BlueCross BlueShield of Tennessee
An Independent Licensee of the Blue Cross and Blue Shield Association

ADMINISTRATIVE SERVICES AGREEMENT
BETWEEN
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
AND
CITY OF FRANKLIN, TENNESSEE

This Administrative Services Agreement (the "Agreement"), is by and between City of Franklin, Tennessee ("Employer") and BlueCross BlueShield of Tennessee, Inc. ("BlueCross"), and is effective as stated in Section 3.1 of this Agreement. Employer and BlueCross may be individually referred to in this Agreement as a "Party" and are collectively referred to in this Agreement as the "Parties".

WHEREAS, Employer has established a self-funded Employee Welfare Benefit Plan; however, Employer represents that this Employee Welfare Benefit Plan ("Plan") is not subject to ERISA;

WHEREAS, BlueCross offers to sponsors of self-funded employee welfare benefit plans certain administrative and related services in connection with such sponsors' administration of their plans; and

WHEREAS, Employers seeks for BlueCross to provide, and BlueCross seeks to provide, administrative services to and on behalf of Employer and the Plan as set forth in this Agreement.

NOW THEREFORE, in consideration of the promises, covenants, representations, and warranties set forth herein, and other consideration, the sufficiency of which is hereby acknowledged, the Parties each hereby agree as follows:

ARTICLE I – RESPONSIBILITIES OF THE PARTIES

1.1. BlueCross. BlueCross shall provide administrative claims payment services in accordance with the terms of the Benefit Documents, shall perform other services as set forth in this Agreement, and shall perform other duties specifically assumed by BlueCross pursuant to this Agreement. BlueCross does not assume any financial risk or obligation with respect to Approved Claims. BlueCross shall perform its services and duties in accordance with the terms of this Agreement and applicable law and will administer the benefits in accordance with BlueCross's customary administrative standards and practices and generally accepted standards applicable to claims administration, including other licensees of the Association.

1.2. Employer. Employer shall perform the obligations set forth in this Agreement, including maintaining the Plan in accordance with applicable law, providing information to BlueCross regarding the Plan and Members necessary to administer the Plan, and timely funding and payment of Approved Claims and ASFs. Employer may designate a third party to perform any of its duties under this Agreement; provided, however, such designation shall not release Employer from its obligations pursuant to this Agreement and such third-

parties, in performing such duties, shall be subject to the same performance obligations as applicable to Employer.

1.3. Benefit Documents. Employer shall provide BlueCross with a current, detailed, accurate copy of the Benefits Documents, which are attached as Exhibit A ("Benefit Documents"), and any changes to the Plan. Employer shall notify BlueCross of any planned changes Employer intends to make to the terms and/or conditions of the Benefit Documents or the Plan. Notification shall be made sufficiently in advance of any such changes so as to permit BlueCross reasonable time to review and/or implement such changes. It is Employer's obligation to ensure all Benefit Documents, whether produced by BlueCross or Employer, meet the requirements of applicable laws. Employer agrees that all Association-mandated language shall be included in its Benefit Documents. BlueCross shall not be responsible for administering any Benefit Document that has not been reviewed and accepted by BlueCross. Until Employer has approved the Benefits Documents, BlueCross will administer the quoted benefits according to the descriptions contained in Employer's Benefits Documents last accepted by BlueCross.

1.4. Stop Loss Coverage. Employer has entered into a stop loss arrangement with a stop loss vendor. BlueCross's duties with regard to this stop loss arrangement are set forth in Exhibit C.

1.5. Fiduciary Responsibility. Employer is solely responsible for the fiduciary responsibilities of administering its Plan and maintaining adequate funding to support the Plan, determining eligibility under the Plan, and preparing and providing its covered employees with copies of Benefit Documents. Although Employer's Plan is not subject to ERISA, Employer acknowledges that BlueCross is acting in a ministerial capacity and is not the "Administrator," the "Claims Fiduciary," nor the "Named Fiduciary" of Employer's Plan, as those terms are defined in ERISA. The "Plan Administrator" of the Plan, as that term is defined in ERISA, is Employer.

1.6. Claims Funding. Employer shall timely pay the invoiced amount for Approved Claims. Nothing in this Agreement shall obligate or shall be deemed to obligate BlueCross to use its funds to satisfy any of Employer's obligations pursuant to this Agreement or Plan benefits. Employer's assets and amounts contributed by Members, if applicable, are the only source or sources of funding and payment of Approved Claims or any other benefit provided under the Plan.

1.7. Administrative Services Fees ("ASF(s)"). Employer shall timely pay ASFs in accordance with the Agreement. The initial ASF shall be due and payable on the Effective Date of this Agreement.

1.8. Approved Claims. BlueCross shall notify Employer weekly of the estimated amounts necessary to fund the Approved Claims. Employer shall then appropriately fund the Approved Claims in accordance with this Agreement.

ARTICLE II – CONFIDENTIALITY

2.1. Confidential Information.

2.1.1. The parties acknowledge that Employer is subject to the Tennessee Open Records Act ("TORA"); however, the Parties acknowledge that this Agreement and Confidential Information shall be treated as confidential, proprietary and trade secret information. Employer

further acknowledges and agrees that BlueCross Confidential Information relating to provider identifiable information, payment rates and discounts, fee schedules, allowed amounts, policies and procedures and/or all other information in which BlueCross has proprietary interest, is proprietary and a valuable trade secret of BlueCross and that any disclosure or unauthorized use thereof will cause irreparable harm and loss to BlueCross. Notwithstanding the foregoing, BlueCross agrees to provide to Employer information reasonably requested by Employer in BlueCross' possession to the extent required for Employer to meet its disclosure obligations with respect to the Plan under applicable law.

2.1.2. The Parties agree that any Protected Health Information that is commingled with Confidential Information disclosed under this Agreement shall be subject to the Business Associate Agreement between the Parties.

2.2. Uses and Disclosures of Confidential Information. Neither Party shall use or disclose the Confidential Information of the other Party, except as permitted herein.

2.2.1. BlueCross's Release or Disclosure. BlueCross may disclose Employer's Confidential Information to providers within BlueCross's networks, to BlueCross's affiliates and other licensees of the Association, and BlueCross's Representatives who: (A) need to know such Employer Confidential Information; and (B) are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Agreement. BlueCross may also disclose Employer's Confidential Information pursuant to a valid administrative, judicial or court order.

2.2.2. Employer's Release or Disclosure of Confidential Information. Employer shall use BlueCross Confidential Information solely for the purpose of administering Employer's Plan under this Agreement and in accordance with applicable law. Employer shall not disclose BlueCross's Confidential Information to a third party, including an Employer Service Vendor. BlueCross may disclose Confidential Information of Employer to an Employer Service Vendor as requested by Employer, provided, however that (A) BlueCross, Employer and such Employer Service Vendor first must enter into an information sharing agreement approved by BlueCross, (B) any such disclosure shall be subject to the requirements of applicable laws and regulations and their implementing guidance, the policies and procedures of the Association, this Agreement, and such fully-executed information sharing agreement, and (C) the Parties acknowledge and agree that, notwithstanding the foregoing, BlueCross is under no obligation to release BlueCross Confidential Information at any time. Any information sharing agreement adopted pursuant to this section shall include:

2.2.2.1. Written authorization by Employer to release the Confidential Information to the Employer Service Vendor;

2.2.2.2. A statement that the Employer Service Vendor must have such information in order to perform their job as it relates to the administration of the Plan;

2.2.2.3. Protections for the Confidential Information;

2.2.2.4. Prohibitions against use of the data to obtain trade secrets, confidential business information, personally identifiable information, or otherwise use in a competitive manner against BlueCross or other licensees of the

Association;

2.2.2.5. A statement by the Employer and Employer Service Vendor that the disclosure of the Confidential Information is limited to the minimum necessary to fulfill the purpose for which it will be disclosed;

2.2.2.6. A detailed description of the intended use (and any impermissible uses) of the Confidential Information;

2.2.2.7. A statement that the Confidential Information will not be resold or otherwise commercialized by Employer Service Vendor or any other person;

2.2.2.8. The right for BlueCross to confirm, through an audit, that the Confidential Information is not being used or disclosed in an impermissible manner; and

2.2.2.9. A statement that the Confidential Information will be returned or securely destroyed by the Employer Service Vendor when it is no longer needed for the purpose for which it was disclosed;

2.2.2.10. A statement that the Employer Service Vendor will notify BlueCross when the Employer Service Vendor's ownership changes;

2.2.2.11. A statement that the Employer Service Vendor will defend or settle and/or hold harmless and indemnify BlueCross, as well as it officers, agents and employees, from all claims, losses, or suits resulting from the Employer Service Vendor's breach of the information sharing agreement or its unauthorized use or disclosure of Confidential Information;

2.2.2.12. A statement that the Employer Service Vendor will comply with all laws, rules and regulations applicable to the sharing of information that includes Confidential Information contemplated under the information sharing agreement and that failure to comply with such laws shall be considered a material breach of such agreement;

2.2.2.13. Any other requirement BlueCross deems necessary based on the intended use of the Confidential Information.

2.2.3. Right of Refusal. BlueCross reserves the right to refuse to release: (A) Confidential Information if BlueCross determines, in its sole discretion, that such release has the potential to damage BlueCross, including its reputation or competitive position in the market, or (B) any information BlueCross reasonably believes it cannot divulge due to applicable state or federal laws, Association provisions, applicable privileges or judicial or administrative orders. In no instance shall Employer itself, nor shall Employer allow a third party to, use or disclose BlueCross's Confidential Information: (A) to be aggregated with information of other third parties; (B) for the commercial purposes of any person; or (C) to compete directly or indirectly against BlueCross.

2.3. Rights in Data. The Parties agree that BlueCross owns claim or payment data recorded for or otherwise integrated into BlueCross's data, BlueCross claims processing or other systems, or BlueCross Confidential Information.

2.4. Legally Compelled. Employer may disclose Confidential Information if legally compelled by a valid judicial or administrative order; provided however, that Employer shall make every attempt to keep BlueCross's Confidential Information confidential, shall only disclose the minimum information necessary to comply with the order, shall provide written notice to BlueCross immediately upon making the determination that BlueCross's Confidential Information must be disclosed and shall only disclose the information after BlueCross has been notified and has the opportunity to consent to or challenge such disclosure.

2.5. Protected Health Information. The Parties have entered into a Business Associate Agreement, the terms of which control the use and disclosure of Protected Health Information, as defined by HIPAA.

2.6. Survival. This Article 2 shall survive termination of the Agreement.

ARTICLE III – TERM AND TERMINATION

3.1. Term. This Agreement becomes effective at 12:01 A.M. Eastern Time on July 1, 2023 (the "Effective Date") and shall remain in effect until the earliest of the following events:

3.1.1. Until June 30, 2024, unless Employer and BlueCross agree in a writing executed by both Parties to extend the term prior to June 30, 2024;

3.1.2. After the Initial Term of the Agreement, either Party may terminate the Agreement by giving the other Party no less than sixty (60) days advance written notice of the terminating Party's intent to terminate the Agreement as of the date specified in such notice.

3.1.3. Any other date mutually agreed upon by the Parties; or

3.1.4. Any of the events specified in Section 3.2.

3.2. Termination by BlueCross. Notwithstanding the provisions of Section 3.1 above, this Agreement shall terminate upon the occurrence of any of the following events, as determined by BlueCross, such termination to be effective as of the date identified by BlueCross in its notice of termination to the Employer:

3.2.1. Employer's failure to timely provide adequate funds, as set forth in Exhibit B, as necessary for the payment of Approved Claims;

3.2.2. Employer's failure to pay any ASFs, late payment penalty or other amounts as set forth in Exhibit B, or otherwise due to BlueCross under this Agreement;

3.2.3. Employer ceases to maintain the Plan;

3.2.4. At any time BlueCross reasonably believes that Employer does not have the financial ability to adequately and timely fund claims, and Employer has failed to immediately provide adequate assurances of such ability to BlueCross; or

3.2.5. At any time Employer fails to comply with applicable law or otherwise materially breaches this Agreement, after the procedures in Section 3.7 have been followed.

3.3. Termination for Invalid Use of Information. If Employer uses or discloses BlueCross's Confidential Information in any manner not authorized by this Agreement, such disclosure shall constitute a material breach that is not subject to cure or correction, and BlueCross may terminate the Agreement immediately pursuant to Section 3.7.

3.4. BlueCross's Right to Reinstate. BlueCross has the sole discretion to decide whether to reinstate this Agreement if it was terminated pursuant to Subsections 3.2 or 3.3. If BlueCross elects to reinstate this Agreement, Employer shall pay any amounts due and owing under the Agreement prior to its termination plus a reinstatement fee, which shall be $1,000.00.

3.5. Termination by Employer. Notwithstanding the provisions of Section 3.1 above, Employer may terminate this Agreement immediately if the following occurs:

3.5.1. BlueCross has been declared insolvent by the State of Tennessee, and its assets and obligations have been turned over to a receiver appointed by the State; or

3.5.2. BlueCross materially breaches its duties under this Agreement, and such breach is not subject to cure or correction, after the procedures in Section 3.7 have been followed.

3.6. Material Breach. A material breach is the failure by one Party (the "Breaching Party") to perform or carry out a material function or duty required by the terms of this Agreement, where the failure to perform that function or duty seriously impairs the ability to perform of the other Party (the "Non-breaching Party"). If the Non-breaching Party determines that a material breach has occurred, it must notify the Breaching Party in writing of the breach as soon as practicable, and must allow the Breaching Party no less than thirty (30) days to cure or correct the breach if the Parties determine that the breach is able to be cured or corrected. If the breach is not cured or corrected in such cure period, the Non-breaching Party may terminate the Agreement upon no less than thirty (30) days' notice of termination, the effective date of the termination being specified in such notice. If the Non-breaching Party determines that the breach is not capable of being cured or corrected, the Non-breaching Party may immediately terminate the Agreement upon notice to the Breaching Party, effective as of the date set forth in such notice. If either Party disputes a claimed material breach or that a material breach has been cured or corrected, such Party may immediately request dispute resolution, pursuant to the terms of Article IV of this Agreement.

3.7. Effect of Termination. The terms and conditions set forth herein shall be of no further force or effect upon termination of the Agreement, except as follows:

3.7.1. The Parties' rights and obligations intended to survive termination of this Agreement shall continue in effect notwithstanding its termination.

3.7.2. Termination of this Agreement, except as provided to the contrary herein, shall not affect the rights, obligations and liabilities of the Parties arising prior to termination.

3.7.3. The termination of this Agreement does not excuse Employer from paying to BlueCross any and all fees, amounts, reimbursements or claim payments accrued through the date of termination. If termination occurs retroactively, any and all fees, amounts, reimbursements or funding of Approved Claims accrued through the date of termination of the Agreement, including any Run-Out Period, shall be payable to BlueCross by Employer.

3.8. Administration After Termination. Employer and BlueCross may agree on a method by which BlueCross will process Run-Out Claims. The administration of the processing of Run-Out Claims by BlueCross following termination of this Agreement will be subject to Employer's continued timely and sufficient funding of claims payments. There is a separate and distinct administrative fee for BlueCross providing administrative services to pay Run Out Claims, which is set forth in Exhibit B.

3.9. Final Settlement. Any services performed by BlueCross on Employer's behalf after termination of the Agreement will cease no later than 18 months after termination of this Agreement ("Process Conclusion Date"). BlueCross will then complete a final calculation that reconciles any and all claims payments, fund transfers, recoveries received, and other monies potentially due under the Agreement to determine the amount necessary to finalize both Parties' obligations under this Agreement. BlueCross will send Employer an agreement memorializing the final obligations of the Parties under the Agreement (hereinafter, the "Final Settlement Agreement") no later than two years after termination of this Agreement. Employer will have thirty (30) days from the date of the letter attached to the Final Settlement Agreement to dispute any of the calculations in the Final Settlement Agreement. If Employer has not disputed the Final Settlement Agreement, or returned a signed Final Settlement Agreement to BlueCross within the provided time period, Employer shall be deemed to have approved and executed the Final Settlement Agreement and BlueCross reserves the right to reduce the Final Settlement Amount to take into account the final amount due BlueCross under the Agreement. Any amounts recovered beyond the Final Settlement shall be retained by BlueCross as reasonable compensation for Services under this Agreement.

ARTICLE IV – DISPUTE RESOLUTION

4.1. Non-binding Arbitration. Any dispute related to this Agreement, which the Parties are unable to resolve through informal discussion within sixty (60) days of the date a Party notifies the other Party in writing of any such dispute, claim, or controversy, shall be resolved through non-binding arbitration or some other mutually acceptable dispute resolution procedure (e.g., mediation). The American Arbitration Association shall conduct such arbitration or mediation, unless the Parties mutually agree in writing upon some other dispute resolution agency or venue.

4.2. Award. A single arbitrator shall be required to issue a written decision explaining the basis of the decision and the manner of calculating any award. The arbitrator may not award any damages excluded under Section 5.3 and must make its decision in accordance with the terms of this Agreement and applicable laws. The arbitrator's decision may be entered and enforced in any State or Federal court. Should the Parties agree, the award of the arbitrator shall be final and shall not be subject to appeal to any other authority. The

arbitrator's decision may only be vacated, modified or corrected for the reasons set forth in section 10 or 11 of the United States Arbitration Act, if the award contains material errors of law or is arbitrary and capricious.

ARTICLE V – LIABILITY AND INDEMNIFICATION

5.1. BlueCross Indemnification to Employer.

5.1.1. BlueCross neither insures nor underwrites any of Employer's obligations or liabilities under the Plan and shall have no obligations to Employer related thereto. BlueCross is responsible solely for its acts and for the acts of its subcontractors and employees acting within the scope of their duties under this Agreement. BlueCross is not responsible for any acts or omissions of Employer or its agents or any third parties associated with or contracted by Employer.

5.1.2. BlueCross shall indemnify, defend and hold harmless Employer, its directors, officers and employees against any and all third party Losses arising out of or in connection with BlueCross's gross negligence or willful misconduct in the performance of its obligations under the Agreement, provided, however, that BlueCross shall have no obligation to indemnify and hold harmless under this section if the cause of such Losses was the result of (i) the fault, criminal conduct or fraudulent acts of Employer or any of its directors, officers, employees or agents; (ii) direction given by Employer or its directors, officers, employees or agents in the design or administration of the Plan; (iii) Employer's breach of its fiduciary duties; (iv) Employer's violation of laws; or (v) Employer's infringement of the intellectual property rights of a third party.

5.1.3. BlueCross's liability to Employer pursuant to this Agreement shall be limited to the value of the ASFs received by BlueCross under the Agreement prior to the occurrence of the act, action, or failure to act that forms the basis of BlueCross's liability.

5.1.4. Notwithstanding the foregoing, BlueCross's duty to indemnify for Losses and hold Employer harmless pursuant to Subsection 5.1.2 shall not extend to Losses arising out of or in connection with acts or omissions of any non-employee Network Providers that provide services to Members.

5.2. Employer Indemnification of BlueCross.

5.2.1. Employer shall indemnify and hold harmless BlueCross, its directors, officers, employees and agents against any and all Losses arising out of, or in connection with, any of Employer's actions or decisions relating to the design, administration or funding of the Plan. Further, Employer shall indemnify and hold harmless BlueCross, its directors, officers, employees and agents, for any and all Losses arising out of, or in connection with, Employer's (i) failure to provide information or notices required under this Agreement or otherwise required by law; (ii) breach of fiduciary duties under ERISA; (iii) failure to comply with COBRA, including lawsuits, IRS fines, or claims, that result from incorrect premium collection or eligibility information supplied to BlueCross; (iv) use or disclosure of Confidential Information, including unauthorized use or disclosure of BlueCross Confidential information or disclosures made by BlueCross at Employer's direction to an

Employer Services Vendor or other third party; (v) failure to comply with applicable law; (vi) liability for any Taxes or Penalties, as specified in Exhibit E to this Agreement; and (vii) infringement of any third party's intellectual property rights. Employer. Employer is responsible for making eligibility and benefit determinations in connection with the Plan, timely funding and paying all fees and claims for covered services and paying any other expenses related to or arising in connection with the Plan. The Parties acknowledge that a governmental entity, as the same is defined in the Tennessee Code Annotated Section 29-20-102, may be protected by the limitation of liability imposed by the Tennessee Governmental Tort Liability Act, as defined in Tennessee Code Annotated Section 29-20-101 et seq.

5.2.2. To the extent Employer directs BlueCross to administer prescription drug benefits with a traditional pricing model, Employer shall indemnify and hold BlueCross harmless to the greatest extent permitted under law for any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, expenses, fines and taxes, including but not limited to legal fees and expenses, resulting from or arising out of or in connection Employer's direction to adopt traditional PBM pricing and BlueCross's administration of traditional PBM pricing. The foregoing indemnification and hold harmless obligation shall be in addition to, and not in lieu of, any other indemnification provided by Employer to BlueCross under the Agreement and without regard to any limitation of liability under this Agreement. Further, Employer understands, agrees and acknowledges that (i) BlueCross may decline to provide services in connection with the traditional PBM pricing at any time upon notice to Employer; and (ii) BlueCross assumes no liability for any action taken pursuant to the Employer's direction, the traditional PBM pricing, or the Agreement.

5.3. Limitation on Liability. In no event will the measure of Losses payable by either Party to the other include, nor will either Party be liable to the other for, any consequential, indirect, incidental, exemplary, special or punitive damages (including damages due to business interruption, trading losses, competitive advantage or goodwill) arising from or related to this Agreement, whether or not foreseeable, and regardless of the cause of such damages even if the Party has been advised of the possibility of such damages in advance.

5.4. Legal Actions.

5.4.1. Legal Actions Brought Against BlueCross. If a third party claim is asserted against BlueCross that is based upon actions taken or the language of this Agreement, and litigation, arbitration and/or other legal proceeding is commenced against BlueCross by a Member or provider ("Action"):

5.4.1.1. BlueCross will provide written notice to Employer as soon as practicable, but in no event more than one hundred twenty (120) days after the initial notice of such Action was received by BlueCross, where Employer is not also a party to such Action. Additionally, BlueCross will provide Employer with information with respect to the status of such Action at reasonable intervals. BlueCross may select and retain counsel as it deems appropriate in connection with such Action with respect to the interests of BlueCross.

5.4.1.2. Employer will provide BlueCross with reasonable cooperation in the defense of such Action.

5.4.1.3. Subject to the indemnity provisions of the Agreement, Employer shall remain liable for the full amount of any benefits paid as a result of such Action, in addition to all costs of legal fees, penalties, interest and other expenses recovered by a Member or provider in connection with the Action. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider as a result of any Action, or any legal fees or costs recovered by a Member or provider in connection therewith.

5.4.2. Legal Actions Brought Against Employer. If an Action is brought against Employer:

5.4.2.1. Employer will select and retain counsel and will assume liability for the payment of legal fees, costs and disbursements in connection with such Action.

5.4.2.2. BlueCross will provide Employer with reasonable cooperation in the defense of such Action.

5.4.2.3. Subject to the indemnity provisions of the Agreement, Employer shall be liable for the full amount of any benefits Losses paid as a result of such Action, as well as any legal fees, penalties, interest and costs recovered by a Member or provider in connection therewith. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider as a result of such Action, or any legal fees or costs recovered by a Member or provider in connection therewith.

ARTICLE VI – MISCELLANEOUS PROVISIONS

6.1. Acceptance by Payment of Fees. BlueCross expects that Employer will demonstrate its acceptance of the terms of this Agreement by signing below. In the event that Employer has not signed the Agreement by the Effective Date, this Agreement will be considered accepted by and binding upon both parties if and when Employer makes a payment to BlueCross in order to receive the services described in this Agreement.

6.2. Amendment. This Agreement may be modified, amended, renewed or extended only upon mutual agreement, in writing, signed by the duly authorized officers of Employer and BlueCross.

6.3. Assignment. This Agreement may be assigned to a subsidiary or affiliate of Employer upon ninety (90) days prior written notice to, and with the express written consent of, BlueCross. BlueCross shall not unreasonably withhold its consent to any such assignment by Employer.

6.4. Binding Effect of Agreement. The Agreement shall be binding upon and inure to the benefit of the Parties, their agents, officers, directors, employees, successors, and assigns unless otherwise set forth herein or agreed to by the Parties hereto.

6.5. Impossibility of Performance. If an act or omission by a third party, including governmental entities, Network Providers or vendors, renders the performance of this Agreement illegal, impossible or impractical, the affected Party shall notify the other of the nature of that act or omission (the "Adverse Event.") The Parties shall meet and, in good faith, attempt to negotiate a modification to this Agreement that minimizes the Adverse Event. Notwithstanding any other provision of this Agreement, if the Parties fail to reach a negotiated modification concerning the Adverse Event, then the affected Party may immediately terminate this Agreement upon giving written notice to the other Party.

6.6. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and such counterparts shall constitute one and the same instrument.

6.7. Entire Agreement. This Agreement, including the exhibits and any attachments hereto, all of which are incorporated herein by reference, contains the entire agreement between BlueCross and Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to

the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect. The exhibits and attachments to this Agreement include the following:

6.7.1. Exhibit A – Benefit Documents

6.7.2. Exhibit B – Administrative Services Fees

6.7.3. Exhibit C – Duties of and Services Provided by BlueCross

6.7.4. Exhibit D – Medical Management Services Provided by BlueCross

6.7.5. Exhibit E – Duties of Employer

6.7.6. Exhibit F – Automated Clearinghouse (ACH) Authorization Agreement

6.7.7. Exhibit G – Inter-Plan Arrangements

6.7.8. Exhibit H – COBRA Administration Agreement

6.7.9. Exhibit I – Health and Wellness Services

6.7.10. Exhibit J – Reserved

6.7.11. Exhibit K – Reserved

6.7.12. Exhibit L – Reserved

6.7.13. Exhibit M – Online Enrollment Specifications through BlueCross Secured Website

6.7.14. Exhibit N – Grievance Services

6.7.15. Exhibit O – Savings Guarantee

6.7.16. Exhibit P – Pharmacy Services

6.7.17. Exhibit Q – Reserved

6.7.18. Exhibit R – Reserved

6.7.19. Exhibit S – Audits, Records Access & Confidentiality

6.7.20. Exhibit T – Reserved

6.7.21. Exhibit U – Reserved

6.7.22. Exhibit V – Reserved

6.7.23. Exhibit W – Shared Savings

6.7.24. Exhibit X – Addendum

6.8. Governing Law. This Agreement is subject to and shall be governed by the laws of the United States and State of Tennessee, without regard to conflict of laws provisions.

6.9. Interpretation.

6.9.1. If the provisions of this Agreement are in any way inconsistent with the provisions of the Benefit Documents, then the provisions of this Agreement shall prevail and the other provisions shall be deemed modified to the extent necessary to give effect to such provisions.

6.9.2. If the provisions of this Agreement are in any way inconsistent with the provisions of the Exhibits and Attachments hereto, then the provisions of Exhibits and Attachments shall prevail and the inconsistent provisions of this Agreement shall be deemed modified to the extent necessary to give effect to such provisions.

6.9.3. For purposes of this Agreement, the words “include,” “includes” and “including” shall be deemed to be followed by the words “without limitation”, and the word “or” shall not be exclusive.

6.10. Independent Entities.

6.10.1. This Agreement is not intended to create nor deemed or construed to create any relationship between Employer and BlueCross other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither the Parties nor their respective directors, officers, employees or representatives shall be construed to be the partner, joint venturer, agent, employer, or representatives of the other Party.

6.10.2. On behalf of itself and its participants, Employer hereby acknowledges its understanding that this Agreement constitutes a contract solely between Employer and BlueCross which is an independent corporation operating under a license from the Association permitting BlueCross to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that BlueCross is not contracting as the agent of the Association.

6.10.3. Employer acknowledges that BlueCross is independent from any provider rendering services to Members, and that BlueCross is not responsible for any acts or omissions by a provider in rendering care or services to a Member.

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

6.11. Legal Action. All actions are subject to Article IV, Dispute Resolution.

6.12. Notices. Any notice, request, demand or other communication required to be given pursuant to this Agreement shall be in writing, sent by certified or registered mail, return

receipt requested, or by Federal Express or other overnight mail delivery for which evidence of delivery is obtained by the sender, to BlueCross or Employer at the addresses set forth below. The notice shall be effective on the date the notice was posted.

If to BCBST:
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Attn: Vice President Sales & Account Management

With a copy not constituting notice to:
BlueCross BlueShield of Tennessee, Inc.
One Cameron Hill Circle
Chattanooga, TN 37402
Attn: Senior Vice President and General Counsel

If to Employer:
City of Franklin
109 3rd Avenue South
Franklin, TN 37064

6.13. No Third Party Rights. Except as specifically provided herein, none of the provisions of this Agreement is intended to create third party rights or status in any person or entity.

6.14. Reserved.

6.15. Severability. If any provision of this Agreement is declared illegal, void or unenforceable, the remaining provisions shall remain in force and effect, unless the severance of that provision substantially deprives a Party of the benefit of its bargain or increases the cost of performing its duties pursuant to this Agreement.

6.16. Subsidiaries and Affiliates. Any of the functions to be performed by BlueCross under this Agreement may be performed by BlueCross or any of its subsidiaries, affiliates or designees.

6.17. Survival. The rights and obligations of the Parties as set forth herein shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the Parties as expressed herein.

6.18. Waiver of Breach. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

6.19. Other Acceptable Forms of this Document. The following shall have the same legal effect as an original: facsimile copy, imaged copy, scanned copy, and/or an electronic version.

ARTICLE VII - DEFINITIONS

7.1. "Action" means litigation, arbitration and/or other legal proceeding commenced against BlueCross by a Member or provider.

7.2. "Agreement" means this administrative services agreement entered into by Employer and BlueCross, including all Exhibits and Attachments hereto.

7.3. "Approved Claims" means claims processed and approved for payment by BlueCross in accordance with this Agreement.

7.4. "ASF(s)" means Administrative Services Fee(s).

7.5. "Association" means the BlueCross and BlueShield Association.

7.6. "Benefits Documents" means the benefit documents, which summarize the benefits of the Employer's Plan and are attached hereto as Exhibit A.

7.7. "BlueCross" means BlueCross and BlueShield of Tennessee, Inc.

7.8. "BlueCross Confidential Information" means Confidential Information that BlueCross discloses or authorizes be disclosed to Employer, including BlueCross pricing and payment data and information, such as payment rates, allowed amounts, fee schedules, discounts and payment methodologies; claims data (whether at claim level or aggregated), data and information regarding providers, BlueCross research and technical information; BlueCross's processes, procedures or policies, and information obtained from and/or about the Association and its programs.

7.9. "Confidential Information" means all information or material (whether tangible or intangible) that is shared with or disclosed to the other Party pursuant to this Agreement and the Parties' relationship, including information identified as proprietary and/or confidential information, information that is confidential as a matter of law (e.g., personnel records), and BlueCross Confidential Information disclosed to Employer. The following shall not constitute Confidential Information for purposes of this Agreement: (a) Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a Party or its Representatives; (b) Confidential Information that was available to a Party on a non-confidential basis prior to its disclosure by the other Party or its Representatives; (c) Confidential Information that becomes available to a Party on a non-confidential basis from a third party (other than BlueCross's affiliates, subsidiaries or vendors or the Association or other licensee of the Association), provided that third party is not known to be subject to any prohibition against transmitting that information; (d) information that was independently developed by a Party without an use of or reference to the Confidential Information of the other Party, as shown by documents and other competent evidence, or (e) Protected Health Information.

7.10. "Effective Date" means July 1, 2023.

7.11. "Employee Welfare Benefit Plan" shall have the same meaning as defined in ERISA.

7.12. "Employer" means City of Franklin.

7.13. "Employer Service Vendor" means any person providing services to or on behalf of Employer in connection with its obligations to the Plan or under the Agreement.

7.14. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

7.15. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations, as amended.

7.16. "Initial Term" means July 1, 2022 through June 30, 2023.

7.17. "Losses" means any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties and expenses, including legal costs and expenses.

7.18. "Member" means an eligible Employee or eligible Dependent and as that term is further defined in the Benefit Documents.

7.19. "Plan" means the self-funded Employee Welfare Benefit Plan established by Employer for the benefit of its eligible Employees and their eligible Dependents.

7.20. "Plan Administrator" means the Employer.

7.21. "Representatives" means a Party's directors, officers, employees, agents, advisors, Business Associates (as such term is defined in HIPAA), contractors and other representatives.

7.22. "Run- Out Claims" means those claims incurred for Covered Services performed prior to the termination of this Agreement, but not yet paid and/or not submitted for payment to BlueCross prior to the termination of this Agreement, where the date a claim is "incurred" is the date the particular service was rendered or the supply was furnished

7.23. "Subscriber" means an Eligible Employee enrolled in Employer's Plan.

7.24. "Term" means July 1, 2023 through June 30, 2024.

7.25. All non-defined, but capitalized terms included in this Agreement are defined in the Benefit Documents.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives. The undersigned persons hereby warrant that they are duly authorized to bind each of their represented Parties to the terms of this Agreement.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.		**CITY OF FRANKLIN**	
By:	DocuSigned by: Robin Young BFBEEA0C880F4B2...	By:	DocuSigned by: Eric Stuckey CD3688F4049D49E...
Print Name:	Robin Young	Print Name:	Eric Stuckey
Title:	SVP & CMO	Title:	City Administrator
Date:	7/5/2023	Date:	7/19/2023
Address:	1 Cameron Hill Circle	Address:	109 3rd Avenue South
	Chattanooga, TN 37402		Franklin, TN 37064
		Employer ID No.	62-6000290

EXHIBIT A TO THE ADMINISTRATIVE SERVICES AGREEMENT

BENEFIT DOCUMENTS

Exhibit A consists of the following Benefit Documents

One (1) Medical EOC

One (1) Vision EOC

EXHIBIT B TO THE ADMINISTRATIVE SERVICES AGREEMENT

ADMINISTRATIVE SERVICES FEES (ASFS) AND CLAIMS FUNDING METHODOLOGY

1. ASFs. Employer shall pay to BlueCross the following ASFs:

1.1. Medical ASF

Rates effective as of:	July 1, 2022	August 1, 2022 – September 30, 2022[1]	October 1, 2022	July 1, 2023	July 1, 2024	July 1, 2025	July 1, 2026
Medical ASF	$43.16 per Subscriber per month	$0.00 per Subscriber per month	$43.16 per Subscriber per month	$44.02 per Subscriber per month	$44.90 per Subscriber per month	$45.80 per Subscriber per month	$46.72 per Subscriber per month
Medical Main ASF	**$43.16 per Subscriber per month**	**$0.00 per Subscriber per month**	**$43.16 per Subscriber per month**	**$44.02 per Subscriber per month**	**$44.90 per Subscriber per month**	**$45.80 per Subscriber per month**	**$46.72 per Subscriber per month**
COBRA - Std w/INL and 1 OSV	$0.83 per Subscriber per month	$0.83 per Subscriber per month	$0.83 per Subscriber per month	$0.85 per Subscriber per month	$0.87 per Subscriber per month	$0.89 per Subscriber per month	$0.91 per Subscriber per month
Musculoskeletal Program	$0.90 per Subscriber per month	$0.90 per Subscriber per month	$0.90 per Subscriber per month	$0.92 per Subscriber per month	$0.94 per Subscriber per month	$0.96 per Subscriber per month	$0.98 per Subscriber per month
PhysicianNow (replaced with Teladoc effective July 1, 2023)	$0.46 per Subscriber per month	$0.46 per Subscriber per month	$0.46 per Subscriber per month	$0.47 per Subscriber per month	$0.48 per Subscriber per month	$0.49 per Subscriber per month	$0.50 per Subscriber per month
Medical Guaranteed ASF	**$45.35 per Subscriber per month**	**$2.19 per Subscriber per month**	**$45.35 per Subscriber per month**	**$46.26 per Subscriber per month**	**$47.19 per Subscriber per month**	**$48.14 per Subscriber per month**	**$49.11 per Subscriber per month**
Medical Total ASF	**$45.35 per Subscriber per month**	**$2.19 per Subscriber per month**	**$45.35 per Subscriber per month**	**$46.26 per Subscriber per month**	**$47.19 per Subscriber per month**	**$48.14 per Subscriber per month**	**$49.11 per Subscriber per month**

[1] BlueCross will provide a 2 month Fee Holiday of the Main Administrative Services Fee illustrated above, excluding additional services and broker commissions. Broker commissions will be billed monthly during the Fee Holiday period, along with any applicable additional services purchased. The Fee Holiday will be applied as follows: 2 month(s) in Year 1. Additional fees not indicated above, such as HRA administration, HSA administration, and Stop Loss Interface Fees are not included in the Fee Holiday. The Fee Holiday is contingent upon both medical and pharmacy, on the RX04 network, being administered by BlueCross through 6/30/27 of the multi-year agreement. If pharmacy is carved out prior to 6/30/27 of the multi-year fee guarantee, the Fee Holiday must be repaid. If medical is terminated prior to 6/30/27 of the multi-year fee guarantee, the Fee Holiday must be repaid.

1.1.1. The financial offer above is contingent upon both medical and pharmacy being administered by BlueCross for the duration of the multi-year agreement.

1.1.2. BlueCross may adjust the above fees at any time, under the following circumstances:

1.1.2.1. Changes in the Plan, BlueCross's duties, legislation, regulation or required assessment or tax that changes BlueCross' cost in administering the plan;

1.1.2.2. Termination or addition of a subsidiary, operation or class of employees covered under the Agreement;

1.1.2.3. Fluctuation of the number of Subscribers by more than 10%

percent by location, state and/or in aggregate. Calculation of the Medical Total ASF was based on 709 Subscribers; or

1.1.2.4. Fluctuation of the Member to Subscriber ratio by +/- 0.05. The Medical Total ASF was based on a Member to Subscriber ratio of 2.52.

1.1.2.5. Federal, state, or local government action, change in law or regulation (or interpretation of a law or regulation) which impacts the benefit levels or affects BlueCross' ability to meet its obligations under this Agreement to Employer, to Employer's Covered Members or to BlueCross' Network Providers, including but not limited to, legislation, regulation(s) or government action(s) which impose requirements that affect: (i) BlueCross' ability to determine or administer Covered Services; (ii) providers' delivery of care or the fees providers charge; or (iii) BlueCross' contracts with Network Providers. Upon the occurrence of an event described in this Section 1.1.2.5, the Parties will make a good faith effort to reach a new agreement that equitably reflects the circumstances as altered by such law, regulation or government action.

1.2. Allowance

Type of Allowance Fund	**July 1, 2022 – June 30, 2027**
Wellness	$25,000
BlueCross shall provide an allowance to Employer to fund Plan-related expenses ("Allowance"). Such Allowance can be used, during the period for which Allowance is provided, as specified by BlueCross, for BlueCross products or services, or products or services purchased by Employer from a third-party related to BlueCross administered benefit programs. If Employer purchases services from a third party, Employer must provide BlueCross receipts from such third party in order for the Allowance to be applied toward such expenses. Consultant fees are not eligible for reimbursement with the Allowance. All requests for reimbursement shall be made within sixty (60) days of the end of the period, as specified by BlueCross. Any unused Allowance shall be forfeited. Notwithstanding the foregoing, the allowance above is contingent upon both medical and pharmacy being administered by BlueCross for the duration of the multi-year agreement.	

1.3. Vision ASF

Rates effective as of:	**July 1, 2023**
Vision ASF	$0.75 per Vision Subscriber per month

2. Inter-Plan Arrangements (BlueCard) Fees[1]. When Members access health care services

outside of Tennessee, claims for those services are received by the licensee of the Association where the provider is located (the "Host Plan") and forwarded electronically to BlueCross for adjudication. For claims from providers that participate in the Host Plan's provider network, the Member and Plan get the benefit of access to the terms and conditions of the Host Plan's contracted arrangement with the provider, including pricing arrangements. The currently applicable fees for such access to Host Plan's networks and arrangements (including administrative processing) are as follows:

Access Fees	The Access Fee is charged by the Host Plan to BlueCross for making the Host Plan's network available to Employer's Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential BlueCross receives from the applicable Host Plan subject to a maximum of $2,000 per claim. When charged, BlueCross passes the Access Fee directly on to Employer.	3.62% of network savings, capped at $2,000.00 per claim Effective January 1, 2024: 3.46% of network savings capped at $2,000.00 per claim
Administrative Expense Allowance (AEA) Fee	The AEA Fee is a fixed per-claim dollar amount charged by the Host Plan to BlueCross for administrative services the Host Plan provides in processing claims for Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, BlueCross passes the AEA Fee directly on to Employer.	$5.00 per claim professional and $11.00 per claim institutional
Nonparticipating Provider Fee		$3.00 per claim
BlueCross BlueShield Global® Core Fee		$4.35 per claim Member-submitted, $5.50 per claim professional, and $18.55 per claim institutional

[1] See Exhibit G for more detail about Inter-Plan Arrangements. Any fees under such arrangements are set by specific program policies that may change from time to time through a process that the Association administers, and are subject to change by the Association without notice.

3. Reports. BlueCross shall provide Employer with access to BlueCross's standard reporting and interactive reports at no additional charge. Any additional reports requested by Employer shall be subject to an additional charge determined by BlueCross, such charge which will be billed separately. Upon termination of this Agreement, Employer shall pay BlueCross for any and all requested reports, such payment being made in advance of

receiving the requested report.

4. Timing, Calculation and Funding of Monthly ASFs. Employer shall pay the applicable ASFs for all Subscribers covered or added during the month. If Employer adds a Subscriber retroactively, Employer shall pay the applicable ASFs for that Subscriber, calculated from the Subscriber's correct enrollment date to the current date. When Employer provides enrollment data and that data does not match BlueCross's data, BlueCross's data will be used to determine the ASF. BlueCross will work with Employer to resolve the discrepancy. If no agreement can be reached, BlueCross's records will control. Until the dispute is resolved, Employer must pay the ASFs based on BlueCross's records.

4.1. Monthly Enrollment. The monthly ASF is determined each month based on enrollment. On the 15th day of each month, Employer shall determine the number of Subscribers covered under Employer's Plan, and this shall be the basis for the ASFs charged by BlueCross for the following month.

4.1.1. Enrollment Changes. Any changes to the initial enrollment will be charged to Employer in accordance with the following:

4.1.1.1. Subscriber added on or before the 15th day of the month: Employer will be charged the monthly ASFs for that Subscriber.

4.1.1.2. Subscriber added after the 15th day of the month: Employer will not be charged the monthly ASFs for that Subscriber.

4.1.1.3. Subscriber termed on or after the 15th day of the month: Employer will be charged the monthly ASFs for that Subscriber.

4.1.1.4. Subscriber termed before the 15th day of the month: Employer will not be charged the monthly ASFs for that Subscriber.

4.2. Funding of ASFs and Adjustments. On the 20th day of each month, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to pay BlueCross's ASFs for the following calendar month, and funds necessary to complete any adjustments to Approved Claims, fixed, previously agreed-upon charges, previous ASFs and any due late fees. Such payments shall be made in accordance with the Direct Debit Authorization Agreement, which is an Automated Clearinghouse (ACH) Authorization Agreement, attached to this Agreement as Exhibit F. Employer will transfer the amount specified by BlueCross into Employer's account so such funds shall be available for ACH debit by the first day of the following month (the "Due Date").

4.2.1. If the full amount specified by BlueCross pursuant to this paragraph is not received by BlueCross by the Due Date, BlueCross may immediately suspend payment of all Approved Claims on behalf of Employer, regardless of the date claims were incurred, until all amounts due and owing are received by BlueCross. If BlueCross elects to not suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding. Notwithstanding the foregoing, BlueCross does not otherwise waive any termination rights it has under the Agreement by electing to suspend payment of Approved Claims.

4.2.2. If Employer notifies BlueCross of a Member's termination within ninety (90)

days of the Member's termination, BlueCross will credit Employer with any ASFs that were paid for that Member for that time period.

4.2.3. If Employer does not notify BlueCross of a Member's termination within ninety (90) days of the Member's termination, BlueCross will only credit Employer for the most recent ninety (90) day period of ASFs that were paid by Employer for that Member's coverage.

5. Additional Administration Charges. The cost of services outlined below may be billed as a direct cost to Employer.

5.1. Creation, production, and printing non-standard Member material.

5.2. Investigation and litigation of disputed claims, including the amount of the settlement and any damages (including punitive damages, unless subject to indemnification pursuant to Article V of the Agreement).

5.3. Development and production of customized or unique reports requested by Employer, such as management reports, claim reports, reports for stop loss carriers, and other special reports.

5.4. Customized or unique systems development required by Employer.

5.5. Reprinting materials/ID cards off cycle due to changes or misinformation provided by or on behalf of Employer to BlueCross.

5.6. Non-standardized Member mailings.

5.7. Training for on-line eligibility in excess of standard training package.

5.8. Diabetes Prevention Program (DPP) enrollment is on a participation -specific basis, with fees assessed for the first 6 months of participation and on a monthly basis thereafter*. Employer shall be responsible for any reporting, withholding and taxes associated with all applicable services.

Diabetes Prevention Program (DPP) Fees

Fee	Per Participant Charge	Description
Monthly Participation (Months 1-12)	$60 Per Participant Per Month	The monthly charge for months 1-12 includes set-up and implementation, Member registration, welcome kit containing a cellular-enabled scale, diabetes prevention program coaching and education. Member access to 24/7 on call support, mobile app and web portal and personal challenges.
Monthly Participation (Months 13-24)	$30 Per Participant Per Month	The monthly charge for months 13-24 includes continued access to the program's functionality that was available in months 1-12.

Replacement Device	$150 per replacement	Lost or damaged cellular-enabled scale replacements are the responsibility of the Employer.

*Each Participant has an initial minimum enrollment term of six (6) consecutive months. After the 6-month requirement has been fulfilled, participation will be evaluated monthly and charges for the services will continue monthly or until the Participant has discontinued Active participation for a consecutive six (6) month period.

"Active" participation means a Participant is engaging in one or more of the following activities: live coaching sessions, digital coaching sessions, communication exchange between a Livongo coach and Participant related to diabetes prevention, mobile app usage, Participant support call, shared data with care team, weigh-ins, food logging, or portal logins.

5.9. Diabetes Management Program (DMP) enrollment is on a participation-specific basis, with fees assessed for the first 6 months of participation and on a monthly basis thereafter*. Employer shall be responsible for any reporting, withholding and taxes associated with all applicable services.

Diabetes Management Program (DMP) Fees

Fee	Per Participant Charge	Description
Monthly Participation	$67 Per Participant Per Month	The monthly charge includes set-up and implementation, Member registration, welcome kit containing FDA-approved data enabled blood glucose meter, unlimited supply of test strips, first line acute response to alerts generated from the use of the glucometer device, diabetes coaching and education, Member access to 24/7 on call support, mobile app and web portal with tips of the day.
Replacement Device	$167 per replacement	Lost or damaged blood glucose meter replacements are the responsibility of the Employer.

* Each Participant has an initial minimum enrollment term of six (6) consecutive months. After the 6-month requirement has been fulfilled, participation will be evaluated monthly and charges for the services will continue monthly or until the Participant has discontinued Active participation for a consecutive six (6) month period.

"Active" use of the DMP means a Participant is engaging in one or more of the following activities: blood glucose checks or submission, live coaching sessions, digital coaching sessions, communication exchange between a Livongo coach and Participant related to diabetes management, mobile app usage, Member support call, shared data with care team, or portal logins.

5.10. Teladoc™ Health myStrength Complete participation on a participation-specific basis, with fees assessed for the first 6 months of engagement and on a monthly basis thereafter. In addition to claim visit costs related to visits with a mental health Practitioner, myStrength Complete program fees will be charged at $14 Per Participant Per Month billed via claims. Once a Participant is no longer participating in the program for 6 months, the program fees will no longer be charged.

5.11. Independent Dispute Resolution ("IDR") Fees for Certain Out-of-Network Provider Claims: Federal administration fees, Certified IDR Entity fees, reasonable legal costs, if applicable, in connection with the IDR process established by the No Surprises Act (within the Consolidated Appropriations Act, 2021) for certain out-of-network provider claims. These amounts are in addition to the final amount paid to the provider for the medical claim itself.

5.12. AdHoc requests for clinical information, including plan of care, for a specific member or set of members:

5.12.1. Requests for a discussion/consult/review with a BlueCross Medical Director or Pharmacy Director will incur a charge of $375 per hour assessed in 15-minute increments.

5.12.2. Requests for a Care Management Nurse to provide detailed information, including Case Management Notes, in excess of 2 members per quarter will incur a charge of $125 per hour assessed in 15-minute increments.

6. Security Interest. As collateral for the payment of any amounts due BlueCross under this Agreement, Employer hereby grants to BlueCross a preferential security interest in all proceeds of Employer's debiting account, both with respect to the funds deposited initially and any additional amounts paid thereafter. In the event of a default by Employer of any of its obligations under this Agreement, including the prompt payment when due of any invoice sent to it by BlueCross, BlueCross shall have the immediate right, upon written notice to Employer, to offset the proceeds of the Account against the amount of any unpaid invoice or other obligation owed to BlueCross.

7. Claims Funding Methodology. Pursuant to Section 1.6 of the Agreement, the Parties agree that on a mutually acceptable day of each week, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to fund Approved Claims incurred in the preceding week, and BlueCross shall simultaneously initiate the debit for Approved Claims to be paid. The debit will clear Employer's account the following business day. BlueCross adjudicates claims in accordance with its internal administrative procedures.

7.1. If the full amount specified by BlueCross pursuant to this paragraph is not made available to BlueCross within the specified time period, BlueCross may immediately suspend payment of all Approved Claims, regardless of the date claims were incurred, until all amounts due are received by BlueCross.

7.2. If BlueCross elects not to suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% percent per month on the amount of all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.

7.3. If a partial amount is available, BlueCross may elect to utilize those funds to pay

Approved Claims until full payment is made by Employer. BlueCross has full discretion to determine which Approved Claims will be paid with these partial funds, and may or may not exercise that discretion.

7.4. BlueCross shall provide Employer with a list of Approved Claims paid on behalf of Employer, within 30 calendar days following the end of each month during which this Agreement remains in effect.

8. Run Out Claims. BlueCross will administer run out claims for Employer at the termination of this Agreement for a period of 180 days from the date this Agreement terminates. The monthly ASFs for performing this service shall be the same as the ASFs charged Employer at termination of the Agreement. The monthly ASFs for performing this service shall be based on an average of the number of Subscribers covered under this Agreement for the 3 months immediately prior to the termination date of this Agreement. This fee shall be billed for the first 3 months of the run-out period.

9. Premium Billed Ancillary Products. If Employer has requested that BlueCross provide additional services through other products (i.e., dental), or has requested that BlueCross collect premiums or premium equivalents from subscribers or Members to fund other benefits offered by Employer (i.e., life insurance offered through another carrier, etc.), any additional funds due from Employer to BlueCross for remittance to other carriers or providers of services shall be remitted to BlueCross on the same basis as the ASFs.

EXHIBIT C TO THE ADMINISTRATIVE SERVICES AGREEMENT

DUTIES OF AND SERVICES PROVIDED BY BLUECROSS

1. Generally. It is understood and agreed that BlueCross is empowered and required to act with respect to the Plan only as expressly stated in this Agreement. Employer and BlueCross agree that BlueCross's role under this Agreement is to provide administrative claims payment and similar administrative services in accordance with the terms of the Benefit Documents and the Agreement; that BlueCross does not assume any financial risk or obligation with respect to Approved Claims; and that the services rendered by BlueCross under this Agreement are merely ministerial, and shall not include the power to exercise control over the Plan's assets, if any, or discretionary authority over the Plan.

2. Enrollment: Forms and I.D. Cards. BlueCross shall enroll those individuals who have completed an enrollment form and are determined by Employer to be eligible for benefits under the Plan. Employer shall provide BlueCross with enrollment information in a mutually agreeable format, (i.e., electronically, faxed, paper, etc.) BlueCross is not responsible for verifying data submitted by Employer. BlueCross shall be entitled to rely on the information furnished to it by Employer. Employer shall hold BlueCross harmless for inaccurate information provided by Employer or BlueCross's inability to perform under this Agreement as a result of Employer's failure to provide such information in a timely manner.

    2.1. BlueCross will not furnish enrollment forms to Employer, since Employer will enroll Members and maintain eligibility online as described in Exhibit M, Online Enrollment Specifications through BlueCross Secured Website.

    2.2. Once Employer has notified BlueCross in writing that a new Member is eligible for benefits, BlueCross shall update its systems to reflect that Member's coverage.

    2.3. Once Employer has notified BlueCross in writing that a Member should be terminated as no longer eligible for coverage, BlueCross shall update its systems to reflect that change in the Member's coverage in accordance with Exhibit B.

    2.4. BlueCross will conduct certification and verification of incapacitated dependent information.

3. Claims Processing. BlueCross shall provide claims processing services on behalf of Employer for all properly submitted claims. BlueCross will follow current industry practices and its internal claims processing procedures regarding payment of claims, including timeliness and accuracy of claims payments. For purposes of this paragraph 3, the term "claim(s)" is defined as a request from a provider of Covered Services and/or a Member for payment of monies due for the rendering of Covered Services under the Benefit Documents, and in conformity with any agreements BlueCross enters into with such providers of Covered Services.

   3.1. When necessary, BlueCross shall furnish to Employer, for distribution to Members, forms to be used for claims submission, and any other forms determined to be necessary by BlueCross for the administration of the Benefit Documents.

   3.2. BlueCross will coordinate with other payors, including Medicare, in adjusting claims according to the terms and conditions of coverage, including Medicare Secondary Payor rules. This may delay finalization of the adjudication of a claim, depending on when data is received regarding the claim. If Medicare is primary, BlueCross will adjudicate benefits based on the Medicare allowed amount.

   3.3. BlueCross shall furnish each Member claiming benefits with an explanation of each claim that is paid, denied or rejected.

   3.4. BlueCross shall give Members a reasonable opportunity to appeal a denied claim or any portion of a claim within the time frames specified by ERISA, according to the appeals procedure defined in the Benefit Documents; however, Employer shall retain final discretionary authority and responsibility for claims payment decisions.

   3.5. If Employer notifies BlueCross of a Member's termination from coverage after the Member's termination date, and Approved Claims for that Member were paid in the interim, BlueCross shall request reimbursement from the provider on Employer's behalf to the extent possible. However, if Employer does not notify BlueCross of a Member's termination from coverage ninety (90) days or more after the date of Member's termination of coverage, BlueCross shall not be obligated to attempt to collect any claim payments which were paid before notice of termination was received by BlueCross.

   3.6. If Employer notifies BlueCross of a Member's termination from coverage after the Member's termination date, and BlueCross made payment of benefits directly to such Member, BlueCross will attempt recovery unless Employer directs BlueCross in writing not to attempt recovery from such Member.

      3.6.1. If Employer's Benefit Documents include coverage for pharmacy benefits that are paid by BlueCross's pharmacy vendor or Provider-Administered Specialty Products that are paid by BlueCross, claims paid after a Member's termination cannot be recovered from the provider, pharmacy or any other person or entity, as applicable. However, BlueCross will attempt recovery from the Member on these claims. If Employer does not wish BlueCross to attempt recovery from a specific Member, Employer must direct BlueCross accordingly in writing.

3.6.2. If a claim payment is less than fifty dollars ($50), BlueCross has no obligation to attempt to collect said claim payment.

3.6.3. If a claim payment was made for services rendered through the BlueCard program, BlueCross has no obligation to attempt to collect claim payments that were for less than fifty dollars ($50), or in accordance with stated limits in effect at the Host Plan location.

3.6.4. If Employer directs BlueCross to use the services of an outside collection agency to collect a claim payment, the fees charged by such entity shall be the sole responsibility of Employer.

3.6.5. If benefits are not recoverable from a provider or Member, Employer remains liable to fund all claims.

3.7. BlueCross will provide Employer with a monthly statement with respect to claims paid in the prior month.

3.8. At the termination of this Agreement and provided that Employer pays BlueCross the applicable fees set forth in Exhibit B, BlueCross shall administer the payment of Run Out claims for Employer. These claims shall be administered as any other claim handled during the term of the Agreement, and shall be subject to the same restrictions.

3.9. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, pandemic or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with BlueCross's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, BlueCross shall have the right, without first seeking consent from Employer, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Document but is undertaken in order to minimize the effect such catastrophic event has on Members, including: (i) waiving referral, prior authorization or pre-certification requirements for medical and/or pharmacy services; (ii) waiving administrative holds and terminations due to nonpayment of premiums; (iii) allowing early refills on prescription medications; (iv) offering medical and behavioral health visits through telehealth; and (v) reducing or waiving cost-sharing obligations for services. As soon as practicable after a catastrophic event, BlueCross shall report its actions to Employer. Employer shall reimburse BlueCross for all amounts paid in good faith, or as required by law, under the circumstances and such amounts shall constitute Approved Claims for which Employer is responsible for payment, even if the charges incurred were not for services otherwise covered under the Benefits Documents.

4. Network Administration. BlueCross shall administer its established cost containment programs and access and availability benefits management programs, as selected by

Employer. BlueCross's provider contracts and medical policies control network administration.

4.1. BlueCross shall make available the Blue Network selected by Employer, including network hospitals and other providers or practitioners with which BlueCross has contracted, ("Blue Network") to provide Covered Services to Members. All agreements between providers of services and BlueCross are the sole property of BlueCross, and BlueCross retains the right to the use and control of these provider agreements.

4.2. Employer acknowledges that BlueCross does not act either as the agent of or in any fiduciary capacity with respect to Employer, any of its Plans, or any of its Members, when BlueCross negotiates its provider and/or vendor arrangements.

4.3. Employer acknowledges that the Blue Network Provider contracts cannot be modified to meet any specific requirements of Employer, and that BlueCross has the discretion to change the composition, name, etc. without Employer's consent or approval. BlueCross does not guarantee that a specific provider will remain in the network, and BlueCross has the right to determine network adequacy, and to establish and modify billing guidelines and reimbursement arrangements for Network Providers.

4.4. BlueCross negotiates various payment arrangements with providers, including per diem, percent of charges, diagnosis related groups (DRGs,) global case rate and fee schedule arrangements, which vary by provider. Certain facilities may have multiple or a combination of these arrangements. All of these arrangements provide payment to the provider, and claims processed using one of these arrangements are considered Approved Claims.

4.4.1. Savings/discounts are not stated herein in actual amounts or percentages, nor are they guaranteed, since credits can vary by facility, type of service provided and the specific provider agreement at a given facility.

4.4.2. The provider's charge to BlueCross will usually be less than the rate charged for a similar service to the general public. In some cases, however, the rate negotiated by BlueCross for a particular service may be higher than the provider's rate for that service charged to the general public, and BlueCross will pay the negotiated rate.

4.4.3. BlueCross has certain special arrangements with some providers that may exempt those providers from certain administrative and medical management requirements, including, but not limited to, prior authorization, appropriateness review, notification and written referral requirements.

4.4.4. BlueCross may negotiate a settlement of a reimbursement dispute with a provider as part of its internal administrative procedures.

4.5. Negotiating Discounts with Out-of-Network Providers. When permitted by Association rules and guidelines, BlueCross may negotiate a reduction in billed charges for Members' claims for certain Covered Services received from Out-of-Network Providers (as defined in Section 5.4 below) located outside of Tennessee. Claims eligible for this service must meet

BlueCross's established criteria. As consideration for this service, BlueCross shall receive a fee of fifteen percent (15%) of the reduction of billed charges.

5. Reimbursement to Network and Out-of-Network Providers.

5.1. "Network Providers" are providers that have agreed to participate in the Blue Network, and to accept BlueCross's applicable pre-negotiated payment allowance for certain Covered Services as payment in full, and therefore should not bill the Members for any amount in excess of the payment allowance for such service(s). The pre-negotiated payment will be based upon charges for Covered Services or upon an alternative method of payment, including per diem amounts, percent of charges, global case rate and fee schedule arrangements, and may be further reduced by other contractual reductions, adjustments, discounts or offsets based on BlueCross's agreements with Network Providers. Network Providers will file Members' claims with BlueCross, and BlueCross will make payment directly to Network Providers.

5.1.1. In the unlikely event of a systems failure at BlueCross ("Outage") rendering it temporarily impossible to determine which Network Provider rendered services during a specific time period while the Agreement is in force, BlueCross will make estimated payments to Network Providers. This estimate will be based on past service to BlueCross Members, and will be proportionately divided among Employer and other Groups which BlueCross insures or to which BlueCross provides administrative and claims processing service. When the capability to determine which Network Providers did provide services during the Outage is restored, BlueCross will adjudicate the claims submitted on behalf of Members, and notify Employer of any adjustments necessary to Employer's claims processing funding.

5.2. When a Member receives services from a Network Provider, he or she will be responsible for payment of the applicable Deductible, Coinsurance, Cost-Sharing and/or Copayment, as well as charges for any non-covered services. A Member's Coinsurance for Covered Services received from a Network Provider will be based on the provisions of the Network Provider's contract, and the lesser of (i) the Network Provider's pre-negotiated payment allowance, or (ii) charges for Covered Services at the time such Services are provided. BlueCross will not recalculate Coinsurance in the event it recovers a discount or savings with respect to Covered Services after a claim for such Services is paid. Rather, Employer will receive a payment or credit for such savings or discounts.

5.3. The Member's liability for non-covered services, including services that are not covered because of a benefit maximum or other limitation contained in the Benefit Documents, will be based on the Network Provider's actual charges for such services.

5.4. "Out-of-Network Providers" are providers that do not participate in the Blue Network. BlueCross's payment for Covered Services to any Out-of-Network Provider will be based on Maximum Allowable Charge for the service performed. Except as required by applicable law, (including the No Surprises Act enacted as part of the Consolidated Appropriations Act , 2021 as described later in this Exhibit C), upon receipt of a completed claim form, and provided adequate funding from Employer is available, BlueCross shall make payment for Covered Services to the

Out-of-Network Provider and not the Member, unless BlueCross receives proof of payment from the Member before payment is made to the provider. Except as required by applicable law, when the Member receives services from an Out-of-Network Provider, he or she will be responsible for the payment of any difference between BlueCross's payment and such provider's charge(s), and responsible for any applicable Deductible, Copayment, and Coinsurance, as well as payment of charges for any non-covered services. The Member's responsibility for Coinsurance will be based on the Maximum Allowable Charge for that service. Maximum Allowable Charge shall be calculated as determined by BlueCross in accordance with the EOC, BlueCross policies and applicable law.

5.5. When Members obtain Covered Services outside of Tennessee, BlueCross's Blue Network reimbursement rules do not apply. Please refer to Exhibit G, Inter-Plan Arrangements, for a description of how out-of-state providers are reimbursed.

5.6. BlueCross is responsible for reporting and remitting only those abandoned property funds that were provider payments made with BlueCross funds.

5.7. Employer is required to reimburse the Veteran's Administration ("VA") according to federal law. BlueCross has an agreement with the VA in which there is an established fee schedule. Federal law requires payment to the VA, regardless of the network status, and regardless of the amount of benefits provided for services by an Out-of-Network Provider. BlueCross will reimburse the VA at the rate set forth in the agreement between BlueCross and the VA. The Plan will pay the VA as if it were a Network Provider.

5.8. BlueCross's contracts with Network Providers may include a variety of payment methodologies. These payment methodologies may obligate BlueCross to pay an amount that is in addition to the underlying cost of the service rendered. These additional costs may include program fees, incentive payments, bonus payments, or quality payouts. These provider reimbursements will be passed to Employer as part of the billing process detailed in this Agreement.

5.9. No Member shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under the Plan to a third party, and such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims. Benefit payments under the Plan may not be assigned, transferred, or in any way made over to another party by a Member. Nothing contained in this Agreement or the Plan shall be construed to make the Employer, Plan or BlueCross liable to any third party to whom a Member may be liable for medical care, treatment, or services. If a written authorization is provided to BlueCross by a Covered Person, BlueCross may pay a benefit directly to a provider of medical care, treatment, or services instead of the Member as a convenience to the Member; when this is done, all of the Plan's obligation to the Member with respect to such benefit shall be discharged by such payment. However, BlueCross reserves the right not to honor any direct payment request to any third party, including but not limited to, any provider. The foregoing does not preclude any assignment of payment to Medicaid to the extent required by law. Neither BlueCross, nor the Plan will honor claims for benefits brought by a third- party; such third-party shall not have standing to bring any such claim either independently, as a Member or beneficiary, or derivatively, as an assignee of a Member or beneficiary.

6. Medical Management Services. BlueCross will provide certain services through its Medical Management program. These are described in Exhibit D to this Agreement.

7. Claims Payments Adjustments.

7.1. Whenever BlueCross becomes aware that a claims payment to a provider or Member is less than the amount to which the provider or Member is entitled, BlueCross shall promptly adjust the underpayment to reflect the proper amount that should be remitted.

7.2. Whenever BlueCross becomes aware that a claims payment to a provider or Member is more than the amount to which the provider or Member is entitled, BlueCross shall make a diligent attempt to recover such overpayment, in accordance with its customary administrative procedures. In the event any part of an overpayment is recovered, Employer will receive a credit from BlueCross. BlueCross shall not be required to institute any legal proceeding to recover such overpayment. BlueCross will follow its policies and procedures to settle overpayments.

7.2.1. If a claim payment was made for services rendered through the BlueCard program, BlueCross has no obligation to attempt to collect claim payments that were for less than fifty dollars ($50), or in accordance with stated limits in effect at the Host Plan location.

7.2.2. BlueCross will assume liability for an unrecovered overpayment only if and when it is determined that:

7.2.2.1. the overpayment was caused by an act or omission of BlueCross subject to indemnification under Article V, Section 5.1;

7.2.2.2. all reasonable means of recovery under the circumstances have been exhausted; and

7.2.2.3. BlueCross's acts or omissions were not undertaken at the express direction of Employer.

7.2.3. BlueCross is not liable for interest on recovered overpayments.

7.2.4. Employer acknowledges and agrees that, except in cases of fraud committed by the provider, BlueCross cannot, under Tennessee state law, recover overpayments from providers more than 18 months after the date that BlueCross paid the claim submitted by the provider.

7.2.5. In no event does BlueCross have an obligation to recover on liability for overpayments of claims that were adjudicated for payment more than three (3) years before the overpayment is discovered.

7.3. The Parties acknowledge that Employer may not contact Network Providers directly or indirectly regarding rates or charges for services provided to Members. All such contact with Network Providers must be by and through BlueCross.

7.4. Overpayment Recoveries: BlueCross, on behalf of Employer has the right to obtain a refund of an overpayment on any claim(s) paid by BlueCross to a provider or a Covered Person. Unless otherwise agreed upon between BlueCross and the provider, when a provider fails to return an overpayment to BlueCross, BlueCross has the right to utilize the following mechanisms to recover the overpayment: For purposes of Sections 7.4.1 through 7.4.6 below, "Other Plan(s)" or "Another Plan" means any health benefit plan other than the Plan, including, but not limited to, individual and group plans or insurance policies that are administered or insured by BlueCross.

7.4.1. BlueCross has the right to recover overpayments from future payments due by BlueCross to a provider in conjunction with BlueCross's payment of medical claims for the Plan, or from Other Plans, up to an amount equal to the overpayment (hereinafter "Claim Recovery"). When BlueCross identifies an overpayment, BlueCross notifies the provider in writing, identifying the overpayment (including the medical claim(s) at issue), the provider's ability to grieve BlueCross's determination of the overpayment, and the timeline for submitting payment for the overpayment. If the provider does not return the requested overpayment as directed, BlueCross may initiate the Claim Recovery process against future payments consistent with this section.

7.4.2. BlueCross has the right to reduce payment to a provider by the amount necessary to recover the overpayment to such provider and to reimburse BlueCross for the amount BlueCross reimbursed to Employer (net of fees, if any) in connection with such overpayment. Employer acknowledges and agrees that BlueCross reimburses Employer and the Plan for such overpayments to providers with BlueCross's general funds and such reimbursement is not contingent on BlueCross's recovery from the provider.

7.4.3. If BlueCross has made overpayments to a provider for medical claims relating to members enrolled in more than one (1) Other Plan, BlueCross may initiate its Claim Recovery process for multiple overpayments collectively, against future payments owed to such provider on behalf of Another Plan, as part of a single transaction, resulting in an overpayment recovery amount which shall be applied in accordance with BlueCross policies, which prioritize application based on the age of the overpayments, beginning with the oldest outstanding overpayment or has the right to apply the Claim Recovery process as otherwise set forth in this Section 7.4. BlueCross shall not apply recovered amounts in a manner that prioritizes Overpayments based upon the funding type of any plan (*e.g.*, whether the plan is fully-insured or self-funded).

7.4.4. Employer acknowledges that BlueCross, may from time to time, conduct Claim Recovery activities with respect to contracted and non-contracted providers as permitted under the terms of any applicable contract and applicable law. If BlueCross conducts Claim Recovery, BlueCross shall record overpayments and returned funds separately and maintain claim details at the Member account, and group levels.

7.4.5. Subject to the exception(s) set forth in this Section 7.4, Employer agrees that BlueCross will recover overpayments in accordance with its recovery

process and that Employer has no separate or independent right to recover any overpayment from BlueCross, provider, or Another Plan.

7.4.6. Employer may, at its option, request on a semi-annual basis, a report on the status of all outstanding overpayments.

7.5. In the event that BlueCross becomes aware that a claims payment to a provider or Member was or might have been the result of a fraud, BlueCross shall:

7.5.1. Notify the Plan as soon as possible about the alleged fraudulent claims;

7.5.2. Provide reasonable assistance to the Plan in recovering the alleged fraudulent claims; and

7.5.3. Report the suspected fraud to the appropriate law enforcement agency.

8. Annual Renewal Claims Analysis.

8.1. BlueCross will provide an annual renewal analysis of Employer's claims experience. BlueCross will also provide assistance in benefit design.

8.2. Upon request, but not more often than annually, BlueCross will provide an analysis of Employer's claims incurred but not yet reported.

8.3. Upon request, but not more often than annually, BlueCross will provide an analysis of the suggested funding levels for Employer's Plan, as administered by BlueCross.

8.4. Employer acknowledges that these analyses are estimates only, and that the actual experience may differ from these estimates. These are for Employer's use only, and are not prepared for distribution to or reliance by third parties.

9. Mental Health Parity. The parties acknowledge and agree that Employer is solely responsible for complying with all applicable provisions of ERISA and other laws applicable to Employer's Plan, including the Mental Health Parity and Addiction Equity Act and its implementing regulations, as amended from time to time ("MHPAEA"). BlueCross agrees to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer to comply with these obligations.

10. Duties with regard to BlueRe of Tennessee Stop Loss Coverage. Employer has stop loss coverage with BlueRe of Tennessee ("BlueRe"). BlueCross will perform and provide the following on behalf of Employer:

10.1. Provide any records needed for the proper administration of stop loss coverage to BlueRe.

10.2. Provide Employer the following information at renewal:

Census	
Age/ Gender	Subscriber Count by age/gender
Zip Codes	Subscriber Count by LOB, State, Zip
Plan Design Summary/ Plan Document	Evidence of Coverage

Trigger Reports:	
50% of Specific Report	50% Report (Includes Diagnosis Only)
Medical & Rx	

10.3. Coordinate payment to brokers, and any other commission, as may be directed by Employer.

10.4. Provide monthly Claimants at 50% of Specific Attachment Point Reports.

11. RESERVED.

12. Section 111 Mandatory Secondary Payor Reporting. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), titled Medicare Secondary Payor, (hereinafter "Section 111") mandates that, effective January 1, 2009, all group health plans or their representatives submit certain information to CMS. BlueCross is registered as a medical "Required Reporting Entity" as required under Section 111. BlueCross shall report the Plan's medical information required by Section 111. Under no circumstances will BlueCross be required to report workers' compensation or liability insurance information required under Section 111. Employer shall provide all Social Security numbers, tax identification numbers, and the "total number of employees" (as that is defined in the MMSEA) information to BlueCross. BlueCross will not be responsible for any deficiency resulting from Employer's failure to provide such information to BlueCross.

13. Distribution of Materials.

13.1. Employer shall handle and distribute enrollment materials in a timely manner and promptly provide to BlueCross the information necessary to administer this Agreement. Employer's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.

13.2. Employer shall distribute notices that Employer and/or BlueCross are legally required to provide (e.g., special enrollment rights) in a timely manner and in accordance with all applicable laws. Any off-renewal changes require 60-days advance notice to Members. Employer shall provide BlueCross with enough advance notice of any off-renewal changes, not to be less than 90 days, for BlueCross to meet its obligations under any applicable law and this Agreement. Employer shall indemnify BlueCross and hold BlueCross harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such notices.

13.3. If BlueCross provides its enrollment and/or change forms ("Forms") and/or any benefit summaries, and/or comparison sheets ("Documents") in an electronic medium, and Employer delivers Documents electronically to Members or includes Documents on Employer's internal intranet or by similar means or for similar purposes, Employer agrees that:

13.3.1. electronic access shall be limited to Employer's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;

13.3.2. they will replace any hard-copy Forms that have been modified by BlueCross;

13.3.3. the hard-copy documents on file with BlueCross shall control in the event

of any discrepancy; and

13.3.4. Employer remains solely responsible for the content of the Documents and all other legal requirements pertaining to them (e.g., distribution).

13.4. BlueCross will create a draft Summary of Benefits and Coverage ("SBC"), based on services provided by BlueCross, and provide to Employer. Employer shall review SBC, and revise or supplement as required, prior to distribution. Employer remains solely responsible for SBC content and all other legal requirements pertaining to SBC (e.g., distribution). BlueCross shall not charge Employer for draft SBC. BlueCross may charge Employer for translation of SBC to any language other than English.

14. Member Outreach. BlueCross or its subcontractor, shall have the right to contact Members to perform services under this Agreement, or as otherwise required by law, a regulatory body, or an accrediting agency. Employer warrants that the contact information included in its enrollment data was obtained directly from the applicable Member and that Members are aware they may be contacted via that information for non-telemarketing calls, emails, and/or text messages.

15. Provider Administered Specialty Pharmacy Products. Provider Administered Specialty Pharmacy Products are those Specialty Pharmacy Products administered to a Member by a health care provider, whether or not a Network Provider, rather than self-administered by the Member. Provider Administered Specialty Products can only be dispensed from a specialty pharmacy in the BlueCross Preferred Specialty Pharmacy Network.

15.1. Provider Administered Specialty Pharmacy Products are those products that meet all three of the following criteria:

(a) Require in-depth patient teaching, coordination of care, and frequent monitoring to ensure successful use;

(b) Described by at least one of the following:

i. produced through genetic technology or biopharmaceutical processes;

ii. target a chronic, rare, genetic, or complex disease; or

iii. require unique handling, distribution, and/or administration; and

(c) Are set forth on the Provider Administered Specialty Pharmacy Product List which is maintained by BlueCross (available at www.bcbst.com), as may be amended from time to time for any reason.

15.2. "Preferred Specialty Pharmacy Network" means BlueCross's network of pharmacies that are permitted to dispense Provider-Administered Specialty Pharmacy Products to providers.

All the medications set forth on the Provider Administered Specialty Pharmacy Product List have been determined by BlueCross to meet criteria (a) and (b) of Section 15.1 above. However, some products meeting criteria in (a) and (b) of Section 15.1 above may be excluded from the list. A Provider Administered Specialty Product may be added or removed from this list at any time for any reason. Provider Administered Specialty Pharmacy Products can only be dispensed from a pharmacy in BlueCross's Preferred Specialty Pharmacy Network. BlueCross will adjudicate claims for Provider Administered Specialty Pharmacy Products for the Employer.

16. Group Health Plan Federal Requirements.

16.1. Machine Readable Files. The Parties acknowledge and agree that Employer's Plan is required to publicly disclose in-network negotiated rates, billed out-of-network charges, and prescription drug pricing information to the public through machine readable files ("MRFs". BlueCross agrees (a) to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer to comply with these obligations or (b) at the direction of Employer, to post MRFs on its website on behalf of the Plan, provided however, that Employer retains liability for any Losses resulting from Employer's failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.

16.2. Contract Terms. The Parties acknowledge and agree that, nothing in this Agreement shall directly or indirectly restrict BlueCross from (i) providing provider-specific cost or quality of care information or data to referring providers, Employer, Members or individuals eligible to become Plan Members; (ii) electronically accessing de-identified claims and encounter information or data under the Plan for each Plan Member, upon request and consistent with applicable law, including but not limited to HIPAA, GINA, and the ADA, or (iii) sharing such Plan information or data, or directing such Plan data be shared, with a HIPAA business associate of the Plan consistent with applicable law and the terms of this Agreement.

16.3. Price Comparison Tool. The Parties acknowledge and agree that Employer's Plan is subject to requirements under applicable law to provide Members with price comparison tools. BlueCross agrees to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer to comply with the price comparison tool obligations, or (b) at the direction of Employer, to make available to Plan Members a price comparison tool, provided however, that Employer retains liability for any Losses resulting from Employer's failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.

16.4. ID Cards. BlueCross will [not] supply identification cards. BlueCross will supply identification cards issued at the group's initial enrollment to Employer and identification cards issued at any other time to Employer. Identification cards will be issued in the name of Subscribers and Dependents.

16.5. Provider Directory Tool. BlueCross will provide Provider Directories through online access and in accordance with applicable law.

16.6. Continuity of Care. The Parties acknowledge and agree that Employer's Plan is subject to continuity of care protections in instances when terminations of certain contractual relationships result in changes in provider or facility network status. BlueCross agrees to coordinate impacted Member's transitions to more appropriate care settings in accordance with applicable law.

16.7. Health Care and Prescription Drug Reporting. The Parties acknowledge and agree that the Employer's Plan is subject to requirements under applicable law to report certain health care cost information annually to the federal government, such as costs relating to prescription drugs and air ambulance services. BlueCross agrees (a) to cooperate with Employer in providing information reasonably requested by Employer or its designee in order for Employer's Plan to comply with these reporting obligations, or (b), at the direction of the Employer, to report on the Plan's behalf, provided however, that Employer retains

liability for any Losses resulting from Employer's failure to provide timely to BlueCross any requested information for BlueCross to perform under this section.

16.8. No Surprises Act. The Parties acknowledge and agree that the Employer's Plan is subject to requirements under the No Surprises Act that is part of the Consolidated Appropriations Act, 2021 (hereinafter, the "NSA"). BlueCross will process those out-of-network claims subject to the NSA in accordance with the terms of the NSA and its implementing regulations. BlueCross will also engage in the Independent Dispute Resolution ("IDR") process with providers, as required under the NSA. Fees for IDR services are set forth in Exhibit B.

EXHIBIT D TO THE ADMINISTRATIVE SERVICES AGREEMENT

MEDICAL MANAGEMENT SERVICES PROVIDED BY BlueCross

Employer has selected several of BlueCross's Medical Management programs for use by Employer in administering its Plan. All services utilize current medical guidelines and standards. While these services are described below, the services may be updated from time to time without prior notice to Employer.

MEDICAL MANAGEMENT

1. Inpatient Review.

    1.1. Inpatient Precertification. BlueCross will review inpatient admissions (hospital, subacute facility, skilled nursing facility, inpatient rehabilitation, and 23-hour observation stays) to evaluate the appropriateness of certain procedures and Medical Necessity of the requested services. An initial length of stay is assigned upon admission. Emergency inpatient admissions are reviewed within 24 hours of admission or the next business day. Employer's Plan follows BlueCross's standard precertification requirements.

    1.2. Concurrent Review of per diem admissions. BlueCross will review Members' inpatient care (hospital, subacute facility, skilled nursing facility, and inpatient rehabilitation) to ensure Medically Necessary and Medically Appropriate care is delivered. Concurrent review is performed as services are being rendered.

    1.3. Outlier Review of DRG admissions. BlueCross will review any outlier days billed by a DRG facility on targeted claims after a service is rendered and before payment is made to ensure cost-effectiveness.

2. Retrospective Review. BlueCross will review targeted claims after a service is rendered and before payment is made. The purpose of retrospective review is to provide determinations regarding Medical Necessity, eligibility and benefits.

3. Prospective Review. BlueCross will review targeted, non-emergency related care procedures, non-routine diagnostics and non-routine pharmacy treatments, as determined by BlueCross, for medical appropriateness and the necessity of the requested procedure and setting prior to the procedure being performed.

4. Pre-determination Review. When requested by a provider or Member, BlueCross will conduct a prospective review to determine whether a procedure will be covered.

5. Specialty Pharmacy Review. If BlueCross administers claims related to Provider Administered Specialty Pharmacy Products, as described in Exhibit C, then BlueCross will review specific drugs administered by licensed health care professionals.

6. Home Health, Home Infusion Therapy Review. BlueCross will review prescriptions for home health care services and home infusion therapy to evaluate the physician's plan of

treatment, appropriateness of setting and Medical Necessity of the prescribed services, both prospectively and concurrently.

7. Lifestyle/Health Educational Program. BlueCross will send condition-specific educational materials to low-risk Members identified through the prior authorization process.

8. Care Coordination. BlueCross's Care Coordination process systematically identifies opportunities to coordinate and manage Members' total care.

   8.1. Emergency Services Management Program. Nurses will contact Members who frequently seek emergency room services, identify reasons for the frequent utilization, and provide assistance in controlling future inappropriate use of emergency room services.

   8.2. Transition of Care. Throughout the different stages of a Member's treatment, nurses coordinate the Member's transitions to more appropriate care settings.

   8.3. Condition-specific Care Coordination Program. Through this program, BlueCross provides assessment and management of low-risk and moderate-risk Members with specific conditions, such as heart disease, respiratory disease, diabetes, asthma or hypertension.

9. Catastrophic Medical and Transplant Case Management. BlueCross's Catastrophic Medical and Transplant Case Management program utilizes a comprehensive approach that includes benefit analysis, preauthorization, concurrent review, discharge planning and cost-effective continuity of care for Members. Members with high-risk conditions such as terminal illness, severe injury, major trauma, cognitive or physical disability, or transplant are identified through prior authorization, medical data and claims data. Registered nurses work with the Member, health care providers and primary caregivers to coordinate the most appropriate, cost-effective care settings.

   Benefits paid through the Catastrophic Medical and Transplant Case Management program may vary from the benefits described in the Plan. This is done when BlueCross has determined that the alternative benefits are more Medically Appropriate, cost effective, and ensure the best outcomes. Employer will fund these benefits, and BlueCross's administration of benefits pursuant to the Catastrophic Medical and Transplant Case Management program shall be within the scope of its duties.

10. RESERVED

11. RESERVED

12. Behavioral Health Management. BlueCross will provide the following services as part of its Behavioral Health Inpatient Utilization Management program:

   12.1. Inpatient Pre-certification. BlueCross will review all facility based level-of-care admissions (acute care, residential care, partial hospital care, intensive outpatient care and any other care in lieu of acute care) to evaluate the appropriateness of treatment applying Medical Necessity criteria. Emergency inpatient admissions are reviewed within 24 hours of admission or the next business day.

12.2. Concurrent Review. BlueCross will review the care of Members in facility-based treatment (acute, residential, partial hospital, intensive outpatient or any other care in lieu of behavioral health acute care) to ensure Medically Necessary and Medically Appropriate care is delivered. Lengths of stay are authorized when care requested meets Medical Necessity criteria.

12.3. Discharge Planning. BlueCross will assess the Member's behavioral health condition and monitor the behavioral health program's discharge planning to ensure appropriate continuation of care, as necessary, when the Member leaves that particular level of care.

12.4. Case Management. BlueCross's Behavioral Health Case management process identifies high risk Members in facility based levels of care and assesses opportunities to coordinate and manage the Member's total behavioral health care to ensure the best outcomes while the Member remains in facility based levels of care.

13. Musculoskeletal Procedures. BlueCross will review targeted, non-routine procedures such as the following: spinal injections, spinal surgery, and hip, knee or shoulder surgery for medical appropriateness and the necessity of the requested procedure and setting prior to the procedure being performed.

14. BlueCross shall have the authority, in its discretion, to institute from time to time, utilization management, case management, disease management or other care-related programs. These are processes that demonstrate potential improvement in access, quality, efficiency and Member satisfaction. When BlueCross institutes a care-related program, approved services provided through such programs are deemed Covered Services even if they are normally excluded under the Benefits Documents.

EXHIBIT E TO THE ADMINISTRATIVE SERVICES AGREEMENT

DUTIES OF EMPLOYER

1. Services. Employer shall:

   1.1. Provide BlueCross with a current, detailed description of the Benefit Documents and any subsequent changes, for acceptance by BlueCross;

   1.2. Timely pay and fund all fees and claims as described in this Agreement;

   1.3. Provide BlueCross with the necessary Subscriber and Member eligibility information and timely provide updates to such information;

   1.4. Perform other duties and services as described in this Agreement.

2. Notification Regarding Members. Employer shall notify BlueCross of the addition or deletion of Members as described below:

   2.1. When a new Member should be added, Employer shall notify BlueCross within forty-five (45) days of the effective date of coverage for that Member. If BlueCross is not notified that a new Member should be added within this time frame, BlueCross shall have no obligation to adjudicate any claims that were incurred prior to this time frame.

   2.2. When a Member should be terminated from coverage, Employer shall notify BlueCross within forty-five (45) days of the effective date of that Member's termination.

3. Final Authority.

   3.1. Except as otherwise specifically stated in this Agreement, Employer retains all final authority and responsibility for the Plan including the benefit design of the Plan, funding of claims, claims payment decisions, cost containment program decisions, eligibility and benefit determinations, compliance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), compliance with HIPAA, compliance with reporting and remitting abandoned property funds (except as referenced in Exhibit C, Section 5.6) if required by law, and compliance with any other state and federal laws or regulations applicable to Employer or the administration of the Plan. The phrase "eligibility and benefit determinations" means that Employer determines who is eligible to participate, (i.e., who are employees or dependents) and generally what medical services and supplies are included or excluded as Covered Services identified in the Benefit Documents, but does not include the ultimate responsibility for making medical necessity or other medical management determinations.

   3.2. If Employer uses an Employer Service Vendor to provide enrollment data and that third party's data does not match BlueCross's data, BlueCross's data and records will be used to determine the ASF unless and until BlueCross and Employer are able to resolve the discrepancy.

3.3. Employer shall submit all information to BlueCross in writing. The accuracy of any changes performed and administered by BlueCross at the instruction of Employer in benefit design, enrollee status, etc., is the responsibility of Employer. BlueCross is entitled to rely on Employer's instructions in performing its duties under this Agreement.

3.4. A Member has the right to appeal any decision regarding or arising out of this Agreement, and that appeals process is defined in the Benefits Documents and the Plan.

4. Eligibility and Enrollment. As of the first day of the Term of this Agreement, Employer will have delivered enrollment information regarding Members to BlueCross. Employer shall deliver all employee and dependent eligibility status changes to BlueCross on a monthly basis, or more frequently as mutually agreed by the Parties.

4.1. Employer shall be responsible for verifying identity of Members to confirm eligibility and for promptly rescinding coverage of ineligible individuals.

4.2. Employer shall be responsible for providing each Subscriber with a copy of any required documents.

4.3. If an employee waives his/her (or his/her dependents') coverage under the Plan at enrollment or open enrollment, Employer will maintain the original of the waiver, and if the employee has a qualifying event during the plan year, Employer will certify to BlueCross that the employee executed a waiver at enrollment or open enrollment.

5. Financial Obligations.

5.1. Claims Funding. Employer is financially responsible for the timely funding of all Approved Claims and is the Payor of benefits for all Members. Employer will provide BlueCross with such authorizations as are necessary to ensure that required instruments are valid with respect to funding Approved Claims for Covered Services.

6. Assessments.

6.1. Employer retains responsibility and liability for all benefits and expenses incident to the Plan, including any federal, state or local taxes, assessments, or similar government-imposed fees, other than BlueCross's income taxes, that are related to the Plan, the Plan's Members, enrollees, or participants, or BlueCross's services under this Agreement ("Assessments"). For example, Assessments may be based on: (i) the number of covered lives in the Plan, (ii) the number of covered lives in a given geographic region, (iii) fees paid or payable to BlueCross for services provided under this Agreement, including premiums or premium equivalents, (iv) Approved Claims paid pursuant to this Agreement, or (v) other assessment methodologies that measure the relative value of benefits or services provided or delivered under the Plan. If at any time, during or after the term of this Agreement, BlueCross is required to pay any Assessment on Employer's behalf, Employer shall reimburse BlueCross an amount equal to such Assessment(s), which will be disclosed to Employer via invoice. Additionally, BlueCross pays if any taxes,

penalties or interest are imposed, assessed or accrued on any Assessment, Employer will reimburse BlueCross such additional amounts equal to the tax, penalty or interest.

6.2. Employer will pay these additional amounts to BlueCross within thirty (30) days following mailing of invoice. Payments not received within the thirty (30) day period are subject to the late payment charge described in Exhibit B.

6.3. Employer will pay these additional amounts even if the validity of Assessments has not been finally determined. If it is finally determined that such Assessments were not valid, to the extent such Assessments are refunded or otherwise returned to BlueCross by the appropriate Federal, state or local governmental entity, BlueCross will refund to Employer an amount equal to those additional amounts previously paid by Employer plus interest, if any, determined in accordance with BlueCross's regular procedures then in effect, less a pro rata share of any expenses incurred by BlueCross in contesting the validity of such Assessments.

7. Use of Names and Service Marks. Employer agrees to allow BlueCross to use Employer's name and service mark on I.D. cards and other forms necessary to implement this Agreement, for BlueCross's internal purposes, and to promote Employer's relationship with BlueCross to potential or existing providers. BlueCross shall not use Employer's name or service mark for any other purpose without the prior written consent of Employer.

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

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

8. Claims Incurred and Submitted but not yet Adjudicated. Employer can request reports regarding claims incurred and submitted but not yet adjudicated through the Account Manager.

EXHIBIT F TO THE ADMINISTRATIVE SERVICES AGREEMENT

DIRECT DEBIT AUTHORIZATION AGREEMENT

Employer has signed a separate Direct Debit Authorization Agreement, which is hereby incorporated by reference as part of this Agreement.

EXHIBIT G TO THE ADMINISTRATIVE SERVICES AGREEMENT

INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services.

Overview

BlueCross 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 BlueCross serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BlueCross serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BlueCross remains responsible for fulfilling our obligations to Employer. Our 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 Inter-Plan Arrangements. Note that Dental Care Benefits except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Us to provide the specific service or services are not processed through Inter-Plan Arrangements.

1.1. 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.

1.1.1. Liability Calculation Method Per Claim – In General.

1.1.1.1. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member 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 BlueCross by the Host Blue.

1.1.1.2. Employer 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 BlueCross by the Host Blue under the contract between the Host Blue and the provider. Sometimes, this negotiated price may be greater for a given service or services than billed charge in accordance with how the Host Blue has negotiated with its participating healthcare provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge.

1.1.2. Claims Pricing.

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

1.1.2.1. 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

1.1.2.2. 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

1.1.2.3. 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.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific claim and the actual amount the Host

Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, 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 over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

1.1.3. BlueCard Program Fees and Compensation.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which BlueCross is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in Exhibit B. BlueCard Program Fees and compensation may be revised from time to time as described in section 1.7 below.

1.2. Special Cases: Value-Based Programs.

1.2.1. Value-Based Programs Overview.

Employer's Members 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 Homes and Shared Savings arrangements.

1.2.2. Value-Based Programs under the BlueCard Program.

1.2.2.1. 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: Per member per month, provider incentives, gain share, risk share, retrospective settlements, prospective settlements, share of target savings, Care Coordination Fees and/or other allowed amounts.

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

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

- 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.
- 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 follows:

1.2.2.1.1. Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BlueCross 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:

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

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

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

1.2.3. Care Coordinator Fees.

Host Blues may also bill BlueCross for Care Coordinator Fees for provider services which we will pass on to Employer as follows:

1.2.3.1. PMPM billings; or

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

As part of this Agreement/contract, BlueCross and Employer will not impose Member cost sharing for Care Coordinator Fees.

1.2.4. Value-Based Programs under Negotiated Arrangements.

If BlueCross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, BlueCross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in the BlueCard Program section.

As part of this Agreement, BlueCross and Employer may agree/have agreed to waive Member cost sharing for care coordinator fees.

1.2.5. Value-Based Programs Definitions.

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

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

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

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

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

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

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

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

1.3. Prepayment Review & Return of Overpayments.

If a Host Blue conducts prepayment review activities, including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill BlueCross up to a maximum of sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill BlueCross the lesser of the full amount of the third-party fees or up to sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross. and the Host Blue, and these fees may be charged to Employer.

Recoveries of overpayments/from a Host Blue, or its participating and nonparticipating providers, or from post-payment review activities, can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare 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. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BlueCross they will be credited to Employer. When a Host Blue identified and collects these recovery amounts, the Host Blue may bill BlueCross up to a maximum of sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. When this occurs, the Host Blue may bill the lesser of the full amount of the third party fees or up to sixteen percent (16%) of the savings identified, unless an alternative reimbursement arrangement is agreed upon by BlueCross and the Host Blue, and these fees may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, BlueCross will 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. 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 healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of this Agreement.

1.4. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BlueCross will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability. See also Exhibit E, paragraph 6.

1.5. Nonparticipating Providers Outside BlueCross's Service Area.

1.5.1. Member Liability Calculation.

1.5.1.1. In General

When Covered Services are provided outside of BlueCross's service area by nonparticipating providers, the amount(s) a Member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BlueCross will make for the Covered Services as set forth in this paragraph. Payments for certain out-of-network services, including out-of-network emergency services will be governed by applicable federal and state law.

1.5.1.2. Exceptions

In some exception cases, BlueCross may pay claims from nonparticipating healthcare providers outside of BlueCross's service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by BlueCross in BlueCross's sole and absolute discretion or by applicable law. In other exception cases, BlueCross may pay such claims based on the payment BlueCross would make if BlueCross were paying a nonparticipating provider inside of BlueCross's service area. This may occur where the Host Blue's corresponding payment would be more than BlueCross's in-service area nonparticipating provider payment, BlueCross may negotiate a payment. BlueCross may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BlueCross will make for the Covered Services as set forth in this paragraph.

1.5.2. Fees and Compensation.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association

and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer are set forth in Exhibit B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section 1.7 below.

1.6. Blue Cross Blue Shield Global® Core.

1.6.1. 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.

1.6.1.1. 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. In such cases, the hospital will submit Member 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. **Members must contact BlueCross to obtain precertification for non-emergency inpatient services.**

1.6.1.2. 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.

1.6.1.3. 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 BlueCross, 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.

1.6.2. Blue Cross Blue Shield Global Core-Related Fees.

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core are set forth in Exhibit B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section 1.7 below.

1.7. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation.

Modifications or changes to Inter-Plan arrangement fees are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BlueCross 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 given written notice of termination before the effective date of this change. 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 BlueCross will then allow such modifications to become part of this Agreement.

EXHIBIT H TO THE ADMINISTRATIVE SERVICES AGREEMENT

COBRA ADMINISTRATION PROVIDED BY BlueCross

In the event that any Member is entitled to continuation of their benefits under the Benefit Documents, BlueCross will continue to perform its duties under this Agreement with regard to that Member as outlined below. That Member shall be charged the amount allowed by law (currently, 102% of the premium equivalent charged to active Subscribers, and 150% if the Member is disabled). BlueCross's and Employer's obligations under this Exhibit shall terminate upon termination of this Agreement.

1. When an eligible employee (and/or his or her spouse) first enrolls in Employer's Plan, and Employer has notified BlueCross of this enrollment, BlueCross shall:

    1.1. Issue an initial COBRA notice to the eligible employee at the home address supplied by Employer. We will send a single notice to the eligible employee and spouse if BlueCross's information is that he or she reside at the same address and enrolled at the same time;

    1.2. Send a separate notice to the spouse, if:

        1.2.1. The spouse lives at a separate address from the eligible employee (and BlueCross is made aware of this by Employer prior to issuing the notice); or

        1.2.2. The spouse becomes enrolled in Employer's Plan at a different time from the eligible employee;

    1.3. Issue these notices within 14 days of the date Employer notifies BlueCross that the eligible employee and/or spouse has enrolled.

2. Once notified by Employer that a Subscriber and/or Dependents are eligible for COBRA continuation ("Eligible COBRA Participant"), BlueCross shall:

    2.1. Remove the Member(s) from Employer's eligible Member record at BlueCross;

    2.2. Send a COBRA Qualifying Event Notice to the Eligible COBRA Participant, along with enrollment forms and rate and benefit information within 14 days of receiving notice from Employer that a Qualifying Event has occurred;

    2.3. Send premium equivalent notices to the Eligible COBRA Participant, either by mail or other acceptable method;

    2.4. Collect all necessary payments and premium equivalents from said Member, in such amounts as directed by Employer, for all benefits selected to be continued by the Qualified Beneficiaries. If BlueCross does not receive the necessary payments from a Qualified Beneficiary, BlueCross will:

        2.4.1. Place a stop-pay on the Qualified Beneficiary's benefits; and

        2.4.2. Cancel the Qualified Beneficiary's coverage at the end of the grace period.

2.5. Provide claims processing services;

2.6. Provide access to the Blue Network(s);

2.7. Provide all notices and other documentation required under COBRA on Employer's behalf once a Member goes on COBRA; and

2.8. Terminate the COBRA continuation coverage at the appropriate time.

2.9. When a notification of termination is generated, (i.e., for failure to submit the enrollment form and pay the applicable premium during the statutory election and/or grace period, non-payment of premium charges or expiration of the applicable eligibility period for COBRA continuation coverage) BlueCross will:

2.9.1. Notify the Qualified Beneficiary of the coverage termination, as well as the reason and effective date thereof;

2.9.2. Notify Employer of any termination of coverage;

2.9.3. Mail information regarding any available conversion coverage to the terminated Qualified Beneficiary.

2.10. When a Termination of Coverage letter is sent, it will be sent to the Member's current address, as contained in BlueCross's records.

2.11. If Employer terminates its Plan, BlueCross shall not send out Termination of Coverage letters.

3. Employer, as the Plan Administrator, shall:

3.1. Provide the eligibility information for all Qualified Beneficiaries to BlueCross with the monthly eligibility information;

3.2. Notify BlueCross, using BlueCross's form, that a Subscriber and/or Dependents are eligible for COBRA within 30 days of the Qualifying Event;

3.3. Provide timely notice of the following information (but in no event more than 30 days) to BlueCross in writing when a Qualifying Event occurs: (a) the name and address of the Qualified Beneficiaries; (b) type of qualifying event; (c) the date of the Qualifying Event; (d) the date that Employer-sponsored health coverage would otherwise terminate; (e) the Qualified Beneficiary's ID number; (f) the Qualified Beneficiary's date of birth; and

3.4. Notify BlueCross of any changes that it becomes aware of that might affect the Eligible COBRA Participant's coverage under COBRA.

4. ASF for COBRA-Related Services:

4.1. For Qualified Beneficiaries who have BlueCross-administered health benefits:

4.1.1. Employer shall pay BlueCross the ASF included in Exhibit B;

4.1.2. Employer shall pay BlueCross the same ASF for eligible COBRA Participants as is charged for Subscribers.

4.2. For Qualified Beneficiaries who elect COBRA continuation, but not for BlueCross administered health benefits, Employer shall pay BlueCross 2% of the premium equivalent remitted.

4.3. Payment for COBRA administration services is as follows:

4.3.1. For Qualified Beneficiaries who elect COBRA Continuation for BlueCross administered health benefits:

4.3.1.1. Employer shall pay to BlueCross the currently charged ASF for all Eligible COBRA Participants;

4.3.2. From each premium equivalent remitted by Eligible COBRA Participants, BlueCross shall:

4.3.2.1. Retain 2% of the premium equivalent received by BlueCross;

4.3.2.2. Credit Employer with the remainder of the premium equivalent received by BlueCross.

4.3.3. For Qualified Beneficiaries who do not elect COBRA Continuation for BlueCross administered health benefits:

4.3.4. From each premium equivalent remitted by Eligible COBRA Participants, BlueCross shall:

4.3.4.1. Retain 2% of the premium equivalent received by BlueCross;

4.3.4.2. Send a separate check to Employer for the remainder of the premium equivalent received by BlueCross.

5. BlueCross will provide COBRA administration for all Members covered under Employer's Plan.

6. "Qualified Beneficiary" means each individual person who is eligible for COBRA continuation coverage, whether formerly covered under the BlueCross administered plan as a Subscriber or a dependent, or covered under another of Employer's benefits plans.

7. "Eligible COBRA Participant" means the group of a Subscriber and/or Dependents, whether formerly covered under the BlueCross or another of Employer's benefit plans, that have elected to be covered together as a family unit and are issued one invoice for COBRA Continuation Coverage by BlueCross.

EXHIBIT I TO THE ADMINISTRATIVE SERVICES AGREEMENT

HEALTH AND WELLNESS SERVICES

Employer has selected the Health and Wellness Services described below.

1. Services.

1.1. Teladoc™ Health. Teladoc Health provides access to practitioners via telephone, internet or other telecommunication device, whereby the Practitioner may diagnose a Member's ailment, recommend therapy and, where appropriate, write a non-DEA controlled prescription. Teladoc Health's myStrength Complete gives Members the ability to schedule appointments with mental health Practitioners for talk therapy and prescription medication management, when appropriate, and also includes access to certified coaches, digital programs, engagement guidance, and crisis outreach depending on the Member's needs. In addition to claim visit costs related to visits with a mental health Practitioner, myStrength Complete program fees will be charged on a Per Participant Per Month basis as described in Exhibit B.

1.2. Diabetes Prevention Program. The program aims to prevent Members from developing diabetes. Members at risk for developing type 2 diabetes are identified through a pre-diabetes screening questionnaire. Once enrolled, Members have access to the DPP's standard suite of tools, such as cellular-enabled scales, interactive coaching sessions, online classes, etc., that help the Member make lifestyle changes and decrease their likelihood of developing diabetes. BlueCross's DPP utilizes a digitally based platform to administer the program. Program fees will be charged on a per-Member basis as described in Exhibit B.

1.3. Diabetes Management Program. The program aims to reduce hemoglobin A1C levels, emergency room visits and outpatient visits for Members with diabetes who participate in the program. The DMP gives the Member access to monitoring via connected meter and real-time insights, unlimited supply of test strips and lancets shipped direct to Member with automated reordering based on usage, 24/7 support and access to clinical coaches for diabetes education and support. Real-time insights help Members share reports with their provider and receive health notifications and reminders to help keep them on track. The DMP utilizes a digitally-based platform to administer the program. Program fees will be charged on a Per Participant Per Month basis as described in Exhibit B.

EXHIBIT J TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT K TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT L TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT M TO THE ADMINISTRATIVE SERVICES AGREEMENT

ONLINE ENROLLMENT SPECIFICATIONS THROUGH BlueCross SECURED WEBSITE

1. BlueCross's Duties and Responsibilities.

   1.1. BlueCross will provide a PIN for website access.

   1.2. BlueCross will provide instruction upon Employer's request. Such instruction may be done by telephone or personal contact.

   1.3. BlueCross will accept data and process enrollment, status change and termination requests in accordance with the eligibility guidelines.

   1.4. BlueCross has the right to audit Employer's data transmissions for accuracy and completeness.

2. Employer's Duties and Responsibilities.

   2.1. Employer will submit data only on eligible individuals.

   2.2. Employer is responsible for the accuracy and completeness of all data submitted.

   2.3. Employer will submit data on a timely basis in accordance with this Agreement.

   2.4. Employer assumes responsibility for notifying BlueCross when Employer's group administrator or enrollment contact changes, so that BlueCross can revoke that individual's website access. BlueCross will revoke access within 5 working days of being notified. If Employer does not inform BlueCross of any such change, and a former group administrator or enrollment contact enters fraudulent or incorrect information through the website, Employer is responsible for these actions.

EXHIBIT N TO THE ADMINISTRATIVE SERVICES AGREEMENT

GRIEVANCE SERVICES

This Exhibit describes duties regarding grievance services:

1. First Level Grievance
   - 1.1 BlueCross shall conduct the first level grievance on Employer's behalf. For purposes of handling the first level Grievance, BlueCross is a Limited Fiduciary, as that term is defined in ERISA.
   - 1.2 BlueCross' first level grievance committee shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.
   - 1.3 A written decision concerning the grievance shall be sent to the Member and to Employer within the timeframe set forth in the Plan.
   - 1.4 Member shall have the opportunity to submit written testimony and any additional written information to the committee. Oral testimony will not be permitted at the first level grievance.
   - 1.5 First level grievance shall be the only mandatory level of grievance.
2. Second Level Grievance
   - 2.1 Employer does not have a Second Level Grievance.
3. External Review.
   - 3.1 Employer does not have External Review.
4. The Plan and BlueCross' grievance processes shall be subject to and comply with the review standards applicable to ERISA plans, whether or not the Plan is otherwise governed by ERISA.
5. BlueCross shall, upon Employer's request, provide to Employer any grievance information related to a grievance handled by BlueCross.
6. Nothing in the Plan shall establish a grievance process that contradicts any statement in this Section.
7. BlueCross shall not be required to perform any grievance services not expressly stated in this Section.

EXHIBIT O TO THE ADMINISTRATIVE SERVICES AGREEMENT

SAVINGS GUARANTEE BLUE NETWORK

1. Savings Guarantee.

BlueCross guarantees that, of the claims that are approved for Eligible Charges, Employer will see a savings over the amount charged by Network Providers. The Savings Guarantee will be 63%. This Savings Guarantee applies only to Eligible Charges received from a Network Provider.

1.1. This Savings Guarantee is valid only for the period July 1, 2023, through June 30, 2024, (the "SG Effective Period").

1.2. The measuring period for the Savings Guarantee is the applicable Plan Year, not to exceed 12 months.

1.3. The Savings Guarantee is based on the following facts and assumptions:

1.3.1. An enrollment of 737 lives and 2.52 contract size, and a network penetration of 95%.

1.3.2. No substantial changes (i.e. including but not limited to the addition of a new participating hospital or the termination of a participating hospital) in the Blue Network P, or network service area.

1.3.3. The following provider utilization by type: (a) Inpatient, 19.6%; Outpatient, 39.2%; and Physician 41.2%.

1.4. BlueCross reserves the right to change or nullify the Savings Guarantee if any of the following occur:

1.4.1. A +/-10% change in overall enrollment or contract size, enrollment by location, state or addition/closing of a location.

1.4.2. Network penetration falls below 93%.

1.4.3. A substantial change to the Blue Network, or the network service area. In such instance, adjustments will be made accordingly and communicated to Employer as soon as reasonably possible, but not later than 30 days prior to the effective date of the adjustment.

1.4.4. Provider utilization by type deviates +/-5% from the above percentages.

1.5. Savings Guarantee applies to in-network medical charges only and excludes network access fees, zero discount claims, behavioral health claims, pharmacy claims, provider administered specialty pharmacy claims, and claims over $100,000.

1.6. A Network Savings Summary report will be provided on a quarterly basis.

2. BlueCross will determine the actual Savings Guarantee Percentage and provide Employer with the amount of any applicable refund, if necessary, no later than three months after the end of the applicable Plan Year.

    2.1. If the achieved savings percentage is 3-4.9 percentage points below the Savings Guarantee, then BlueCross will refund $4.41 per Subscriber per month.

    2.2. If the achieved savings percentage is 5 percentage points below the Guarantee, then BlueCross will refund an additional $8.80 per Subscriber per month.

    2.3. Any amounts owed to Employer by BlueCross will be paid within 30 days of when BlueCross delivers the Savings Guarantee calculation to Employer. Delivery may be accomplished via U.S. mail, electronic mail, or fax. Delivery may also be made in person by a representative of BlueCross.

3. Termination of this Exhibit.

    This Savings Guarantee is valid only for the SG Effective Period. Should Employer terminate the Agreement before the end of the SG Effective Period, this Savings Guarantee will be invalid.

EXHIBIT P TO THE ADMINISTRATIVE SERVICES AGREEMENT

PHARMACY SERVICES

Employer has selected BlueCross to provide pharmacy benefit management services with respect to Employer's Plan.

1. DEFINITIONS

The following definitions apply for purposes of this Exhibit only.

"Covered Drug(s)" means those prescription drugs, supplies, and other items that are covered under the Plan.

"Drug Formulary" means the list of FDA-approved prescription drugs and supplies developed by BlueCross' Pharmacy and Therapeutics Committee. The drugs and supplies included on the Drug Formulary will be modified by BlueCross from time to time as a result of factors, including, but not limited to, medical appropriateness, pharmaceutical manufacturer Pharmacy Rebate arrangements, and patent expirations.

"Home Delivery Network" means BlueCross' network of Participating Pharmacies where prescriptions are filled and delivered to Members via mail delivery service. The Home Delivery Network does not include pharmacies in the Specialty Pharmacy Network.

"Manufacturer Administrative Fees" means those administrative fees paid by manufacturers to the pharmacy benefit manager pursuant to a contract between the pharmacy benefit manager and the manufacturer in connection with the pharmacy benefit manager's administering, invoicing, allocating, and collecting Pharmacy Rebates.

"Member Submitted Claim" means a paper claim submitted by a Member for Covered Drugs dispensed by a Pharmacy for which the Member paid cash.

"Over the Counter Drug" or **"OTC"** means a drug available without a written prescription.

"Participating Pharmacy" means any pharmacy within BlueCross' Pharmacy network licensed to provide Covered Drugs to Members.

"Pharmacy Rebate" is revenue received by BlueCross from rebate aggregators or pharmaceutical manufacturers, which is related to Members' utilization of Covered Drugs. The following are specifically excluded from the definition of Pharmacy Rebate and shall be retained by BlueCross: (a) contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met; and (b) rebates attributable to any payment BlueCross receives for a Provider Administered Specialty Pharmacy Product claim as defined in Exhibit C ; and (c) Manufacturer Administrative Fees.

"Prescription Drug Claim" means a Member Submitted Claim or claim for payment submitted by a Participating Pharmacy as a result of dispensing a Covered Drug to a Member.

"Retail 30 Network" means BlueCross' network of retail Participating Pharmacies that are permitted to dispense Covered Drugs to Members typically in a 30-day supply.

"Specialty Pharmacy Network" means BlueCross' network of Participating Pharmacies that are permitted to dispense Self-Administered Specialty Pharmacy Products to Members.

"Self- Administered Specialty Pharmacy Product" means those Specialty Pharmacy Products that a Member administers rather than a provider. Self-Administered Specialty Pharmacy Products can only be dispensed from a specialty pharmacy in the Specialty Pharmacy Network and must meet all three of the following criteria:

a) Require in-depth patient teaching, coordination of care, and frequent monitoring to ensure successful use;

b) Described by at least one of the following:

i. produced through genetic technology or biopharmaceutical processes;

ii. target a chronic, rare, genetic, or complex disease; or

iii. require unique handling, distribution, and/or administration; and

c) Are set forth in the Drug Formulary which is maintained by BlueCross (available at www.bcbst.com), as may be amended from time to time for any reason.

All the medications set forth in the Drug Formulary have been determined by BlueCross to meet criteria (a) and (b) above. However, some products meeting criteria in (a) and (b) above may be excluded from the Drug Formulary. A Self-Administered Specialty Pharmacy Product may be added or removed from the Drug Formulary at any time for any reason.

2. PHARMACY SERVICES

BlueCross will provide the following pharmacy benefit management services:

Employer and Member Services	
Toll-free consumer advisor number for Members	Designated account team
Coordinated eligibility submission	Benefit plan setup
Member Submitted Claim processing	Electronic claims processing
Network Pharmacy Services	
Pharmacy help desk	Pharmacy reimbursement
Pharmacy network management	ePrescribing
Home Delivery Services	
Customer service for Members	Benefit education
Extended Payment Program	Prescription delivery – standard
“Worry Free” Fills	Bridge supply
Specialty Pharmacy Network Services	
Benefit education	Prescription delivery – standard
Reporting Services	
Web-based client reporting	Billing reports
Website Services	

BlueAccess - access to benefit, drug, health and wellness information; prescription ordering capability; My RX Choices and customer service	Specialist pharmacist - access to specialized pharmacists to answer non-urgent questions via email about medications for chronic conditions.

Cost Containment and Trend Management Solutions		
Solution	**Description**	**Fee**
Formulary Management	Drug Formulary program based on evidence-based medicine, integrated utilization management leveraging best practice guidelines and physician expertise to comparatively review and assess new and existing drugs for safety, efficacy and cost control.	No Additional Fee
POS Safety Messaging	A concurrent drug utilization program design to assist with preventing drug-related adverse events. Online, real-time drug utilization analysis is performed at the point of prescription dispensing, whether the dispensing occurs at the retail Pharmacy or at the home delivery Pharmacy.	No Additional Fee
Utilization Management	Represents a wide variety of rules-driven programs such as prior authorization, quantity limits, and step therapy to manage trends in patient drug utilization and client drug spend. • Prior Authorization - Monitors the dispensing of high-cost medications and those with the potential for misuse by requiring special approval (authorization) for certain drugs. • Step Therapy - Manages drug costs by ensuring that patients try first-line (first step), clinically effective, lower-cost medications before they “step up” to higher-cost medication. • Quantity Management - Sets dispensing limits for certain drugs based on FDA approved dosing guidelines.	No Additional Fee
Drug Coverage Determinations	Includes initial determinations and reconsideration processes and criteria for benefit design related requests, plan exclusion reviews (clinical or administrative reviews of non-Covered Drugs), copay reviews, plan limit reviews (e.g. age, gender, days’ supply limits), administrative reviews, clinical benefit reviews and direct claim reject reviews. The initial determinations and reconsideration processes are in addition to and occur before the Grievance Procedure. Members may submit Grievances in accordance with the Grievance Procedure outlined in their EOC.	No Additional Fee
Integrated Benefit Management	Integrated solution that provides real-time shared deductible and out-of-pocket accumulations between the medical and pharmacy benefit.	No Additional Fee
Specialty Pharmacy Management	Program encourages the adherence to safe and effective use of specialty pharmacy drugs according to prescribed regimens. The program achieves savings by establishing benefits for specialty prescriptions, limiting distribution to preferred vendors, establishing prior authorization criteria to assure appropriate utilization, and renegotiating of drug prices annually.	No Additional Fee

RxSafety	Program provides enhanced fraud, waste and abuse monitoring solution focused on combating the misuse and unintentional overuse of medications in Tennessee and nationally. This program protects Members by coupling the safety components of BlueCross' medical, behavioral and pharmacy programs by combing strategies into a holistic solution.	No Additional Fee
High Cost Claimant Review	An integrated management program targeting cost stratification and focused interventions for high dollar pharmacy claimants as part of a comprehensive Member population health solution.	No Additional Fee
Retail Vaccine Program	This preventive services program broadens the reach of flu and other vaccines while reducing costs by providing a convenient and less expensive alternative through the Retail 30 Network.	No Additional Fee
Drug Savings Review	Program to communicate with providers to suggest missing or alternate drug therapies for members taking certain medications. This program consists of algorithmic and clinician reviews that examine members' diagnoses and drug dosages, and when appropriate, recommends changes in therapy. When the algorithm identifies a potentially harmful prescription, specialty trained pharmacists notify the prescribing physician and vending pharmacist before the drug is dispensed.	No Additional Fee
Core Medication Management	Program for members with chronic conditions to ensure they are taking medications properly by addressing potential adherence issues and closing gaps in care. This program analyzes pharmacy claims data and notifies members and providers with refill and late to fill notifications per member's preferred method of communication.	No Additional Fee

2.1 Participating Pharmacies. The amount paid to the Participating Pharmacy for Prescription Drug Claims may or may not be equal to the amount charged to Employer, and BlueCross will absorb any negative margin or retain any positive margin. Subject to applicable law, BlueCross may communicate with Members regarding benefit design, cost savings, availability and use of the selected networks, as well as provide supporting services.

A list of Participating Pharmacies is available to Members on-line. BlueCross does not direct or exercise any control over the professional judgment exercised by any pharmacist providing pharmaceutical related services.

2.2 Any reports requested upon termination will incur an ad hoc fee. BlueCross shall not be obligated to release such report until the fee has been paid.

EXHIBIT Q TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT R TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT S TO THE ADMINISTRATIVE SERVICES AGREEMENT

AUDITS and RECORDS ACCESS

1. Audit of BlueCross.

1.1. Audits Generally. During the term of this Agreement, Employer may audit BlueCross, at Employer's own expense, in accordance with the following requirements:

1.1.1. Employer shall provide a written audit request to BlueCross at least 45 days in advance of the requested audit date. Such request shall include the requested audit date, the requested auditor, the manner of compensation for the auditor, and information about the nature, purpose, scope and objectives of the audit.

1.1.2. Employer and BlueCross will agree on an independent, third party auditor to conduct the audit ("Auditor").

1.1.3. The audit shall be conducted in accordance with the terms of BlueCross's standard audit agreement and this Agreement. The audit agreement shall be finalized and executed by BlueCross, the Auditor, and Employer prior to the commencement of the audit.

1.1.4. The audit shall be limited in scope to claims paid within the 12 months prior to the date the Audit Agreement is executed by the final signatory ("Audit Time Period").

1.1.5. Employer agrees that its audit rights are limited to BlueCross and do not extend to BlueCross's vendors or subcontractors. Any BlueCross audit shall be performed based on the information in BlueCross's records.

1.1.6. With respect to any audit, claims adjustments will be based on actual claims reviewed and not upon sampling, statistical projections or extrapolations.

1.1.7. The Parties agree that claims adjudicated following BlueCross's claims processing guidelines shall be deemed to have been properly adjudicated, including, but not limited to, the claims processed through the BlueCard program.

1.1.8. BlueCross shall be required to supply only such information which is in its possession and which is reasonably necessary for Employer to administer the Plan or for the auditor to perform its duties provided in the mutually agreed upon agreement, provided that such disclosure is not prohibited by any third party contracts to which BlueCross is a signatory or any requirements of the law. Employer hereby represents that, to the extent any disclosed information contains personally identifiable or health information about a Member, the Member has authorized disclosure to Employer or Employer otherwise has the legal authority to have access to such information.

1.1.9. Employer shall not hire a third party to conduct a contingent fee audit, where the third party's compensation, in whole or in part, is based on a percentage of errors (or savings, or uncovered recoveries, etc.), which may be found by the third party in its audit. BlueCross may request, and Employer will provide, the proposal for compensation of any requested auditor.

1.2. Medical Claims Audits.

1.2.1. While this Agreement is in effect, Employer may perform one medical claims audit during each calendar year.

1.2.2. After the termination of this Agreement by either Party and any applicable run-out period, Employer may perform one medical claims audit during the 15 months after the effective date of termination. With respect to medical claims audits, medical claims include claims for Provider Administered Specialty Pharmacy Products when BlueCross has agreed to administer those claims.

1.2.3. The only claims subject to audit are those claims paid during the Audit Time Period. Any claims paid prior to the Audit Time Period shall not be subject to audit.

1.2.4. For each Audit Time Period, no more than 250 claims shall be selected for review.

1.2.5. Claims audits will be conducted using the Benefit Plan approved by and in the possession of BlueCross and that was in effect at the time the claims being audited were adjudicated. Submitting the Benefit Plan to BlueCross later than six (6) months after the start of the applicable Benefit Period will cause Employer to lose its right to audit that Benefit Period.

1.3. Pharmacy Claims Audits.

1.3.1. While this Agreement is in effect, Employer may perform one pharmacy claims audit during each calendar year.

1.3.2. After the termination of this Agreement by either Party and any applicable run-out period, Employer may perform one pharmacy claims audit during the 15 months after the effective date of termination.

1.3.3. The only claims subject to audit are those claims paid during the Audit Time Period. Any claims paid prior to the Audit Time Period shall not be subject to audit.

1.3.4. For each Audit Time Period, no more than 250 claims shall be selected for review.

1.3.5. Claims audits will be conducted using the Benefit Plan approved by and in the possession of BlueCross and that was in effect at the time the claims being audited were adjudicated. Submitting the Benefit Plan to BlueCross later than six (6) months after the start of the applicable Benefit Period will

cause Employer to lose its right to audit that Benefit Period.

1.4. Clinical Process Audits.

1.4.1. In lieu of an audit identified above, Employer may perform one clinical process audit during each calendar year that this Agreement is in effect.

1.4.2. Employer shall have no right to conduct a clinical process audit upon termination of this Agreement.

1.4.3. The only processes subject to audit are those processes that were performed by BlueCross during the Audit Time Period. Any process performed by BlueCross prior to the Audit Time Period shall not be subject to audit.

1.4.4. With respect to a clinical process audit, the audit, scope and methodology will be consistent with generally acceptable auditing standards.

1.4.5. For each Audit Time Period, no more than 25, randomly selected case files shall be reviewed as part of a clinical process audit.

2. Reports. BlueCross will provide to Employer reports as specified in Exhibit B.

3. Books and Records. BlueCross shall maintain books and records directly related to its payment of claims on behalf of Employer pursuant to this Agreement, in accordance with its customary business practices. Upon execution of an applicable agreement relating to use and confidentiality, BlueCross shall make such books and records available for inspection by authorized representatives of Employer at BlueCross's home office, during normal business hours, upon reasonable advance written request, at Employer's expense, during the term of this Agreement and for 6 years from the date of the Final Settlement. The required agreement shall be determined by BlueCross based on the intended use of the information.

EXHIBIT T TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT U TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT V TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT W TO THE ADMINISTRATIVE SERVICES AGREEMENT

SHARED SAVINGS

BlueCross will perform recovery services in the identified areas and, as compensation for these services, BlueCross will retain a percentage of any recovery ("Shared Savings") as identified below. Shared Savings will be taken in accordance with BlueCross's administrative processes. Shared Savings will be reconciled via reporting updated on a weekly basis.

1. Legal Recoveries. BlueCross may represent the interest of Employer in any litigation against a third party where the claims are related to subrogation or overpayments for pharmaceutical products, medical devices, durable medical equipment/supplies, and/or other such claims resulting in causes of action described below. This representation grants BlueCross the ability to identify, pursue, negotiate settlements of, and/or recover direct legal or equitable claims related to the services performed pursuant to this Agreement. Employer grants to BlueCross the specific authority and discretion to opt Employer in or out of any class or direct settlement in which both BlueCross and/or Employer may be considered class members or settling parties, and the authority to pursue any recoveries for claims paid as a result of fraud, abuse or other inappropriate action by a third party. These claims include, but are not limited to, all legal claims Employer can assert whether based on common law or statute, such as RICO, antitrust, deceptive trade practices, consumer fraud, insurance fraud, unjust enrichment, breach of fiduciary duty, breach of contract, breach of covenant of good faith and fair dealing, torts (including fraud, negligence and product liability), breach of warranty, medical monitoring, false claims and kickbacks. If BlueCross obtains a recovery from any of these efforts, BlueCross will reimburse Employer's pro rata share of the recovery. This share is calculated from the Employer's claims history of Covered Members at the time of such recovery, less the Employer's pro rata share of the costs, if any, fees paid to outside counsel and any other costs incurred in obtaining a recovery. BlueCross will not charge the Employer for any costs if BlueCross does not obtain a recovery that exceeds those costs. The authority granted herein survives the termination of this Agreement.

   1.1 Subrogation Recoveries.

      1.1.1 BlueCross will enforce Employer's subrogation rights. For all subrogation recoveries received on or after July 1, 2022, BlueCross will retain a fee of 39% of the gross subrogation recovery. Employer is responsible for payment of: (a) any outside attorneys' fees incurred in enforcing Employer's subrogation rights; and (b) any other expenses arising in connection with litigation to enforce its subrogation interest, including, but not limited to, court costs and discovery expenses.

      1.1.2 For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, and any expenses associated with the litigation. The remaining amount is the net recovery, and the amount that Employer will receive as a credit.

   1.2 Mass Tort Recoveries.

      1.2.1 BlueCross will perform mass tort recoveries on behalf of Employer. BlueCross will retain a fee of 39% of all mass tort recoveries received on or after July 1, 2022.

1.2.2 For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, the attorneys' fee (if any) and any other litigation expenses from each recovery amount received. This net recovery is the amount that Employer will receive as a credit.

1.3 Class Action Recoveries.

1.3.1 BlueCross will perform class action recoveries on behalf of Employer. BlueCross will retain a fee of 39% of all class action recoveries received on or after July 1, 2022.

1.3.2 For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, the attorneys' fee (if any) and any other litigation expenses from each recovery amount received. This net recovery is the amount that Employer will receive as a credit.

2. Audit Services. BlueCross will conduct audits in varying manners and forms, including but not limited to, pre-payment claims audits, post-payment claims audits, eligibility overpayment audits, and provider audits. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross' right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 39% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial audit finding. BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.

3. Coordination of Benefit Services. BlueCross will conduct coordination of benefits activities. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross' right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 39% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial finding. BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.

4. Provider Administered Specialty Pharmacy Product Rebates. BlueCross may receive rebates and other consideration related to claims for Provider Administered Specialty Pharmacy Products ("Provider Administered Specialty Pharmacy Product Rebates"). BlueCross retains 100% of Provider Administered Specialty Product Rebates. Contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met are specifically excluded from the definition of Provider Administered Specialty Pharmacy Product Rebates and shall be retained by BlueCross.

5. Pharmacy Rebates.

5.1 For Pharmacy Rebates based on service dates occurring on or after July 1, 2017, Employer will receive 100% of Pharmacy Rebates (as defined in Pharmacy Services Exhibit).

EXHIBIT X TO THE ADMINISTRATIVE SERVICES AGREEMENT

ADDENDUM

This Addendum shall modify and supersede the attached Administrative Services Agreement, Contract 2022-0256 (the "Agreement") entered into on July 01, 2022, by the City of Franklin, Tennessee ("City") and BlueCross BlueShield of Tennessee, Inc. ("Vendor"). The Agreement together with this Addendum and the attached document(s) constitute the entire agreement ("Contract"). Acceptance of payment as stated in the Agreement constitutes Vendor's acceptance of all terms and conditions stated herein.

Standard Terms and Conditions

1. Indemnification and Limitations of Liability. The City, being a Tennessee governmental entity, is governed by the provisions of the Tennessee Governmental Tort Liability Act, Tenn. Code Ann. § 29-20-101 et. seq. for causes of action sounding in tort. Further, no contract provision requiring a Tennessee political entity to indemnify or hold harmless the Vendor beyond the liability imposed by law is enforceable because it appropriates public money and nullifies governmental immunity without the authorization of the General Assembly.
2. Confidentiality and Proprietary rights. City may be required to disclose documents under state or federal law. City shall notify Vendor if a request for documents has been made and shall give Vendor a reasonable opportunity under the circumstances to respond to the request by redacting proprietary or other confidential information. .
3. Warranties/Limitation of Liability/Waiver. The City reserves all rights afforded to local governments under law for all general and implied warranties. The City does not waive any rights it may have to all remedies provided by law and therefore any attempt by Vendor to limit its liability shall be void and unenforceable.
4. Waiver. Neither party's failure or delay to exercise any of its rights or powers under the Contract will constitute or be deemed a waiver or forfeiture of those rights or powers. For a waiver of a right or power to be effective, it must be in writing signed by the waiving party. An effective waiver of a right or power shall not be construed as either (a) a future or continuing waiver of that same right or power, or (b) the waiver of any other right or power.
5. Severability. If any term or provision of the Contract is held to be illegal or unenforceable, the validity or enforceability of the remainder of the Contract will not be affected.
6. Precedence. In the event of conflict between this Addendum and the provisions of the Agreement, or any other contract, agreement or other document to which the Agreement or this Addendum may accompany or incorporate by reference, the provisions of this Addendum will, to the extent of such conflict (or to the extent the Agreement is silent), take precedence unless such document expressly states that it is amending this Addendum.
7. Entire Agreement. The Contract between the parties and supersedes any prior or contemporaneous communications, representations or agreements between the parties, whether oral or written, regarding the subject matter of the entire Contract. The terms and conditions of this Addendum may not be changed except by an amendment expressly referencing this Addendum by section number and signed by an authorized representative of each party.
8. Applicable Law; Choice of Forum/Venue. The Contract constitutes the entire agreement and is made under and will be construed in accordance with the laws of the State of

Tennessee without giving effect to any state's choice-of-law rules. The choice of forum and venue shall be exclusively in the Courts of Williamson County, Tennessee. The Vendor acknowledges and agrees that any rights or claims against the City of Franklin or its employees, or elected or appointed officials hereunder, and any remedies arising there from, shall be subject to and limited to those rights and remedies, if any, available under Tenn. Code Ann. §§ 9-8-101 through 9-8-407.

9. Survival. This Addendum shall survive the completion of or any termination of the Contract, agreement or other document to which it may accompany or incorporate by reference.
10. Modification and Amendment. This Agreement may be modified only by a written amendment signed by all Parties.

CITY OF FRANKLIN, TENNESSEE

DocuSigned by:
Eric Stuckey
CD3688F4049D49E...
Signature

_Eric Stuckey, City Administrator_____
Print Name and Title

7/19/2023
Date

Approved as to form:

DocuSigned by:
J. Blake Harper
5A398B475DD6467...
J. Blake Harper, Staff Attorney

BLUECROSS BLUESHIELD OF TENNESSEE, INC.

DocuSigned by:
Robin Young
BFBEEA6C880F4B2...
Signature

Robin Young SVP & CMO
Print Name and Title

7/19/2023
Date