES LLC	7101 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	5	2	10
59	262979248	1497276596	MATTHEW MARTINEZ	UPTOWN DENTAL ASSOCIATES LLC	7101 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	76	61	230
60	262979248	1679069223	JACOB GREAVES	UPTOWN DENTAL ASSOCIATES LLC	7101 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	209	140	609
61	263385615	1811969561	KIRK KIRACOFE	KIRACOFE KIRK L DDS	6208 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	61	30	183
62	263641371	1447324280	DAVID TUGGLE	SANDIA ORAL SURGERY AND DENTAL	7009 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87109	IN	7	4	27
63	263840763	1972748747	DEREK GRAFF	GRAFF DEREK J DMD	3180 N BUTLER AVE	STE 200	FARMINGTON	NM	87401	IN	2	1	6
64	263881013	1366561060	EMERSON VICUNA	EMERSON L VICUNA DDS INC	1010 BRIDGE BLVD SW	STE F	ALBUQUERQUE	NM	87105	IN	15	11	29
65	264085466	1447601042	TUYET PHI TRUONG	ROBERT KERSCHEN DMD	7400 HOLLY AVE NE		ALBUQUERQUE	NM	87113	IN	4	4	17
66	264085466	1821014432	ROBERT KERSCHEN	ROBERT KERSCHEN DMD	7400 HOLLY AVE NE		ALBUQUERQUE	NM	87113	OON	54	34	126
67	264562151	1013983261	REUBEN JAMHARIAN	JAMHARIAN REUBEN A DMD	11001 SPAIN RD NE	STE A	ALBUQUERQUE	NM	87111	OON	17	11	47
68	264662661	1154565851	DANA CASAUS	DANA M CASAUS DDS MS PC	5910 CUBERO DR NE	STE D	ALBUQUERQUE	NM	87109	IN	11	4	25
69	270263596	1518163724	FAZILA WILLIAMSON	RITA RANCH DENTAL GROUP	8160 S HOUGHTON RD	STE 130	TUCSON	AZ	85747	IN	1	1	3
70	270268833	1962631275	RAJA SHAH	BEST SMILES TWO LLC	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	1	1	2
71	270268905	1609098789	RUSSELL TRAPNELL	ABQ ORTHODONTICS	2010 WYOMING BLVD NE	STE G	ALBUQUERQUE	NM	87112	IN	8	5	13
72	270268905	1609098789	RUSSELL TRAPNELL	ABQ ORTHODONTICS	6401 LOS VOLCANES RD NW		ALBUQUERQUE	NM	87121	IN	45	17	92
73	270268905	1609178177	QUINTIN RUPP	ABQ ORTHODONTICS	2010 WYOMING BLVD NE	STE G	ALBUQUERQUE	NM	87112	IN	29	11	68
74	270268905	1609178177	QUINTIN RUPP	ABQ ORTHODONTICS	6401 LOS VOLCANES RD NW		ALBUQUERQUE	NM	87121	IN	29	10	70
75	270284116	1659589836	JENNIFER LAMONT	JENNIFER K LAMONT DDS PC	7050 BARSTOW ST NE	STE A	ALBUQUERQUE	NM	87111	OON	4	2	8
76	270411251	1952620338	SCOTT ELLEDGE	ELLEDGE SCOTT L DMD	402 KIVA CT		SANTA FE	NM	87505	IN	2	1	9
77	270585367	1285024729	RAKTIM BIR	PERFECT TEETH	510 NM HIGHWAY 528 I		BERNALILLO	NM	87004	IN	1	1	1
78	270585367	1285024729	RAKTIM BIR	PERFECT TEETH VENADA PLAZA	510 HIGHWAY 528	STE I	BERNALILLO	NM	87004	IN	4	4	16
79	270900635	1215122932	MARC PACHECO	ABQ ENDODONTICS	10429 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	18	10	40
80	270900635	1356508931	DAVID HADLEY	ABQ ENDODONTICS	10429 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	42	24	76
81	270900635	1891989158	JEFFREY CLARK	ABQ ENDODONTICS	10429 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	21	13	46
82	270914433	1437314234	ZACHARY ADKINS	ADKINS ZACHARY E DDS	3900 EUBANK BLVD NE	STE N17	ALBUQUERQUE	NM	87111	OON	16	10	33
83	271359888	1639607799	ALFONSO LARA BRAIN	ASPEN DENTAL	308 EASTERN BLVD		CANANDAIGUA	NY	14424	IN	1	1	2
84	271467916	1366617953	BRIAN JENSEN	LIGHTHOUSE DENTAL GROUP	1177 N EAGLE RD		EAGLE	ID	83616	IN	1	1	4
85	271499570	1376606350	MICHAEL TAYLOR	TAYLOR ORTHODONTICS LLC	200 W WILSHIRE BLVD	STE E	ROSWELL	NM	88201	IN	4	1	4
86	271617983	1285869792	THERON BURK	PEACH TREE DENTAL LLC	3700 COORS BLVD NW	STE D	ALBUQUERQUE	NM	87120	IN	181	95	696
87	271700657	1295956613	SHEILA HARRIS	NATOMAS CROSSING DENTAL CARE	4190 TRUXEL RD		SACRAMENTO	CA	95834	IN	1	1	2
88	271851304	1073601506	GEORGE KEANNA	NATURAL DENTAL SERVICES	5910 CUBERO DR NE	STE B	ALBUQUERQUE	NM	87109	OON	4	3	6
89	271870485	1609010644	ROLAND SANCHEZ	CONQUISTADOR DENTAL LLC	704 CHRISTOPHER DR		BELEN	NM	87002	IN	131	61	349
90	272806805	1649919523	JARED SALAS	JUST CLEAN SMILES LLC	3615 STATE HWY 47		PERALTA	NM	87042	OON	5	5	21
91	272901538	1023320165	KRISTIN HENDRICKS	WHOLE CHILD DENTAL LLC	1439 S SAINT FRANCIS DR		SANTA FE	NM	87505	IN	3	3	11
92	272901538	1114509080	TANNER GRAY	WHOLE CHILD DENTAL LLC	1439 S SAINT FRANCIS DR		SANTA FE	NM	87505	IN	1	1	6

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93	272901538	1417942624	KATHALYN MALONE	WHOLE CHILD DENTAL LLC	1439 S SAINT FRANCIS DR		SANTA FE	NM	87505	IN	5	5	23
94	272901538	1922448687	JASON GONZALEZ	WHOLE CHILD DENTAL LLC	1439 S SAINT FRANCIS DR		SANTA FE	NM	87505	IN	2	1	8
95	272945115	1194881532	JOSEPH SLAUGHTER	BRYCE B HEINER DMD MD LLC	2103 TELSHOR CT		LAS CRUCES	NM	88011	OON	1	1	2
96	273267056	1235444340	CHRISTOPHER EHAT	DENTAL PARTNERS OF LOMAS	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	1	1	4
97	273267056	1396048567	MATTHEW THOMAS	DENTAL PARTNERS OF LOMAS	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	3	2	9
98	273267056	1770713620	ELIZABETH WILSON	DENTAL PARTNERS OF LOMAS	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	39	20	92
99	273267056	1992083596	MARK CLAYTON	DENTAL PARTNERS OF LOMAS	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	2	2	5
100	273663868	1205141157	AMY MATTE	AMY C MATTE DDS PC	1441 CARLISLE BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	73	39	171
101	273721708	1033467568	WADE HINRICHS	COMFORT DENTAL CENTRAL	13031 CENTRAL AVE NE		ALBUQUERQUE	NM	87123	IN	28	13	71
102	273721708	1235444340	CHRISTOPHER EHAT	COMFORT DENTAL CENTRAL	13031 CENTRAL AVE NE		ALBUQUERQUE	NM	87123	IN	19	13	46
103	273721708	1982085940	ANDREW FARR	COMFORT DENTAL CENTRAL	13031 CENTRAL AVE NE		ALBUQUERQUE	NM	87123	IN	22	9	51
104	273727392	1396048567	MATTHEW THOMAS	DENTAL PARTNERS	5308 4TH ST NW		ALBUQUERQUE	NM	87107	IN	35	18	107
105	273727392	1619283702	DOUGLAS CHISHOLM	DENTAL PARTNERS	5308 4TH ST NW		ALBUQUERQUE	NM	87107	IN	38	18	109
106	273727392	1992083596	MARK CLAYTON	DENTAL PARTNERS	5308 4TH ST NW		ALBUQUERQUE	NM	87107	IN	40	15	108
107	273859017	1144356908	PATRICK CORIZ	CORIZ DENTAL LLC	1101 MEDICAL ARTS AVE NE	BLDG 1B	ALBUQUERQUE	NM	87102	IN	71	41	163
108	274130020	1316326374	KETAN PATEL	PEPPERMINT DENTAL	4411 SAN MATEO BLVD NE	STE E1	ALBUQUERQUE	NM	87109	IN	15	10	47
109	274414056	1467607382	JONATHAN BOWERS	JENNIFER OKI DMD	8400 OSUNA RD NE	STE 3B	ALBUQUERQUE	NM	87111	IN	95	57	228
110	274414056	1477705069	JENNIFER OKI	JENNIFER OKI DMD	8400 OSUNA RD NE	STE 3B	ALBUQUERQUE	NM	87111	IN	11	11	28
111	274439684	1104923085	KERRY ROSS	ROSS FAMILY DENTAL	10330 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	65	38	198
112	274439684	1124125091	JASON ROSS	ROSS FAMILY DENTAL	10330 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	62	42	192
113	274471867	1215465760	JONATHAN ARAGON	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	85	33	281
114	274471867	1356652358	DAVID LILLIAN	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	6	5	13
115	274471867	1558748434	STACEY REISS	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	11	5	16
116	274471867	1780811984	RYAN WILSON	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	12	10	36
117	274471867	1841850278	BRENDAN SCHLEYER	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	10	5	82
118	274471867	1992114995	MICHAEL SANCHEZ	ALBUQUERQUE MODERN DENTISTRY	2800 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	126	46	243
119	274471980	1356652358	DAVID LILLIAN	NE HEIGHTS MODERN DENTISTRY	5901 WYOMING BLVD NE	STE W	ALBUQUERQUE	NM	87109	IN	3	3	11
120	274471980	1730717869	KATELYN KREH	NE HEIGHTS MODERN DENTISTRY	5901 WYOMING BLVD NE	STE W	ALBUQUERQUE	NM	87109	IN	10	5	35
121	274471980	1780811984	RYAN WILSON	NE HEIGHTS MODERN DENTISTRY	5901 WYOMING BLVD NE	STE W	ALBUQUERQUE	NM	87109	IN	7	6	19
122	274471980	1841850278	BRENDAN SCHLEYER	NE HEIGHTS MODERN DENTISTRY	5901 WYOMING BLVD NE	STE W	ALBUQUERQUE	NM	87109	IN	4	3	10
123	274471980	1952683724	KEE JU HONG	NE HEIGHTS MODERN DENTISTRY	5901 WYOMING BLVD NE	STE W	ALBUQUERQUE	NM	87109	IN	81	33	184
124	274854296	1912121849	SHANE MATT	SHANE E MATT DDS	1717 WEST 6TH ST	STE 365	AUSTIN	TX	78703	OON	4	1	15
125	300750536	1114229416	DAVID CLAYDEN	CELEBRACES NM LLC	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	8	8	8
126	320419603	1790097160	JOHN GILBRETH	GILBRETH GROUP LLC	4111 BARBARA LOOP SE	STE B	RIO RANCHO	NM	87124	IN	26	21	58
127	320465281	1255987616	KATELYN BOBBITT	ABQ MODERN DENTAL GROUP	12611 MONTGOMERY BLVD NE	STE A-1	ALBUQUERQUE	NM	87111	IN	53	24	194
128	320465281	1780811984	RYAN WILSON	ABQ MODERN DENTAL GROUP	12611 MONTGOMERY BLVD NE	STE A-1	ALBUQUERQUE	NM	87111	IN	2	2	8
129	320465281	1841850278	BRENDAN SCHLEYER	ABQ MODERN DENTAL GROUP	12611 MONTGOMERY BLVD NE	STE A-1	ALBUQUERQUE	NM	87111	IN	3	3	6
130	330834203	1720189228	STEVEN BEULIGMANN	BEULIGMANN STEVEN A DDS	1299 CARLSBAD VILLAGE DR		CARLSBAD	CA	92008	OON	3	2	8
131	331624998	1982712212	MARIANNE DIACHENKO	MARIANNE DIACHENKO DDS	25 E WASHINGTON ST	STE 302	CHICAGO	IL	60602	OON	1	1	3
132	361236610		OUT OF COUNTRY MEXICO	OUT OF COUNTRY MEXICO	123 ANY ST		BROWNSVILLE	TX	78520	OON	13	6	16
133	364582124	1053335950	MICHAEL CROCKETT	FAMILY DENTISTRY	31 S 63RD ST	STE 5	MESA	AZ	85206	OON	1	1	3
134	364709800	1134147390	COLLEEN WILLIAMS	SERENITY DENTAL AND SPA	441 WYOMING BLVD NE		ALBUQUERQUE	NM	87123	IN	2	2	4
135	364709800	1407823008	MY HO	SERENITY DENTAL AND SPA	441 WYOMING BLVD NE		ALBUQUERQUE	NM	87123	IN	12	7	34
136	364709800	1841388154	DWIGHT HOWARD	SERENITY DENTAL AND SPA	441 WYOMING BLVD NE		ALBUQUERQUE	NM	87123	IN	1	1	3
137	364914702	1831240217	MICHAEL WILKERSON	KIDS PLACE	1101 S MAIN ST		BOERNE	TX	78006	IN	3	2	19
138	371741676	1205904026	MATTHEW FELTS	MATTHEW H FELTS DDS LLC	800 N CEDAR		T OR C	NM	87901	IN	4	1	13
139	371762521	1063672236	ANDREA D ADDARIO	ROCKY MOUNTAIN PEDIATRIC PLLC	7505 MULBERRY WOOD DR	STE 150	COLORADO SPGS	CO	80908	IN	5	5	13
140	371776523	1356652358	DAVID LILLIAN	ENCHANTED HILLS DENTISTRY	470 NEW MEXICO 528	STE A	BERNALILLO	NM	87004	IN	3	2	10
141	371776523	1558748434	STACEY REISS	ENCHANTED HILLS DENTISTRY	470 NEW MEXICO 528	STE A	BERNALILLO	NM	87004	IN	3	1	3
142	371776523	1659847069	TRACY TRAM	ENCHANTED HILLS DENTISTRY	470 NEW MEXICO 528	STE A	BERNALILLO	NM	87004	IN	17	10	41
143	371776523	1841850278	BRENDAN SCHLEYER	ENCHANTED HILLS DENTISTRY	470 NEW MEXICO 528	STE A	BERNALILLO	NM	87004	IN	1	1	5

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144	371776523	1932548799	BRYAN GRAZIANO	ENCHANTED HILLS DENTISTRY	470 NEW MEXICO 528	STE A	BERNALILLO	NM	87004	IN	37	20	89
145	371776523	1659847069	TRACY TRAM	ENCHANTED HILLS DENTISTRY LLC	470 HIGHWAY 528	STE A	BERNALILLO	NM	87004	IN	4	3	13
146	383850699	1871572479	JEFFREY SCOTT	CRYSTAL COAST DENTISTRY	202 WB MCLEAN DR		CAPE CARTERET	NC	28584	IN	1	1	5
147	383987830	1720160609	PETER TAFOYA	PETER J TAFOYA DDS LLC	404 KIVA CT	STE D	SANTA FE	NM	87505	IN	1	1	3
148	412117827	1700915691	JOHN SALAZAR	JOHN A SALAZAR DMD	5900 CUBERO DR NE	STE F	ALBUQUERQUE	NM	87109	OON	38	24	93
149	421606345	1205901972	LISA ARNHART	CANONCITO HEALTH CENTER	129 MEDICINE HORSE RD		TOHAJILEE	NM	87026	IN	1	1	4
150	450705453	1134571623	CHRISTOPHER GALLEGOS	MOUNTAIN DENTAL ALBERQUERQUE	3740 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	133	83	302
151	450705453	1164423984	ASLI KIRAN	MOUNTAIN DENTAL ALBERQUERQUE	3410 INDIAN SCHOOL RD NE		ALBUQUERQUE	NM	87106	IN	37	26	77
152	450705453	1164423984	ASLI KIRAN	MOUNTAIN DENTAL ALBERQUERQUE	3410 INDIAN SCHOOL RD NE		ALBUQUERQUE	NM	87106	IN	22	8	45
153	450705453	1306865647	C ROSS LONG	MOUNTAIN DENTAL ALBERQUERQUE	3740 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	167	119	283
154	450705453	1346787165	TAYLOR LEEPER	MOUNTAIN DENTAL ALBERQUERQUE	3740 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87120	IN	38	27	72
155	450705453	1891841714	RONALD JOHNSON	MOUNTAIN DENTAL ALBERQUERQUE	3410 INDIAN SCHOOL RD NE		ALBUQUERQUE	NM	87106	IN	5	5	12
156	451285877	1013328988	SARA MAAS	FAMILIA DENTAL ESP LLC	1508 N RIVERSIDE DR		ESPANOLA	NM	87532	IN	3	1	10
157	451285877	1104501766	DHARA PATEL	FAMILIA DENTAL ESP LLC	1508 N RIVERSIDE DR		ESPANOLA	NM	87532	IN	1	1	7
158	451296456	1144920349	SANDRA MARSHALL	FAMILY SMILES LLC	5505 CENTRAL AVE NE		ALBUQUERQUE	NM	87108	IN	2	1	6
159	451296456	1194455352	FABIAN MENDOZA	FAMILY SMILES LLC	5505 CENTRAL AVE NE		ALBUQUERQUE	NM	87108	IN	17	14	60
160	451296456	1497960561	BONGMIN AN	FAMILY SMILES LLC	4201 CENTRAL AVE NW	STE F1	ALBUQUERQUE	NM	87105	IN	17	12	67
161	451296456	1699475616	ADHM ASFAN	FAMILY SMILES LLC	4201 CENTRAL AVE NW	STE F1	ALBUQUERQUE	NM	87105	IN	23	18	114
162	451296456	1821611054	XINGYOU SHI	FAMILY SMILES LLC	6001 WINTER HAVEN DR NW		ALBUQUERQUE	NM	87120	IN	11	7	54
163	451296456	1902536162	LILIANA MORA	FAMILY SMILES LLC	6001 WINTER HAVEN DR NW		ALBUQUERQUE	NM	87120	IN	20	13	81
164	451504242	1093813354	PE CHANG	OMNI DENTAL	8005 MARBLE AVE NE		ALBUQUERQUE	NM	87110	OON	2	2	10
165	452050419	1497960561	BONGMIN AN	FAMILIA DENTAL LAS CRUCES LLC	1160 EL PASEO RD		LAS CRUCES	NM	88001	IN	1	1	3
166	452244197	1407140361	KEVIN HARRISON	KEVIN HARRISON DMD MS	8300 PALOMAS AVE NE	STE D	ALBUQUERQUE	NM	87109	OON	21	12	31
167	452657021	1033398490	KAREN MISLA	ADVENTURE DENTAL AND ORTHODONT	5000 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	5	5	22
168	452657021	1609955194	SANDRA SMITH	ADVENTURE DENTAL AND ORTHODONT	5000 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	7	4	35
169	452657021	1710066972	AURORA ZINK	ADVENTURE DENTAL AND ORTHODONT	5000 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	18	11	57
170	452657254	1033398490	KAREN MISLA	HERO DENTAL OF SANTA FE PC	2027 CERRILLOS RD		SANTA FE	NM	87505	IN	1	1	3
171	452657254	1225478183	DAVID DUNIVEN	HERO DENTAL OF SANTA FE PC	2027 CERRILLOS RD		SANTA FE	NM	87505	IN	4	4	19
172	452657254	1962934612	TAYLOR USITALO	HERO DENTAL OF SANTA FE PC	2027 CERRILLOS RD		SANTA FE	NM	87505	IN	1	1	1
173	452963558	1245587476	SKYLAR LIGHTHALL	DENTAL PARTNERS OF COTTONWOOD	9401 COORS BLVD NW		ALBUQUERQUE	NM	87114	IN	49	31	181
174	452963558	1467861153	RYAN YOUNG	DENTAL PARTNERS OF COTTONWOOD	9401 COORS BLVD NW		ALBUQUERQUE	NM	87114	IN	33	21	115
175	452963558	1720438716	BOKANG BOGOPANE	DENTAL PARTNERS OF COTTONWOOD	9401 COORS BLVD NW		ALBUQUERQUE	NM	87114	IN	48	32	171
176	453005514	1063712909	STEVEN FIFE	STEVEN R FIFE DDS PC	2240 GRANDE BLVD SE	STE 101	RIO RANCHO	NM	87124	IN	50	27	130
177	453250380	1265729404	KELLEY HOLLINGSWORTH R	SANTA FE MODERN DENTISTRY AND	3569 ZAFARANO DR		SANTA FE	NM	87507	IN	3	1	10
178	453357796	1073862900	MARGO RAINEY	TRUCARE DENTAL GROUP	4824 MCMAHON BLVD NW	STE 119	ALBUQUERQUE	NM	87114	IN	24	15	79
179	453357796	1487403499	MATTHEW WRIGHT	TRUCARE DENTAL GROUP	4824 MCMAHON BLVD NW	STE 119	ALBUQUERQUE	NM	87114	IN	1	1	5
180	453357796	1902062573	ANDREA PATTERSON	TRUCARE DENTAL GROUP	4824 MCMAHON BLVD NW	STE 119	ALBUQUERQUE	NM	87114	IN	13	10	48
181	453357796	1932549094	KENDRA VELASQUEZ	TRUCARE DENTAL GROUP	4824 MCMAHON BLVD NW	STE 119	ALBUQUERQUE	NM	87114	IN	5	5	10
182	453458452	1912275991	JOHN MORRIS	HOLLYWOOD ORTHODONTICS	1213C US HIGHWAY 491		GALLUP	NM	87301	IN	10	1	10
183	453533632	1194960914	LANCE CLARK	COMFORT DENTAL OF RIO BRAVO	1698 RIO BRAVO BLVD SW		ALBUQUERQUE	NM	87105	IN	48	20	103
184	453533632	1568619930	CODY MCGARRY	COMFORT DENTAL OF RIO BRAVO	1698 RIO BRAVO BLVD SW		ALBUQUERQUE	NM	87105	IN	39	27	117
185	453533632	1699141523	JARED GALVIN	COMFORT DENTAL OF RIO BRAVO	1698 RIO BRAVO BLVD SW		ALBUQUERQUE	NM	87105	IN	32	20	70
186	453533632	1801906607	JANICE SALAZAR	COMFORT DENTAL OF RIO BRAVO	1698 RIO BRAVO BLVD SW		ALBUQUERQUE	NM	87105	IN	48	25	109
187	453629120	1316271646	AARON KHAIRA	CABEZON ORTHODONTICS	2401 CABEZON BLVD SE	STE 104	RIO RANCHO	NM	87124	IN	21	7	21
188	453629120	1235596149	VAUGHN CALL	CABEZON PEDIATRIC DENTISTRY	2421 CABEZON BLVD SE	STE 101	ALBUQUERQUE	NM	87124	IN	242	148	867
189	453629120	1316271646	AARON KHAIRA	CABEZON PEDIATRIC DENTISTRY	2421 CABEZON BLVD SE	STE 101	ALBUQUERQUE	NM	87124	IN	5	3	5
190	453629120	1316271646	AARON KHAIRA	CABEZON PEDIATRIC DENTISTRY	2421 CABEZON BLVD SE	STE 101	ALBUQUERQUE	NM	87124	IN	5	2	5
191	453629120	1366673766	CAMERON HATCH	CABEZON PEDIATRIC DENTISTRY	2421 CABEZON BLVD SE	STE 101	ALBUQUERQUE	NM	87124	IN	252	151	850
192	453629120	1255938957	BIANCA RAMIREZ	DEMING CHILDRENS DENTISTRY	1310 E PINE ST	STE B	DEMING	NM	88030	IN	1	1	5
193	453629120	1346584331	HECTOR SORIA	DEMING CHILDRENS DENTISTRY	1310 E PINE ST	STE B	DEMING	NM	88030	IN	1	1	3
194	453629120		KELLY WELLS	LOBO CHILDRENS DENTISTRY LLC	10221 CENTRAL AVE NE		ALBUQUERQUE	NM	87123	IN	2	2	7

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195	453629120	1508509019	SORNA SARKER	LOBO CHILDRENS DENTISTRY LLC	10221 CENTRAL AVE NE		ALBUQUERQUE	NM	87123	IN	2	2	7
196	453629120	1043401268	DANIEL BORRERO	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	14	13	44
197	453629120	1225722069	BRANDON SABINSKY	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	3	3	13
198	453629120	1225728330	JASKIRAN GILL	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	19	18	80
199	453629120	1235596149	VAUGHN CALL	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	2	1	16
200	453629120	1316271646	AARON KHAIRA	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	11	3	11
201	453629120	1508509019	SORNA SARKER	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	7	7	35
202	453629120	1639756463	JOSEPH SINIBALDI	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	1	1	1
203	453629120	1811530819	BRIAN SPENCER	PEDIATRIC DENTAL ASSOCIATES OF	2801 EUBANK BLVD NE	STE J	ALBUQUERQUE	NM	87112	IN	40	33	178
204	453629120	1023515723	KWAN HO YUN	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	2	1	15
205	453629120	1043401268	DANIEL BORRERO	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	10	8	34
206	453629120	1225722069	BRANDON SABINSKY	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	124	79	641
207	453629120	1225728330	JASKIRAN GILL	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	4	4	13
208	453629120	1366673766	CAMERON HATCH	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	1	1	2
209	453629120	1386885002	CHRISTINA CHUNG	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	3	2	11
210	453629120	1396345963	JACK WELLS	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	8	7	43
211	453629120	1417239666	LILY CHA	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	2	2	8
212	453629120	1497191746	KELLY WELLS	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	3	3	15
213	453629120	1700040888	LEILANI TANAKA	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	7	6	24
214	453629120	1720008469	ANTHONY NIETO	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	4	2	14
215	453629120	1811530819	BRIAN SPENCER	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	5	5	15
216	453629120	1831563741	GABRIEL SENTIES RAMIREZ	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	7	3	11
217	453629120	1851666481	ARMANDO CHAVEZ	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	4	4	15
218	453629120	1932494408	JUNG LEE	RIO GRANDE CHILDRENS DENTISTRY	106 MAIN ST NE	STE B	LOS LUNAS	NM	87031	IN	2	1	6
219	453629120	1043401268	DANIEL BORRERO	ROUTE 66 CHILDRENS DENTISTRY	111 COORS BLVD NW	STE E6	ALBUQUERQUE	NM	87121	IN	2	2	5
220	453629120	1720008469	ANTHONY NIETO	ROUTE 66 CHILDRENS DENTISTRY	111 COORS BLVD NW	STE E6	ALBUQUERQUE	NM	87121	IN	2	2	9
221	453629120		GAREN UTUJIAN	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	16	6	16
222	453629120	1043401268	DANIEL BORRERO	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	16	13	56
223	453629120	1144743188	KAYLA SPENCER	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	1	1	4
224	453629120	1225728330	JASKIRAN GILL	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	4	4	17
225	453629120	1285933119	GAREN UTUDJIAN	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	5	4	5
226	453629120	1285933119	GAREN UTUDJIAN	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	9	4	9
227	453629120	1497191746	KELLY WELLS	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	15	15	47
228	453629120	1851666481	ARMANDO CHAVEZ	SOUTH VALLEY CHILDRENS DENTIST	3510 COORS BLVD SW	STE A	ALBUQUERQUE	NM	87121	IN	43	29	197
229	453629120	1386885002	CHRISTINA CHUNG	SPENCER TASKER PEDIATRIC DENTI	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	1	1	3
230	453629120	1437519758	JOHN JEPPSEN	SPENCER TASKER PEDIATRIC DENTI	9211 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	33	3	33
231	453629120	1437519758	JOHN JEPPSEN	SPENCER TASKER PEDIATRIC DENTI	9211 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	44	13	47
232	453629120	1043401268	DANIEL BORRERO	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	13	13	56
233	453629120	1144743188	KAYLA SPENCER	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	22	19	95
234	453629120	1225728330	JASKIRAN GILL	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	3	3	18
235	453629120	1235596149	VAUGHN CALL	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	66	42	265
236	453629120	1366673766	CAMERON HATCH	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	15	14	57
237	453629120	1386885002	CHRISTINA CHUNG	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	82	63	329
238	453629120	1386885002	CHRISTINA CHUNG	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	5	5	19
239	453629120	1396345963	JACK WELLS	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	161	107	652
240	453629120	1396345963	JACK WELLS	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW FL 3		ALBUQUERQUE	NM	87114	IN	3	3	14
241	453629120	1417239666	LILY CHA	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	118	89	498
242	453629120	1437519758	JOHN JEPPSEN	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	2	2	2
243	453629120	1437519758	JOHN JEPPSEN	TASKER HATCH ROWAN LLC	9211 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	1	1	1
244	453629120	1497191746	KELLY WELLS	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	1	1	3
245	453629120	1528219540	DOUGLAS REID	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	6	6	16

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246	453629120	1700040888	LEILANI TANAKA	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	73	64	314
247	453629120	1801634274	DANIAL AHMADI	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	18	18	72
248	453629120	1811530819	BRIAN SPENCER	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	4	4	25
249	453629120	1912578949	CAMILA IBAGON	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	1	1	3
250	453629120	1932494408	JUNG LEE NOURI	TASKER HATCH ROWAN LLC	9201 EAGLE RANCH RD NW		ALBUQUERQUE	NM	87114	IN	33	22	160
251	454000616	1801505607	BROCK DESOTO	SANDIS SMILES FOR MILES LLC	901 RIO GRANDE BLVD NW	STE A194	ALBUQUERQUE	NM	87104	IN	2	2	12
252	454000616	1801505607	BROCK DESOTO	SANDIS SMILES FOR MILES LLC	901 RIO GRANDE BLVD NW	STE A194	ALBUQUERQUE	NM	87104	IN	2	1	2
253	454037234	1063610228	RYAN SAVAGE	SAVAGE RYAN P DDS	10151 MONTGOMERY BLVD NE	STE 2B	ALBUQUERQUE	NM	87111	IN	10	9	15
254	454044573	1013029743	ANGELA PINKERTON	DURANGO KIDS PEDIATRIC DENT PC	20 PIONEER AVE		DURANGO	CO	81301	IN	1	1	4
255	454218053	1447577739	TAMERA COFFMAN	DUKE CITY PEDIATRIC DENTISTRY	8220 LOUISIANA BLVD NE	STE A	ALBUQUERQUE	NM	87113	IN	281	141	1106
256	454431561	1740552827	BILLIE ADAMS	PEAK FAMILY DENTISTRY	4710 EUBANK NE	UNIT A	ALBUQUERQUE	NM	87111	OON	26	15	54
257	454482816		MONIQUE LEE	SANDIA HEIGHTS DENTAL CARE	12241 ACADEMY RD NE	STE 203	ALBUQUERQUE	NM	87111	IN	1	1	1
258	454482816	1134120769	MONIQUE LEON	SANDIA HEIGHTS DENTAL CARE	12241 ACADEMY RD NE	STE 203	ALBUQUERQUE	NM	87111	IN	33	17	90
259	455344802	1457545048	JASON NOAH	GJ WEST DENTAL PROFFESIONAL	2502 HIGHWAY 6 50	STE 700	GRAND JUNCTION	CO	81505	IN	2	1	6
260	455533987	1518114651	LINDSAY CHRISTENSEN	LINDSAY CHRISTENSEN DMD	1 CALLE MEDICO	STE 2	SANTA FE	NM	87505	OON	2	2	2
261	460526658	1275361966	DALLIN MILNE	JONAH L FOUTZ	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	14	13	67
262	460526658	1285003210	BRYAN STEWART	JONAH L FOUTZ	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	46	23	144
263	460526658	1750422804	BLAINE MILNE	JONAH L FOUTZ	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	17	8	71
264	460526658	1780106757	DUSTIN PETERSON	JONAH L FOUTZ	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	15	13	51
265	460526658	1811209786	SEAN MORGAN	JONAH L FOUTZ	1625 RIO BRAVO BLVD SW	STE 33	ALBUQUERQUE	NM	87105	IN	44	28	166
266	460766262	1114329695	NOAH JUEDES	TAOS DENTAL GROUP	1392 WEIMER RD	STE A	TAOS	NM	87571	IN	1	1	2
267	460766262	1306178132	JUSTIN NYLUND	TAOS DENTAL GROUP	1392 WEIMER RD	STE A	TAOS	NM	87571	IN	1	1	1
268	460766262	1881180560	PARKER SEUBERT	TAOS DENTAL GROUP	1392 WEIMER RD	STE A	TAOS	NM	87571	IN	1	1	2
269	461078915	1427379130	DANEN SJOSTROM	SJOSTROM DANEN S DDS	7007 WYOMING BLVD NE	STE C2	ALBUQUERQUE	NM	87109	IN	199	117	922
270	461310972	1285019935	RICHARD SOLOMON	ALEGRE DENTAL PETROGLYPHS	2116 VISTA OESTE NW	STE 202	ALBUQUERQUE	NM	87120	IN	2	2	3
271	461310972	1841671096	GREGORY PISOTTI	ALEGRE DENTAL PETROGLYPHS	2116 VISTA OESTE NW	STE 202	ALBUQUERQUE	NM	87120	IN	142	81	384
272	461310972	1881338804	VANESSA GARCIA	ALEGRE DENTAL PETROGLYPHS	2116 VISTA OESTE NW	STE 202	ALBUQUERQUE	NM	87120	IN	12	11	38
273	461310972	1881338804	VANESSA GARCIA	ALEGRE DENTAL PETROGLYPHS	2116 VISTA OESTE NW	STE 202	ALBUQUERQUE	NM	87120	IN	10	8	26
274	461310972	1649973868	TODD ROHDE	BEAR CANYON FAMILY DENTISTRY	7007 WYOMING BLVD NE	STE B2	ALBUQUERQUE	NM	87109	IN	76	39	198
275	461310972	1871185298	JASMINE ARNEJA	BEAR CANYON FAMILY DENTISTRY	7007 WYOMING BLVD NE	STE B2	ALBUQUERQUE	NM	87109	IN	5	4	19
276	461310972	1073709440	CHRISTOPHER MCCAFFREY-	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	4	2	12
277	461310972	1073709440	CHRISTOPHER MCCAFFREY-	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	5	4	10
278	461310972	1346724234	GREGORY WELLS	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	1	1	5
279	461310972	1346724234	GREGORY WELLS	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	1	1	4
280	461310972	1790777068	CRAIG LAYTON	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	3	3	8
281	461310972	1790777068	CRAIG LAYTON	FAMILY DENTAL ALBUQUERQUE	8400 OSUNA RD NE	STE 4A	ALBUQUERQUE	NM	87111	IN	9	6	30
282	461310972	1285019935	RICHARD SOLOMON	HEARTLAND DENTAL	5700 SAN ANTONIO DR NE	STE A1	ALBUQUERQUE	NM	87109	IN	1	1	6
283	461310972	1396127619	JESSE VAROZ	HEARTLAND DENTAL	5700 SAN ANTONIO DR NE	STE A1	ALBUQUERQUE	NM	87109	IN	90	47	225
284	461310972	1285019935	RICHARD SOLOMON	NEW MEXICO PRO DNT ASS	9384 VALLEY VIEW DR NW	STE 200	ALBUQUERQUE	NM	87114	IN	110	62	339
285	461310972	1306978721	STEVEN HEINICKE	RIO RANCHO DENTAL ARTS	4120 BARBARA LOOP SE		RIO RANCHO	NM	87124	IN	2	1	5
286	461310972	1891153615	AUDRA MARTINEZ	RIO RANCHO DENTAL ARTS	4120 BARBARA LOOP SE		RIO RANCHO	NM	87124	IN	36	19	104
287	461328256	1083888184	STEPHEN CITO	ALBUQUERQUE PEDIATRIC DENTAL A	3900 EUBANK BLVD NE	STE 2	ALBUQUERQUE	NM	87111	IN	11	9	49
288	461328256	1225478183	DAVID DUNIVEN	ALBUQUERQUE PEDIATRIC DENTAL A	3900 EUBANK BLVD NE	STE 2	ALBUQUERQUE	NM	87111	IN	14	11	79
289	461328256	1508396698	CORI DOMINGUEZ	ALBUQUERQUE PEDIATRIC DENTAL A	3900 EUBANK BLVD NE	STE 2	ALBUQUERQUE	NM	87111	IN	34	27	155
290	461328256	1083888184	STEPHEN CITO	TINY TEETH CHILDRENS DENTISTRY	828 HIGHWAY 60		SOCORRO	NM	87801	IN	1	1	6
291	461435374	1124363379	DANIEL RUDD	RUDD DANIEL B DDS	4320 RIDGECREST DR SE	STE E	RIO RANCHO	NM	87124	IN	48	9	54
292	461992273	1104114164	PHILIP GALLEGOS	GALLEGOS FAMILY DENTISTRY	4411 MONTANO RD NW	STE D	ALBUQUERQUE	NM	87120	IN	190	98	449
293	461992273	1427464098	ADAM BURNETT	GALLEGOS FAMILY DENTISTRY	4411 MONTANO RD NW	STE D	ALBUQUERQUE	NM	87120	IN	84	59	208
294	462186387	1013179530	JOYCE JEFFRIES	COTTONWOOD ORAL AND MAX SURG	9674 EAGLE RANCH RD NW	STE 1	ALBUQUERQUE	NM	87114	IN	32	25	143
295	462532800	1336370477	CASSIE FEDE	FEDE FAMILY DENTISTRY	6800 MONTGOMERY BLVD NE	STE F	ALBUQUERQUE	NM	87109	IN	98	47	234
296	462590634	1295965630	TINA NGUYEN	ADVANTAGE DENTAL CARE LLC	9212 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87111	IN	1	1	3

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297	462696574	1033369749	DAVID COLLETTE	DAVID C COLLETTE	8310 PALOMAS AVE NE	STE B	ALBUQUERQUE	NM	87109	IN	15	11	50
298	462800654	1700191533	COLIN FORDE	FORDE COLIN A DDS	7520 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87109	IN	69	35	158
299	463207012	1205566486	SAMANTHA WONG	ENCHANTED SMILES LLC	305 RIO COMMUNITIES BLVD		BELEN	NM	87002	IN	5	5	11
300	463207012	1528392115	MADELYN FLETCHER STARK	ENCHANTED SMILES LLC	305 RIO COMMUNITIES BLVD		BELEN	NM	87002	IN	9	7	19
301	463207012	1689788689	ROBERT QUINTANO	ENCHANTED SMILES LLC	305 RIO COMMUNITIES BLVD		BELEN	NM	87002	IN	4	2	9
302	463438594	1083658355	HOA TRAN	HOA V TRAN DDS	9551 PASEO DEL NORTE NE	STE A	ALBUQUERQUE	NM	87122	IN	26	17	95
303	463449413	1003257379	STEPHANIE PADILLA	PADILLA DENTAL LLC	3809 EUBANK BLVD NE		ALBUQUERQUE	NM	87111	IN	7	5	20
304	463449413	1710409438	MICHAEL DUNN	PADILLA DENTAL LLC	3809 EUBANK BLVD NE		ALBUQUERQUE	NM	87111	IN	100	62	317
305	463449413	1790901247	CHRISTOPHER PADILLA	PADILLA DENTAL LLC	3809 EUBANK BLVD NE		ALBUQUERQUE	NM	87111	IN	45	33	135
306	464240697	1558429043	BARNEY CARTER	DR BARNEY W CARTER DMD PC	3900 EUBANK BLVD NE	STE 19	ALBUQUERQUE	NM	87111	IN	69	40	160
307	464373374	1326381716	OMAR PEREYRA	HONEST TOOTH INC	4233 MONTGOMERY BLVD NE	STE 120W	ALBUQUERQUE	NM	87109	IN	63	35	166
308	464685998	1003331984	JONATHAN HSI	FAMILIA DENTAL LOS LUNAS LLC	1620 MAIN ST NW	STE D	LOS LUNAS	NM	87031	IN	15	9	67
309	464685998	1104501766	DHARA PATEL	FAMILIA DENTAL LOS LUNAS LLC	1508 N RIVERSIDE DR		ESPANOLA	NM	87532	IN	3	2	17
310	464685998	1104501766	DHARA PATEL	FAMILIA DENTAL LOS LUNAS LLC	1620 MAIN ST NW	STE D	LOS LUNAS	NM	87031	IN	19	11	86
311	464805470	1003963059	SHARMIN MERAJ	NORTH BEACH DENTAL CARE LLC	9120 CHESAPEAKE AVE	STE 301	NORTH BEACH	MD	20714	IN	1	1	4
312	464805470	1053668939	SHEILA MAZHARI	NORTH BEACH DENTAL CARE LLC	9120 CHESAPEAKE AVE	STE 301	NORTH BEACH	MD	20714	IN	3	2	19
313	464805470	1164822219	ERIC GABRIEL	NORTH BEACH DENTAL CARE LLC	9120 CHESAPEAKE AVE	STE 301	NORTH BEACH	MD	20714	IN	1	1	3
314	464805470	1982965307	CHRISTOPHER WOLF	NORTH BEACH DENTAL CARE LLC	9120 CHESAPEAKE AVE	STE 301	NORTH BEACH	MD	20714	IN	4	4	13
315	465512217	1346435989	MELISSA RAVAGO	MELISSA RAVAGO DMD	8400 OSUNA RD NE	STE 2B	ALBUQUERQUE	NM	87111	IN	80	34	214
316	470968046		ROBERT BRANDES	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	1	1	5
317	470968046	1376825059	SETH STOCKTON	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	28	23	86
318	470968046	1760763973	ERIN STOCKTON	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	44	30	146
319	470968046		ROBERT BRANDES	STOCKTON 22 INC	12540 STATE HIGHWAY 14 N		SANDIA PARK	NM	87047	IN	2	1	3
320	470968046	1376825059	SETH STOCKTON	STOCKTON 22 INC	12540 STATE HIGHWAY 14 N		SANDIA PARK	NM	87047	IN	19	16	56
321	470968046	1760763973	ERIN STOCKTON	STOCKTON 22 INC	12540 STATE HIGHWAY 14 N		SANDIA PARK	NM	87047	IN	64	42	239
322	470968046	1992329833	CRAIG VERMETTE	STOCKTON 22 INC	12540 STATE HIGHWAY 14 N		SANDIA PARK	NM	87047	IN	1	1	3
323	470968046	1992329833	CRAIG VERMETTE	STOCKTON 22 INC	12540 STATE HIGHWAY 14 N		SANDIA PARK	NM	87047	IN	3	3	12
324	471194458	1164694626	ATEM REED	ATEM AKWON EDWIN REED DDS	7007 WYOMING BLVD NE	STE A4	ALBUQUERQUE	NM	87109	IN	50	26	136
325	471444644	1053676734	GRETCHEN KELLEY	KELLY FAMILY DENTAL CENTER	4801 MONTANO RD NW	STE A3	ALBUQUERQUE	NM	87120	IN	66	53	181
326	471444644	1346595071	JONATHAN KELLEY	KELLY FAMILY DENTAL CENTER	4801 MONTANO RD NW	STE A3	ALBUQUERQUE	NM	87120	OON	148	104	452
327	472196413	1225018575	CHARLES GALLAGHER	ACADEMY DENTAL CARE	6425 HOLLY AVE NE		ALBUQUERQUE	NM	87113	OON	13	11	21
328	472196413	1699089607	CHELSEA GONZALES	ACADEMY DENTAL CARE	6425 HOLLY AVE NE		ALBUQUERQUE	NM	87113	OON	112	59	232
329	472212971	1134103211	LOUIS BUSH	UNIQUE SMILES LLC	8616 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87112	IN	36	19	103
330	472430799	1609485077	JOSEPH POTTER	GS DENTAL LLC	7030 HOLLY AVE NE		ALBUQUERQUE	NM	87113	IN	10	9	24
331	472430799	1609485077	JOSEPH POTTER	GS DENTAL LLC	7910 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	34	25	86
332	472430799	1689746497	VASILIOS PAVLAKOS	GS DENTAL LLC	7030 HOLLY AVE NE		ALBUQUERQUE	NM	87113	IN	12	10	37
333	472430799	1851520787	RYAN SILL	GS DENTAL LLC	7030 HOLLY AVE NE		ALBUQUERQUE	NM	87113	OON	11	11	26
334	472430799	1851520787	RYAN SILL	GS DENTAL LLC	7910 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	OON	33	26	94
335	472645894	1871799262	JANSEN DONOGHUE	SANDIA PEAK DENTAL	8000 EUBANK BLVD NE		ALBUQUERQUE	NM	87122	IN	10	6	22
336	472802151	1134342470	CURTIS LEE	DESERT WILLOW DENTAL CARE LLC	7520 MONTGOMERY BLVD NE	BLDG D11	ALBUQUERQUE	NM	87109	IN	31	20	77
337	472802151	1134342470	CURTIS LEE	DESERT WILLOW DENTAL CARE LLC	7520 MONTGOMERY BLVD NE	BLDG D11	ALBUQUERQUE	NM	87109	IN	3	2	7
338	473130717	1144438516	SARAH KASSAM	SANDIA DENTAL CARE	6800 MONTGOMERY BLVD NE	STE C	ALBUQUERQUE	NM	87109	IN	55	27	116
339	473223401	1568717759	SPENCER MORGAN	LLSEA LLC	9501 PASEO DEL NORTE NE	STE A	ALBUQUERQUE	NM	87122	IN	71	42	219
340	473378624	1780930545	DREW STEEL	STEEL ORAL AND MAX SURG	8228 LOUISIANA BLVD NE	STE B	ALBUQUERQUE	NM	87113	IN	51	41	229
341	473550928	1396091799	BOYD NEWSOME	RIVERPOINT FAMILY COSMETIC AND	4421 IRVING BLVD NW	STE B	ALBUQUERQUE	NM	87114	IN	212	107	430
342	473550928	1508344185	JEFFREY SNYDER	RIVERPOINT FAMILY COSMETIC AND	4421 IRVING BLVD NW	STE B	ALBUQUERQUE	NM	87114	IN	56	39	75
343	473972925	1699840744	ROBERT URQUHART	ROBERT URQUHART DDS PC	8400 OSUNA RD NE	STE 4B	ALBUQUERQUE	NM	87111	IN	34	23	100
344	474138541	1497004733	CURTIS PINO	PINO PERIODONTICS	7007 WYOMING BLVD	STE 1	ALBUQUERQUE	NM	87199	OON	30	24	46
345	474219455	1902062573	ANDREA PATTERSON	TRUCARE DENTAL WYOMING BLVD	1510 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87112	IN	23	9	67
346	474308034	1366717944	LINDSAY ESSENMACHER	ESSENMACHER FAMILY DENTAL	8310 PALOMAS AVE NE	STE C	ALBUQUERQUE	NM	87109	IN	133	83	256
347	474308034	1477966810	NIKITA GOYAL	ESSENMACHER FAMILY DENTAL	8310 PALOMAS AVE NE	STE C	ALBUQUERQUE	NM	87109	IN	64	49	250

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348	474308034	1841049202	ELIZABETH KUBILIUS	ESSENMACHER FAMILY DENTAL	8310 PALOMAS AVE NE	STE C	ALBUQUERQUE	NM	87109	IN	65	46	206
349	474308034	1841049202	ELIZABETH KUBILIUS	ESSENMACHER FAMILY DENTAL	8310 PALOMAS AVE NE	STE C	ALBUQUERQUE	NM	87109	IN	0	0	0
350	474591569	1144621251	KRANTIKUMARI BELLAM	DR DENTAL OF NEW MEXICO	800 JUAN TABO BLVD NE	STE Q	ALBUQUERQUE	NM	87123	IN	30	15	88
351	474591569	1811321003	SUNEEL NAMBURI	DR DENTAL OF NEW MEXICO	800 JUAN TABO BLVD NE	STE Q	ALBUQUERQUE	NM	87123	IN	20	15	69
352	474667450	1770971079	BRANDON CERA	BRANDON CERA DDS LLC	806 CALLE MEJIA		SANTA FE	NM	87501	OON	1	1	3
353	474788059	1356660724	MARTIN GONZALEZ	RIO DENTAL AND ORTHODONTICS	3634 RIO RANCHO BLVD NE	SUITE 102	RIO RANCHO	NM	87144	IN	52	28	123
354	474899311	1003220203	SHANE CLARK	SHANE THOMAS CLARK	7520 MONTGOMERY BLVD NE	BLDG E1	ALBUQUERQUE	NM	87109	IN	27	21	52
355	474927543	1144313883	TIMOTHY SMITH	VFD LTD	3472 MAIN ST NE		LOS LUNAS	NM	87031	IN	107	67	224
356	474927543	1881338804	VANESSA GARCIA	VFD LTD	3472 MAIN ST NE		LOS LUNAS	NM	87031	IN	44	29	113
357	474983558	1073921805	HENRY TRUONG	CELEBRATE DENTAL AND BRACES	120 E HIGHWAY 550		BERNALILLO	NM	87004	IN	39	16	123
358	474983558	1740695931	SANDRA MONTES	CELEBRATE DENTAL AND BRACES	120 E HIGHWAY 550		BERNALILLO	NM	87004	IN	11	8	43
359	474983558	1780106757	DUSTIN PETERSON	CELEBRATE DENTAL AND BRACES	120 E HIGHWAY 550		BERNALILLO	NM	87004	IN	1	1	5
360	474997571	1518916543	JAMES ANDERSON	NMBFD LTD	1430 BOSQUE FARMS BLVD		BOSQUE FARMS	NM	87068	IN	100	47	253
361	475080668	1609073378	TRANG LE	WISTERIA DENTAL	1904 WELLSPRING AVE SE	STE 101	RIO RANCHO	NM	87124	IN	84	43	228
362	475080668	1730865692	ELLA ALGERMISSEN	WISTERIA DENTAL	1904 WELLSPRING AVE SE	STE 101	RIO RANCHO	NM	87124	IN	8	6	27
363	475080668	1932549094	KENDRA VELASQUEZ	WISTERIA DENTAL	1904 WELLSPRING AVE SE	STE 101	RIO RANCHO	NM	87124	IN	9	7	26
364	475174589	1427439421	SARAH OPPEL BROWN	SARAH OPPEL DDS	7520 MONTGOMERY BLVD NE	BLDG D2	ALBUQUERQUE	NM	87109	OON	61	39	188
365	475463127	1114229416	DAVID CLAYDEN	CELEBRACES 550 LLC	120 E HIGHWAY 550		BERNALILLO	NM	87004	IN	1	1	1
366	475679532	1881003648	KAPIL GREWAL	KAPIL GREWAL DDS	200 OAK ST NE	STE 4	ALBUQUERQUE	NM	87106	IN	64	33	217
367	510661509	1003355363	DAVID CHODOSH	UPTOWN PARK DENTAL PRACTICE	2100 LOUISIANA BLVD NE	STE 104	ALBUQUERQUE	NM	87110	IN	21	10	52
368	510661509	1003355363	DAVID CHODOSH	UPTOWN PARK DENTAL PRACTICE	2100 LOUISIANA BLVD NE	STE 104	ALBUQUERQUE	NM	87110	IN	6	4	16
369	510661509	1528392115	MADELYN FLETCHER STARK	UPTOWN PARK DENTAL PRACTICE	2100 LOUISIANA BLVD NE	STE 104	ALBUQUERQUE	NM	87110	IN	1	1	1
370	510661509	1871799262	JANSEN DONOGHUE	UPTOWN PARK DENTAL PRACTICE	2100 LOUISIANA BLVD NE	STE 104	ALBUQUERQUE	NM	87110	IN	1	1	6
371	562664351	1215143862	CHRISTOPHER LARMOUR	WESTSIDE ORAL SURGERY	9101 HIGH ASSETS WAY NW	STE 101	ALBUQUERQUE	NM	87120	IN	1	1	4
372	568476530	1881803708	FELICIA BERHMAN	BERHMAN FELICIA L DDS	4101 MORRIS ST NE	STE E	ALBUQUERQUE	NM	87111	OON	28	16	69
373	585304834	1487740403	ROBERT DARMITZEL	ROBERT E DARMITZEL, DDS	1300 LUISA ST	STE 6	SANTA FE	NM	87505	OON	1	1	3
374	585697401	1396048567	MATTHEW THOMAS	MATTHEW THOMAS DDS	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	1	1	2
375	593260957	1497814776	MICHAEL WITCHER	MOUNTAIN VIEW DENTISTRY	5458 S CHESTATEE		DAHLONEGA	GA	30533	IN	2	1	4
376	593365515	1013053487	SERGE PRESCOTT	COAST FLORIDA PA	4161 TAMIAMI TRL	STE 604	PORT CHARLOTTE	FL	33952	IN	4	2	9
377	593365515	1356453955	GEARY YAMASHITA	COAST FLORIDA PA	4161 TAMIAMI TRL	STE 604	PORT CHARLOTTE	FL	33952	IN	3	1	4
378	593365515	1821181835	JON BAUMBAUER	COAST FLORIDA PA	4161 TAMIAMI TRL	STE 604	PORT CHARLOTTE	FL	33952	IN	1	1	1
379	593365515	1942963277	GABRIELLA PEREZ	COAST FLORIDA PA	4161 TAMIAMI TRL	STE 604	PORT CHARLOTTE	FL	33952	IN	1	1	1
380	611802888	1639535560	HYUNJUNG PARK	DENTAL HOUSE TRADE WINDS	7930 WYOMING BLV NE	STE C	ALBUQUERQUE	NM	87109	IN	6	5	13
381	613664866	1164937421	SHANE KROHNFELDT	CHELSEA GONZALES DDS	6425 HOLLY AVE NE		ALBUQUERQUE	NM	87113	OON	19	16	23
382	680667876	1003355363	DAVID CHODOSH	COTTONWOOD PARK DENTISTRY LLC	10320 COTTONWOOD PARK NW	STE D	ALBUQUERQUE	NM	87114	IN	1	1	2
383	680667876	1104142561	CARA SCHOLL	COTTONWOOD PARK DENTISTRY LLC	10320 COTTONWOOD PARK NW	STE D	ALBUQUERQUE	NM	87114	IN	11	5	23
384	680667876	1952381774	WILLIAM SAPP	COTTONWOOD PARK DENTISTRY LLC	10320 COTTONWOOD PARK NW	STE D	ALBUQUERQUE	NM	87114	IN	38	20	103
385	742804498	1912047523	MARTY ARMIJO	ARMIJO MARTY D DDS	6100 COORS BLVD NW	STE K6	ALBUQUERQUE	NM	87120	IN	19	9	43
386	742841470	1679567242	STEPHEN CHRISTIANSEN	STEPHEN H CHRISTIANSEN DDS	4801 MCMAHON BLVD NW	STE 230	ALBUQUERQUE	NM	87114	IN	85	57	249
387	751860185	1477572956	JAMES ZAMORA	CUBERO DENTAL ASSOCIATES	8300 PALOMAS AVE NE	STE E	ALBUQUERQUE	NM	87109	OON	1	1	1
388	751860185	1477572956	JAMES ZAMORA	CUBERO DENTAL ASSOCS PA	5920 CUBERO DR NE		ALBUQUERQUE	NM	87109	OON	23	13	52
389	752340663		TYLER MISKO	ROBERT GRIME DDS	8901 MILWAUKEE AVE		LUBBOCK	TX	79424	OON	1	1	1
390	800932230	1255579264	TRAVIS RUDD	BEAR CANYON ORAL & FACIAL SURG	10151 MONTGOMERY BLVD NE	STE 2D	ALBUQUERQUE	NM	87111	IN	11	8	33
391	810703049	1326722919	ALYSSA CANDELARIA	CHAMISA HILLS FAMILY DENTAL	1105 GOLF COURSE RD SE	BLDG A	RIO RANCHO	NM	87124	IN	14	14	45
392	810703049	1982692091	JOHN CANDELARIA	CHAMISA HILLS FAMILY DENTAL	1105 GOLF COURSE RD SE	BLDG A	RIO RANCHO	NM	87124	IN	83	45	222
393	810796767	1336989136	SEYED SHOKROLLAHI	STEVE OLLASON DDS	10151 MONTGOMERY BLVD NE	STE B	ALBUQUERQUE	NM	87111	OON	31	24	69
394	810796767	1336989136	SEYED SHOKROLLAHI	STEVE OLLASON DDS	10151 MONTGOMERY BLVD NE	STE B	ALBUQUERQUE	NM	87111	OON	8	3	19
395	810796767	1508287897	STEVE OLLASON	STEVE OLLASON DDS	10151 MONTGOMERY BLVD NE	STE B	ALBUQUERQUE	NM	87111	OON	34	28	67
396	811037138	1609187244	STACEY MONTANO	STACEY MONTANO DDS LLC	3901 GEORGIA ST NE	STE G1	ALBUQUERQUE	NM	87110	IN	82	39	190
397	811052144	1659635266	RUSSELL ASH	RUSSELL D ASH DDS	5850 EUBANK BLVD NE	STE B38	ALBUQUERQUE	NM	87111	IN	38	17	99
398	811079503	1710368790	JOHN OLLASON	JACK OLLASON FAMILY DENTISTRY	3901 GEORGIA ST NE	STE D2	ALBUQUERQUE	NM	87110	OON	27	13	72

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Row Number	TIN	PROVIDER NPI	Provider Name	Facility	Address 1	Address 2	City	State	ZIP	Network Status (In or Out)	Claims	Claimants	Procedures
399	811087652	1356074546	ARASH ROHAM	RANCHO PALOS VERDES DENTISTRY	28901 S WESTERN AVE	STE 135	RCH PALOS VRD	CA	90275	IN	2	1	3
400	811693495	1215339270	THOMAS DUNN	THOMAS W DUNN DDS	3710 BOSQUE PLAZA LN NW	STE 100	ALBUQUERQUE	NM	87120	IN	34	17	83
401	811901574	1396919106	STEWART ANDERSON	LEGACY DENTAL PARTNERS LLC	5343 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	73	38	211
402	811901574	1558471037	DEREK LINES	LEGACY DENTAL PARTNERS LLC	5343 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	66	38	198
403	811901574	1902520083	QUINN BOYACK	LEGACY DENTAL PARTNERS LLC	5343 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	64	33	166
404	811962280		YVETTE GRANADOS	DUKE CITY DENTAL	901 RIO GRANDE BLVD NW	STE G158	ALBUQUERQUE	NM	87104	IN	2	2	4
405	811962280	1205566486	SAMANTHA WONG	DUKE CITY DENTAL	901 RIO GRANDE BLVD NW	STE G158	ALBUQUERQUE	NM	87104	IN	1	1	1
406	811962280	1679139877	BENJAMIN WANG	DUKE CITY DENTAL	901 RIO GRANDE BLVD NW	STE G158	ALBUQUERQUE	NM	87104	IN	22	20	63
407	811962280	1841388154	DWIGHT HOWARD	DUKE CITY DENTAL	901 RIO GRANDE BLVD NW	STE G158	ALBUQUERQUE	NM	87104	IN	154	95	360
408	813069617	1700131190	WAEL BORHAM	WAEL BORHAM DDS LLC	608 S ALAMEDA BLVD		LAS CRUCES	NM	88005	IN	2	1	7
409	813433487	1134686298	BRANDON CLAYTON	COMFORT DENTAL RIO RANCHO	2003 SOUTHERN BLVD SE	STE 133	RIO RANCHO	NM	87124	IN	21	11	76
410	813433487	1467811844	STEPHEN VAUGHAN	COMFORT DENTAL RIO RANCHO	2003 SOUTHERN BLVD SE	STE 133	RIO RANCHO	NM	87124	IN	26	12	90
411	813433487	1669994844	JENNIFER GEE	COMFORT DENTAL RIO RANCHO	2003 SOUTHERN BLVD SE	STE 133	RIO RANCHO	NM	87124	IN	15	9	59
412	813433487	1811120926	JOHN LEINWEBER	COMFORT DENTAL RIO RANCHO	2003 SOUTHERN BLVD SE	STE 133	RIO RANCHO	NM	87124	IN	13	7	53
413	813438741	1144412180	ALLAN STAKER	DENTAL PARTNERS OF ALAMEDA LLC	1125 ALAMEDA BLVD NW		ALBUQUERQUE	NM	87114	IN	19	9	63
414	813438741	1477745560	ERIC PACHECO	DENTAL PARTNERS OF ALAMEDA LLC	1125 ALAMEDA BLVD NW		ALBUQUERQUE	NM	87114	IN	12	6	42
415	813438875	1033367917	ANDREW MCFARLAND	DENTAL PARTNERS	7900 SAN PEDRO DR NE	STE C5	ALBUQUERQUE	NM	87109	IN	41	19	135
416	813438875	1063934511	VASU SHAH	DENTAL PARTNERS	7900 SAN PEDRO DR NE	STE C5	ALBUQUERQUE	NM	87109	IN	2	2	6
417	813438875	1932657392	GABRIEL MAESTAS	DENTAL PARTNERS	7900 SAN PEDRO DR NE	STE C5	ALBUQUERQUE	NM	87109	IN	8	4	26
418	814183197	1730501032	LI BAO	A BETTER SMILE DENTISTRY LLC	475 COORS BLVD NW	STE A	ALBUQUERQUE	NM	87121	IN	8	5	23
419	814205372	1104080431	MICHAEL SWEENEY	MICHAEL A SWEENY DMD LLC	4111 BARBARA LOOP SE	STE D2	RIO RANCHO	NM	87124	IN	44	22	121
420	814485296	1013170133	BRIAN HATCH	HATCH BRIAN K	1904 WELLSPRING AVE SE	STE 105	RIO RANCHO	NM	87124	IN	196	108	732
421	814485296	1205352739	ALICIA NGUYEN	HATCH BRIAN K	1904 WELLSPRING AVE SE	STE 105	RIO RANCHO	NM	87124	IN	12	12	44
422	814485296	1205352739	ALICIA NGUYEN	HATCH BRIAN K	1904 WELLSPRING AVE SE	STE 105	RIO RANCHO	NM	87124	IN	15	11	49
423	814512979	1407940844	KURT LAMBERT	DR KURT P LAMBERT DDS PC DDS	4101 MORRIS ST NE	STE D	ALBUQUERQUE	NM	87111	IN	37	18	84
424	814554017	1881755825	GEORGE HANNA	SOCORRO DENTAL LLC	204B NEEL AVE		SOCORRO	NM	87801	IN	5	4	17
425	814706725	1336589951	SUNIL KUMAR RED GUDDET	APEX DENTAL	6330 RIVERSIDE PLAZA LN NW	STE 165	ALBUQUERQUE	NM	87120	IN	35	22	90
426	814739479	1346305026	VIRGINIA ZAFARANO	FAMILY DENTAL HEALTHCARE	4550 EUBANK BLVD NE	STE 203	ALBUQUERQUE	NM	87111	IN	10	7	44
427	815354188	1003848938	KAREN LOVATO	KAREN LOVATO DDS	8300 CARMEL AVE NE	STE 101	ALBUQUERQUE	NM	87122	IN	11	9	32
428	820641486	1144515453	MEGHAN MCMENEMY	SHADOW MOUNTAIN DENTAL	6800 MONTGOMERY BLVD NE	STE M	ALBUQUERQUE	NM	87109	OON	30	14	62
429	821238189	1073964730	TIMOTHY NGO	SUNSET DENTAL LLC	6211 4TH ST NW	STE 13	ALBUQUERQUE	NM	87107	IN	66	31	236
430	821352549	1528392115	MADELYN FLETCHER STARK	TELEDENTISTRY_COM	9030 W SAHARA AVE	#699	LAS VEGAS	NV	89117	IN	1	1	1
431	821352549	1619151248	POOJA SANTWANI	TELEDENTISTRY_COM	9030 W SAHARA AVE	#699	LAS VEGAS	NV	89117	IN	1	1	1
432	821352549	1982967543	ERIC WESTERGARD	TELEDENTISTRY_COM	9030 W SAHARA AVE	#699	LAS VEGAS	NV	89117	IN	1	1	1
433	821824846	1760912711	BRETT HAGGERTY	HAGGERTY DENTAL	5124 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	70	46	234
434	821961676	1093153033	ALEXIS BROWN	ALEXIS BROWN DDS	5250 MANHATTAN CIR		BOULDER	CO	80303	OON	2	1	3
435	822095912	1306043922	QUAN TRAN	KNEELAND DENTAL CARE	1628 ALAMEDA BLVD NW		ALBUQUERQUE	NM	87114	IN	12	6	37
436	822095912	1992254825	DOROTHY NGUYEN	KNEELAND DENTAL CARE	1628 ALAMEDA BLVD NW		ALBUQUERQUE	NM	87114	IN	11	3	31
437	822266290	1750758231	FIELFER MURGA	DENTAL WELLNESS PC	1010 BRIDGE BLVD SW	STE E	ALBUQUERQUE	NM	87105	IN	14	5	27
438	822266290	1750758231	FIELFER MURGA	DENTAL WELLNESS PC	2019 GALISTEO ST	STE H3	SANTA FE	NM	87505	IN	1	1	4
439	822306595	1023397544	ERIC WINTERTON	ERIC WINTERTON DDS LLC	943 MAIN ST SW		LOS LUNAS	NM	87031	IN	62	32	146
440	822432784	1548782352	MICHAEL ISHAM	ISHAM DENTAL	3900 EUBANK BLVD NE	STE 5	ALBUQUERQUE	NM	87111	IN	3	3	21
441	822596835	1588732820	ANNE HEMPSTEAD	GRACE CHILDRENS DENTISTRY	6400 HOLLY AVE NE	STE M	ALBUQUERQUE	NM	87113	IN	3	2	19
442	823080875	1710398565	KARTIK ANTANI	NAPA DENTAL MANAGEMENT LLC	10820 COMANCHE RD NE		ALBUQUERQUE	NM	87111	IN	25	14	83
443	823122367		SHAUGHN MCCORMICK	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	1	1	2
444	823122367	1265416069	BARBARA LEWIS HEYWOOD	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	4	4	8
445	823122367	1366851495	KYE KINZER	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	7	6	15
446	823122367	1447601042	TUYET PHI TRUONG	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	5	3	8
447	823122367	1518186402	MASSOUD TEHRANIAN TOR	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	1	1	2
448	823122367	1699475616	ADHM ASFAN	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	7	5	11
449	823122367	1700577970	RODRIGUE DIKUBA	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	1	1	1

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450	823122367	1720762859	NGUYEN LE	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	1	1	2
451	823122367	1790777068	CRAIG LAYTON	ASPEN DENTAL	1700 MAIN ST SW		LOS LUNAS	NM	87031	IN	1	1	2
452	823183204	1265844807	JAJUNG YOON	SB DENTAL LLC	219 COURTHOUSE RD SE		LOS LUNAS	NM	87031	IN	52	28	180
453	823326397	1073987988	ASHLEE ARAGON	A TO Z CHILDRENS DENTISTRY	1209 BONITA ST	STE A	GRANTS	NM	87020	IN	1	1	6
454	823533463	1730494279	ASHWINI BICHU	PARTNERS IN DENTAL HEALTH I	317 EDWIN DR		VIRGINIA BEACH	VA	23462	IN	1	1	2
455	823756516	1710297486	ZACHARY CURRIE	ZACHCURRIEDDS LLC	1851 OLD US 66	STE C	EDGEWOOD	NM	87015	IN	6	6	19
456	823756516	1710297486	ZACHARY CURRIE	ZACHCURRIEDDS LLC	1851 OLD US 66	STE C	EDGEWOOD	NM	87015	IN	31	21	82
457	824017972	1083376123	ALEXANDER COLLINS HORN	NEW MEXICO COMMUNITY DENTAL	2116 HINKLE ST SE		ALBUQUERQUE	NM	87102	IN	1	1	3
458	824017972	1679771976	MARTHA HOLLIDAY	NEW MEXICO COMMUNITY DENTAL	2116 HINKLE ST SE		ALBUQUERQUE	NM	87102	IN	2	2	4
459	824209600	1053817932	NICOLAUS JUNGMAN	CITRACADO DENTAL GROUP	500 W EL NORTE PKWY		ESCONDIDO	CA	92026	OON	1	1	4
460	824959476	1215420120	ERIKA BELLE	VALER DENTAL COORS LLC	1514 COORS BLVD NW		ALBUQUERQUE	NM	87121	IN	4	3	15
461	824959476	1235242801	KURTIS LIGHTHEART	VALER DENTAL COORS LLC	1514 COORS BLVD NW		ALBUQUERQUE	NM	87121	IN	1	1	6
462	824959476	1356993729	AMIR VAHDANI	VALER DENTAL COORS LLC	1514 COORS BLVD NW		ALBUQUERQUE	NM	87121	IN	1	1	5
463	824959476	1548749732	MICHAELA GABALDON	VALER DENTAL COORS LLC	1514 COORS BLVD NW		ALBUQUERQUE	NM	87121	IN	4	4	24
464	824959476	1699383166	CHRISTOPHER LO	VALER DENTAL COORS LLC	1514 COORS BLVD NW		ALBUQUERQUE	NM	87121	IN	27	19	97
465	825210299	1063545242	GEORGE HITZEL	CHAMPAGNE DENTAL CORP	1330 S BELCHER RD		CLEARWATER	FL	33764	IN	1	1	3
466	830697477	1174500755	MARY LUCERO	MORNINGSTAR FAMILY DENTAL LLC	1005 MAIN ST SW		LOS LUNAS	NM	87031	IN	46	25	106
467	830808084	1144920349	SANDRA MARSHALL	ASPEN DENTAL	10010 COORS BLVD NW	STE B	ALBUQUERQUE	NM	87114	IN	4	2	11
468	830808084	1891437596	ANDREW BOWERS	ASPEN DENTAL	10010 COORS BLVD NW	STE B	ALBUQUERQUE	NM	87114	IN	14	9	22
469	830808084	1144920349	SANDRA MARSHALL	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	17	10	38
470	830808084	1144920349	SANDRA MARSHALL	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	1	0	3
471	830808084	1538779111	MEHZABIN HIRJI	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	4	4	10
472	830808084	1578865507	LISA LE	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	2	2	10
473	830808084	1699840744	ROBERT URQUHART	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	1	1	9
474	830808084	1700894763	JEFFREY LUFFEY	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	1	1	2
475	830808084	1821056938	NAVBIR AURORA	AURORA DENTAL NM LLC	2424 LOUISIANA BLVD NE	STE 501	ALBUQUERQUE	NM	87110	IN	25	16	62
476	830962975	1124573399	DREW WILLIAMS	SIERRA DENTAL AND ORTHODONTICS	4277 TENNYSON ST	STE 102	DENVER	CO	80212	IN	1	1	5
477	831144307	1003225236	DAN LAFFERTY	ABQ GENTLE DENTISTRY LLC	4550 EUBANK BLVD NE	STE 101	ALBUQUERQUE	NM	87111	IN	79	43	204
478	831144307	1831707736	TYLER MARTINEZ	ABQ GENTLE DENTISTRY LLC	4550 EUBANK BLVD NE	STE 101	ALBUQUERQUE	NM	87111	IN	9	8	23
479	831144307	1831707736	TYLER MARTINEZ	ABQ GENTLE DENTISTRY LLC	4550 EUBANK BLVD NE	STE 101	ALBUQUERQUE	NM	87111	IN	12	7	40
480	832092261	1669404257	HAMID ZEHTAB	HAMID ZEHTAB DMD INC	3620 S BRISTOL ST	STE 207	SANTA ANA	CA	92704	IN	1	1	2
481	832189844	1326737875	COLLIN ZWEIFEL	JACKSON FAMILY DENTISTRY LLC	N168W20060 MAIN ST		JACKSON	WI	53037	IN	1	1	5
482	832568787	1336291137	ALFRED LOPEZ	ALFRED LOPEZ DDS	10409 MONTGOMERY PKWY NE	STE 1	ALBUQUERQUE	NM	87111	OON	8	4	15
483	832574841	1649756206	BRANDON TERHUNE	BRANDON TERHUNE DDS	7520 MONTGOMERY BLVD NE	BLDG E STE 12	ALBUQUERQUE	NM	87109	OON	29	15	48
484	832737381	1184973349	KEVIN MINK	DRD LLC	6521 PARADISE BLVD NW	STE M	ALBUQUERQUE	NM	87114	IN	1	1	6
485	832737381	1184973349	KEVIN MINK	DRD LLC	6521 PARADISE BLVD NW	STE M	ALBUQUERQUE	NM	87114	IN	39	31	107
486	832737381	1548551435	JACOB ROGERS	DRD LLC	6521 PARADISE BLVD NW	STE M	ALBUQUERQUE	NM	87114	IN	22	15	72
487	832788082	1346489374	KERI GIRON	SHAMAINE R GIRON DDS LLC	3900 EUBANK BLVD NE	STE 10	ALBUQUERQUE	NM	87111	OON	12	6	40
488	832788082	1346556040	SHAMAINE GIRON	SHAMAINE R GIRON DDS LLC	3900 EUBANK BLVD NE	STE 10	ALBUQUERQUE	NM	87111	IN	4	4	10
489	833001073	1306416318	MATTHEW KARLOFF	CAPITAL DENTAL LLC	5609 S 27TH ST		LINCOLN	NE	68512	IN	1	1	4
490	833407555	1215354600	MICHAEL LYSONSKI	EDGEWOOD DENTAL	1917 OLD US 66	STE D	EDGEWOOD	NM	87015	IN	36	18	117
491	833513392	1174805642	SRINIVASA MIDTHANA	SALUD DENTAL GROUP CHAPARRAL	320 MCCOMBS RD	STE E	CHAPARRAL	NM	88081	IN	1	1	5
492	833684751	1174805642	SRINIVASA MIDTHANA	SALUD DENTAL GROUP ALBUQUERQUE	3803 ATRISCO DR NW	STE D	ALBUQUERQUE	NM	87120	IN	45	25	189
493	833717954	1013086453	ROBERT ASTLES	RIO RANCHO DENTAL ASSOCIATES	2200 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	35	27	103
494	833717954	1013086453	ROBERT ASTLES	RIO RANCHO DENTAL ASSOCIATES	2200 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	3	2	10
495	833717954	1316556962	BAHRAM BARZEGARI	RIO RANCHO DENTAL ASSOCIATES	2200 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	34	25	107
496	833717954	1962421610	KENNETH RODRIGUEZ	RIO RANCHO DENTAL ASSOCIATES	2200 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	26	18	65
497	834450438	1346771904	ALEXIS PHILLIPS	BOISE CHILDRENS DENTISTRY PLLC	136 E MALLARD DR		BOISE	ID	83706	IN	3	2	14
498	840802682	1396824900	JOHN MATTHEWS	JOHN MATTHEWS, JR, DDS	7608 N UNION BLVD	STE A	COLORADO SPGS	CO	80920	OON	6	2	9
499	841387575	1548707128	NEESHA BIR	PERFECT TEETH	6101 CANDELARIA RD NE		ALBUQUERQUE	NM	87110	IN	29	13	72
500	841450760	1285024729	RAKTIM BIR	PERFECT TEETH	5800 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	37	16	100

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501	841953199	1578523205	CHARLES SCHLESINGER	COMFORTABLE DENTISTRY 4U	918 PINEHURST RD SE	STE 103	RIO RANCHO	NM	87124	IN	36	13	89
502	842014748	1538804919	CHRISTOPHER GRAHAM	CHRIS YONGHYUN KIM	5900 CUBERO DR NE	STE B	ALBUQUERQUE	NM	87109	IN	28	25	98
503	842014748	1811413594	CHRIS KIM	CHRIS YONGHYUN KIM	5900 CUBERO DR NE	STE B	ALBUQUERQUE	NM	87109	IN	155	88	500
504	842143776	1144679275	ROBERT HANN	ROBERT HANN	7520 MONTGOMERY BLVD NE	BLDG D9	ALBUQUERQUE	NM	87109	IN	29	13	59
505	842302326	1841852555	JAYSON GARCIA GURULE	BELEN FAMILY DENTISTRY	1501 E RIVER RD		BELEN	NM	87002	IN	54	25	169
506	843161440	1861655953	QUINTON GARDNER	GILBERT ROAD DENTAL CARE	944 N GILBERT RD	STE 104	MESA	AZ	85203	IN	2	1	10
507	843283819	1356652358	DAVID LILLIAN	BOSQUE SMILES DENTISTRY	5600 COORS BLVD NW	STE G4	ALBUQUERQUE	NM	87120	IN	4	3	17
508	843283819	1629417902	JAE YANG	BOSQUE SMILES DENTISTRY	5600 COORS BLVD NW	STE G4	ALBUQUERQUE	NM	87120	IN	102	41	194
509	843283819	1730717869	KATELYN KREH	BOSQUE SMILES DENTISTRY	5600 COORS BLVD NW	STE G4	ALBUQUERQUE	NM	87120	IN	22	11	44
510	843283819	1780811984	RYAN WILSON	BOSQUE SMILES DENTISTRY	5600 COORS BLVD NW	STE G4	ALBUQUERQUE	NM	87120	IN	3	3	8
511	843283819	1841850278	BRENDAN SCHLEYER	BOSQUE SMILES DENTISTRY	5600 COORS BLVD NW	STE G4	ALBUQUERQUE	NM	87120	IN	2	2	10
512	843397051	1972097574	ENNSEN MURAO	MARBELLA DENTAL STUDIOS	4845 E THUNDERBIRD RD STTE3		SCOTTSDALE	AZ	85254	IN	1	1	5
513	843643274	1700266889	DAVID ANDERSON	BRIGHT PEDIATRIC DENTISTRY	1434 E 9400 S	STE 205	SANDY	UT	84093	IN	5	2	16
514	843701638	1578609921	JEFFREY HAGEN	SOUTHWEST ORAL MAX SURGEONS	5900 CUBERO DR NE	STE A	ALBUQUERQUE	NM	87109	IN	23	15	72
515	843701638	1902895246	WAI PONG NG	SOUTHWEST ORAL MAX SURGEONS	5900 CUBERO DR NE	STE A	ALBUQUERQUE	NM	87109	IN	10	8	33
516	844169367	1053710293	ANDREW MCDONALD	RIO GRANDE ORTHODONTICS LLC	8010 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	2	2	4
517	844169367	1134672165	JASON KLINGLER	RIO GRANDE ORTHODONTICS LLC	7510 MONTGOMERY BLVD NE	STE 203	ALBUQUERQUE	NM	87109	IN	1	1	1
518	844169367	1134672165	JASON KLINGLER	RIO GRANDE ORTHODONTICS LLC	8010 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	18	8	36
519	844169367	1437733524	GIOVANNI AVILA	RIO GRANDE ORTHODONTICS LLC	8010 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	1	1	1
520	844443719	1194715011	RAFAT MANSOUR	MANSOUR FAMILY DNT INVISALIGN	8201 GOLF COURSE RD NW	STE C3	ALBUQUERQUE	NM	87120	IN	18	12	75
521	844531626	1265844807	JAJUNG YOON	RIO RANCHO SMILES	1316 JACKIE RD SE	STE 200	RIO RANCHO	NM	87124	IN	11	7	32
522	844823826		NICHOLAS JENSEN	SUNDANCE DENTAL CARE OF RIO RA	770 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	1	1	0
523	844823826	1306285671	NICHOLAS JENSEN	SUNDANCE DENTAL CARE OF RIO RA	770 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	157	83	504
524	844823826	1386487437	CADE NYKAMP	SUNDANCE DENTAL CARE OF RIO RA	770 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	4	4	10
525	844823826	1386487437	CADE NYKAMP	SUNDANCE DENTAL CARE OF RIO RA	770 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	5	5	14
526	844823826	1750422804	BLAINE MILNE	SUNDANCE DENTAL CARE OF RIO RA	770 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	4	3	20
527	845115625	1063943793	HAMID RANJBARAN	SOUTHWEST DENTAL	1137 COMMERCIAL DR SE		RIO RANCHO	NM	87124	IN	54	36	171
528	845115625	1932624178	JESSE JOHNSON	SOUTHWEST DENTAL	1137 COMMERCIAL DR SE		RIO RANCHO	NM	87124	IN	1	1	4
529	845175406	1710385208	SAHIL ARORA	SAHIL ARORA DDS PLLC	1467 W ELLIOT RD	STE 101	GILBERT	AZ	85233	IN	2	1	7
530	850105601	1952664039	JASON SCHULTZ	PRESBYTERIAN HEALTHCARE SRVCS	6100 PAN AMERICAN EAST FWY NE	STE 355	ALBUQUERQUE	NM	87109	IN	9	7	33
531	850164038	1013350495	MATTHEW MATTE	ISLETA HEALTH CENTER	1 SAGEBRUSH ST SW		ALBUQUERQUE	NM	87105	IN	4	4	7
532	850164038	1699330969	JONATHAN PAUWELS	ISLETA HEALTH CENTER	1 SAGEBRUSH ST SW		ALBUQUERQUE	NM	87105	IN	4	2	16
533	850164038	1013350495	MATTHEW MATTE	PUEBLO OF ISLETA HEALTH CENTER	1 SAGEBRUSH ST		ISLETA	NM	87022	IN	3	2	3
534	850164038	1699330969	JONATHAN PAUWELS	PUEBLO OF ISLETA HEALTH CENTER	1 SAGEBRUSH ST		ISLETA	NM	87022	IN	2	2	17
535	850206810	1376869362	DOMINGO VALLES	ANTONIO JOHN E DMD	6349 HIGHWAY 550		CUBA	NM	87013	IN	8	3	22
536	850206810	1407314701	KAREN OJEDA	ANTONIO JOHN E DMD	6349 HIGHWAY 550		CUBA	NM	87013	IN	2	1	3
537	850206810	1225489248	MICHAEL MANZANARES	PRESBYTERIAN MEDICAL SERVICES	2300 GRANDE BLVD SE	STE A	RIO RANCHO	NM	87124	IN	1	1	1
538	850206810	1245343748	INEZ LOPEZ	PRESBYTERIAN MEDICAL SERVICES	903 C FIFTH ST		ESTANCIA	NM	87016	IN	11	7	32
539	850210848	1023066933	GARY ODASSO	PUEBLO OF SAN FELIPE DENTAL CL	8 CEDAR RD		ALGODONES	NM	87001	IN	2	1	5
540	850213473	1811244965	RAHUL SHAMAPANTH	JEMEZ HEALTH CENTER	110 SHEEP SPRINGS WAY		JEMEZ PUEBLO	NM	87024	OON	2	1	4
541	850214449	1164554861	DAVID LOPOUR	SMILES BY DESIGN	5110 MASTHEAD ST NE	STE A	ALBUQUERQUE	NM	87109	OON	92	46	191
542	850224409	1003310053	ERIN O NEAL	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	7	4	10
543	850224409	1376774653	JEREMIAH DYE	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	23	15	51
544	850224409	1417223694	LIANG TSO TUNG	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	1	1	1
545	850224409	1427581537	LAURA PAUWELS	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	8	6	16
546	850224409	1437733524	GIOVANNI AVILA	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	3	3	7
547	850224409	1508509019	SORNA SARKER	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	1	1	2
548	850224409	1548587991	SHIRLENA WATERS	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	1	1	1
549	850224409	1902888340	MARK BRUM	1ST CHOICE COMMUNITY HEALTHCAR	2001 CENTRO FAMILIAR BLVD SW		ALBUQUERQUE	NM	87105	IN	12	9	26
550	850224409	1003310053	ERIN O NEAL	FCCH EDGEWOOD DENTAL	7 MUNICIPAL WAY		EDGEWOOD	NM	87015	IN	2	1	4
551	850224409	1376774653	JEREMIAH DYE	FCCH EDGEWOOD DENTAL	7 MUNICIPAL WAY		EDGEWOOD	NM	87015	IN	4	3	4

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552	850224409	1457840266	BRITTANY MCDANIEL	FCCH EDGEWOOD DENTAL	7 MUNICIPAL WAY		EDGEWOOD	NM	87015	IN	6	5	10
553	850224409	1871930099	MELISSA JACKSON	FCCH EDGEWOOD DENTAL	7 MUNICIPAL WAY		EDGEWOOD	NM	87015	IN	19	10	35
554	850224409	1104142561	CARA SCHOLL	FIRST CHOICE COMMUNITY HEALTHC	145 DON PASQUAL RD NW		LOS LUNAS	NM	87031	IN	3	3	6
555	850224409	1417223694	LIANG TSO TUNG	FIRST CHOICE COMMUNITY HEALTHC	145 DON PASQUAL RD NW		LOS LUNAS	NM	87031	IN	27	21	39
556	850224409	1427587229	VINH DUONG	FIRST CHOICE COMMUNITY HEALTHC	145 DON PASQUAL RD NW		LOS LUNAS	NM	87031	IN	1	1	4
557	850224409	1760222400	VINCENT KIET DUONG	FIRST CHOICE COMMUNITY HEALTHC	145 DON PASQUAL RD NW		LOS LUNAS	NM	87031	IN	2	2	5
558	850224409	1992385819	BRENDAN DELINE	FIRST CHOICE COMMUNITY HEALTHC	145 DON PASQUAL RD NW		LOS LUNAS	NM	87031	IN	11	7	26
559	850225202	1932278447	W GREGORY ROSE	W GREGORY ROSE DDS	4550 EUBANK BLVD NE	STE 201	ALBUQUERQUE	NM	87111	OON	21	9	45
560	850226344	1255439808	SCOTT MILTENBERGER	LARRY B LUBAR DDS	3901 GEORGIA ST NE	STE C4	ALBUQUERQUE	NM	87110	OON	8	5	19
561	850227640	1205050044	MARY ROSE TWOHIG	JAMES E TWOHIG DDS PA	7441 ALAMEDA BLVD NE	STE A	ALBUQUERQUE	NM	87113	OON	47	30	112
562	850244047	1982754131	ROBERT LUCERO	ROBERT T LUCERO DDS PC	1710 WYOMING BLVD NE		ALBUQUERQUE	NM	87112	IN	9	8	18
563	850252547	1801095062	REED CANNON	HIGH MESA DENTAL ARTS	106 LONGVIEW DR	STE A	WHITE ROCK	NM	87544	OON	2	1	4
564	850254824	1497880694	DAVID HARNICK	HARNICK ORTHODONTICS	10425 MONTGOMERY PKWY NE		ALBUQUERQUE	NM	87111	IN	4	2	11
565	850254824	1497880694	DAVID HARNICK	HARNICK ORTHODONTICS	8631 GOLF COURSE RD NW	STE F	ALBUQUERQUE	NM	87114	IN	4	3	7
566	850254824	1588047906	KARI GRAEBER	HARNICK ORTHODONTICS	10425 MONTGOMERY PKWY NE		ALBUQUERQUE	NM	87111	IN	5	3	14
567	850254824	1588047906	KARI GRAEBER	HARNICK ORTHODONTICS	8631 GOLF COURSE RD NW	STE F	ALBUQUERQUE	NM	87114	IN	12	7	21
568	850254824	1588047906	KARI GRAEBER	HARNICK ORTHODONTICS	8631 GOLF COURSE RD NW	STE F	ALBUQUERQUE	NM	87114	IN	2	2	2
569	850255349	1942668553	KAREN GUTIERREZ	DRS. GORMLEY & GUTIERREZ PEDIA	2701 MISSOURI AVE	STE C	LAS CRUCES	NM	88011	IN	3	2	15
570	850255937	1952427510	THOMAS HEFLIN	THOMAS H HEFLIN DDS	8000 CARMEL AVE NE		ALBUQUERQUE	NM	87122	IN	29	24	114
571	850255937	1952427510	THOMAS HEFLIN	THOMAS H HEFLIN DDS	8000 CARMEL AVE NE		ALBUQUERQUE	NM	87122	IN	13	5	38
572	850262886	1700153475	MICHAEL FANNING	MICHAEL J FANNING DDS	8130 VENTURA ST NE	STE A	ALBUQUERQUE	NM	87122	IN	66	18	68
573	850280406	1740383306	BILL GALBRETH	WILLIAM E GALBRETH DMD PC	4830 JUAN TABO BLVD NE	STE H	ALBUQUERQUE	NM	87111	IN	5	5	21
574	850280827	1588736193	DUANE BEERS	DUANE H BEERS DMD	200 MANZANARES AVE E		SOCORRO	NM	87801	OON	1	1	1
575	850281694	1417937533	LEE CAIN	LEE E CAIN DDS	3001 ISLEAT BLVD SW		ALBUQUERQUE	NM	87105	IN	11	7	28
576	850285143	1881605533	DONNA THOMPSON	DONNA M THOMPSON DDS PC	1212 E 20TH ST		FARMINGTON	NM	87401	IN	2	1	4
577	850291599	1023713831	SEAN MOORE	GHERARDI & MOORE PA	8310 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	32	23	80
578	850291599	1770638207	ROBERT GHERARDI	GHERARDI & MOORE PA	8310 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	17	12	35
579	850291599	1912312265	JOSEPH GHERARDI	GHERARDI & MOORE PA	8310 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	49	40	115
580	850291599	1972658029	DAVID MOORE	GHERARDI & MOORE PA	8310 PALOMAS AVE NE	STE A	ALBUQUERQUE	NM	87109	IN	73	51	181
581	850291791	1831248202	STEVEN TRAUB	STEVEN J TRAUB DDS	7520 MONTGOMERY BLVD NE	BLDG D2	ALBUQUERQUE	NM	87109	OON	11	5	26
582	850291959	1053327429	TOM BAIAMONTE	ROBERT C SUPPLE DMD	8401 OSUNA RD NE	STE C	ALBUQUERQUE	NM	87111	OON	12	8	22
583	850291959	1710993100	ROBERT SUPPLE	ROBERT C SUPPLE DMD	8401 OSUNA RD NE	STE C	ALBUQUERQUE	NM	87111	OON	42	24	74
584	850291959	1780020263	BETHANY HANN	ROBERT C SUPPLE DMD	8401 OSUNA RD NE	STE C	ALBUQUERQUE	NM	87111	IN	6	3	12
585	850299734	1336130913	LESLIE HUTCHINS	LESLIE HUTCHINS, DDS	3711 EUBANK BLVD NE		ALBUQUERQUE	NM	87111	OON	8	6	15
586	850328086	1629101845	W HAM	WALTICE B HAM DDS	4101 MORRIS ST NE	STE G	ALBUQUERQUE	NM	87111	OON	42	24	123
587	850333926	1730260472	JAYNE BUTTNER	JAYNE M BUTTNER DDS MS PC	6800 MONTGOMERY BLVD NE	STE B	ALBUQUERQUE	NM	87109	IN	12	6	24
588	850336893	1285714121	STEPHEN HUBBERT	FIRST NATIONS CMTY HLTH SOURCE	5608 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	2	1	2
589	850336893	1336421130	TRAM NGUYEN	FIRST NATIONS CMTY HLTH SOURCE	5608 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	1	1	1
590	850336893	1538779111	MEHZABIN HIRJI	FIRST NATIONS CMTY HLTH SOURCE	5608 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	9	5	17
591	850336893	1962837617	SEO KIM	FIRST NATIONS CMTY HLTH SOURCE	5608 ZUNI RD SE		ALBUQUERQUE	NM	87108	IN	12	4	23
592	850346260	1194737049	LINDA NICHOLS	NICHOLS LINDA K	3900 EUBANK BLVD NE	STE 11	ALBUQUERQUE	NM	87111	IN	17	9	46
593	850346260	1194737049	LINDA NICHOLS	NICHOLS LINDA K	3900 EUBANK BLVD NE	STE 11	ALBUQUERQUE	NM	87111	IN	3	0	7
594	850348216	1891130951	CECIL SANDOVAL	SANDOVAL CECIL C DDS	601 DALIES AVE		BELEN	NM	87002	IN	68	31	144
595	850349688		PATRICK HOOPER	JOLYNN GALVIN DDS PA	3111 EUBANK BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	30	20	84
596	850349688	1629565643	PATRICK HOOPER	JOLYNN GALVIN DDS PA	3111 EUBANK BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	2	2	8
597	850349688	1629565643	PATRICK HOOPER	JOLYNN GALVIN DDS PA	3111 EUBANK BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	1	1	1
598	850349688	1669593216	THOMAS SCHRIPSEMA	JOLYNN GALVIN DDS PA	3111 EUBANK BLVD NE	STE A	ALBUQUERQUE	NM	87111	IN	3	1	5
599	850356911	1669590618	STEVEN HOLBROOK	STEVEN E HOLBROOK DMD	8228 LOUISIANA BLVD NE	STE C	ALBUQUERQUE	NM	87113	IN	43	19	97
600	850359150	1669507737	MARTIN GOEBBEL	SOUTHERN BOULEVARD DENTAL CORP	2716 SOUTHERN BLVD SE		RIO RANCHO	NM	87124	IN	63	30	167
601	850368132	1467524926	TERESA MONDRAGON	TERESA L MONDRAGON DDS	4101 MORRIS ST NE	STE C	ALBUQUERQUE	NM	87111	OON	1	1	3
602	850373680	1033107206	JOHN MATTE	JOHN J MATTE DDS PA	637 SAN MATEO BLVD SE	STE B	ALBUQUERQUE	NM	87108	IN	12	6	27

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603	850385803	1578571790	ANTHONY ALGERMISSEN	ANTHONY ALGERMISSEN DDS	7520 MONTGOMERY BLVD NE	BLDG E12	ALBUQUERQUE	NM	87109	IN	50	31	87
604	850385803	1730865692	ELLA ALGERMISSEN	ANTHONY ALGERMISSEN DDS	7520 MONTGOMERY BLVD NE	BLDG E12	ALBUQUERQUE	NM	87109	IN	3	3	8
605	850398305	1316057193	GILBERT FERNANDEZ	GILBERT FERNANDEZ, DDS	6911 TAYLOR RANCH RD NW	STE 5	ALBUQUERQUE	NM	87120	IN	34	23	81
606	850398305	1316057193	GILBERT FERNANDEZ	GILBERT FERNANDEZ, DDS	6911 TAYLOR RANCH RD NW	STE 5	ALBUQUERQUE	NM	87120	IN	129	56	345
607	850401940	1528191392	MARK MCCONNELL	MARK S MCCONNELL DDS	5925 WYOMING BLVD NE	STE B	ALBUQUERQUE	NM	87109	OON	8	5	22
608	850402782	1164480554	DIANA BACA	DIANA M BACA DDS PA	5900 CUBERO DR NE	STE C	ALBUQUERQUE	NM	87109	IN	48	21	107
609	850405240	1922131788	JOHANNA ROMO	JOHANNA P ROMO DDS	5925 WYOMING BLVD NE	STE A	ALBUQUERQUE	NM	87109	OON	13	8	23
610	850407726	1548486079	JEFFREY MATTILA	JEFFREY R MATTILA, DDS	200 LINCOLN AVE		GRANTS	NM	87020	OON	4	2	10
611	850408436	1033189113	MONICA BOEHMER	MONICA BOEHMER DDS	3309 JUAN TABO BLVD NE	STE A	ALBUQUERQUE	NM	87111	OON	17	13	45
612	850412090	1346595071	JONATHAN KELLEY	KELLEY JONATHAN DDS	4801 MONTANO RD NW	STE A3	ALBUQUERQUE	NM	87120	IN	3	3	6
613	850430039	1780707067	BRIAN GRIBBLE	GRANT DAVIS DENTAL ASSOC P C	3610 CALLE CUERVO NW	STE A	ALBUQUERQUE	NM	87114	IN	77	38	208
614	850430039	1891194361	CONNOR HOLLOWWA	GRANT DAVIS DENTAL ASSOC P C	3610 CALLE CUERVO NW	STE A	ALBUQUERQUE	NM	87114	IN	126	71	381
615	850430039	1912122912	JOHN DAVIS	GRANT DAVIS DENTAL ASSOC P C	3610 CALLE CUERVO NW	STE A	ALBUQUERQUE	NM	87114	IN	96	54	297
616	850433202	1073609020	JEFFREY SUPPLE	JEFFREY J SUPPLE DMD PC	10409 MONTGOMERY PKWY	STE 102	ALBUQUERQUE	NM	87111	IN	15	6	43
617	850434155	1033878848	VIRGINIA BAUTISTA DE COR	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	1	1	5
618	850434155	1053319269	LUCINDA LEWIS	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	7	4	22
619	850434155	1134774862	ROSANNA FLORES	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	8	7	48
620	850434155	1366521965	JACK DURAN	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	1	1	5
621	850434155	1407930027	RYAN LEE	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	1	1	2
622	850434155	1770849796	ZELLISHA QUAM	ALBUQUERQUE IHS DENTAL CLINIC	9169 COORS BLVD NW		ALBUQUERQUE	NM	87120	IN	11	8	26
623	850445375	1114931433	JENNIFER CASAUS	JENNIFER I CASAUS DDS	5920 CUBERO DR NE		ALBUQUERQUE	NM	87109	IN	8	7	12
624	850447335	1104990571	JAMES SLAMAN	JAMES SLAMAN DDS	8650 ALAMEDA BVLD NE	STE 140E	ALBUQUERQUE	NM	87122	OON	26	16	74
625	850447335	1295090975	ANNE HARRISON	JAMES SLAMAN DDS	8650 ALAMEDA BVLD NE	STE 140E	ALBUQUERQUE	NM	87122	IN	4	4	14
626	850447335	1538133517	JOE WILSON	JAMES SLAMAN DDS	8650 ALAMEDA BVLD NE	STE 140E	ALBUQUERQUE	NM	87122	OON	1	1	1
627	850448006	1942306725	PETRA MAYER	PETRA I MAYER DDS PC	7520 MONTGOMERY BLVD NE	STE D-6	ALBUQUERQUE	NM	87109	OON	23	14	33
628	850449156	1689746497	VASILIOS PAVLAKOS	VASILIOS J PAVLAKOS DDS	3904 JUAN TABO BLVD NE		ALBUQUERQUE	NM	87111	IN	17	11	38
629	850452653	1982820445	RANDALL GARCIA	GARCIA RANDALL E DDS	1950 7TH ST		LAS VEGAS	NM	87701	IN	1	1	3
630	850456023	1578670774	MIKE ROUSSEL	MIRA CONSULTING INC	6808 ACADEMY PARKWAY EAST NE	STE A2	ALBUQUERQUE	NM	87109	IN	8	5	37
631	850456023	1578670774	MIKE ROUSSEL	MIRA CONSULTING INC	6808 ACADEMY PARKWAY EAST NE	STE A2	ALBUQUERQUE	NM	87109	IN	3	3	18
632	850466967	1023024536	MARK JOHNSON	MARK W JOHNSON DDS	5115 COORS BLVD NW	STE F	ALBUQUERQUE	NM	87120	OON	15	15	34
633	850467219	1396957460	RANDY ALKIRE	RANDY G ALKIRE DDS MS PC	1316 JACKIE RD SE	STE 300	RIO RANCHO	NM	87124	IN	5	1	8
634	850468858	1649342551	JENNIFER RIDGEWAY	JENNIFER RIDGEWAY DDS	7520 MONTGOMERY NE	STE D1	ALBUQUERQUE	NM	87109	IN	18	8	32
635	850474804	1508255878	BRYCE HASLAM	LAS CRUCES ENDODONTICS	3045 E UNIVERSITY AVE	STE C	LAS CRUCES	NM	88011	IN	1	1	2
636	850475859	1730177767	DONALD GUTIERREZ	DONALD P GUTIERREZ DMD PC	1441 CARLISLE BLVD NE	STE A	ALBUQUERQUE	NM	87110	OON	66	50	160
637	850476869	1154347201	EZLEN TRUJILLO	E RONALD TRUJILLO FAMILY DENTI	2050 BOTULPH RD	STE C	SANTA FE	NM	87505	IN	3	1	4
638	850477721	1437112752	ARMAND GIANNINI	ARMAND J GIANNINI JR DDS PC	7910 WYOMING BLVD NE	STE B	ALBUQUERQUE	NM	87109	IN	175	98	428
639	850480144	1750362877	FOOK CHOON LEE	FOOK C LEE DDS PC	2017 SAN MATEO BLVD NE		ALBUQUERQUE	NM	87110	IN	87	43	203
640	850480937	1669527560	SHAUN HWANG	HWANG SHAUN K DDS	8611 GOLF COURSE RD NW		ALBUQUERQUE	NM	87114	IN	62	36	219
641	851395811	1427597608	BENJAMIN STOGSDILL	MAVEN DENTISTRY LLC	7520 MONTGOMERY BLVD NE	BLDG D7	ALBUQUERQUE	NM	87109	OON	16	10	40
642	851909805	1053795112	JORDAN GHIASSI	GHIASSI PERIODONTICS LLC	2100 CALLE DE LA VUELTA	STE E 101	SANTA FE	NM	87505	OON	1	1	1
643	851946150	1083064398	JOSHUA EASTHAM	HIGH DESERT DENTAL LLC	132 WALNUT AVE		GRAND JUNCTION	CO	81501	OON	2	1	4
644	852052303	1588150957	LIGIA PADILLA	SUCCESS SMILES ORTHODONTICS	8216 LOUISIANA BLVD NE		ALBUQUERQUE	NM	87113	IN	34	17	79
645	852102987	1952032039	MARGARITA GARCIA	HILL COUNTRY DENTAL CENTER	1112 S MAIN ST	STE A	BOERNE	TX	78006	IN	2	1	5
646	852260033	1215420120	ERIKA BELLE	VALER DENTAL	120 EUBANK BLVD SE		ALBUQUERQUE	NM	87123	IN	7	4	17
647	852260033	1356993729	AMIR VAHDANI	VALER DENTAL	120 EUBANK BLVD SE		ALBUQUERQUE	NM	87123	IN	6	5	13
648	852260033	1487403499	MATTHEW WRIGHT	VALER DENTAL	120 EUBANK BLVD SE		ALBUQUERQUE	NM	87123	IN	5	4	15
649	852260033	1487611331	JACK SMALLEY	VALER DENTAL	120 EUBANK BLVD SE		ALBUQUERQUE	NM	87123	IN	1	1	3
650	852438183	1194383752	CRAIG TESTERMAN	SONRISA FAMILY DENTAL RIO RANC	2345 SOUTHERN BLVD SE	STE B1	RIO RANCHO	NM	87124	IN	16	13	39
651	852438183	1285112748	WESLEY HANCHETT	SONRISA FAMILY DENTAL RIO RANC	2345 SOUTHERN BLVD SE	STE B1	RIO RANCHO	NM	87124	IN	32	20	87
652	852438183	1336138031	BRENTON MASON	SONRISA FAMILY DENTAL RIO RANC	2345 SOUTHERN BLVD SE	STE B1	RIO RANCHO	NM	87124	IN	12	6	34
653	852438183	1194383752	CRAIG TESTERMAN	TRI DENTAL LLC	3715 LAS ESTANCIAS CT SW	STE 101	ALBUQUERQUE	NM	87121	IN	12	11	28

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654	852438183	1285112748	WESLEY HANCHETT	TRI DENTAL LLC	3715 LAS ESTANCIAS CT SW	STE 101	ALBUQUERQUE	NM	87121	IN	36	29	82
655	852438183	1336138031	BRENTON MASON	TRI DENTAL LLC	3715 LAS ESTANCIAS CT SW	STE 101	ALBUQUERQUE	NM	87121	IN	94	59	252
656	852501615	1366187726	HELENA WU	HIGH DESERT DENTAL	3520 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87107	IN	94	48	271
657	852501615	1710463799	CHRISTOPHER RODAS	HIGH DESERT DENTAL	3520 MONTGOMERY BLVD NE		ALBUQUERQUE	NM	87107	IN	29	17	81
658	853193532	1275916686	NOAH NG	NOAH NG	11130 LOMAS BLVD NE	STE F2	ALBUQUERQUE	NM	87112	IN	20	19	85
659	853193532	1376926006	BECKY CHIEM	NOAH NG	11130 LOMAS BLVD NE	STE F2	ALBUQUERQUE	NM	87112	IN	29	20	121
660	853193532	1477162659	ALEXANDRIA CHEN	NOAH NG	11130 LOMAS BLVD NE	STE F2	ALBUQUERQUE	NM	87112	IN	8	5	27
661	853986256	1861920696	COREY WOODS	BLUE SKY DENTAL	10555 MONTGOMERY BLVD NE	STE 160	ALBUQUERQUE	NM	87111	IN	68	35	170
662	854132781	1124513288	ALEKSEY KOZLOV	ALEKSEY KOZLOV	2 BIRCH RD		CEDAR CREST	NM	87008	OON	15	11	53
663	854198326	1144316407	GREG SANCHEZ	SANCHEZ HENRY DENTAL ASSOC	1109 CARDENAS NE		ALBUQUERQUE	NM	87110	OON	15	5	30
664	854198326	1346609708	KYLE HENRY	SANCHEZ HENRY DENTAL ASSOC	1109 CARDENAS NE		ALBUQUERQUE	NM	87110	OON	15	6	29
665	856000565		NEW MEXICO MEDICAID	NM HUMAN SERVICE DEPT	PO BOX 200791		DALLAS	TX	75320	OON	2	2	7
666	860811801	1689713869	ROGER DULVICK	ROGER J DULVICK DDS PC	4125 W CHANDLER BLVD		CHANDLER	AZ	85226	OON	2	1	5
667	860927641	1750427357	BRIAN DENNIS	BRIAN K DENNIS DDS	8400 OSUNA RD NE	STE 6A	ALBUQUERQUE	NM	87111	OON	17	10	38
668	860980866	1538133517	JOE WILSON	JOE R WILSON DDS PC	205 RIO COMMUNITIES BLVD		RIO COMMUNITIES	NM	87002	IN	58	27	154
669	861144916	1679561716	DONNA KIDBY	ENCHANTMENT DENTAL PC	1442 SAINT FRANCIS DR	STE A	SANTA FE	NM	87505	OON	1	1	4
670	861166182	1902907876	DAN PHAM	PHAM FAMILY DENTISTRY	16019 NACOGDOCHES RD	STE 110	SAN ANTONIO	TX	78247	IN	7	6	36
671	861912220	1083376123	ALEXANDER COLLINS HORN	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	21	16	55
672	861912220	1407952245	TINA WANG	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	3	2	10
673	861912220	1518977396	GAYLINA REACHI	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	38	25	90
674	861912220	1518977396	GAYLINA REACHI	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	16	9	34
675	861912220	1699100370	HEATHER PREBER	ABQ DENTISTS	7127 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	64	38	162
676	861912220	1699100370	HEATHER PREBER	ABQ DENTISTS	7127 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	4	1	8
677	861912220	1740622349	ANNE SCOTT	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	22	13	46
678	861912220	1740622349	ANNE SCOTT	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	27	15	54
679	861912220	1750026043	ROSA RODRIGUEZ	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	2	1	2
680	861912220	1750026043	ROSA RODRIGUEZ	ABQ DENTISTS	7127 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	4	4	11
681	861912220	1801634274	DANIAL AHMADI	ABQ DENTISTS	7127 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	22	20	66
682	861912220	1801634274	DANIAL AHMADI	ABQ DENTISTS	7127 PROSPECT PL NE		ALBUQUERQUE	NM	87110	IN	24	14	59
683	861912220	1891437596	ANDREW BOWERS	ABQ DENTISTS	3900 EUBANK BLVD NE	STE 14	ALBUQUERQUE	NM	87111	IN	3	3	9
684	861912220	1407952245	TINA WANG	ABQ DENTISTS EAST MOUNTAINS	11896 HWY 14		TIJERAS	NM	87059	IN	9	5	23
685	861912220	1518977396	GAYLINA REACHI	ABQ DENTISTS EAST MOUNTAINS	11896 HWY 14		TIJERAS	NM	87059	IN	3	3	3
686	861912220	1740622349	ANNE SCOTT	ABQ DENTISTS EAST MOUNTAINS	11896 HWY 14		TIJERAS	NM	87059	IN	1	1	1
687	861986708	1275613788	TIMOTHY GUTIERREZ	RYAN STERK	1513 CARLISLE BLVD NE		ALBUQUERQUE	NM	87110	IN	15	11	32
688	861986708	1497100341	RYAN STERK	RYAN STERK	1513 CARLISLE BLVD NE		ALBUQUERQUE	NM	87110	IN	31	22	84
689	862076810	1134783723	MATTHEW THOMPSON	SUMMIT FAMILY DENTAL OF BERNAL	7800 CARR WAY NE	STE 105	RIO RANCHO	NM	87144	IN	54	29	153
690	870870861	1790948529	SHELLY TRAN	LAS CRUCES DENTAL	2001 E LOHMAN AVE	STE 121	LAS CRUCES	NM	88001	IN	3	2	9
691	870870861	1982124210	GABRIEL TRUJILLO	LAS CRUCES DENTAL	2001 E LOHMAN AVE	STE 121	LAS CRUCES	NM	88001	IN	1	1	1
692	870909656	1467025411	ERIC BOMAN	KENNETH M COX	6615 S EASTERN AVE	STE 106	LAS VEGAS	NV	89119	IN	1	1	3
693	872000307		ANGELA TORRES	ANGELA TORRES DMD	6800 MONTGOMERY BLVD NE	STE H	ALBUQUERQUE	NM	87109	OON	23	16	66
694	872092225	1740855618	SARAH KIM	SMILEPOINT DENTAL RIO BRAVO	3211 COORS BLVD SW	STE D2	ALBUQUERQUE	NM	87121	IN	5	3	21
695	872092225	1740855618	SARAH KIM	SMILEPOINT DENTAL RIO BRAVO	3211 COORS BLVD SW	STE D2	ALBUQUERQUE	NM	87121	IN	1	0	2
696	872298041	1225342918	DUANE MARSHALL	MOUNTAIN VIEW FAMILY DENTISTS	4405 JAGER DR NE	STE C1	RIO RANCHO	NM	87144	IN	16	11	57
697	873239770	1528108289	ANDREW SOHN	ALBUQUERQUE ORAL SURGERY PC	6800 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	2	1	2
698	873239770	1750359618	LIONEL CANDELARIA	ALBUQUERQUE ORAL SURGERY PC	6800 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	26	14	49
699	873888313	1689969800	ALEXANDER NOURI	NOURI FAMILY DENTISTRY LLC	6400 CENTRAL AVE SW		ALBUQUERQUE	NM	87105	IN	218	79	494
700	873888313	1932494408	JUNG LEE NOURI	NOURI FAMILY DENTISTRY LLC	6400 CENTRAL AVE SW		ALBUQUERQUE	NM	87105	IN	2	2	5
701	874149500	1992320915	BRADY CARLEN	MOUNTAIN VIEW DENTAL	2081 1ST ST		ALAMOGORDO	NM	88310	IN	1	1	1
702	874199054	1457525263	PETER ROUKEMA	PAGOSA PEAK FAMILY DENTISTRY	228 VILLAGE DR		PAGOSA SPRINGS	CO	81147	IN	4	2	10
703	874199054	1801405576	JAIME ASTORGA	PAGOSA PEAK FAMILY DENTISTRY	228 VILLAGE DR		PAGOSA SPRINGS	CO	81147	IN	2	2	7
704	874272158	1790130821	QUINN YOST	MILK TOOTH	1115 AVIATION BLVD		HERMOSA BEACH	CA	90254	IN	1	1	3

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705	874360271	1396158333	CHARLES ROBERTS	CHARLES WAYNE ROBERTS DMD PLLC	6417 34TH ST	STE 400	LUBBOCK	TX	79407	IN	1	1	2
706	881490856	1386767267	DOROTHY NARVAEZ WOOD	DENTAL IMPLANT SPECIALISTS NV	6420 MEDICAL CENTER ST	STE 101	LAS VEGAS	NV	89148	OON	2	1	2
707	882578443	1275172181	BRENT JORGENSEN	JORGENSEN ORTHODONTICS LLC	1401 BARBARA LOOP SE		RIO RANCHO	NM	87124	IN	7	3	14
708	882578443	1275172181	BRENT JORGENSEN	JORGENSEN ORTHODONTICS LLC	8400 OSUNA RD NE	STE 2C	ALBUQUERQUE	NM	87111	IN	6	2	14
709	882578443	1770669368	GREGORY JORGENSEN	JORGENSEN ORTHODONTICS LLC	1401 BARBARA LOOP SE		RIO RANCHO	NM	87124	IN	15	7	31
710	882578443	1770669368	GREGORY JORGENSEN	JORGENSEN ORTHODONTICS LLC	6501 PARADISE BLVD NW	STE B	ALBUQUERQUE	NM	87114	IN	19	8	44
711	882578443	1770669368	GREGORY JORGENSEN	JORGENSEN ORTHODONTICS LLC	8400 OSUNA RD NE	STE 2C	ALBUQUERQUE	NM	87111	IN	4	2	10
712	882749373	1023451325	MICHIA HARRIS	WE MAKE KIDS SMILE LLC	540 MAIN ST		PRNC FREDERCK	MD	20678	IN	1	1	0
713	883013143	1952827032	KAMAL PREET SANDHU	KAMAL PREET KAUR SANDHU DDS	1170 W 11TH ST		TRACY	CA	95376	OON	1	1	3
714	884191946	1164067153	SEUNGYEON KIM	ALSBURY AND LIFEWAY DENTAL PLL	699 NE ALSBURY BLVD		BURLESON	TX	76028	IN	2	1	4
715	884234878	1568748168	AMBER MILLER	GALLEGOS ENDODONTIC LLC	7520 MONTGOMERY BLVD NE	BLDG C	ALBUQUERQUE	NM	87109	IN	24	18	44
716	884234878	1568748168	AMBER MILLER	GALLEGOS ENDODONTIC LLC	7520 MONTGOMERY BLVD NE	BLDG C	ALBUQUERQUE	NM	87109	IN	3	2	7
717	884234878	1831326560	JOHN GALLEGOS	GALLEGOS ENDODONTIC LLC	7520 MONTGOMERY BLVD NE	BLDG C	ALBUQUERQUE	NM	87109	IN	9	8	18
718	900000207	1184293649	ELLIOTT ROMO	LOUIS R RIVERA, DDS	4824 MCMAHON BLVD NW	STE 105	ALBUQUERQUE	NM	87114	OON	7	3	19
719	900000207	1477528511	LOUIS RIVERA	LOUIS R RIVERA, DDS	4824 MCMAHON BLVD NW	STE 105	ALBUQUERQUE	NM	87114	OON	10	8	33
720	900214282	1386739340	DAVID GIAQUINTO	COTTONWOOD DENTAL LLC	3613 STATE HWY 528 NW	STE D	ALBUQUERQUE	NM	87114	IN	48	27	123
721	900254463	1851475065	THEODORE CHO	CHO THEODORE D DDS LLC	2216 BROTHERS RD		SANTA FE	NM	87505	OON	1	1	5
722	900864928	1063046316	STEPHANIE ZARRASOLA	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	36	19	90
723	900864928	1285156349	AMANDA HAND	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	11	7	43
724	900864928	1356652358	DAVID LILLIAN	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	2	2	11
725	900864928	1558748434	STACEY REISS	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	13	8	20
726	900864928	1780811984	RYAN WILSON	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	3	3	8
727	900864928	1841850278	BRENDAN SCHLEYER	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	5	4	12
728	900864928	1992283576	JUSEMMY ARCE	EAGLE POINTE DENTISTS AND ORTH	6230 PASEO DEL NORTE NE	STE B	ALBUQUERQUE	NM	87113	IN	77	33	206
729	900893804	1154734762	MARISOL KING	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	50	29	191
730	900893804	1265729404	KELLEY HOLLINGSWORTH R	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	1	1	1
731	900893804	1346787165	TAYLOR LEEPER	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	7	5	8
732	900893804	1346787165	TAYLOR LEEPER	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	21	12	41
733	900893804	1356652358	DAVID LILLIAN	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	3	3	21
734	900893804	1780811984	RYAN WILSON	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	1	1	2
735	900893804	1841850278	BRENDAN SCHLEYER	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	2	1	6
736	900893804	1992283576	JUSEMMY ARCE	COTTONWOOD SMILES DENTISTRY AN	3400 NM 528 NW	STE A107	ALBUQUERQUE	NM	87114	IN	13	10	57
737	900903768	1063046316	STEPHANIE ZARRASOLA	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	5	3	18
738	900903768	1356652358	DAVID LILLIAN	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	1	1	5
739	900903768	1447082979	AFRA HUSSAIN	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	10	7	46
740	900903768	1780811984	RYAN WILSON	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	5	5	13
741	900903768	1841850278	BRENDAN SCHLEYER	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	2	2	5
742	900903768	1881029668	TARYN YEE PAIVA	ALBUQUERQUE MODERN DENTISTS	6810 MENAUL BLVD NE	STE B	ALBUQUERQUE	NM	87110	IN	74	27	236
743	901036260	1225407604	MICHAEL CONNER	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	106	41	265
744	901036260	1285156349	AMANDA HAND	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	59	27	151
745	901036260	1346787165	TAYLOR LEEPER	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	18	11	68
746	901036260	1356652358	DAVID LILLIAN	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	3	3	13
747	901036260	1558748434	STACEY REISS	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	19	7	29
748	901036260	1780811984	RYAN WILSON	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	3	3	11
749	901036260	1841850278	BRENDAN SCHLEYER	RIO RANCHO MODERN DENTISTRY	950 UNSER BLVD SE	STE 100	RIO RANCHO	NM	87124	IN	9	5	19
750	911829118	1467444745	THOMAS LANTZ	PERFECT TEETH	13140 CENTRAL AVE SE	STE E	ALBUQUERQUE	NM	87123	IN	33	18	61
751	911884161	1003302811	JULIETA SANCHEZ MARTINE	QUINTANA DENTAL PRACTICE	7520 MONTGOMERY BLVD NE	BLDG E10	ALBUQUERQUE	NM	87109	IN	8	8	26
752	911884161	1295885101	MARK MILLER	QUINTANA DENTAL PRACTICE	7520 MONTGOMERY BLVD NE	BLDG E10	ALBUQUERQUE	NM	87109	IN	1	1	3
753	911884161	1720079635	OSCAR QUINTANA	QUINTANA DENTAL PRACTICE	8501 CANDELARIA RD NE	BLDG BC	ALBUQUERQUE	NM	87112	IN	160	82	373
754	911955085	1871594408	FRANK DOMINGUEZ	PERFECT TEETH	4500 ARROWHEAD RIDGE DR SE		RIO RANCHO	NM	87124	IN	46	21	109
755	921735532	1073987988	ASHLEE ARAGON	DARREN HALTOM DDS MS	8300 CARMEL AVE NE	STE 602	ALBUQUERQUE	NM	87122	IN	50	37	197

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756	921735532	1750511192	DAVID GREENE	DARREN HALTOM DDS MS	8300 CARMEL AVE NE	STE 602	ALBUQUERQUE	NM	87122	IN	19	14	88
757	921735532	1750511192	DAVID GREENE	DARREN HALTOM DDS MS	8300 CARMEL AVE NE	STE 602	ALBUQUERQUE	NM	87122	IN	19	13	107
758	921735532	1891858940	DARREN HALTOM	DARREN HALTOM DDS MS	8300 CARMEL AVE NE	STE 602	ALBUQUERQUE	NM	87122	IN	4	4	4
759	921735532	1073987988	ASHLEE ARAGON	DARREN HALTOM SPEC PARTNERS	3301 COORS BLVD NW	STE 1	ALBUQUERQUE	NM	87120	IN	4	3	20
760	921735532	1407230857	ZARAH AHMED	DARREN HALTOM SPEC PARTNERS	3301 COORS BLVD NW	STE 1	ALBUQUERQUE	NM	87120	IN	26	17	115
761	921735532	1669714184	KAITLYN DARCY	DARREN HALTOM SPEC PARTNERS	10433 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	12	3	12
762	921735532	1750511192	DAVID GREENE	DARREN HALTOM SPEC PARTNERS	3301 COORS BLVD NW	STE 1	ALBUQUERQUE	NM	87120	IN	7	7	31
763	921735532	1750511192	DAVID GREENE	DARREN HALTOM SPEC PARTNERS	3301 COORS BLVD NW	STE 1	ALBUQUERQUE	NM	87120	IN	3	1	10
764	921735532	1891858940	DARREN HALTOM	DARREN HALTOM SPEC PARTNERS	10433 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	74	12	74
765	921735532	1891858940	DARREN HALTOM	DARREN HALTOM SPEC PARTNERS	3730 ELLISON RD NW	STE B	ALBUQUERQUE	NM	87114	IN	4	4	4
766	921735532	1891858940	DARREN HALTOM	DARREN HALTOM SPEC PARTNERS	725 MAIN ST SE		LOS LUNAS	NM	87031	IN	3	3	3
767	921735532	1295014769	DERRICK BACA	KAITLYN DARCY DDS	1209 BONITA ST	STE B	GRANTS	NM	87020	IN	15	8	37
768	921735532	1407230857	ZARAH AHMED	KAITLYN DARCY DDS	1209 BONITA ST	STE B	GRANTS	NM	87020	IN	2	1	8
769	921738847	1023332350	CHUN XIAO SUN	JOSHUA SUN DDS	8400 OSUNA RD NE	STE 1A	ALBUQERQUE	NM	87111	IN	22	13	28
770	921749337	1689950503	JARED SOUTHWELL	ENCANTO DENTAL GROUP	2455 S TELSHOR BLVD		LAS CRUCES	NM	88011	IN	1	1	4
771	921789809	1558313882	LILLIAN JAIME	SUNSHINE DENTAL	10411 LAGRIMA DE ORO RD NE		ALBUQUERQUE	NM	87111	IN	4	3	10
772	922302472	1700191533	COLIN FORDE	DENTAL DESIGN STUDIO LLC	5920 WHITEMAN DR NW		ALBUQUERQUE	NM	87120	IN	52	21	135
773	922358355	1942407812	CLAY KIM	POTOMAC ORAL MAX SURG	995 PRINCE FREDERICK BLVD	STE 104	PRNC FREDERCK	MD	20678	IN	3	1	9
774	922929880	1215380076	AARON STROH	BF DENTAL PLLC	3607 E BELL RD		PHOENIX	AZ	85032	IN	1	1	3
775	923360057	1588150957	LIGIA PADILLA	SSO SOUTH VALLEY	6660 CENTRAL AVE SW		ALBUQUERQUE	NM	87121	IN	6	3	13
776	924024192	1629149851	SPENCER TASKER	ABQ PEDIATRIC DENTISTRY	4620 JEFFERSON LN NE	STE C	ALBUQUERQUE	NM	87109	IN	211	111	863
777	924024192	1629149851	SPENCER TASKER	SJT PEDIATRIC DENTISTRY PLLC	1724 GRANDE BLVD SE		RIO RANCHO	NM	87124	IN	17	16	48
778	931448931	1184277329	TONY NGUYEN	TAYLOR RANCH DENTAL LLC	6111 TAYLOR RANCH RD NW		ALBUQUERQUE	NM	87120	IN	82	45	223
779	931448931	1215143862	CHRISTOPHER LARMOUR	TAYLOR RANCH DENTAL LLC	6111 TAYLOR RANCH RD NW		ALBUQUERQUE	NM	87120	IN	1	1	1
780	931448931	1972655405	JEREMY MORRISON	TAYLOR RANCH DENTAL LLC	6111 TAYLOR RANCH RD NW		ALBUQUERQUE	NM	87120	IN	4	4	9
781	931754337	1407424526	ABRAHAM ROBLES	MICHAEL A CERONE DDS	845 S MAIN ST	STE 303	LOMBARD	IL	60148	OON	1	1	2
782	931980170	1508394297	GRANT ALLEN	RIO RANCHO FAMILY DENTAL CARE	4041 RIDGE ROCK RD SE		RIO RANCHO	NM	87124	IN	105	69	395
783	931980170	1841214921	GRANT ALLEN	RIO RANCHO FAMILY DENTAL CARE	4041 RIDGE ROCK RD SE		RIO RANCHO	NM	87124	IN	67	45	262
784	932412301	1063030393	RAFAEL RASCON	BOSQUE 801 LLC	3613 NM HIGHWAY 528 NW	528	ALBUQUERQUE	NM	87114	IN	26	15	81
785	932949944	1053920934	TAIS LOWRY	TAIS LOWRY DDS	12378 POWAY RD	STE B	OIWAY	CA	92064	OON	3	1	8
786	933110406	1194202051	EVAN MITCHELL	EVAN MITCHELL DDS LLC	2600 THE AMERICAN RD SE	STE 369	RIO RANCHO	NM	87124	IN	14	8	35
787	933312256	1710019047	MICHAEL HAIGHT	PARKWAY DENTAL NM LLC	10409 MONTGOMERY PKWY NE	STE 201	ALBUQUERQUE	NM	87111	IN	49	24	157
788	933312256	1710019047	MICHAEL HAIGHT	PARKWAY DENTAL NM LLC	10409 MONTGOMERY PKWY NE	STE 201	ALBUQUERQUE	NM	87111	IN	0	0	0
789	933629795	1932494408	JUNG LEE NOURI	HAPPY CAMPERS PEDIATRIC DENT	8212 LOUISIANA BLVD NE	STE A	ALBUQUERQUE	NM	87113	IN	3	2	15
790	933637472	1144819947	JAZMINE CHAVEZ	PEARL HOUSE DENTAL HYGIENE STU	1 CENTRAL AVE NW	STE C	ALBUQUERQUE	NM	87102	OON	5	5	10
791	934330712	1720762859	NGUYEN LE	ROSEMARY DENTAL SPA LLC	3309 JUAN TABO BLVD NE	STE B	ALBUQUERQUE	NM	87111	IN	22	16	73
792	934330712	1720762859	NGUYEN LE	ROSEMARY DENTAL SPA LLC	3309 JUAN TABO BLVD NE	STE B	ALBUQUERQUE	NM	87111	IN	6	2	15
793	934552911	1770713620	ELIZABETH WILSON	COMFORT DENTAL	4701 LOMAS BLVD NE		ALBUQUERQUE	NM	87110	IN	1	1	2
794	990836215	1932336989	WILLIAM GALBRETH	GALBRETH DENTAL LLC	7520 MONTGOMERY BLVD NE	BLDG D3	ALBUQUERQUE	NM	87109	IN	77	41	189
795	991422156	1609809656	KIRK WONDRA	RESTORE DENTAL LLC	701 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	12	10	30
796	991422156	1750733440	CHRISTOPHER CHRISTENSEI	RESTORE DENTAL LLC	701 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	27	17	64
797	991422156	1750733440	CHRISTOPHER CHRISTENSEI	RESTORE DENTAL LLC	701 BROADMOOR BLVD NE		RIO RANCHO	NM	87124	IN	1	0	3
798	991956748	1427619238	BENJAMIN WAITES	JUST CLEAN SMILES	3615 STATE HIGHWAY 47		PERALTA	NM	87042	IN	24	12	100
799	991956748	1427619238	BENJAMIN WAITES	JUST CLEAN SMILES	3615 STATE HIGHWAY 47		PERALTA	NM	87042	IN	20	13	77
800	991956748	1649919523	JARED SALAS	JUST CLEAN SMILES	3615 STATE HIGHWAY 47		PERALTA	NM	87042	IN	1	1	1
801	992353085	1346489374	KERI GIRON	KERI GIRON DDS	3900 EUBANK BLVD NE	UNIT 14	ALBUQUERQUE	NM	87111	OON	3	3	7
802	992920357	1699348854	APELDIN AGHASSI	QUEEN CREEK MODERN DENTISTRY	25166 S ELLSWORTH RD, STE B107		QUEEN CREEK	AZ	85142	IN	3	2	17
803	993127939		ROBERT BRANDES	GOUD STOCK CORPORATION LLC	12540 N HIGHWAY 14		SANDIA PARK	NM	87047	IN	1	1	0
804	993127939	1114165255	ROBERT BRANDES	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	1	1	0
805	993127939	1376825059	SETH STOCKTON	GOUD STOCK CORPORATION LLC	12540 N HIGHWAY 14		SANDIA PARK	NM	87047	IN	15	15	10
806	993127939	1376825059	SETH STOCKTON	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	2	2	7

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Row Number	TIN	PROVIDER NPI	Provider Name	Facility	Address 1	Address 2	City	State	ZIP	Network Status (In or Out)	Claims	Claimants	Procedures
807	993127939	1376825059	SETH STOCKTON	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	3	2	0
808	993127939	1760763973	ERIN STOCKTON	GOUD STOCK CORPORATION LLC	12540 N HIGHWAY 14		SANDIA PARK	NM	87047	IN	20	20	42
809	993127939	1760763973	ERIN STOCKTON	GOUD STOCK CORPORATION LLC	6830 MONTGOMERY BLVD NE	STE A	ALBUQUERQUE	NM	87109	IN	10	8	4
810	993127939	1992329833	CRAIG VERMETTE	GOUD STOCK CORPORATION LLC	12540 N HIGHWAY 14		SANDIA PARK	NM	87047	IN	2	2	11
811	993127939	1992329833	CRAIG VERMETTE	GOUD STOCK CORPORATION LLC	12540 N HIGHWAY 14		SANDIA PARK	NM	87047	IN	1	1	2
812	993371093	1598347981	SHAREH SHOKOOHI	RIO RANCHO SMILES	1316 JACKIE RD SE	STE 200	RIO RANCHO	NM	87124	IN	2	2	4

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City of Albuquerque

DPPO Provider Counts

Appendix F

Vendor Name	Blue Cross and Blue Shield of New Mexico
Contact Name	Amanda Romero
Contact Number	505-900-4021

Confidential and Proprietary

Provide the number of providers who have their PRIMARY location in the indicated area. Each unique provider should be counted only once. Where a multi-provider exists, each provider should be counted once.

DPPO Network						
	General Dentists		Specialists		Orthodontists	
3-digit code	# of Unique Providers	% Open To New Members	# of Unique Providers	% Open To New Members	# of Unique Providers	% Open To New Members
870XX	244	94.3%	28	100.0%	32	93.8%
871XX	591	96.8%	78	97.4%	53	98.1%
873XX	85	97.6%	15	80.0%	16	100.0%

Provide the number of contracted provider locations in the indicated area. Locations may be counted more than once if multiple locations exist. Where a multi-provider practice exists, each location should be counted once.

DPPO Network						
	General Dentists		Specialists		Orthodontists	
3-digit code	# of Locations	% Open To New Members	# of Locations	% Open To New Members	# of Locations	% Open To New Members
870XX	N/A	N/A	N/A	N/A	N/A	N/A
871XX	N/A	N/A	N/A	N/A	N/A	N/A
873XX	N/A	N/A	N/A	N/A	N/A	N/A

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THE CITY OF ALBUQUERQUE

City of Albuquerque
Appendix F - DENTAL PPO PLAN PROCEDURES

Vendor Name	Blue Cross and Blue Shield of New Mexico
Contact Name	Amanda Romero
Contact Number	505-900-4021

Complete the chart indicating your allowances for contracted network providers and UCR for non-network

Confiden

Code	Name	In-network	
		3-digit zip 870	3-digit zip 871
D0120	Periodic Oral Evaluation - Established Patient	$35	$38
D1110	Prophylaxis - Adult	$67	$72
D0274	Bitewings - Four Radiographic Images.	$43	$47
D2392	Resin-based Composite - Two Surfaces, Posterior	$154	$169
D0210	Intraoral - Complete Series Of Radiographic Images	$95	$101
D0220	Intraoral - Periapical First Radiographic Image	$19	$21
D0150	Comprehensive Oral Evaluation - New Or Established Patient	$57	$61
D4910	Periodontal Maintenance	$109	$111
D2391	Resin-based Composite - One Surface, Posterior	$118	$128
D0140	Limited Oral Evaluation - Problem Focused	$53	$57
D1208	Topical Application Of Fluoride	$27	$28
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	$187	$197
D1206	Topical Application Of Fluoride Varnish	$33	$34
D1120	Prophylaxis - Child	$49	$53
D2740	Crown - Porcelain/ceramic Substrate	$853	$897
D2950	Core Buildup, Including Any Pins When Required	$184	$194
D0230	Intraoral - Periapical Each Additional Radiographic Image	$15	$16
D1351	Sealant - Per Tooth	$39	$42
D2393	Resin-based Composite - Three Surfaces, Posterior	$191	$208
D7210	Extraction, Erupted Tooth Requiring Removal Of Bone And/or Sectioning Of Tooth, And Including Elevat	$190	$202
D7140	Extraction, Erupted Tooth Or Exposed Root (elevation And/or Forceps Removal)	$108	$117
D0272	Bitewings - Two Radiographic Images.	$30	$33
D4381	Localized Delivery Of Antimicrobial Agents Via Controlled Release Vehicle Into Diseased Crevicular T	$78	$76
D2331	Resin-based Composite - Two Surfaces, Anterior	$135	$146
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	$105	$115
D2330	Resin-based Composite - One Surface, Anterior	$108	$116
D2332	Resin-based Composite - Three Surfaces, Anterior	$163	$176

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City of Albuquerque

Dental PPO Current Benefit Design

Appendix F

Vendor Name	Blue Cross and Blue Shield of New Mexico
Contact Name	Amanda Romero
Contact Number	505-900-4021

Complete the grid indicating the benefit design you are quoting.

	Current & Requested		Requested/Proposed	
Plan Features	**Dental PPO**	**MAC/ Out of Network**	**Dental PPO**	**Out of Network**
Routine: Preventive & Diagnostic	100%	80%	100%	80%
Basic Services	85%	85%	100%	80%
Major Services	50%	50%	50%	50%
Annual Maximum (Preventive & Diagnostic)	None	None	None	None
Annual Maximum (Basic & Major)	$1,500	$1,500	$1,500	$1,500
Deductible (Basic & Major)	$50/$150	$50/$150	$50/$150	$50/$150
Orthodontia	50%	50%	50%	50%
Lifetime Orthodontia Maximum	$1,200	$1,200	$1,200	$1,200
No Age Limit	Child or Adult	Child or Adult	Child or Adult	Child or Adult
Dependent Age	26		26	
Exams and X-Rays	Routine		Routine	
3rd Annual Exam Benefit	Routine		Routine	
Cleanings, Flouride Treatments	Routine		Routine	
Space Maintainers	Routine		Routine	
Emergency (Palliative Treatment)	Routine		Routine	
Topical Fluoride	Routine		Routine	
Periodontal Maintentance	Routine		Routine	
Sealants	Routine		Routine	
Basic Restorative (fillings)	Basic		Basic	
Oral Surgery (Simple Extractions)	Basic		Basic	
Oral Surgery (Surgical Extractions)	Basic		Basic	
Endodontics	Basic		Basic	
Periodontics	Basic		Basic	
Stainless Steel Crowns	Major		Major	
Restorative (Cast Crown & Onlays)	Major		Major	
Bridges, Partial Dentures, Complete Dentures	Major		Major	
Bridge and Denture Repairs	Major		Major	
Implants	Major		Major	
TMJ (medically necessary)	Major		Major	
Limitations:				
Preventive: Oral Exams	Twice per year		Twice per year	
Comprehensive Evaluation	Twice per 12 months		Twice per 12 months	
Preventive Routine prophylaxes (cleanings)	Twice per year		Twice per year	
Preventive: X-Rays:	Full mouth, once in a 5-year period		Full mouth, once in a 5-year period	
Preventive: X-Rays:	Bitewing, twice per year		Bitewing, twice per year	
Preventive: Routine Cleanings	Twice per calendar year		Twice per calendar year	
Preventive: Flouride Treatment	Twice per calendar year up to age 19		Twice per calendar year up to age 19	
Preventive: Space Maintainers	Once per area per lifetime up to age 14		Once per area per lifetime up to age 14	
Basic: Fillings	Amalgam & Composite 1 per tooth per 12 months		Amalgam & Composite 1 per tooth per 12 months	
Basic: Sealants	Once per tooth per lifetime up to age 16		Once per tooth per lifetime up to age 16	
Basic: Restorative Crowns & Inlays	Five year waiting period for replacement last performed		Five year waiting period for replacement la	
Major: Implants	Once per tooth in any 5 year period		Once per tooth in any 5 year period	
Major: Restorative Onlays	Five year waiting period for replacement last performed		Five year waiting period for replacement last performed	
Major: Prosthodontics (Bridges,Dentures)	Five year waiting period for replacement last performed		Five year waiting period for replacement last performed	
Out-of-Network	Maximum Allowable Fee		Maximum Allowable Fee	

Note: Please indicate if you have a contract to limit balance billing the member when utilizing out of network providers. Explain in the comment box below.

Comments & Deviations (please list any deviations from requested benefits above).

Most participating dentists agree to accept our maximum allowable amount and not to balance bill patients. Occasionally, out-of-network dentists may balance bill for any services over the allowed amount, any deductibles, and any noncovered services. The provider may bill a patient directly for any portion of the services provided under the following circumstances:

- When the plan lists a patient copayment/coinsurance for a covered service.