



Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

ADMINISTRATIVE SERVICES CONTRACT
WEEKLY INVOICE PROGRAM

Group Name:

Address:

Customer ID:

Effective Date:

This Contract commences on the above effective date (“Effective Date”) and is made between Blue Cross Blue Shield of Michigan, a Michigan non-profit mutual insurance corporation (“BCBSM”) and the group customer named above (“Group”), as the plan sponsor and administrator of its group health care plan (“Plan”).

This Contract sets forth the administrative responsibilities of BCBSM and Group’s financial and other obligations with respect to BCBSM’s role as a service provider to the Plan.

By entering into this Contract, Group and BCBSM hereby agree that, to the extent the Plan is governed by the Employee Retirement Income Security Act of 1974 (“ERISA”), their relationship is that of Group as “Plan Fiduciary” and BCBSM as “Service Provider” as those terms are used in Department of Labor guidance including 29 C.F.R. §2550.408b-2.

BCBSM and Group agree as follows:

ARTICLE I
DEFINITIONS

- A. “BCBS Plan”** means a company that has been licensed by BCBSA other than BCBSM.
- B. “BCBSA”** means the Blue Cross and Blue Shield Association.
- C. “BlueCard Program”** means the national program established by BCBSA under which Claims are processed by BCBS Plans when Enrollees receive health care services outside of Michigan. BCBSA mandates the policies, procedures and disclosures of the BlueCard Program and amends them from time to time. Schedule B sets forth BCBSA’s required disclosures for the BlueCard Program and is incorporated into this Contract. If BCBSA amends the disclosures, such amendments shall automatically become a part of this Contract upon BCBSM giving sixty (60) days prior written notice to Group.
- D. “Claim”** means, for the lines of business set forth in Schedule A, a payment request from a health care provider or an Enrollee for a health care service, product, or prescription drug provided to an Enrollee, with an incurred date during the term of this Contract. Claims billed to Group are negotiated rates paid to health care providers pursuant to BCBSM or a BCBS Plan’s provider agreements, which may include both service-based and value-based reimbursement. Service-based reimbursement means a BCBSM or BCBS Plan fee for a health care service. Value-based reimbursement means a fee for Quality Programs, as more fully described in Exhibit 1 to Schedule A.

BCBSM and BCBS Plans negotiate provider reimbursement rates on their own behalf, and not Group, and may set rates for health care services to cover any obligations to health care providers. Through this Contract, Group receives the benefit of provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims. Except as set forth in Schedule A, BCBSM does not retain any portion of Claims as compensation and all amounts collected from Group in Claims are used to satisfy provider obligations.

- E.** **“Contract”** means this administrative services contract and any schedules, parts, exhibits and addenda attached hereto and incorporated herein by reference as amended from time to time.
- F.** **“Contract Year”** means the period from the Effective Date to the first Renewal Date, or the period from one Renewal Date to the next Renewal Date. If termination occurs other than at the end of a Contract Year, Contract Year means that period from the Effective Date or the most recent Renewal Date to the termination date.
- G.** **“Coverages”** means the health care benefits set forth in the benefit design document or Part C of the Group Enrollment and Coverage Agreement and BCBSM’s medical policies, which are incorporated into this Contract.
- H.** **“Employee”** means the following which are eligible and enrolled for Coverage under the terms of the Plan or as required by law: (i) employees as designated by Group; (ii) retirees and their surviving spouses as designated by the Group; and (iii) COBRA beneficiaries.
- I.** **“Enrollee”** means an individual that Group enrolled as an Employee, spouse or dependent in the Plan pursuant to *Article II.B*.
- J.** **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended, 29 USC 1101, *et seq*, and regulations promulgated thereunder.
- K.** **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended, Public Law 104-191 of 1996, *et seq*, and regulations promulgated thereunder.
- L.** **“PPACA”** means the Patient Protection and Affordable Care Act, as amended, Public Law 111-148 of 2010, *et seq*, and regulations promulgated thereunder.
- M.** **“Quality Programs”** refer to BCBSM or BCBS Plan programs funded with value-based provider reimbursement. Quality Programs are governed by separate agreements with health care providers and are designed to improve health care outcomes and control health care costs.
- N.** **“Rebates”** means retrospective payments collected from drug manufacturers and paid to BCBSM that are attributable to Enrollee drug utilization.
- O.** **“Renewal Date”** means the date one (1) year after the Effective Date, and the same date of every subsequent year. The Renewal Date may be changed by mutual agreement of BCBSM and Group.
- P.** **“Transition Assistance Period” or “TAP”** means the period that begins on the Termination Date and concludes twenty-four (24) months thereafter, during which BCBSM shall provide those services, and Group shall perform those obligations, set forth in *Article IV.B*.

ARTICLE II
GENERAL RESPONSIBILITIES

- A. Claims Administrator Status.** Group delegates to BCBSM the responsibility and discretionary authority as claims administrator to make Plan interpretations and final benefit determinations. BCBSM's claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §503. By assuming these specifically delegated responsibilities as claims administrator, BCBSM does not thereby assume any other duty of the Group as Plan administrator or any other fiduciary function Group performs on behalf of its Plan. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is binding on the Enrollee, Group, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious. Group retains all other fiduciary responsibilities and duties under ERISA not specifically delegated to BCBSM in this Contract. BCBSM shall not be responsible for Group's failure to meet any of its financial obligations or Plan administrator responsibilities with respect to the Plan.
- B. Eligibility and Enrollment.** Prior to the Effective Date, Group shall notify BCBSM of all Enrollees that will be covered by the Plan. During the term of this Contract, following agreed upon procedures, Group shall notify BCBSM of all changes in Plan enrollment. Until BCBSM has been properly notified of changes to Group's Plan enrollment, BCBSM shall continue to process Claims for Enrollees as listed on BCBSM's computer membership programs. Group represents and warrants that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including PPACA.
- C. Claims Processing.** During the term of this Contract, Claims will be directly submitted to BCBSM and will be processed according to the Coverages and BCBSM's standard operating procedures for Claims. Notwithstanding the foregoing, Claims from out-of-state providers may, depending on the type of payment request, be directly submitted to the applicable out-of-state BCBS Plan and are processed and paid under the BlueCard Program as set forth in Schedule B. Claims from out-of-state providers are reported and billed to Group as they are received by BCBSM from a BCBS Plan and may include a BlueCard Access Fee for processing the Claim.
- D. Disputed Claims.** Group shall notify BCBSM in writing of any Claim that Group disputes within sixty (60) days of Group's access to a paid Claims listing. BCBSM shall investigate such Claim and respond to Group within a reasonable time period. Upon BCBSM's request, Group shall execute any reasonably necessary documents that will allow BCBSM to recover any amounts that may be owed by a third party with respect to such disputed Claim. If BCBSM recovers any amount from a third party or if BCBSM determines that the disputed Claim is not Group's financial responsibility or is incorrect, then BCBSM shall give Group a credit for the recovered or corrected amount (reduced by any stop loss credits given by BCBSM relating to such disputed Claim).
- E. Recoveries.**
1. Subrogation. BCBSM shall be subrogated to all of Group's, the Plan's, or an Enrollee's rights with respect to any Claim. BCBSM will use reasonable efforts to evaluate information provided by the Enrollee and other sources to identify Claims in which the Plan may have a subrogation or reimbursement interest. However, BCBSM is not obligated to pursue any subrogation or reimbursement claim, including commencing, becoming a party to, or intervening in any litigation. BCBSM will remit to Group the funds recovered from third parties less (a) any attorney fees resulting from recovery litigation undertaken by BCBSM, (b) any negotiated lien reduction, and (c) the percentage set forth on Schedule A. Group will reasonably assist in any BCBSM recovery efforts, including providing BCBSM with requested Plan documents.

2. Class Actions and Similar Litigation. Group and the Plan authorize BCBSM to act on their behalf in any health care class action or other similar litigation of which BCBSM has knowledge, e.g., a drug manufacturer or product liability lawsuit ("Class Action"). Group and the Plan further authorize BCBSM to submit Claims, agree to any Class Action settlement, and collect and remit to Group any funds recovered less any reasonable expenses incurred by BCBSM. If Group notifies BCBSM that it desires to independently pursue a Class Action, BCBSM will provide Group with applicable Claims and other necessary information.

F. Benefit Litigation Defense. If a third party initiates a claim, suit, or proceeding against the Plan, Group, or BCBSM relating to benefits payable under the Plan or any of the administrative services subject to this Contract ("Litigation"):

1. Each party shall provide prompt written notice of the Litigation to the other party if served with such Litigation.
2. Group may request that BCBSM select counsel and defend litigation. BCBSM retains the right to deny this request and require Group to defend the Litigation.
3. Whenever Group or BCBSM is a party in any Litigation, regardless of who defends the litigation, Group and BCBSM each reserve the right, at their own cost and expense, to retain counsel to protect their own interests.
4. Regardless of who defends the litigation, Group and BCBSM shall reasonably cooperate with each other to provide all relevant information and documents within their respective control that are not subject to a privilege or confidentiality obligation; and to reasonably assist each other to defend, settle, compromise, or otherwise resolve the Litigation. Whenever either party is served with any Litigation, the party served shall take all steps necessary to prevent a default in the Litigation prior to determining which party will defend such Litigation.
5. BCBSM shall have full authority to settle or compromise such Litigation, without Group's specific consent, unless:
 - a. \$50,000 or more is at issue in the Litigation;
 - b. State tax issues or mandated benefit issues are part of the Litigation and Group has requested BCBSM to defend the Litigation; or
 - c. Settlement of the Litigation could have a material adverse impact on Plan costs or administration.

If Group's consent to settle or compromise Litigation is required, such consent shall not be unreasonably withheld. If Group withholds consent for any reason and the final resolution of the Litigation is equal to or greater than a settlement or compromise proposed by BCBSM, Group shall pay BCBSM the additional cost of any subsequent settlement, compromise or judgment including all of BCBSM's reasonable attorney fees and costs for proceeding with the Litigation.

6. When Group defends the Litigation, Group shall have full authority to settle or compromise such Litigation without BCBSM's consent, unless BCBSM has notified Group that the Litigation may have a material adverse impact on BCBSM.

If BCBSM's consent to settle or compromise Litigation is required, such consent shall not be unreasonably withheld. If BCBSM withholds consent for any reason and the final resolution of the Litigation is equal to or greater than a settlement or compromise proposed by Group, BCBSM shall pay the additional cost of any subsequent settlement, compromise or judgment including all of Group's reasonable attorney fees and costs for proceeding with the Litigation.

7. When BCBSM defends the Litigation, the cost and expenses of such defense shall be paid by BCBSM. However, Group shall pay for any judgment, award, settlement or payment of amounts due with respect to the underlying Litigation.
8. Subject to *paragraph 6* above, when the Group defends the Litigation, Group shall pay the cost and expenses of such defense, reasonable attorney fees and any judgment, award, settlement or payment of amounts due with respect to the underlying Litigation.

G. Group Audits.

1. Group, at its own expense, shall have the right to audit Claims incurred under this Contract; however, audits shall not occur more frequently than once every twelve months and shall not include Claims from previously audited periods or Claims paid prior to the last twenty-four (24) months.
2. Prior to any audit, Group and BCBSM must mutually agree upon any independent third-party auditor that Group wishes to perform the audit. BCBSM shall not unreasonably withhold its consent. Additionally, prior to audit, Group and any third-party auditor shall sign BCBSM's audit agreement.
3. All audits shall be conducted pursuant to BCBSM corporate policy and other requirements at the time of the audit. The parties acknowledge staffing constraints may exist in servicing concurrent Group initiated audits. Therefore, after notice from Group requesting an audit, BCBSM will have up to ninety (90) days to begin gathering requested documentation and to schedule the on-site phase of the audit.
4. Sample sizes shall not exceed two hundred (200) Claims and shall be selected to meet standard statistical requirements (i.e., 95% Confidence Level; precision of +/- 3%). If BCBSM agrees to any additional Claims above the 200, Group shall reimburse BCBSM for Claims documentation in excess of 200 Claims at fifty dollars (\$50.00) per Claim.
5. Following the on-site activity and prior to disclosing the audit findings to Group, the auditor shall meet with BCBSM management and present the audit findings.
6. BCBSM shall have no obligation to make any payments or reimbursements in connection with audit findings to Group unless there has been a recovery from the provider, Enrollee, or third-party carrier, as applicable. No adjustments or refunds shall be made based on the auditor's statistical projections of sampled dollar errors. An audit error will not be assessed if the Claim payment is consistent with BCBSM policies and procedures, or consistent with specific provisions contained in this Contract or other written Group instructions agreed to by BCBSM.

H. Disclosures. Group shall disclose the following to Enrollees in writing:

1. BCBSM services being provided.
2. BCBSM does not insure any Enrollees.
3. Group is responsible for the payment of Claims.
4. Group is responsible for Plan benefits and any changes thereto.
5. Group is responsible for eligibility and enrollment.

I. Health Care Provider Interest. Group acknowledges that various states including Michigan have enacted prompt payment legislation with respect to the payment of Claims that may require the payment of interest to providers under circumstances dictated by statute. BCBSM will invoice the Group for any interest required by statute and Group shall pay such interest. Additionally, out-of-state Claims may be inclusive of any interest owed by statute or required by the terms of provider contracts with the out-of-state BCBS Plan. Out-of-state Claims are reported and billed to Group as submitted to BCBSM by the out-of-state BCBS Plan.

- J. Confidentiality.** The terms of this Contract and the items set forth below are confidential and shall not be disclosed or released to a third party without the prior written consent of BCBSM, unless required by law.
1. Provider Proprietary Information. Health care provider names, addresses, tax identification numbers, and financial amounts paid to such providers.
 2. BCBSM and Other BCBS Plan Proprietary Information. BCBSM's or any other BCBS Plan's methods of reimbursement, amounts of payments, discounts and access fees; BCBSM's administrative fees and, if applicable, stop loss fees; those processes, methods, and systems developed for collecting, organizing, maintaining, relating, processing and transacting comprehensive membership, provider reimbursement and health care utilization data.
- K. Coordination with Medicare.** Group shall timely notify BCBSM whether Medicare is the primary payer for Claims of any Enrollee. BCBSM shall change such Enrollee's eligibility record within fifteen (15) business days of BCBSM's receipt of Group's notice.
- L. Prescription Drug Benefits.** To the extent Group has engaged BCBSM to administer prescription drug claims for its Plan, BCBSM or its subcontractor shall process all prescription drug claims according to the Coverages, participating pharmacy contracts, and fees set forth on Schedule A. Payments to participating pharmacies may include prescription drug costs, dispensing fees, and incentive fees for dispensing a generic drug or compounding a prescription drug.

BCBSM may contract with rebate administrators ("Rebate Administrators") to submit drug claims for Rebates. Group, directly or indirectly, will not submit any claims for Rebates. Rebate Administrators may retain a portion of the gross Rebates as a claims processing and rebate administration fee ("Rebate Administrator Fee"). BCBSM may retain a portion of the Rebates as administrative compensation ("BCBSM Rebate Service Fee"). The Rebate Administrator Fee and BCBSM Rebate Service Fee are set forth in Schedule A. Any change to the Rebate Administrator Fee during a Contract Year shall be effective and automatically incorporated in Schedule A following thirty (30) days notice by BCBSM to Group. BCBSM will distribute Rebates net of any fees set forth in the Schedule A to Group. If BCBSM receives rebate adjustments or de minimis amounts of unidentifiable Rebates that cannot practicably be tied to particular claims, BCBSM will proportionally allocate those Rebate amounts to BCBSM customers with prescription drug benefits.

ARTICLE III **FINANCIAL RESPONSIBILITIES**

- A. Group Responsibilities.** Group shall be responsible and liable for:
1. Claims;
 2. Fees set forth in Schedules A, B, and C, including administrative fees, additional administrative compensation, and any other fees identified therein;
 3. Health Care Provider Interest;
 4. Taxes and surcharges imposed by state and federal governments on Claims or number of Enrollees;
 5. Statutory court costs and attorney fees awarded by a court of competent jurisdiction to an Enrollee as a result of Litigation; and
 6. All other risks, financial obligations, and liabilities which BCBSM may assume or which might otherwise attach with respect to the administration of Coverages.

- B. Group's Weekly Wire and Other Payments.** Group shall make weekly payments of all amounts due to BCBSM within one (1) business day of the invoice issue date. In addition, Group shall pay to BCBSM any separately invoiced amounts within fifteen (15) days of invoice or settlement issue date. If Group's payment for any amount payable under this Contract is more than one (1) business day late, Group shall pay a late fee equal to two percent (2%) of any outstanding amount due or the maximum percentage permitted by law, whichever is less. BCBSM may cease processing Claims retroactive to the last date for which full payment was made.
- C. Interest and Float.** Group shall make payments of amounts due and owing to a designated BCBSM bank account, which funds other BCBSM accounts. To the extent any of those bank accounts are interest bearing, BCBSM retains any interest earned and will not pay or credit any interest to Group. Additionally, banks holding BCBSM accounts may retain float interest earned on transactions with the funds in those accounts.
- D. Schedule A Renewals.** At least thirty (30) days prior to each Renewal Date, BCBSM shall send Group a Schedule A for the new Contract Year with all pricing terms for a single or multiple Contract Year(s). Any renewal Schedule A shall be deemed fully executed and effective as of the Renewal Date if Group fails to sign it and makes any payment according to its terms.
- E. Settlements.**

1. Annual Settlements. Group shall receive its Annual Settlement approximately one hundred twenty (120) days after the end of each Contract Year, which may include a reconciliation of any administrative fees based on BCBSM's enrollment records for the Contract Year at the time the reconciliation is performed.

If the Group has an arrangement whereby it pays additional administrative compensation ("AAC"), the total AAC reported to Group with the annual settlement equals the total amount of AAC collected from Group during the year less any AAC that was refunded to Group pursuant to a stop-loss insurance policy with BCBSM. If the total AAC exceeds the maximum AAC set forth in Schedule A, BCBSM shall return the excess AAC to Group. If the total AAC is less than the minimum AAC set forth in Schedule A, Group shall pay BCBSM the shortfall. Neither Group nor BCBSM shall pay any interest on these payments / refunds.

2. Customer Savings Refund. Customer Savings Refund ("CSR") is the annual report reconciling Claims during the twelve (12) month period 7/1 – 6/30 with any of the following items settled during the same period: (1) retroactive adjustments made in the Michigan Hospital Settlement (MHS), explained below, (2) Class Action recoveries, and (3) any other settlements from litigation and provider audits for which claim readjudication is not practicable.

If a refund is due, Group will receive a CSR payment in the year following the close of the CSR period. In the case of a liability resulting from the MHS, the liability will be reported to Group in the year following the close of the CSR period. A liability will accumulate with interest and may be offset against future CSR payments or Rebates.

MHS liabilities will continue to accumulate from year to year unless Group elects to pay the liability or CSR payments in subsequent years exceed the amount of Group's outstanding MHS liability. BCBSM may in its sole discretion invoice Group for some or all of Group's CSR liability, which invoice shall be paid within thirty (30) days of receipt by Group.

The MHS is designed to reconcile amounts BCBSM paid to a hospital during a year with the total amount of reimbursement due to the hospital. Pursuant to separate agreements between BCBSM and Michigan hospitals, BCBSM makes periodic estimated payments to each hospital based on expected claims for all BCBSM customers. At the end of the contract year with the hospital, BCBSM settles the amount the hospital received in payments with actual claims experience, hospital reward and incentive payments under Quality

Programs, and hospital obligations to Quality Programs. The MHS will result in a gain or loss applied to Group's CSR.

Group will not receive a CSR or incur adjusted liability attributable to a particular hospital until after the finalization of the MHS for a particular hospital. Group's refund or liability attributable to a particular hospital gain or loss, respectively, is proportionate to Group's utilization for that hospital.

- F. Changes in Enrollment or Coverages – Effect on Pricing Terms.** If there is more than a 10 percent (10%) change in the number of Employees from the number stated in Schedule A during any month of the Contract Year or a change in Coverages, BCBSM may revise any affected pricing terms in the Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning on the first day of the first full month following thirty (30) day notification by BCBSM to the Group.

ARTICLE IV

TERMINATION AND TERMINATION ASSISTANCE

A. Termination & Notice.

1. With or Without Cause. Either party may, with or without cause, terminate this Contract by providing the other party with at least ninety (90) days prior written notice of the termination date ("Termination Date").
2. Nonpayment, Partial Payment, Insolvency, or Bankruptcy. Notwithstanding any other Contract provisions, if Group fails to timely pay any amounts owed or becomes insolvent or files for bankruptcy protection, BCBSM may terminate this Contract by providing Group with at least five (5) days prior written notice of the Termination Date.
3. Termination within the First Contract Year. If Group gives notice of termination before the end of the first Contract Year or if BCBSM terminates under *subsection 2* above before the end of the first Contract Year, Group shall pay BCBSM twelve (12) months of the administrative fees as set forth in Schedule A multiplied by the average monthly Employee count (less the administrative fees paid prior to the Termination Date) to compensate BCBSM for its implementation costs.

B. Post-Termination Assistance. BCBSM will assist Group during the TAP and each party's obligations will continue to be governed by the terms of this Contract, except as set forth below.

1. End of Coverage. Notwithstanding any other provisions contained herein, neither BCBSM nor any BCBS Plan shall have any obligation for payment for any health care services which are incurred on or after the Termination Date.
2. Obligation to Pay. Notwithstanding any other provisions contained herein, Group is obligated to timely pay all amounts incurred under the Contract during the TAP.
3. Claims Processing. All Claims incurred, but not paid, prior to the Termination Date shall be processed by BCBSM or other BCBS Plans pursuant to the terms and conditions in this Contract. BCBSM may cease processing Claims if Group fails to timely pay BCBSM for amounts due and owing, is insolvent, or files for bankruptcy. Group represents and warrants that it will be solely liable for any Claims BCBSM does not pay as a result of Group's failure to make timely payment. Group will indemnify, defend, and hold BCBSM harmless for any Litigation or other adversary proceeding brought by an Enrollee whose claim was not paid as a result of Group's failure to timely pay BCBSM. This paragraph is independent of BCBSM's rights under *Article IV.A.2* above.

4. Administrative Fee and Claim Payments. For the first three (3) months of the TAP, Group shall pay the fixed administrative fees and shall continue to make Claim payments in the same manner as prior to the Termination Date. For the next twenty-one (21) months of the TAP, BCBSM will invoice Group for Claims each month. AAC, if any, will continue to be paid for the duration of the TAP.
 5. Settlement – Last Contract Year. Within one-hundred eighty (180) days following the Termination Date, BCBSM shall prepare a settlement statement for the last Contract Year.
 6. Final Settlement. Within ninety (90) days after the expiration of the TAP, BCBSM will prepare a final settlement and will refund any positive balance or invoice Group for any negative balance. Any negative balance will be due within ten (10) days of the date of invoice. The payment to Group or to BCBSM as provided in the immediately preceding sentence shall fully and finally settle, release, and discharge each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported, adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under this Contract.
 7. Group Duty to Notify / Indemnity. Group shall notify BCBSM if, as a result of its insolvency or other status, another party is required by law to receive any refunds, payments, or returned funds from BCBSM under this *Article IV*. Group shall indemnify, defend, and hold BCBSM harmless for any liability, including attorney fees, resulting from Group’s failure to notify BCBSM under this paragraph.
- C. Conversion to Underwritten Group.** If Group converts from a self-funded group to a BCBSM underwritten group, Group shall continue to be obligated for any balance due and Group shall timely pay the amounts due and owing under this Contract in addition to any premium payments as a BCBSM underwritten group.

ARTICLE V

GENERAL PROVISIONS

- A. Entire Agreement.** This Contract represents the entire understanding and agreement of the parties regarding matters contained herein. This Contract supersedes any prior verbal or written agreements and understandings between the parties and shall be binding upon the parties, their successors or assigns. Neither party has executed this Contract in reliance on any representations, warranties, or statements other than those expressly set forth herein.
- B. Indemnity.** Group agrees to indemnify, defend and hold BCBSM harmless from any claims resulting from Group’s breach of any term of this Contract or breach of any obligation or duty not expressly delegated to BCBSM in this Contract, including, but not limited to, Group’s obligation to manage eligibility and enrollment, benefit design, disclose Plan information to Enrollees, respond to requests for Plan documents, and to read and understand the terms of this Contract. The indemnity and hold harmless provisions of this Contract shall survive the termination of the Contract.
- C. Service Mark Licensee Status.** BCBSM is an independent licensee of BCBSA and is licensed to use the “Blue Cross” and “Blue Shield” names and service marks in Michigan. BCBSM is not an agent of BCBSA and, by entering into this Contract, Group agrees that it made this Contract based solely on its relationship with BCBSM or its agents. Group agrees that BCBSA is not a party to this Contract, has no obligations under this Contract, and that no BCBSA obligations are created or implied under this Contract.

D. Notices. Any notice required under this Contract shall be given in writing and sent to the other party by hand-delivery, overnight carrier, email to the other party's representative, or US first class mail at the following address or such other address as a party may designate from time to time.

If to Group:

If to BCBSM:

Address set forth above

Blue Cross Blue Shield of Michigan
600 Lafayette East, Mail Code B612
Detroit, Michigan 48226-2998

E. Amendment. This Contract may be amended only by a written agreement duly executed by authorized representatives of each party provided, however that this Contract may be amended by BCBSM upon written notice to Group in order to facilitate compliance with applicable law including changes in regulations, reporting requirements or data disclosure as long as such amendment is applicable to all BCBSM groups that would be similarly affected by the legal change in question. BCBSM will provide thirty (30) calendar days notice of any such amendment and regulatory provision, unless a shorter notice is necessary in order to accomplish regulatory compliance. Upon Group's request, BCBSM will consult with Group regarding the regulatory basis for any amendment to this Contract as a result of regulatory requirements.

F. Severability. The invalidity or nonenforceability of any provision of this Contract shall not affect the validity or enforceability of any other provision of this Contract.

G. Waiver. The waiver by a party of any breach of this Contract by the other party shall not constitute a waiver as to any subsequent breach.

H. Law. This Contract is entered into in the State of Michigan and, unless preempted by federal law, shall be construed according to the laws of Michigan. Group agrees to abide by all applicable state and federal law. Group agrees that, where applicable, the federal common law applied to interpret this Contract shall adopt as the federal rule of decision Michigan law on the interpretation of contracts.

I. HIPAA. The parties have entered into a business associate agreement that governs the access, use, and disclosure of protected health information. Group certifies that it is the Plan Sponsor and Plan Administrator, performs Plan administration functions, needs access to Enrollee protected health information to carry out such administration functions, and has amended the Plan documents to comply with the requirements of 45 CFR 164.504(f)(2). BCBSM is therefore authorized to provide Group with the minimum necessary Enrollee protected health information for Group to perform its plan administration functions.

J. Force Majeure. Neither BCBSM nor Group shall be deemed to have breached this Contract or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Contract if prevented from doing so by acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, epidemics, pandemics, wars and war-operations, restraints of government, power or communication line failure, judgment, ruling, order of any federal or state court or agency of competent jurisdiction, change in federal or state law or regulation subsequent to the execution of this Contract, or other circumstances beyond the party's reasonable control for so long as such "force majeure" event reasonably prevents performance.

K. Enrollee Out-of-Pocket Maximum Compliance. Group is solely responsible to ensure an Enrollee's maximum out-of-pocket amount complies with PPACA. If a third party provides any essential health benefit(s) to Enrollees, Group shall disclose to BCBSM the name of such third party or parties, the benefits provided, the participants receiving such benefits, applicable claim information, and the cost sharing arrangements for such benefits.

- L. Record Retention.** Group will maintain relevant books, records, policies, procedures, internal practices, and / or data logs relating to this Contract in a manner that permits review for a period of seven (7) years (or ten (10) years in the case of Medicare / Medicaid transactions) after the expiration of this Contract.

If Group conducts, or contracts to have conducted, an internal audit or review of the services performed under any agreement with BCBSM, Group shall provide BCBSM with a copy of such audit or review within thirty (30) days of BCBSM's written request. Group shall also provide a copy of any findings or reports issued by or to any federal or state regulatory agency related to the Plan.

The provisions of this Section shall survive the termination of this Contract.

- M. Summary of Benefits and Coverage.** Group is solely responsible for the creation and distribution of the summary of benefits and coverage form.
- N. Plan Year.** Group's plan year is the one-year period beginning on the Effective Date and each Renewal Date thereafter unless Group notifies BCBSM at least six months in advance of a change thereto.
- O. Knowing Assent.** Group acknowledges that it has had a full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision to knowingly enter into this Contract. Group acknowledges that it has an obligation, as Plan Fiduciary, to determine whether the financial arrangements set forth in this Contract and Schedules are an appropriate Plan expense and for the exclusive benefit of the Plan. Group acknowledges that it has had any questions about this Contract posed to BCBSM fully answered to Group's satisfaction.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

**BUSINESS ASSOCIATE AGREEMENT
FOR ADMINISTRATIVE SERVICES CONTRACT**

Group Name: CITY OF MARQUETTE

Customer ID: 115177

This Business Associate Agreement (“BA Agreement”) is effective upon execution, and amends and is made a part of the Administrative Services Contract (“ASC”) between Blue Cross Blue Shield of Michigan (“BCBSM”) and the group customer named above (“Group”), on behalf of itself and as plan sponsor of its group health plan (“GHP”).

WITNESSETH AS FOLLOWS:

WHEREAS, Group has established and maintains GHP as an employee welfare benefit plan, as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 (“ERISA”) that is **(1) subject to ERISA pursuant to ERISA section 4(a), (2) is a governmental plan as defined by ERISA section 3(32) that is exempt from ERISA pursuant to ERISA section 4(b)(1), or (3) is a church plan as defined in ERISA section 3(33) that is exempt from ERISA pursuant to ERISA section 4(b)(2)** and is therefore subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations codified as 45 CFR Parts 160-164 (collectively, “HIPAA”) as a Covered Entity performing the Covered Functions of a Health Plan.

WHEREAS, Group and GHP represent and warrant GHP has written documentation (“Plan Document”) that informs Enrollees of the benefits to which they are entitled from GHP and describes the procedures for:

- (I) establishing and carrying out funding of the benefits to which Enrollees are entitled under GHP’s plan document
- (II) allocating and delegating responsibility for GHP’s operation and administration under the Plan Document, and
- (III) amending the Plan Document.

WHEREAS, Group, GHP and BCBSM mutually agree to modify the ASC to incorporate the provisions of this BA Agreement to comply with applicable requirements of HIPAA that are applicable to business associates. This BA Agreement further includes additional provisions Group, GHP, and BCBSM desire to have as part of the ASC.

WHEREAS, the Office for Civil Rights, Department of Health and Human Services, recently published final regulations fully implementing the Health Information Technology for Economic and Clinical Health (HITECH) Act (“HITECH Act”) (42 U.S.C. §17934 et. seq.), and also making various technical, conforming and other amendments to the HIPAA rules, being entitled “Modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Non-Discrimination Act; Other Modifications to the HIPAA Rules” (the “Final Rule”) (published at 78 F.R. 5566 (January 25, 2013)), this BA Agreement incorporating those changes as described more fully in the Final Rule.

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, Group, GHP, and BCBSM hereby agree as follows:

I. SERVICES BCBSM PROVIDES

BCBSM will manage, operate and administer Coverage(s) (as defined in the ASC) and perform the services set forth in attached Exhibit 1 with respect to benefits provided to Enrollees under GHP.

II. PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

A. Definitions

All capitalized terms in this BA Agreement that are not defined by this BA Agreement will have the meaning ascribed to them by 45 C.F.R. Parts 160-164. The following terms have the following meanings:

1. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as amended.
2. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subparts A and C, as amended.
3. "Standard Transaction Rule" shall mean the Standards for Electronic Transactions at 45 C.F.R. Parts 160 and 162, as amended.

B. Confidentiality of PHI

BCBSM will maintain the confidentiality of all Protected Health Information (PHI) BCBSM creates or receives for, on behalf of, or from GHP (or another business associate of GHP) in the performance of its duties under the ASC and this BA Agreement. BCBSM will neither use nor disclose PHI except (1) as this BA Agreement permits or requires, (2) as GHP permits or requires in writing, (3) as an Enrollee authorizes, or (4) as Required by Law.

C. Security of PHI

As required by the Security Rule, BCBSM maintains reasonable and appropriate administrative, physical, and technical safeguards, to protect against reasonably anticipated threats or hazards to, and to ensure the security and integrity of, PHI; to protect against reasonably anticipated unauthorized use or disclosure of PHI; and to reasonably safeguard PHI from any intentional or unintentional use or disclosure in violation of this BA Agreement.

D. Permitted Uses and Disclosures

BCBSM may use or disclose PHI only as follows:

1. Functions and Activities

BCBSM may use and disclose PHI as permitted by HIPAA for (a) management, operation, and administration of Enrollee benefits, (b) the services set forth in the ASC and the attached Exhibit 1, and (c) Treatment, Payment, Health Care Operations, and Data Aggregation.

2. Management and Administration

a. Protected Health Information Use

BCBSM may use PHI for BCBSM's proper management and administration or to carry out BCBSM's legal responsibilities.

b. Protected Health Information Disclosure

BCBSM may disclose PHI for BCBSM's proper management and administration or to carry out BCBSM's legal responsibilities only:

(i) if the disclosure is Required by Law, or

(ii) if before the disclosure, BCBSM obtains from the entity to which the disclosure is to be made reasonable assurance, evidenced by written contract, that the entity will hold PHI in confidence, use or further disclose PHI only for the purposes for which BCBSM disclosed it to the entity or as the entity is Required by Law; and notify BCBSM of any instance of which the entity becomes aware that confidentiality of any PHI was breached.

3. Creation of Limited Data Sets and De-Identified Health Information

In conformance with the provisions and requirements set forth in HIPAA, BCBSM may use PHI to:

- a. create De-Identified Health Information, and
- b. create Limited Data Sets containing the minimum necessary amount of PHI reasonably needed for Research, Public Health or Health Care Operations activities.

4. De-Identified Health Information Use and Disclosure

BCBSM may use and disclose De-Identified Health Information for any purpose, including after any cancellation, termination, expiration, or other conclusion of the ASC.

5. Limited Data Set Use and Disclosure (Data Use Agreement)

BCBSM may use and disclose a Limited Data Set for Research, Public Health or Health Care Operations purposes. BCBSM may make such use and disclosure of the Limited Data Set after any cancellation, termination, expiration, or other conclusion of the ASC.

a. DUA - Prohibition on Unauthorized Use and Disclosure

BCBSM will neither use nor disclose the Limited Data Set for any purpose other than as this section permits, as GHP otherwise permits in writing, or as Required by Law. BCBSM will never use or disclose the Limited Data Set in a manner that would violate the HIPAA Privacy Rule, if done by GHP.

b. DUA - No Identification

When using or disclosing a Limited Data Set, BCBSM will not attempt to identify the information contained in the Limited Data Set or contact any individual who may be the subject of information contained in the Limited Data Set.

c. DUA - Information Safeguards

BCBSM will adopt and use appropriate administrative, physical, and technical safeguards to preserve the integrity and confidentiality of the Limited Data Set and to prevent its use or disclosure other than as permitted by this Section or as Required by Law.

d. DUA - Reporting Non-Permitted Use or Disclosure

BCBSM will report to GHP any non-permitted use or disclosures of the Limited Data Set. BCBSM will make the report to GHP not more than fifteen (15) business days after BCBSM learns of such non-permitted use or disclosure.

e. DUA - Permitted Recipients

BCBSM and the following entities may receive and use a Limited Data Set, provided they agree to the same restrictions and conditions applicable to BCBSM's use and disclosure of the Limited Data Set:

- (i) BCBSM affiliates,
- (ii) BCBSM Business Associates,

- (iii) BCBSM subcontractors and agents,
- (iv) other GHP Business Associates,
- (v) and other recipients when those recipients enter into a Data Use Agreement with BCBSM.

E. Minimum Necessary and Limited Data Set

BCBSM's use, disclosure or request of PHI shall utilize a Limited Data Set if practicable. Otherwise, unless excepted by HIPAA, any uses or disclosures of PHI shall be limited to the Minimum Necessary.

F. Disclosure to BCBSM's Subcontractors and Agents

BCBSM may disclose PHI to subcontractors and agents when those subcontractors and agents provide reasonable assurance, as evidenced by a written contract and in accordance with 45 C.F.R. §164.502(e)(1)(ii), that the subcontractors or agents will comply with the same privacy and security obligations with respect to PHI as applies to BCBSM in this BA Agreement, including reasonable and appropriate safeguards to protect such PHI.

G. Disclosures to Group and Group's Business Associates

BCBSM will not disclose any PHI to Group or Group's business associates, except as this BA Agreement permits.

H. Reporting Non-Permitted Use or Disclosure, Security Incidents & Breaches

1. BCBSM will report to GHP any use or disclosure of PHI not permitted by this BA Agreement or in writing by GHP except BCBSM will not report incidental uses and disclosures that occur as a result of a use or disclosure otherwise permitted by this BA Agreement. BCBSM will make the report to GHP not more than fifteen (15) business days after BCBSM learns of such non-permitted use or disclosure.
2. BCBSM will report to GHP any security incident of which it becomes aware. BCBSM will make the report to GHP not more than fifteen (15) business days after BCBSM learns of such security incident.
3. In addition, BCBSM will report, following discovery and without unreasonable delay, but in no event later than fifteen (15) business days following discovery, any Breach of Unsecured PHI as those terms are defined by HIPAA. Any such report shall include the identification (if known) of each Enrollee whose Unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during such Breach, along with any other information required to be reported under the HIPAA.
4. In the event notification to individuals is required under HIPAA, BCBSM will prepare and deliver such notification to individuals on GHP's behalf. Such notifications to individuals will be consistent with the notification content requirements established in HIPAA.

I. Termination for Breach of Privacy Obligations

1. GHP may terminate this BA Agreement and the ASC if BCBSM has engaged in a pattern of activity or practice that constitutes a material breach or violation of BCBSM's obligations regarding PHI as set forth in this BA Agreement and, on notice of such material breach or violation from GHP, BCBSM fails to take reasonable steps to cure the breach or end the violation. If BCBSM fails to cure the material breach or end the violation within twenty (20) business days after receipt of GHP's notice, GHP may terminate the ASC by providing BCBSM written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Termination of the ASC will immediately terminate this BA Agreement.
2. BCBSM may terminate the ASC if GHP has engaged in a pattern of activity or practice that constitutes a material breach or violation of GHP's obligations regarding PHI and, on notice of such material breach or violation from BCBSM, fails to take reasonable steps to cure the breach or end the violation. If GHP fails to cure the material breach or end the violation within twenty (20) business days after receipt of BCBSM's notice, BCBSM may terminate the ASC by providing GHP written notice of termination, stating the uncured material breach or violation that provides the basis for the termination

and specifying the effective date of the termination. Termination of the ASC will immediately terminate this BA Agreement.

J. Disposition of Protected Health Information

1. Return or Destruction After ASC Termination

BCBSM will, if feasible upon cancellation, termination, expiration, or other conclusion of the ASC return to GHP or destroy all PHI in whatever form or medium in BCBSM's custody or control (or in the custody or control of any subcontractor or agent to which BCBSM disclosed PHI), including all copies of and any data or compilations derived from PHI that allow identification of any present or past Enrollee who is a subject of the PHI, except BCBSM may continue to use and disclose De-Identified and Limited Data Set information as permitted by Sections D4 and D5 of this BA Agreement.

2. Disposition When Return or Destruction Not Feasible

To the extent return or destruction of PHI is not feasible, BCBSM's duties, rights, and obligations with respect to Enrollee PHI will continue in full force and effect after the date of the ASC or BA Agreement termination.

III. PHI ACCESS, AMENDMENT, AND DISCLOSURE ACCOUNTING

A. Access

BCBSM will make available to GHP or to the Enrollee for inspection and copying any PHI about the Enrollee that qualifies as part of a Designated Record Set, is not exempted from access, and which BCBSM has in its custody or control, so GHP can meet its access obligations under HIPAA. Any requests for access must be submitted on BCBSM's request form. When required by HIPAA and requested by the Enrollee or GHP, BCBSM shall make such information available in an electronic format such that GHP can meet its obligations under 45 C.F.R. §164.524(c)(2)(ii).

B. Amendment

After BCBSM's receipt of an Enrollee's or GHP's written request on BCBSM's form, or other Business Associate's or Covered Entity's written request, BCBSM will amend the appropriate Designated Record Set PHI BCBSM has in its custody or control, unless, in its sole discretion, BCBSM determines, as HIPAA permits, an amendment is not appropriate. If BCBSM accepts a request to amend PHI, it will make reasonable efforts to inform others, including individuals or entities that received the Enrollee's PHI, of the amendment.

C. Disclosure Accounting

BCBSM will make available to GHP or to the Enrollee the disclosure information regarding the Enrollee, so GHP can meet its disclosure accounting obligations. Further, BCBSM will do the following:

1. Disclosure Tracking

As required by HIPAA, record each disclosure of PHI, unless such disclosure is excepted from accounting by HIPAA, ("Accountable Disclosures"). For each Accountable Disclosure BCBSM will record:

- (a) the disclosure date,
- (b) the name and (if known) address of the entity to whom BCBSM made the disclosure,
- (c) a brief description of PHI disclosed,
- (d) a brief statement of the purpose of the disclosure, and
- (e) any additional information to the extent required by HIPAA and any accompanying regulations.

2. Disclosure Tracking Time Periods

Unless otherwise provided by HIPAA, BCBSM will maintain disclosure information about Accountable Disclosures for six (6) years. Any requests for a report of disclosure accounting must be submitted on BCBSM's request forms.

D. Restriction Requests

GHP will consult with BCBSM before GHP agrees to an Enrollee's request to restrict the use or disclosure of PHI related to the Enrollee that may affect BCBSM. BCBSM will respond to all requests submitted directly by Enrollees to restrict the use or disclosure of Enrollee PHI. GHP will promptly notify BCBSM in writing of any request for restriction on the use or disclosure of PHI. Any restriction requests must be submitted on BCBSM's request forms.

E. Confidential Communications

BCBSM will accommodate an Enrollee's request for confidential communications (the use of reasonable alternative means or alternative locations when communicating PHI to them) if the Enrollee provides a clear statement that disclosure of all or part of the PHI could endanger the Enrollee.

IV. COMPLIANCE WITH STANDARD TRANSACTIONS

A. BCBSM, SUBCONTRACTORS, AND AGENTS

BCBSM will comply, and require any of its subcontractors or agents to comply, with each applicable requirement for the Standard Transaction Rule when conducting all or any part of a Standard Transaction electronically for, on behalf of, or with GHP.

B. TRADING PARTNER AGREEMENTS

BCBSM will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions on behalf of BCBSM that:

1. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;
2. Adds any data element or segment to the maximum defined data set;
3. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or
4. Changes the meaning or intent of the Standard Transaction's implementation specification.

V. INSPECTION OF BOOKS AND RECORDS

BCBSM will make its internal practices, books, and records relating to its use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services to determine GHP's compliance with HIPAA.

VI. DATA EXCHANGE BETWEEN GROUP AND BCBSM

BCBSM may disclose to Group the minimum necessary information regarding whether an individual is an Enrollee participating in, enrolled in, or disenrolled from GHP.

If Group electronically exchanges data with BCBSM regarding the enrollment and disenrollment of Enrollees in GHP, health plan premium payments, and other matters governed by HIPAA, then Group is required to meet the requirements of HIPAA and BCBSM's payer-specific instructions.

VII. SUMMARY HEALTH INFORMATION

Upon Group's written request to either (a) obtain premium bids for providing health insurance coverage for GHP, or (b) modify, amend, or terminate GHP; BCBSM will provide Summary Health Information regarding Enrollees participating in GHP to Group.

VIII. PLAN SPONSOR CERTIFICATION

As Plan Sponsor, Group performs plan administration functions for GHP and needs access to PHI to carry out those plan administration functions. Group, as GHP's Plan Sponsor, has amended GHP's Plan Document to incorporate the provisions 45 CFR 164.504(f)(2) requires.

Group certifies that it has amended GHP's Plan Document to incorporate the provisions 45 CFR 164.504(f)(2) requires and Group agrees to comply with GHP's Plan Document as amended. GHP authorizes BCBSM to disclose the information Group has requested and certifies to BCBSM that such information is the Minimum Necessary PHI for Group to perform the plan administration functions required as described in GHP's Plan Document.

BCBSM may rely on Group's certification and shall have no obligation to verify (1) that GHP's Plan Document has been amended or (2) that Group is complying with GHP's Plan Document as amended.

IX. COMPENSATION TO BCBSM

For the services to Group, GHP, and Enrollees under this BA Agreement; BCBSM reserves the right to charge Group (a) a reasonable Designated Record Set Request Fee consistent with the allowed fees described in 45 C.F.R. §164.524(c)(4) for each request for access to PHI BCBSM fulfills, plus any postage expense BCBSM incurs in delivering such PHI, and (b) a reasonable PHI Disclosure Accounting Fee for each request from GHP for Disclosure Information BCBSM fulfills. BCBSM will provide Group with a fee schedule should BCBSM exercise its right to charge such fees.

X. ENTIRE AGREEMENT

This BA Agreement constitutes the entire agreement of the parties and supersedes all prior communications, understandings and agreements relating to the subject matter hereof, whether oral or written.

XI. AUTOMATIC AMENDMENT TO CONFORM TO APPLICABLE LAW

Upon the compliance date of any final regulation or amendment to final regulations with respect to PHI, Standard Transactions, the security of electronic PHI, or other aspects of HIPAA applicable to this BA Agreement or to the ASC, this BA Agreement will automatically amend such that the obligations imposed on Group, GHP, and BCBSM remain in compliance with such regulations, unless BCBSM elects to terminate the ASC by providing Group and GHP notice of termination in accordance with the ASC.

XII. CONFLICTS

The provisions of this BA Agreement will override and control any conflicting provision of the ASC. All non-conflicting provisions of the ASC will remain in full force and effect.

XIII. SURVIVAL OF PRIVACY AND SECURITY OBLIGATIONS

BCBSM's obligations to preserve the privacy and security of PHI, as specified in this BA Agreement, will survive termination or other conclusion of the ASC and this BA Agreement.

EXHIBIT I

BCBSM ADMINISTRATIVE SERVICES

A. ACTUARIAL AND STATISTICAL

Determining claims projections, pricing administrative services, and stop-loss coverage.

B. BUSINESS PLANNING AND DEVELOPMENT

Business planning and development such as conducting cost-management and planning-related analysis related to managing and operating BCBSM.

C. CLAIMS ADJUDICATION

Examining claims and determining payment levels; including data entry of claims, maintenance of claims experience files, use of medical consultants, review of utilization and reasonable and customary charges, coordination of benefits, and subrogation.

D. CLAIMS/MEMBERSHIP INQUIRIES

Handling inquiries—written, phone, or in-person—related to membership, benefits, claims payment, and claims payment denial.

E. DATA AGGREGATION

Conducting data analyses for Health Care Operations using data BCBSM created or received for, on behalf of, or from GHP and for, on behalf of, or from other Covered Entities for whom BCBSM acts as a Business Associate.

F. ENROLLMENT

Preparing proposals and registering, coding, and preparing new applications; and contacting Group and Enrollees regarding adding, changing, or renewing coverage.

G. FINANCIAL

Performing financial functions, such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlements, and wire transfers.

H. HEALTH CARE OPERATIONS

Conducting activities on behalf of GHP that relate to the functions of GHP that make it a Health Plan; group servicing, including the provision of data analysis for policyholders, plan sponsors, or other customers.

I. MEMBERSHIP FILE UPDATES

Maintaining membership status files and processing inter-plan transfers and contract conversions and changes, subject to conversion fees.

J. MEMBERSHIP VALIDATION

Verifying membership by wire, listing, electronic query, or other methods before or during adjudication.

K. PAYMENT ACTIVITIES

Conducting activities relating to claims payment and management, coverage determination, benefits provision and eligibility, risk adjustment, utilization review, medical necessity determination, and all related functions affecting obligations and amounts payable for health benefits coverage.

L. PHARMACY BENEFITS MANAGEMENT

Providing or arranging (if Group elects to include pharmacy benefits in GHP) the provision of prescription drug management services, such as mail-order and network pharmacy dispensing, and disease and drug utilization management; formulary development and administration, development and improvement of methods of payment or coverage policies.

M. PROVIDER NETWORKS

Establishing, arranging, and maintaining provider networks, including managed care point-of-service, preferred provider, and traditional networks through contractual arrangements with preferred participating hospitals, physicians, incentive programs, quality improvement programs, and other health care providers and with other Health Plans within designated service areas.

N. PUBLIC HEALTH

Approaching medicine as a concern to the health of the community as a whole. Public health includes but is not limited to the following functions: 1) the assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities; 2) the formulation of public policies designed to solve identified local and national health problems and priorities; and 3) the assurance that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention and evaluation of the effectiveness of that care.

O. RESEARCH

Systematically investigating, including research development, testing, and evaluation, in order to develop or contribute to generalizable knowledge.

P. STANDARD REPORTS

Generating monthly statements and claim listings.

Q. STANDARD TRANSACTIONS AND OTHER ELECTRONIC DATA INTERCHANGE

Conducting health care administrative and financial transactions for standards established in 45 CFR Part 162 as Standard Transactions, and engaging in such other electronic data interchange as necessary or appropriate to BCBSM's activities.

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 07/01/2022 thru 06/30/2023)
Administrative Services Contract (ASC)

1. **Group Name** CITY OF MARQUETTE
2. **Customer ID** 115177
3. **ASC Funding Arrangement** Weekly Invoice
4. **Line(s) of Business and Services**

Line of Business	Applicable
Facility	
Professional	
Prescription Drugs	
Dental	X
Vision	
Hearing	

5. Administrative Fees

The below administrative fees cover the Lines of Business and Services checked in Section 4 above, unless otherwise indicated.

A. Fixed Administrative Fees	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2022 Base Admin Fee	\$5.69	204	\$1,160.76	07/01/2022	06/30/2023

B. Variable Administrative Fees – Not Applicable

6. **Data Feeds – Not Applicable**
7. **Advance Deposit – Not Applicable**
8. **Advance Deposit Monthly Cap / Level Payment Amount – Not Applicable**
9. **BCBSM Account**

1840-09397-3	Comerica	0720-00096
Wire Number	Bank	American Bank Association

10. Late Payment / Interest Charges

Late Payment Charge	2.00%
Health Care Provider Interest Charge	12.00%

11. **Buy-Ups – Not Applicable**
12. **Shared Savings Programs – Not Applicable**
13. **Pharmacy Pricing Arrangement – Not Applicable**

14. Additional Pharmacy Services and/or Programs

A. 3rd Party Rx Vendor Fee

If Group's prescription drug benefits are administered by a third-party vendor, BCBSM will charge Group an administrative fee of \$5.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage and administer the medical benefit without administering the prescription drug benefit.

B. High-Cost Drug Discount Optimization Program – *Not Applicable*

15. 3rd Party Stop-Loss Vendor Fee – *Not Applicable*

16. Agent Fees

This Schedule A does not include any fees payable by Group to an Agent. If Group has an Agent Fee Processing Agreement on file with BCBSM, please refer to that agreement for fees and details.

17. Medicare Contracts

If Group has Medicare contracts that are being separated from the current funding arrangement, all figures within the current funding arrangement will be adjusted.

18. Compensation Agreement with Providers

The Group acknowledges that BCBSM or a Host Blue may have compensation arrangements with providers in which the provider is subject to performance or risk-based compensation, including but not limited to withholds, bonuses, incentive payments, provider credits and member management fees. Often the compensation amount is determined after the medical service has been performed and after the Group has been invoiced. The Claims billed to Group include both service-based and value-based reimbursement to health care providers. Group acknowledges that BCBSM's negotiated reimbursement rates include all reimbursement obligations to providers including provider obligations and entitlements under BCBSM Quality Programs. Service-based reimbursement means the portion of the negotiated rate attributed to a health care service. Value-based reimbursement is the portion of the negotiated reimbursement rate attributable to BCBSM Quality Programs, as described in Exhibit 1 to Schedule A. BCBSM negotiates provider reimbursement rates and settles provider obligations on its own behalf, not Group. Group receives the benefit of BCBSM provider rates, but it has no entitlement to a particular rate or to unbundle the service-based or value-based components of Claims.

See Schedule B to ASC and Exhibit 1 to Schedule A for additional information.

19. Out-of-State Claims

Amounts billed for out-of-state claims may include BlueCard access fees and any value-based provider reimbursement negotiated by a Host Blue with out-of-state providers. See Schedule B to ASC and Exhibit 1 to Schedule A for additional information.

Exhibit 1 to the Schedule A: Value-Based Provider Reimbursement

As in prior years, the Claims billed to Group include amounts that BCBSM reimburses health care providers including reimbursement tied to value. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle Claims and does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures, and BCBSM Quality Programs, which are subject to change at BCBSM's discretion. BCBSM shall provide Group with at least sixty (60) days' advance written notice of any additions, modifications or changes to BCBSM Quality Programs describing the change and the effective date thereof.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, for example, Pay-for-Performance (PFP) rates and Value Based Contracting (VBC) rates earned by hospitals, Per Attributed Per Member Per Month ("PaMPM") Provider Delivered Care Management, and Patient Centered Medical Home (PCMH) rates earned by physicians. Provider reimbursement rates also capture provider commitments to BCBSM Quality Program, such as for participation and performance in Collaborative Quality Initiatives ("CQIs"). CQIs address many of the most common and costly areas of surgical and medical care in Michigan. In each CQI, hospitals and physicians across the state collect, share and analyze data on patient risk factors, processes of care and outcomes of care, then design and implement changes to improve patient care.

Providers may also receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement or collected from Group's Customer Savings Refund. Such allocations may be to a pooled fund from which value-based payments to providers are made. For example, pursuant to the Physician Group Incentive Program (PGIP), physicians agree to allocate a percentage of each Claim to a PGIP fund. The PGIP fund, makes reward payments to eligible physician organizations demonstrating particular quality, and physician organizations for participation in collaborative initiatives, and funds CQIs. An additional portion of a provider's contractual reimbursement (the "Risk Allocation") of most claims may be allocated to a Risk Pool for payments to organized systems of care based on cost/quality performance.

As explained in the Blue Card Program disclosure (Schedule B to ASC), an out-of-state Blue Cross Blue Shield Plan ("Host Blue") may also negotiate fee-based and/or value-based reimbursement for their providers. A Host Blue may include all provider reimbursement obligations in Claims or may, at its election, collect some or all of its value-based provider (VBP) reimbursement obligations through a PaMPM benefit expense, as in, for example, the Total Care Program. All Host Blue PaMPM benefit expenses for VBP reimbursement will be consolidated on your monthly invoice and appear as "Out-of-State VBP Provider Reimbursement." The supporting detail for the consolidated amount will be available on e-Bookshelf as reported by each Host Blue Plan. Host Blues determine which members are attributed to eligible providers and calculate the PaMPM VBP reimbursement obligation based only on these attributed members. Host Blue have exclusive control over the calculation of PaMPM VBP reimbursement.

Value-based reimbursement includes other obligations and entitlements pursuant to other BCBSM Quality Programs funded in a similar manner to those described in this Exhibit. Additional information is available at www.valuepartnerships.com and www.bcbs.com/totalcare. Questions regarding provider reimbursement and BCBSM Quality Programs or Host Blue VBP reimbursement should be directed to your BCBSM account representative.

Intellectual property may be developed through BCBSM Quality Programs for subsequent license and use by BCBSM or a third party. Group specifically understands, acknowledges, and agrees that it has no rights to any intellectual property, or derivatives thereof, including, but not limited to, copyrights, patents, or licenses, developed thru BCBSM Quality Programs.

Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

BCBSM 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 Enrollees access healthcare services outside the geographic area BCBSM serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSM serves, Enrollees obtain care from 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, Enrollees may obtain care from Providers in the Host Blue geographical area that do not have a contractual agreement (“Nonparticipating Providers”) with the Host Blue. BCBSM remains responsible for fulfilling its contractual obligations to you. BCBSM’s payment practices in both instances are described below.

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

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Enrollees access covered healthcare services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Enrollee Liability Calculation

The calculation of the Enrollee liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the Participating Provider’s billed covered charges or the negotiated price made available to BCBSM by the Host Blue.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider’s billed charge and the reference

benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

b. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee'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.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

2. Claims Pricing

The Host Blue determines a negotiated price, which is reflected in the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to BCBSM by the Host Blue may be represented by one of the following:

- (i) an actual price. An actual price is a negotiated payment in effect at the time a Claim is processed without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements, and performance-related bonuses or incentives, or
- (iii) an average price. An average price is a percentage of billed 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 an average price in its respective Provider agreements. The use of estimated or average pricing may result in a difference (positive or negative) between the price Group 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 Enrollee and Group 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 Group 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 Group. If Group terminates, Group will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated/drawn down over time. The timeframe for 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. The Host Blue may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which BCBSM is obligated under the BlueCard Program to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), and/or to vendors of BlueCard Program related services. The specific Blue Card Program fees and compensation that are charged to Group and which Group is responsible related to the foregoing are set forth in Exhibit 1 to this Schedule B. BlueCard Program Fees and compensation may be revised annually from time to time as described in H below.

B. Negotiated Arrangements

With respect to one or more Host Blue, instead of using the BlueCard Program, BCBSM may process your Enrollee claims for covered healthcare services through Negotiated Arrangements.

In addition, if BCBSM and Group have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSM's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Enrollees access such network(s). In negotiating such arrangement(s), BCBSM is not acting on behalf of or as an agent for Group, the Group's health care plan or Group Enrollees.

1. Enrollee Liability Calculation

Enrollee liability calculation for covered healthcare services will be based on the lower of either billed covered charges for covered services or negotiated price that the Host Blue makes available to BCBSM that allows Group's Enrollees access to negotiated participation agreement networks of specified Participating Providers outside of BCBSM's service area.

Under certain circumstances, if BCBSM pays the Healthcare Provider amounts that are the responsibility of the Enrollee, BCBSM may collect such amounts from the Enrollee.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSM may include a factor for such settlement or reconciliations as part of the fees BCBSM charges to Group.

Where Group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Enrollees will be responsible for the amount that the healthcare Provider bills for a specified procedure above the reference benefit limit for that procedure. For a Participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a Nonparticipating Provider, that amount will be the difference between the Nonparticipating Provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a Provider's billed charge, the Enrollee will incur no liability, other than any applicable Enrollee cost sharing.

2. Group Liability Calculation

The calculation of Group liability on Claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSM by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Group may be liable for the excess amount even when the Enrollee'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.

3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangement may be revised annually as described in section H below. In addition, the participation agreement with the Host Blue may provide that BCBSM must pay an administrative and/or a network access fee to the Host Blue, and Group further agrees to reimburse BCBSM for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Group under the Negotiated Arrangements are set forth in Exhibit 1 to this Schedule B.

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

Group Enrollees may access covered healthcare services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

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, including but not limited to retrospective settlements, Provider Incentives, share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to BCBSM, which BCBSM will pass directly on to Group as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim.

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

- (i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to Group via an enhanced Provider fee schedule.
- (ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the Claim, they may be billed as a Per Attributed Member Per Month (PaMPM) amount for Value-Based Programs incentives/Shared Savings settlements to Group outside of the Claim system. BCBSM will pass these Host Blue charges directly through to Group as a separately identified amount on the Group's invoices.

The amounts used to calculate either the supplemental factors for estimated pricing or PaMPM 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, the Host Blue will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PaMPM 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 PaMPM price methods, described above, are calculated. If Group terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the administrative services contract.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated / drawn down 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. The Host Blue may retain interest earned on funds held in variance accounts.

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

Care Coordinator Fees

The Host Blue may also bill BCBSM for Care Coordinator Fees for Covered Services which BCBSM will pass on to Group as follows:

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

As part of this agreement / contract, BCBSM and Group will not impose Enrollee cost sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

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

D. Return of Overpayments

Recoveries of overpayments from a Host Blue or its Participating Providers and Nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from the Host Blue to BCBSM they will be credited to the Group account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments or recovery amounts. The fees of such a third party may be charged to Group as a percentage of the recovery.

Unless the Host Blue agrees to a longer period of time for retroactive cancellations of membership, the Host Blue will provide BCBSM the full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, BCBSM will request such refunds for a period of up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement / contract.

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

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSM will provide prior written notice of any such surcharge, tax or other fee to Group, which will be Group liability.

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. Enrollee Liability Calculation

a. In General

When covered healthcare services are provided outside of BCBSM's service area by Nonparticipating Providers, the amount an Enrollee pays for such services will generally be based on either the Host Blue's Nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, BCBSM may pay Claims from Nonparticipating Providers outside of BCBSM's service area based on the Provider's billed charge, such as in situations where an Enrollee did not have reasonable access to a Participating Provider, as determined by BCBSM in BCBSM's sole and absolute discretion or by applicable state law. In other exception cases, BCBSM may pay such Claims based on the payment BCBSM would make if BCBSM were paying a Nonparticipating Provider inside of its service area where the Host Blue's corresponding payment would be more than BCBSM's in-service area Nonparticipating Provider payment. BCBSM may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Enrollee may be responsible for the difference between the amount that the Nonparticipating Provider bills and the payment BCBSM will make for the covered services as set forth in this paragraph.

2. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group and that Group will be responsible for in connection with the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in H below.

G. Blue Cross Blue Shield Global Core (Formerly known as BlueCard Worldwide® Program)

1. General Information

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

- **Inpatient Services**

In most cases, if Enrollees contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Enrollees to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Enrollee Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Enrollee paid in full at the time of service, the Enrollee must submit a Claim to obtain reimbursement for covered healthcare services. Enrollees must contact BCBSM to obtain precertification for non-emergency inpatient services.

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Enrollees pay for covered healthcare services outside the BlueCard service area, they must submit a Claim to obtain reimbursement. For institutional and professional claims, Enrollees should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSM, the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobal.com. If Enrollees need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Group under the Blue Cross Blue Shield Global Core Program and that Group is responsible for relating to the foregoing are set forth in Exhibit 1 to this Schedule B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section H below.

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

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BCBSM shall provide Group with at least sixty (60) 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 Group right to terminate the ASC without penalty by giving written notice of termination before the effective date of the change. If Group fails to respond to the notice and does not terminate the ASC during the notice period, Group will be deemed to have approved the proposed changes, and BCBSM will then allow such modifications to become part of the ASC.

Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at \$2,000.00 per Claim. The percentages for 2022 are:

1. 3.79% for fewer than 1,000 PPO or traditional enrolled Blue contracts;
2. 2.11% for 1,000–9,999 Blue PPO or traditional enrolled Blue contracts;
3. 1.96% for 10,000–49,999 Blue PPO or traditional enrolled Blue contracts;

For Groups with 50,000 or more Blue PPO or Traditional enrolled contracts, Blue Card Access Fees are waived and not charged to the Group. If Group's enrollment falls below 50,000 PPO enrolled contracts, BCBSM passes the BlueCard Access Fee, when charged, directly on to the Group.

Instances may occur in which the Claim payment is zero or BCBSM pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSM will pay the Host Blue's Access Fee and passes it directly on to the Group as stated above even though the Group paid little or had no Claim liability.