BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

ADMINISTRATIVE SERVICES AGREEMENT
between
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
and
CITY OF FRANKLIN, TENNESSEE

This Administrative Services Agreement, including all Exhibits hereto (the "Agreement"), is entered into by and between City of Franklin, Tennessee ("Employer") and BlueCross BlueShield of Tennessee, Inc. ("BlueCross"), and is effective as stated in paragraph 3.1 of this Agreement. Employer and BlueCross are collectively referred to in this Agreement as the "parties."

Employer has established a self-funded Employee Welfare Benefit Plan; however, this Employee Welfare Benefit Plan is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA.") Any references to ERISA contained in the Agreement and Exhibits are solely for the purpose of establishing procedures relating to time frames and are not to be interpreted as a waiver of the inapplicability of ERISA to the remainder of the terms herein. Employer's summary plan description, which summarizes the benefits of the Employee Welfare Benefit Plan, is attached to this Agreement as Exhibit A, and is referred to elsewhere in this Agreement as the "Plan." The eligible Employees and their eligible Dependents are collectively referred to as "Members" in this Agreement, and that term is further defined in the Plan. This Agreement outlines the rights and responsibilities of the parties related to the administration of the Plan. In consideration of the parties' mutual promises, the sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I – RESPONSIBILITIES OF THE PARTIES

1.1 BlueCross. BlueCross is responsible for providing ministerial administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in Exhibit C, and other duties specifically assumed by it pursuant to this Agreement. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross will use its reasonable business judgment in performing its duties under this Agreement, and will administer the benefits under the Plan in accordance with BlueCross' customary administrative standards and practices. BlueCross shall perform its duties in accordance with the terms of this Agreement and generally accepted standards applicable to claims administration, including other plans licensed by the BlueCross and BlueShield Association (the "Association.")

1.2 Employer. Employer is responsible for providing BlueCross with a current, detailed copy of the Plan, any changes to the Plan, and the necessary information to determine employee and dependent eligibility under the Plan, and other duties and services as described in Exhibit E and elsewhere in this Agreement. Employer shall fund all Approved Claims, as described in Article II, and shall pay BlueCross an administrative services fee for providing its services under this Agreement. Employer may designate a third party to perform any of its duties under this Agreement; however, such obligation shall not release Employer from its obligations pursuant to this Agreement. Any reference to "Employer" in this Agreement shall also include third party(ies) designated by Employer to perform any of its duties or obligations under this Agreement.

1.3 Fiduciary Responsibility. Employer is solely responsible for the fiduciary responsibilities of administering its health benefit plans and maintaining adequate funding to support these

plans. Employer is also responsible for, among other things, preparing and providing its covered employees with copies of summary plan descriptions describing its health benefit plans and, as applicable, with copies of summaries of material modifications. Although Employer's health benefit plan is not subject to ERISA, Employer acknowledges that BlueCross is acting in a ministerial capacity and is not the "Administrator," the "Claims Fiduciary," nor the "Named Fiduciary" of its health benefit plans, as that term is defined in ERISA. The "Plan Administrator," as that term is defined in ERISA, is Employer.

1.4 Confidentiality. The parties acknowledge that Employer is subject to the Freedom of Information Act; however, the parties intend that this Agreement and any information provided to the other party pursuant to this Agreement that is identified as proprietary or confidential or that a prudent business person would consider sensitive including, but not limited to, reimbursement information, group membership lists, marketing information, information obtained from or through a party or developed or obtained by a party in connection with the performance of this Agreement, and information obtained from and/or about the BlueCross BlueShield Association and its programs ("Confidential Information"); shall be treated as confidential, proprietary or trade secret information. A party may release Confidential Information to providers or its affiliates, or their respective directors, partners, officers, employees, advisors and other representatives (its "Representatives") who: have a need to know such Confidential Information, for purposes of their participation in or oversight of matters within the scope of this Agreement; and are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Agreement. Each party shall advise its Representatives of their obligation to maintain the confidentiality of such information. Each party is responsible if its Representative breaches this Section. Neither party shall otherwise release nor disclose such Confidential Information to third parties without the other party's prior written consent, except as required by law. This paragraph shall survive the termination of this Agreement.

Notwithstanding anything herein to the contrary, the following shall not constitute Confidential Information for the purposes of this Agreement: (a) Confidential Information that is or becomes generally available to the public other than as a result of a disclosure by a party or its Representatives; (b) Confidential Information that was available to the parties on a non-confidential basis prior to its disclosure by a party or its Representatives; (c) Confidential Information that becomes available to the parties on a non-confidential basis from a third party, provided that third party is not known to be subject to any prohibition against transmitting that information; or (d) Confidential Information disclosed pursuant to applicable law, provided that if permitted by Applicable Law, the disclosing party shall first notify the other party of a disclosure required by Applicable Law.

The parties have entered into a Business Associate Agreement, the terms of which control the release and use of Protected Health Information.

ARTICLE II – PAYMENT OF APPROVED CLAIMS AND ADMINISTRATIVE SERVICES FEES

2.1 Claims Funding. Employer shall pay the invoiced amount for claims processed and approved for payment by BlueCross in accordance with this Agreement ("Approved Claims.") Greater detail regarding this process is contained in Exhibit B. Nothing in this Agreement shall obligate or shall be deemed to obligate BlueCross to use its funds to satisfy any of Employer's obligations pursuant to this Agreement or the Plan's benefits. Employer's assets and amounts contributed by Members, if applicable, are the only source or sources of payment of Approved Claims or any other benefit provided by the Plan.

2.2 Administrative Services Fees ("ASF(s)"). Employer shall pay ASFs in accordance with the Agreement, including but not limited to Exhibit B.

2.2.1 The initial ASF shall be due and payable on the effective date of this Agreement. The ASF is due on the first of each month thereafter.

2.2.2 Approved Claims. BlueCross will notify Employer weekly of the estimated amounts necessary to fund the Approved Claims. Employer will then follow the methodology established in Exhibit B to appropriately fund the Approved Claims.

ARTICLE III - TERM AND TERMINATION

3.1 Term. This Agreement becomes effective at 12:01 A.M. July 1, 2017, (the "Effective Date") and shall remain in effect until the earliest of the following events:

3.1.1 Until June 30, 2020 (“initial term”), unless Employer and BlueCross, by mutual consent, agree in a writing executed by both parties to extend the term prior to June 30, 2020, for up to two additional one-year terms through June 30, 2022;

3.1.1.1 After the initial term of the Agreement, either party may give the other party Sixty (60) days advance written notice of its intent to terminate the Agreement.

3.1.2 Any other date mutually agreed upon by the parties; or

3.1.3 Any of the events specified in Section 3.2.

3.2 Termination by BlueCross Upon Default of Employer. Notwithstanding the provisions of Section 3.1 above, this Agreement will automatically terminate upon the occurrence of any of the following events, as determined by BlueCross:

3.2.1 Employer’s failure to provide adequate funds, as set forth in Exhibit B, as necessary for the payment of Claims pursuant to the Plan;

3.2.2 Employer’s failure to pay any ASFs or late payment penalty as set forth in Exhibit B;

3.2.3 Employer ceases to maintain the Plan;

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

3.2.5 At any time Employer otherwise materially breaches this Agreement, after the procedures in Section 3.6 have been followed.

3.3 Termination for Invalid use of Information. The parties will use any information BlueCross makes available solely for the purpose of administering Employer’s health benefits plan under this Agreement and in accordance with applicable law. Furthermore, if either party uses the information for another purpose, that action constitutes a material breach. This Agreement will then be subject to immediate termination.

3.4 BlueCross’ Right to Reinstate. BlueCross has the sole discretion to decide to reinstate this Agreement if it was terminated pursuant to Subsections 3.2 or 3.3. If BlueCross elects to reinstate this Agreement, Employer shall be responsible for reinstatement fees, which shall be $1,000.00.

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

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

3.5.2 At any time BlueCross materially breaches its duties under this Agreement, after the procedures in Section 3.6 have been followed.

3.6 Material Breach Defined. A material breach is the failure by one party (the breaching party) to perform or carry out a function or duty required by the terms of this Agreement, where the failure to perform that function or duty seriously impairs the ability to perform of the other party (the non-breaching party). If the non-breaching party determines that a material breach has occurred, it must notify the breaching party in writing of the breach as soon as it is practicable to so notify, and must allow the breaching party Thirty (30) days to cure or correct the breach. If the breach is not cured or corrected in that Thirty (30) day period, the non-breaching party may provide Thirty (30) days notice of termination.

3.6.1 If either party disputes a claimed material breach or that a material breach has been cured or corrected, it may immediately request dispute resolution, pursuant to the terms of Article IV of this Agreement.

3.6.2 BlueCross' termination of this Agreement in accordance with Subsection 3.2.1, 3.2.2, 3.2.3, shall not be subject to the notice provisions of this Subsection, nor entitle Employer to submit the dispute for resolution pursuant to Article IV, below.

3.7 Effect of Termination. The terms and conditions set forth herein shall be of no further force or effect if this Agreement is terminated, except as follows:

3.7.1 The parties' rights and obligations intended to survive termination of this Agreement, including Sections 1.4, 5.1, and 6.13 of this Agreement shall continue in effect notwithstanding its termination.

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

3.7.3 The termination of this Agreement does not excuse Employer from forwarding to BlueCross any and all fees, monies, reimbursements or claim payments accrued through the date of termination. If termination occurs retroactively, any and all fees, monies, reimbursements or claim payments accrued through the date that actual written notice of termination is received by BlueCross shall be payable to BlueCross by Employer.

3.8 Administration After Termination. Employer and BlueCross may agree on a method by which BlueCross will continue to process claims incurred during, but received after, the term of this Agreement. The administration of the processing of run out claims by BlueCross following termination of this Agreement will be subject to Employer's continued funding of claims payment. "Run out claims" refers to those claims incurred for Covered Services performed prior to the termination of this Agreement, but not yet paid and/or not submitted for payment to BlueCross prior to the termination of this Agreement. For purposes of this Agreement, the date a claim is "incurred" is the date the particular service was rendered or the supply was furnished. There is a separate and distinct administrative fee for BlueCross providing administrative services to pay run out claims. This is set out in Exhibit B.

3.9 Final Settlement. Any Services performed on Employer's behalf will cease 18 months after termination ("Process Conclusion Date"). BlueCross will then complete a final calculation that reconciles any and all claims payments, fund transfers, recoveries received, etc. to determine the amount necessary to finalize both parties' obligations under this Agreement ("Final Settlement"). BlueCross will send Employer a settlement agreement no later than two years post termination. Employer will have 30 days from the date on the letter attached to the settlement agreement to dispute. If Employer has not disputed the settlement agreement, or returned a signed settlement agreement to BlueCross within the provided time period, Employer shall be deemed to have approved and executed the settlement agreement.

ARTICLE IV - DISPUTE RESOLUTION

4.1 Arbitration/Mediation. The parties may enter into mediation or non-binding arbitration upon written consent of both parties if a mutually agreeable resolution to the matter is not reached through informal discussion.

4.2 Award. The arbitrator shall be required to issue a written decision explaining the basis of the decision and the manner of calculating any award. The arbitrator may not award punitive or exemplary damages and must base the decision on the terms of this Agreement and applicable laws. The arbitrator's decision may be entered and enforced in any State or Federal court. That decision may only be vacated, modified or corrected for the reasons set forth in section 10 or 11 of the United States Arbitration Act, if the award contains material errors of law or is arbitrary and capricious.

4.3 Final Nature of Arbitration. The award of the arbitrator shall be final, and not subject to appeal to any other authority. This does not preclude enforcement, as stated in subsection 4.2.

ARTICLE V – LIABILITY AND INDEMNIFICATION

5.1 BlueCross. BlueCross neither insures nor underwrites any of the Plan's obligations or liabilities under the Plan. Plan will indemnify BlueCross for actions taken at the Plan's direction. BlueCross is responsible solely for its acts and for the acts of its agents and employees acting within the scope of their duties under this Agreement. BlueCross is not responsible for any acts or omissions of any outside vendors associated with or contracted by the Plan.

5.1.1 BlueCross hereby agrees to indemnify and hold harmless Employer, its directors, officers, employees and agents against any and all vicarious liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, expenses and taxes, including but not limited to, attorneys' fees and court costs, resulting from or arising directly or indirectly out of, or in connection with, actions or decisions arising directly from the negligence or wanton and reckless acts or failure to act by BlueCross, or its employees or agents, unless the cause of such liability was the result of the fault, criminal conduct or fraudulent acts of Employer or any of its directors, officers, employees or agents, or resulted from the direction given by Employer or its directors, officers, employees or agents in the administration of the Plan.

5.1.2 BlueCross' liability to Employer pursuant to Subsection 5.1.1 of this Agreement shall be limited to the value of the ASFs received by BlueCross prior to the occurrence of the act, action, or failure to act that forms the basis of BlueCross' liability.

5.1.3 Notwithstanding the foregoing, BlueCross' duty to indemnify and hold Employer harmless shall not extend to acts or omissions of Employer, its officers, directors, or employees or to acts or omissions of any non-employee network providers who provide services to participants in Employer's Plan.

5.2 Employer. Employer retains ultimate responsibility for making eligibility and benefit determinations in connection with the Plan, paying all claims for covered services and paying any other expenses related to or arising in connection with the Plan, except as have been expressly assumed by BlueCross pursuant to this Agreement. The phrase "making eligibility determinations in connection with the Plan" means that Employer determines who is eligible to participate, (i.e., who are employees or dependents) and generally what medical procedures are included or excluded as identified in the Summary Plan Description, but does not include the ultimate responsibility for making medical necessity

determinations. Employer's liability is limited by the Tennessee Governmental Tort Liability Act, T.C.A. § 29-20-101, et seq.

ARTICLE VI - MISCELLANEOUS PROVISIONS

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

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

Employer shall notify BlueCross of any planned changes Employer intends to make to the terms and/or conditions of the Plan. Notification shall be made sufficiently in advance of any such changes so as to permit BlueCross reasonable time to review and/or implement such changes.

6.3 Assignment. See #1 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

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

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

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

6.7 Entire Agreement. See #5 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

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

6.9 Inconsistencies. See #4 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

6.10 Independent Contractors.

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

6.10.2 On behalf of itself and its participants, Employer hereby acknowledges its understanding that this Agreement constitutes a contract solely between Employer

and BlueCross which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting BlueCross to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that BlueCross is not contracting as the agent of the Association.

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

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

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

6.12 Notices. Any notice required to be given pursuant to this Agreement shall be in writing, sent by certified or registered mail, return receipt requested, or by Federal Express or other overnight mail delivery for which evidence of delivery is obtained by the sender, to BlueCross or the Employer at the addresses indicated below, or such other addresses that the parties may hereafter designate. The notice shall be effective on the date the notice was posted.

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

6.14 Plan Funds. In the event there are any refunds, rebates, reimbursements or other payments representing a return of monies paid on behalf of the Plan and its participants for services under this Agreement unless specifically addressed in the Agreement, BlueCross will credit the Plan with the Plan's proportionate share of any such amounts, less any applicable administrative or other fees withheld from such credited amounts by BlueCross for administrative or other expenses.

6.15 Severability. See #3 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

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

6.17 Survival. See #7 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

6.18 Venue. All actions or proceedings instituted by Employer against BlueCross shall be brought in a court of competent jurisdiction located in Hamilton County, Tennessee. All actions or proceedings instituted by BlueCross against Employer shall be brought in a court of competent jurisdiction located in Williamson County, Tennessee.

6.19 Waiver of Breach. See #2 under Addendum to Administrative Services Agreement, City Contract #2017-0090.

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

6.21 Stop Loss Coverage. Employer has entered into a stop loss arrangement with an insurer other than BlueCross (Stop Loss Carrier). BlueCross' duties with regard to this stop loss arrangement are in Exhibit C.

6.22 Required Information. Employer shall provide to BlueCross any information BlueCross requests that is necessary for BlueCross to comply with the terms of this Agreement or State or Federal Law. For example, BlueCross may need to know the number of Employees in order to comply with PPACA and Mental Health requirements.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.

By: _____

Printed Name: John Maki

Title: Vice President, Sales and Account Management

Date: July 20, 2017

Address: 1 Cameron Hill Circle
Chattanooga, TN 37402

CITY OF FRANKLIN

By: _____

Printed Name: Eric S. Stuckey

Title: City Administrator

Date: 9/6/17

Address: 109 3rd Avenue South
Franklin, TN 37064

Employer I.D. No.: 62-6000290

Approved as to form by:

_____
Kristen L. Corn, Assistant City Attorney

EXHIBIT A to the Administrative Services Agreement

EVIDENCE OF COVERAGE (EOC)

The EOC(s) has/have not been approved by Employer.

Once approved and printed, the EOC(s) will be incorporated by reference as part of this Exhibit A.

Exhibit A consists of 1 EOC, as follows:

Health Benefit Plan

EXHIBIT B to the Administrative Services Agreement

ADMINISTRATIVE SERVICES FEES AND CLAIMS FUNDING METHODOLOGY

1. ASFs. Employer shall pay to BlueCross the following ASFs during the Term of this Agreement:

1.1 **Medical ASF**

Rates effective as of:	July 1, 2017	July 1, 2018	July 1, 2019
Medical ASF	$39.10 per Subscriber per month	$40.27 per Subscriber per month	$41.48 per Subscriber per month
Medical Main ASF	**$39.10 per Subscriber per month**	**$40.27 per Subscriber per month**	**$41.48 per Subscriber per month**
Medical Guaranteed ASF	**$39.10 per Subscriber per month**	**$40.27 per Subscriber per month**	**$41.48 per Subscriber per month**
COBRA	$0.75 per Subscriber per month	TBD	TBD
Chronic Condition Management	$2.61 per Subscriber per month	TBD	TBD
Medical Total ASF	**$42.46 per Subscriber per month**	**TBD**	**TBD**

[1]If the parties agree to extend the term for up to two additional one-year terms through June 30, 2022, the Medical ASF shall increase 3% per year for each additional one-year term.

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

1.1.1.1. Changes in the Plan, BlueCross' duties, legislation or regulation;

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

1.1.1.3. Fluctuation of the number of Subscribers by more than 10% percent by location, state and/or in aggregate. Calculation of the Medical Total ASF was based on 663 Subscribers; or

1.1.1.4. Fluctuation of the Member to Subscriber ratio by +/- 0.05. The Medical Total ASF was based on a Member to Subscriber ratio of 2.61.

If Employer terminates this Agreement prior to June 30, 2020, Employer agrees that BlueCross will not receive certain additional income it had anticipated. As liquidated damages for this termination, Employer agrees that it will pay BlueCross an amount equal to one month's Medical Total ASF, based on the last fee paid by Employer.

1.2 **Wellness Fund Allowance**

Wellness Fund Allowance	July 1, 2017
Wellness Fund Allowance	$15,000
The Wellness Fund Allowance can be used for BlueCross wellness products or wellness products from an outside vendor provided during the initial term (July 1, 2017 through June 30 2020). If Employer uses an outside vendor, Employer will provide to BlueCross receipts from that vendor. Any request for reimbursement shall be made by June 30, 2020. Any remaining Wellness Fund Allowance will be forfeited after June 30, 2020.	

2. **Inter-Plan Arrangements (BlueCard) Fees[1].** When Members access health care services outside of Tennessee, claims for those services are received by the Host Licensee where the provider is located and forwarded electronically to BlueCross for adjudication. For claims inside the network, the Member gets the benefit of access to the other Licensee's discounts and provider contracts. The currently applicable fees for such access to Host Licensee networks and for administrative processing are as follows:

BlueCard Network Access Fees	The Access Fee is charged by the Host Blue to BlueCross for making its applicable provider network available to Employer's Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential BlueCross receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged, BlueCross passes the Access Fee directly on to Employer.	4.64% of network savings, capped at $2,000.00 per claim Effective January 1, 2018: 4.30% of network savings, capped at $2,000.00 per claim
Administrative Expense Allowance (AEAs)	The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to BlueCross for administrative services the Host Blue provides in processing claims for Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, BlueCross passes the AEA Fee directly on to Employer.	$5.00 per claim professional and $11.00 per claim institutional

Nonparticipating Provider Fee		$3.00 per claim
BlueCross BlueShield Global Core® Fee		$3.75 per claim Member-submitted, $4.75 per claim professional, and $17.00 per claim institutional

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

3. **Reports**. Employer will have access to BlueCross' interactive reporting tool and will receive a health plan insights package annually. Any additional reports requested will be billed separately. Upon termination of this Agreement, Employer must pay charges for the cost of producing any report in advance of receiving the requested report.

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

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

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

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

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

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

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

   4.2 Funding. On the 20th day of each month, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to pay BlueCross' ASFs for the following calendar month, and funds necessary to complete any adjustments to Approved Claims, fixed, previously agreed-upon charges, previous ASFs and any due late fees. Such payments shall be made in accordance with the Direct Debit Authorization Agreement, which is an Automated Clearinghouse (ACH) Authorization Agreement, attached to this Agreement as Exhibit F. Employer will transfer the amount specified by BlueCross into Employer's account so such funds shall be available for ACH debit by the first day of the following month (the "due date"). If the full amount specified by BlueCross pursuant to this paragraph is not

received by BlueCross within that time period, BlueCross may immediately suspend payment of all Approved Claims on behalf of Employer, regardless of the date claims were incurred, until all amounts due are received by BlueCross. If BlueCross elects to not suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.

5. **Additional Administration Charges.** In addition to the fees previously addressed, the cost of services outlined below will be billed as a direct cost to Employer.

   5.1 Cost of printing non-standard Member material.

   5.2 All costs associated with the investigation and litigation of disputed claims, including the amount of the settlement and any damages (including punitive damages, unless due to a breach of the standard of care as set forth in Article V of the Agreement).

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

   5.4 Cost of customized or unique systems development required by Employer.

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

   5.6 Cost of non-standardized Member mailings.

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

   5.8 Any fees to be paid to Employer's broker/consultant, as directed by Employer. BlueCross will remit the fee to the broker/consultant on Employer's behalf.

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

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

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

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

7.3 If a partial amount is available, BlueCross may elect to utilize those funds to pay Approved Claims until full payment is made by Employer. BlueCross has full discretion to determine which Approved Claims will be paid with these partial funds, and may or may not exercise that discretion.

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

7.4.1 If Employer's Plan includes coverage for pharmacy benefits that are paid through BlueCross' pharmacy vendor's network, BlueCross will provide a total of pharmacy claims paid on behalf of Employer. These claims are administered by a third party for BlueCross, and the information regarding pharmacy claims paid will be forwarded on to Employer as soon as is practicable by BlueCross. The amount remitted to the pharmacy by the PBM may not be equal to the amount charged to BlueCross and Employer.

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

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

Exhibit C to the Administrative Services Agreement

DUTIES OF AND SERVICES PROVIDED BY BlueCross

1. Generally. It is understood and agreed that BlueCross is empowered and required to act with respect to the Plan only as expressly stated in this Agreement and its Exhibits and amendments. Employer and BlueCross agree that BlueCross' role under this Agreement is to provide administrative claims payment services in accordance with the terms of the Plan, including Services set forth in Exhibit A for Members (as that term is defined in the Plan); that BlueCross does not assume any financial risk or obligation with respect to Plan claims; and that the services rendered by BlueCross under this Agreement are merely ministerial, and shall not include the power to exercise control over the Plan's assets, if any, or discretionary authority over the Plan.

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

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

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

   2.3 Once Employer has notified BlueCross in writing that a Member should be terminated as no longer eligible for coverage, BlueCross shall update its systems within 48 hours (unless a power outage beyond BlueCross' control) to reflect that change in the Member's coverage.

      2.3.1 If Employer notifies BlueCross of a Member's termination within ninety (90) days of the Member's termination, BlueCross will credit Employer with any ASFs that were paid for that Member for that time period.

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

   2.4 If Employer's Plan includes coverage for pharmacy benefits that are paid through BlueCross' pharmacy vendor's network, BlueCross will notify its pharmacy vendor of the addition or termination of a Member from coverage, and the pharmacy vendor's systems, pursuant to its agreement with BlueCross, will be updated to reflect the change in the Member's status.

   2.5 BlueCross will provide its standardized Evidence of Coverage describing benefits provided under the Plan to Employer for it to distribute to Members.

   2.6 BlueCross will supply identification cards.

      2.7.1 BlueCross will supply identification cards issued at the group's initial enrollment to Employer and identification cards issued at any other time to Employer.

2.7.2 Identification cards will be issued in the name of Subscribers.

2.7 BlueCross will provide 10 Provider Directories at initial enrollment to Employer. Additional Provider Directories are available at Employer's request.

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

3. Claims Processing. BlueCross shall provide claims processing services on behalf of Employer for all properly submitted claims, in accordance with the terms of the Plan's benefits, as set forth in Exhibit A. BlueCross shall only use funds furnished solely by Employer to process said claims. BlueCross will follow current industry practices and its internal claims processing procedures regarding payment of claims, including timeliness and accuracy of claims payments. For purposes of this Agreement, the term "claim(s)" is defined as a request from a provider of Covered Services and/or a Member for payment of monies due for the rendering of Covered Services under the terms of the Plan, and in conformity with any agreements BlueCross enters into with such providers of Covered Services.

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

3.2 If a Member is also covered by Medicare, BlueCross must coordinate with Medicare in adjusting claims according to the Medicare Secondary Payor rules, and the rules regarding Cross Over Claims. This may delay finalization of a claim, depending on when data is received from Medicare regarding the claim. If Medicare is primary, BlueCross will adjudicate the Plan's benefit based on the Medicare allowed amount.

3.3 BlueCross shall furnish each Member claiming benefits under the Plan with an explanation of why that Member's claim has been paid, denied or rejected, in full or in part.

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

3.5 If Employer uses the services of an outside pharmacy vendor, BlueCross will coordinate benefits or interface with that vendor.

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

3.6.1 If benefits were paid directly to a Member, BlueCross will attempt recovery. If Employer does not wish BlueCross to attempt recovery from a specific Member, Employer must direct BlueCross accordingly in writing.

3.6.2 If Employer's Plan includes coverage for pharmacy benefits that are paid by BlueCross' pharmacy vendor, claims paid after a Member's termination cannot be recovered from the provider. BlueCross will attempt recovery from the Member on these claims. If Employer does not wish BlueCross to

attempt recovery from a specific Member, Employer must direct BlueCross accordingly in writing.

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

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

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

3.6.6 If benefits are not recoverable from a provider or Member, this will not alter Employer's responsibility to fund all claims.

3.7 BlueCross will provide Employer with a monthly statement with respect to claims paid.

3.8 At the termination of this Agreement, BlueCross shall administer the payment of run out claims for Employer. These claims shall be administered as any other claim handled during the term of the Agreement, and shall be subject to the same restrictions. "Run out claims" refers to those claims for Covered Services, performed prior to the termination of this Agreement, but not yet paid and/or not submitted for payment to BlueCross prior to the termination of this Agreement.

4. Network Administration. BlueCross shall administer its established cost containment programs and access and availability benefits management programs, as selected by the Employer and outlined in the Plan. BlueCross' Network Provider contracts and medical policies control network administration.

4.1 BlueCross shall make available its Blue Network P (including Network Hospitals and other providers or practitioners with which BlueCross has contracted) to provide Covered Services to Members, in accordance with the terms of the Plan. All agreements between providers of services and BlueCross are the sole property of BlueCross, and BlueCross retains the right to the use and control of these provider agreements.

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

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

4.4 BlueCross negotiates various reimbursement arrangements with providers, including but not limited to per diem, percent of charges, diagnosis related groups (DRGs,) global case rate and fee schedule arrangements, which vary by provider. Certain facilities may have multiple or a combination of these arrangements. All of

these arrangements provide funding to the provider, and claims processed using one of these arrangements are considered Approved Claims.

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

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

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

4.5 Negotiating Discounts with Out-of-Network Providers. When permitted by Association rules and guidelines, BlueCross shall negotiate a reduction in billed charges for Members' claims for covered services received from Out-of-Network Providers located outside of Tennessee. Claims eligible for this service must meet BlueCross' established criteria. As consideration for this service, BlueCross shall receive a fee of fifteen percent (15%) of the reduction of billed charges.

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

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

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

5.2 When a Member receives services from a Network Provider, he or she will be responsible for payment of the Deductible, Coinsurance and/or Copayment, as well as charges for any non-covered services, as specified in the Plan. A Member's Coinsurance for Covered Services received from a Network Provider will be based on the provisions of the Network Provider's contract, and the lesser of (i) the Network Provider's pre-negotiated payment allowance, or (ii) charges for Covered

Services at the time such Services are provided. BlueCross will not recalculate Coinsurance in the event it recovers a discount or savings with respect to Covered Services after a claim for such Services is paid. Rather, the Plan will receive a payment or credit for such savings or discounts.

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

5.4 "Out-of-Network Providers" are providers that do not participate in the Blue Network P. BlueCross' payment for Covered Services to any Out-of-Network Provider will be based on Maximum Allowable Charge for the service performed. BlueCross shall make payment for Covered Services to the out-of-state Out-of-Network Provider and not the Member. When the Member receives services from an Out-of-Network Provider, he or she will be responsible for the payment of any difference between BlueCross' payment and such Provider's charge(s), and responsible for any applicable Deductible, Copayment, and Coinsurance, as well as payment of charges for any non-covered services. The Member's responsibility for Coinsurance will be based on the Maximum Allowable Charge for that service.

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

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

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

5.8 BlueCross' contracts with Network Providers may include a variety of reimbursement methodologies. These reimbursement methods may obligate BlueCross to pay an amount that is in addition to the underlying cost of the service rendered. These additional costs may include, but are not limited to, program fees, incentive payments, bonus payments, or quality payouts. These provider reimbursements will be passed to Employer as part of the billing process detailed in this Agreement.

6. Reserved.

7. Reserved.

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

8. Claims Payments Adjustments.

9.1 Whenever BlueCross becomes aware that a claims payment to a Provider or Member is less than the amount to which the Provider or Member is entitled under the terms of the Plan, BlueCross shall promptly adjust the underpayment to reflect the proper amount that should be remitted.

9.2 Whenever BlueCross becomes aware of an overpayment under the Plan, BlueCross shall make a diligent attempt to recover such overpayment, in accordance with its customary administrative procedures. In the event any part of an overpayment is recovered, the Plan will receive a credit from BlueCross. BlueCross shall not be required to institute any legal proceeding to recover such overpayment. BlueCross may use its reasonable judgment to compromise and settle overpayments.

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

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

(a) the overpayment was caused by an act or omission of BlueCross that did not meet the standard of care set out in Article V of this Agreement;

(b) all reasonable means of recovery under the circumstances have been exhausted; and

(c) BlueCross' acts or omissions were not undertaken at the express direction of Employer.

9.2.3 BlueCross is not liable for interest on recovered overpayments.

9.2.4 Except in cases of fraud committed by the Provider, BlueCross cannot, under Tennessee state law, recover overpayments from Providers more than 18 months after the date that BlueCross paid the claim submitted by the Provider.

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

9.3 The parties acknowledge that Employer may not contact Network Providers directly regarding rates or charges for services provided to Members through that part of the Plan administered by BlueCross. All such contact with Network Providers must be by and through BlueCross.

9.4 In the event that BlueCross becomes aware that a claims payment to a Provider or Member was or might have been the result of a fraud committed on or against the Plan, BlueCross shall:

(a) Notify the Plan as soon as possible about the alleged fraudulent claims;

(b) Provide reasonable assistance to the Plan in recovering the alleged fraudulent claims; and

(c) Report the suspected fraud to the appropriate law enforcement agency.

10. Reserved.

11. Annual Renewal Claims Analysis.

11.1 BlueCross will provide an annual renewal analysis of Employer's claims experience. BlueCross will also provide assistance in benefit plan design and revisions.

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

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

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

12. Legal Actions.

12.1 If a demand is asserted that is based upon actions taken or the language of this Agreement, and litigation, arbitration and/or other legal proceeding is commenced against BlueCross by a Member or provider ("Action"):

12.1.1 BlueCross will provide written notice to Employer as soon as practicable, but in no event more than One hundred Twenty (120) days after the initial notice of such Action was received by BlueCross, where Employer is not also a party to such Action. Additionally, BlueCross will provide Employer with information with respect to the status of such Action at reasonable intervals. BlueCross may select and retain counsel as it deems appropriate in connection with such Action with respect to the interests of BlueCross. Employer has the right to approve or disapprove this selection, within reason.

12.1.2 Subject to Article V of the Agreement, Employer shall indemnify and defend BlueCross in any such action, and shall be responsible for the defense costs for BlueCross to the extent permitted by law.

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

12.1.4 Employer shall remain liable for the full amount of any benefits paid as a result of such Action. In no event will BlueCross be liable for any amount of benefits paid as a result of any Action.

12.2 If an Action is brought against Employer:

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

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

12.2.3 Only to the extent provided by law, and subject to the Tennessee Governmental Tort Liability Act, Employer shall be liable for the full amount of any benefits paid as a result of such Action, as well as its own legal fees, penalties, interest and costs recovered by a Member or provider in connection herewith. In no event will BlueCross be liable for any amount of benefits paid as a result of such Action.

13. Records and Reports. BlueCross will establish, maintain and provide to Employer, in its standard reporting package, records and reports generated as a result of the administration of the Plan for the purposes of reporting claims experience and conducting audits. BlueCross will not provide any information with regard to BlueCross' provider pricing agreements or any other information that is of a confidential or proprietary nature,

as determined by BlueCross, unless it is subject to an agreement that protects the confidential and proprietary nature of the information. The required agreement shall be determined by BlueCross based on the intended use of the information..

14. Books and Records. BlueCross shall maintain books and records directly related to its payment of claims on behalf of Employer pursuant to this Agreement, in accordance with its customary business practices. It shall make such books and records available for inspection by authorized representatives of Employer at BlueCross' home office, during normal business hours, upon reasonable advance written request, at Employer's expense, during the term of this Agreement and for six (6) years from the date of the Final Settlement, as referred to in Section 3.9 of the Agreement, subject to Employer entering into an agreement that protects the confidential and proprietary nature of the information. The required agreement shall be determined by BlueCross based on the intended use of the information..

15. Conversion. BlueCross does not provide any individual medical conversion policies or certificates to terminated Members.

16. Duties with regard to non-BlueRe of Tennessee Stop Loss Vendor. For a separate Interface fee, BlueCross will perform the following services and provide the following information for Employer to a third party Stop Loss Vendor:

16.1 Provide Stop Loss Vendor and Employer with monthly Claimants at 50% of Specific Attachment Point Reports.

16.2 Submit claims on behalf of the Plan to the Stop Loss Vendor. However, BlueCross will not be responsible for coordinating claims with the Stop Loss Vendor for services or coverage that are not administered by BlueCross.

16.2 BlueCross does not coordinate the payment of the stop loss premium between the Stop Loss Vendor and Employer.

16.3 Provide Stop Loss Vendor the following information at renewal to prepare a renewal of Employer's stop loss coverage. Information to be provided is as follows:

Census	
Age/ Gender	Subscriber Count by age/gender
Zip Codes	Subscriber Count by LOB, State, Zip
Plan Design Summary/ Plan Document	Evidence of Coverage
Trigger Reports:	
50% of Specific Report	50% Report (Includes Diagnosis Only)
Medical & Rx	

16.4 Regardless of whether a claim has met the stop loss dollar limit set out in the agreement between Stop Loss Vendor and Employer, Employer is still responsible for funding all claims processed by BlueCross.

16.5 At the termination of this Agreement, BlueCross has no further obligation to provide any reports referenced in this section to Employer or Stop Loss Vendor, other than standard reports for the time period the Agreement was in force.

16.6 Employer is responsible for paying BlueCross the interface fee of $0.90 per contract per month.

17. Reserved.

18. Reserved.

19. External Audits. On an annual basis, BlueCross will hire an external auditor to perform a SOC 1 (SSAE 16) or alternate type review as required to assist Employer in meeting its compliance requirements under federal law, such as the Sarbanes-Oxley Act. The review will cover a nine-month period, ending on September 30 of each year that this Agreement is in force, and will cover services and actions performed by BlueCross.

20. New York Graduate Medical Education Assessment. On a monthly basis, BlueCross will remit the New York Graduate Medical Education (NY GME) assessment through Empire BlueCross BlueShield. The NY GME is based on the county where a resident lives, not based on claims or services provided. The amount remitted will be invoiced to Employer on its next bill for administrative services.

BlueCross will remit the NY GME only for those Members who are covered by the BlueCross administered portion of Employer's Plan.

The amount remitted will be based on BlueCross' records of addresses of Employer's Subscribers, as of a specific date of the previous month.

20.1.1 As records are updated by Employer, BlueCross will either remit additional amounts, or deduct previously paid amounts, as required by the State of New York.

20.1.2 BlueCross will report the remittance to the State of New York, as required, unless the Employer directs otherwise.

20.2 If the Agreement terminates, and BlueCross has remitted NY GME assessments on Employer's behalf, Employer will reimburse BlueCross for the funds remitted. BlueCross remits the NY GME assessments on a short time lag, so there will continue to be assessments submitted on behalf of Employer after termination.

21. New York Surcharge. If a Member receives services from a New York state hospital (or other diagnostic facility), the New York Surcharge will be built into the claim submitted by the Host Plan, which will submit payment of the New York Surcharge as if it had been incurred by the Host Plan directly. The New York Surcharge will be handled this way regardless of whether or not the Member received services through the BlueCard PPO Program. BlueCross will complete any reports that may be due, unless Employer directs otherwise.

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

23. Distribution of Materials

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

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

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

- electronic access shall be limited to the Employer's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;
- they will replace any hard-copy Forms that have been modified by BlueCross;
- the hard-copy documents on file with BlueCross shall control in the event of any discrepancy; and
- the Employer remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g., distribution).

23.4 BlueCross shall create the Summary of Benefits and Coverage ("SBC") and provide to Employer or its legal representative, for distribution to Members. Employer shall distribute SBC to Members in manner, method and timeframes required under applicable law. The information in the SBC and other Forms provided by BlueCross is based only on those services provided by BlueCross. Employer shall review and approve any Forms and the SBC provided by BlueCross prior to distribution. Employer's distribution of the Forms, SBC, or other materials indicates that Employer has reviewed and approved the content of such materials. In no circumstance will Members be charged for access to, or creation of the SBC. BlueCross shall not charge Employer for the printing or production of the SBC.

Exhibit D to the Administrative Services Agreement

Medical Management Services Provided by BlueCross

Employer has selected several of BlueCross' Medical Management programs for use by Employer in administering its Plan. All services utilize current medical guidelines and standards. While these services are described below, they may be updated from time to time. The most current information regarding these services can be found at BlueCross' website, ***www.bcbst.com***. In the event there is a conflict in the description of the services provided, the information at BlueCross' website shall be controlling.

MEDICAL MANAGEMENT

1. Inpatient Review.

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

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

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

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

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

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

5. Specialty Pharmacy Review. BlueCross will review specific drugs administered by licensed health care professionals that are covered under a medical benefit and not a pharmacy benefit.

6. Home Health, Home Infusion Therapy Review. BlueCross will review prescriptions for home health care services and home infusion therapy to evaluate the physician's plan of treatment, appropriateness of setting and medical necessity of the prescribed services, both prospectively and concurrently.

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

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

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

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

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

9. Catastrophic Medical and Transplant Case Management. Members with high-risk conditions such as terminal illness, severe injury, major trauma, cognitive or physical disability, or transplant are identified through prior authorization, medical data and claims data. Registered nurses work with the Member, health care providers and primary caregivers to coordinate the most appropriate, cost-effective care settings.

BlueCross' Catastrophic Medical and Transplant Case Management program utilizes a comprehensive approach that includes benefit analysis, preauthorization, concurrent review, discharge planning and cost-effective continuity of care for Members.

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

11. Pharmacy Management. BlueCross will monitor drug utilization and costs by the application of a Formulary/Prescribing Guidelines, electronic claims submission, management of the pharmacy network, and review of utilization reports. Optional pharmacy management programs may include: application of Preferred Drug List, Prior Authorization process, the setting of quantity limits on certain medications, Pharmacy Care Management for Special Populations, and Specialty Pharmacy Management.

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

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

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

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

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

Exhibit E to the Administrative Services Agreement

DUTIES OF EMPLOYER

1. Services. As long as this Agreement remains in effect, Employer shall:

   1.1 Provide BlueCross with a current, detailed description of the Plan and any changes in such Plan;

   1.2 Provide BlueCross with the necessary Subscriber and Member eligibility information to enable BlueCross to administer the Plan; and

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

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

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

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

3. Final Authority. Except as otherwise specifically stated in this Agreement, Employer retains all final authority and responsibility for the Plan including, but not limited to, the benefit design of the Plan, claims payment decisions, cost containment program decisions, compliance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), compliance with reporting and remitting abandoned property funds (except as referenced in Exhibit C, Section 5) if required by law, and compliance with any other state and federal laws or regulations applicable to Employer or the administration of the Plan.

   If Employer uses the services of a third party to provide enrollment data and that third party's data does not match BlueCross' data, Employer's data will be used to determine the ASF. BlueCross will work with Employer to resolve the discrepancy. If no agreement can be reached, Employer's records will control. Until the dispute is resolved, Employer must pay the ASF as indicated, based on Employer's records.

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

   BlueCross will administer claims in accordance with the terms and conditions of this Agreement. A Member has the right to appeal any decision regarding or arising out of this Agreement, and that appeals process is defined in the Plan.

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

   4.1 Employer shall be responsible for providing each Subscriber with a copy of the Employee Welfare Benefit Plan and/or the Plan, as determined by Employer.

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

5. Financial Obligations.

(a) Claims Funding. Employer is financially responsible for the funding of all Approved Claims, pursuant to Article II and Exhibit B, and is the Payor of benefits for Members. Employer will provide BlueCross with such authorizations as are necessary to ensure that required instruments are valid with respect to funding Approved Claims for Covered Services under the Plan.

(b) ASFs; Late Charges. Employer agrees to pay promptly all ASFs and/or other charges specified in Article II, Exhibit B, Exhibit F, and elsewhere in this Agreement.

6. Assessments.

(a) If at any time, during or after the term of this Agreement, BlueCross is required to pay any federal, state or local taxes, assessments, or similar government-imposed fees, other than BlueCross' income taxes, that are related to the Plan, the Plan's Members, enrollees, or participants, or BlueCross' services under this Agreement ("Assessments"), Employer will pay BlueCross an additional amount equal to the Assessment. Assessments include, but are not limited to, Assessments based on the number of covered lives in the Plan, the number of covered lives in a given geographic region, fees paid or payable to BlueCross for services provided under this Agreement, including premiums or premium equivalents, Claims paid pursuant to this Agreement, or other assessment methodologies that measure the relative value of benefits or services provided or delivered under the Plan. If any taxes or penalties are imposed, assessed or accrued on any Assessment, Employer will pay BlueCross such additional amounts equal to the tax or penalty.

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

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

(d) If a Member receives services from a New York state hospital (or other diagnostic facility), the New York Surcharge will be built into the claim submitted by the Host Plan, which will submit payment of the New York Surcharge as if it had been incurred by the Host Plan directly. The New York Surcharge will be handled this way regardless of whether or not the Member received services through the BlueCard PPO Program. Employer will fund any surcharges applied. To have a lower surcharge, Employer should elect to participate in the New York state pool by notifying the state of New York.

7. Use of Names and Service Marks. Employer agrees to allow BlueCross to useEmployer's name and service mark on I.D. cards and other forms necessary to implement this

Agreement, and to promote Employer's relationship with BlueCross to potential or existing providers. BlueCross shall not use Employer's name or service mark for any other purpose without the prior written consent of Employer.

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

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

8. Audit of BlueCross. During the term of this Agreement, Employer has the right to audit certain of the functions performed by BlueCross in administering its Plan. Employer may not have access to provider reimbursement or other proprietary information under the control of BlueCross, unless Employer has a compelling reason, to be determined at the discretion of BlueCross, and needs such information to perform its duties in administering the Plan. If Employer needs access to Confidential Information in order to perform such an audit of BlueCross, it shall be subject to Section 9 of this Exhibit to the Agreement.

8.1 The time period for a BlueCross Audit shall not exceed 12 months prior to the date the Audit Agreement is executed by the final signatory to the Audit Agreement ("BlueCross Audit Time Period.") The only Claims subject to audit are those Claims paid during the BlueCross Audit Time Period. Any Claims paid prior to the BlueCross Audit Time Period shall not be subject to audit. The only functions subject to audit are the functions that were performed by BlueCross within the BlueCross Audit Time Period. For each BlueCross Audit Time Period, no more than 250 Claims shall be submitted to BlueCross for review.

8.2 If Employer uses the services of a third party to perform all or any part of an audit, Employer and that third party must both execute BlueCross' current Audit Agreement.

8.3 Employer may perform a simple audit of BlueCross once during the calendar year while this Agreement is in force without any charge by BlueCross. A "simple audit" is one that requires less than Fifty (50) person hours of work by BlueCross employees to assist in the audit. Employer must negotiate the cost, parameters, etc. with BlueCross for an audit that does not fit this definition.

8.4 Should Employer contract with a third party to perform a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.), which may be found by the third party in its audit, BlueCross will cooperate with said third party in the conduct of such contingent fee audit. The parties agree that BlueCross will incur costs in defending its claims adjudication. In consideration for this and BlueCross' cooperation with the auditor, Employer agrees that, in the event the auditor cannot specifically prove that certain

claims were adjudicated incorrectly by BlueCross, Employer will reimburse BlueCross the lesser of:

(a) 3% of the claims the auditor cannot specifically prove were adjudicated incorrectly; or

(b) BlueCross' costs to defend each claim that the auditor alleges were incorrectly adjudicated; or

(c) A flat fee of $1,500.00.

8.5 Employer's right to audit BlueCross without any additional charge terminates with the termination of this Agreement.

8.6 This provision applies whether Employer wishes to audit BlueCross or one of BlueCross' third party vendors.

9. Access to Confidential Information. From time to time, representatives of Employer may need access to certain Confidential Information, as defined in Article I, Section 1.4 of this Agreement, in order to perform its duties under the Plan. Before BlueCross will release any Confidential Information, BlueCross must receive from Employer:

a. Authorization to release the Confidential Information to a specific representative; and

b. A statement that the representative must have such information in order to perform their job as it relates to the administration of the Plan.

Additionally, the representative must sign and return a BlueCross agreement designed to protect the confidential and proprietary nature of the information before BlueCross is under any obligation to release any Confidential Information. The required agreement shall be determined by BlueCross based on the intended use of the information.

9.1 If it is necessary to review BlueCross' Network Provider contracts, they may be reviewed only at BlueCross' headquarters in Chattanooga, Tennessee. Neither Employer nor its agent may have copies of provider contracts.

9.2 The parties have entered into a Business Associate Agreement, the terms of which control the release and use of Protected Health Information.

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

Exhibit F to the Administrative Services Agreement

DIRECT DEBIT AUTHORIZATION AGREEMENT

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

Exhibit G to the Administrative Services Agreement

INTER-PLAN ARRANGEMENT

1. **Out-of-Area Services.**

BlueCross BlueShield of Tennessee ("BlueCross") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Members access healthcare services outside the geographic area BlueCross serves ("Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Service Area, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BlueCross remains responsible for fulfilling our obligations to Employer. Our payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements.

1.1 **BlueCard® Program.**

The BlueCard® program is an Inter-Plan Arrangement. Under this Arrangement when Members access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating providers. BlueCross will remain responsible to Employer for fulfilling BlueCross' contractual obligations under this Agreement. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating providers. The financial terms of BlueCard Program are described generally below.

1.1.1 **Liability Calculation Method Per Claim – In General.**

1.1.1.1 **Member Liability Calculation.**

Unless subject to a fixed dollar copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's Billed Charges for Covered Services or the negotiated price made available to BlueCross by the Host Blue.

1.1.1.2 **Member Liability Calculation.**

The calculation of Employer's liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to BlueCross by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than Billed Charges 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, Employer may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess

amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the Billed Charge.

1.1.2 **Claims Pricing.**

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

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

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

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

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

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

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance.

Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

1.1.3 **BlueCard Fees and Compensation.**

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

1.2 **Negotiated Arrangements.**

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

In addition, if BlueCross and Employer 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 BlueCross' 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 Members access such network(s). In negotiating such arrangement(s), BlueCross is not acting on behalf of or as an agent for Employer, Employer's group health plan or Employer's Members.

1.2.1 **Member Liability Calculation.**

Member liability calculation will be based on the lower of either Billed Charges for Covered Services or negotiated price (Refer to the description of negotiated price under Section 1.1., BlueCard Program) that the Host Blue makes available to BlueCross by the Host Blue and that allows Employer's Members access to negotiated participation agreement networks of specified participating providers outside of BlueCross' service area.

1.2.1.1 **Fees and Compensation.**

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 1.7 below.

In addition, the participation agreement with the Host Blue may provide that BlueCross must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse BlueCross for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer are listed in Exhibit B.

1.3 **Special Cases: Value-Based Programs.**

1.3.1 **Value-Based Programs Overview**.

Employer's Members may access Covered Services from providers that participate in a Host Blue's Value-Based Program. Value-Based programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care Arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

1.3.2 **Value-Based Programs under the BlueCard Program**.

1.3.2.1 Value-Based Programs Administration.

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in the following ways: Per member per month, provider incentives, gain share, risk share, retrospective settlements, prospective settlements, share of target savings, Care Coordination Fees and/or other allowed amounts.

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

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

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

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

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

1.3.2.1.3 Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BlueCross will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account

maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amount being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

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

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

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

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

1.3.3 **Care Coordination Fees**.

Host Blue may also bill BlueCross for Care Coordination Fees for provider services which we will pass on to You as follows:

1.3.3.1 PMBM billings; or

1.3.3.2 Individual claims billings through applicable care coordination codes from the most current edition 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).

1.3.4 **Value-Based Programs under Negotiated Arrangements**.

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

1.4 **Return of Overpayments**.

Recoveries of overpayments can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, utilization review refunds and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim basis or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to BlueCross, they will be credited to Your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to Employer as a percentage of the recovery.

1.5 **Non-Participating Providers Outside BlueCross' Service Area**.

1.5.1 **Member Liability Calculation**.

1.5.1.1 In General.

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

1.5.1.2 Exceptions.

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

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

1.5.2 **Fees and Compensation**.

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

1.6 **BlueCross BlueShield Global Core® Program**.

1.6.1 **Member Liability Calculation**.

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

1.6.1.1 Inpatient Services.

In most cases, if Members contact the BlueCross BlueShield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Member claims to the BlueCross BlueShield Global Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. Members must contact Us to obtain precertification for non-emergency inpatient services.

1.6.1.2 Outpatient Services.

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

1.6.1.3 Submitting a BlueCross BlueShield Global Core.

When members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a BlueCross BlueShield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the BlueCross BlueShield Global Core Service Center address on the form to initiate claims processing. The claim form is available from Us, the BlueCross BlueShield Global Core Service Center, or online at www.bcbsglobalcore.com. If Members need assistance with their

claim submissions, they should call the BlueCross BlueShield 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.

1.6.2 **BlueCross BlueShield Global Core Program-Related Fees**.

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

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

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year.

Exhibit H to the Administrative Services Agreement

COBRA ADMINISTRATION PROVIDED BY BLUE CROSS

In the event that any Member is entitled to continuation of their benefits under the summary plan description issued by Employer because of a Qualifying Event, as that term is defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), BlueCross will continue to perform its duties under this Agreement with regard to that Member as outlined below. That Member shall be charged the amount allowed by law (currently, 102% of the premium equivalent charged to active Subscribers, and 150% if the Member is disabled.) BlueCross' and Employer's obligations under this Exhibit shall terminate at the same time this Agreement ends.

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

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

    1.2 Send a separate notice to the spouse, if:

    - The spouse lives at a separate address from the eligible employee (and BlueCross is made aware of this by Employer prior to issuing the notice); or
    - The spouse becomes enrolled in Employer's health benefit plan at a different time from the eligible employee;

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

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

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

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

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

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

        (A) place a stop-pay on the Qualified Beneficiary's benefits; and

        (B) cancel the Qualified Beneficiary's coverage at the end of the grace period.

    2.5 Provide claims processing services;

    2.6 Provide access to the provider network(s) selected by Employer, and the BlueCard/BlueCard PPO program;

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

    2.8 Terminate the COBRA continuation coverage at the appropriate time.

    2.9 When a notification of termination is generated, (i.e., for failure to submit the enrollment form and pay the applicable premium during the statutory election and/or

grace period, non-payment of premium charges or expiration of the applicable eligibility period for COBRA continuation coverage) BlueCross will:

(A) Notify the Qualified Beneficiary of the coverage termination, as well as the reason and effective date thereof;

(B) Notify Employer of any termination of coverage;

(C) Mail information regarding any available conversion coverage to the terminated Qualified Beneficiary.

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

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

3. Employer is the Plan Administrator for the purposes of COBRA, and shall:

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

3.3 Notify BlueCross that a Subscriber and/or Dependents are eligible for COBRA within 30 days of the Qualifying Event. Employer must submit BlueCross' appropriate form;

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

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

4. As consideration for the above-referenced services:

4.1 For Qualified Beneficiaries who have BlueCross administered health benefits:

4.1 Employer shall pay BlueCross the COBRA administration charge of $0.75 per Subscriber per month, included in the ASF in Exhibit B;

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

4.2 For Qualified Beneficiaries who elect COBRA continuation, but not for BlueCross administered health benefits:

4.2.1 Employer shall pay BlueCross 2% of the premium equivalent remitted.

5. Payment for COBRA administration services is as follows:

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

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

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

5.1.2.1 Retain 2% of the premium equivalent received by BlueCross;

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

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

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

5.2.1.1 Retain 2% of the premium equivalent received by BlueCross;

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

6. BlueCross will provide COBRA administration for all Members covered under Employer's health plan.

7. The parties agree that all provisions of the Agreement will apply to this Exhibit and the services and duties required hereunder.

8. "Qualified Beneficiary" means each individual person who is eligible for COBRA continuation coverage, whether formerly covered under the BlueCross administered plan as a Subscriber or a dependent, or covered under another of Employer's benefits plans. "Eligible COBRA Participant" means the group of a Subscriber and/or Dependents, whether formerly covered under the BlueCross or another of Employer's benefit plans, that have elected to be covered together as a family unit and are issued one invoice for COBRA Continuation Coverage by BlueCross.

Exhibit I to the Administrative Services Agreement

Health and Wellness Services

Employer has selected the Health and Wellness Services described below.

1. Services.

1.1 Chronic Condition Management. Chronic Condition Management is proactive identification and outreach for the purpose of health coaching to address Members' conditions including congestive heart failure, diabetes, asthma and coronary artery disease. Chronic Condition Management aims to stabilize Member health status, assist individuals in improving self-management of conditions, improve adherence to evidence-based guideline recommended preventive care, as well as promote healthy behavior changes designed to improve quality of life and reduce risk factors.

1.2 24/7 Nurseline. BlueCross provides access to experienced nurses via telephone and instant messaging for symptom assessment, general health information, self-care education, and personalized support.

Exhibit M to the Administrative Services Agreement

ONLINE ENROLLMENT SPECIFICATIONS

Through BlueCross Secured Website

BlueCrossBlueCross' Duties and Responsibilities

1. BlueCross will provide a PIN for website access.
2. BlueCross will provide instruction upon Employer's request. Such instruction may be done by telephone or personal contact.
3. BlueCross will accept data, review for accuracy and process enrollment, status change and termination requests in accordance with the eligibility guidelines outlined in the Self-funded Group Application.
4. BlueCross shall maintain a secure website and preserve data as required by law.

Employer's Duties and Responsibilities

1. Employer will submit data only on eligible individuals as outlined in the Self-funded Group Application.
2. Employer will assure that the data submitted is accurate.
3. Employer will submit data on a timely basis in accordance with this Agreement.
4. Employer assumes responsibility for notifying BlueCross when Employer's group administrator or enrollment contact changes, so that BlueCross can revoke that individual's website access. BlueCross will revoke access within 5 working days of being notified. If Employer does not inform BlueCross of any such change, and a former group administrator or enrollment contact enters fraudulent or incorrect information through the website, Employer is responsible for these actions.

Exhibit N to the Administrative Services Agreement

GRIEVANCE SERVICES

This Exhibit describes grievance services.

1. First Level Grievance

   1.1 BlueCross shall conduct the first level grievance on Employer's behalf. For purposes of handling the first level Grievance, BlueCross is a Limited Fiduciary, as that term is defined in ERISA.

   1.2 BlueCross' first level grievance committee shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.

   1.3 A written decision concerning the grievance shall be sent to the Member and to Employer within the timeframe set forth in the Plan.

   1.4 Member shall have the opportunity to submit written testimony and any additional written information to the committee. Oral testimony will not be permitted at the first level grievance.

   1.5 First level grievance shall be the only mandatory level of grievance.

2. Second Level Grievance

   2.1 Employer does not have a Second Level Grievance.

3. External Review.

   3.1 Employer does not have External Review.

4. The Plan and BlueCross' grievance processes shall be subject to and comply with the review standards applicable to ERISA plans, whether or not the Plan is otherwise governed by ERISA.

5. BlueCross shall, upon Employer's request, provide to Employer any grievance information related to a grievance handled by BlueCross.

6. Nothing in the Plan shall establish a grievance process that contradicts any statement in this Section.

7. BlueCross shall not be required to perform any grievance services not expressly stated in this Section.

Exhibit O to the Administrative Services Agreement

SHARED SAVINGS

BlueCross will perform recovery services in the identified areas and, as compensation for these services, BlueCross will retain a percentage of any recovery as identified below. The identified percentages will be taken in accordance with BlueCross' administrative processes.

1. Legal Recoveries.

BlueCross may, as a Claims Fiduciary for Employer, represent the interest of Employer in any litigation against a third party where the claims are related to subrogation or overpayments for pharmaceutical products, medical devices, durable medical equipment/supplies, and/or other such claims resulting in causes of action related to antitrust, consumer protection, fraud, unjust enrichment, RICO, deceptive trade practices. This representation grants BlueCross the ability to identify, pursue, negotiate settlements of, and/or recover direct legal or equitable claims related to the services performed pursuant to this Agreement. Employer grants to BlueCross the specific authority to opt Employer in or out of any class or direct settlement in which both BlueCross and/or Employer may be considered class members or settling parties, and the authority to pursue any recoveries. The authority granted herein survives the termination of this Agreement.

1.1 Subrogation Recoveries.

1.1.1 BlueCross will enforce Employer's subrogation rights. For all subrogation recoveries received on or after July 1, 2017, BlueCross will retain a fee of 29% of the gross subrogation recovery. Employer is responsible for payment of: (a) any outside attorneys' fees incurred in enforcing Employer's subrogation rights; and (b) any other expenses arising in connection with litigation to enforce its subrogation interest, including, but not limited to, court costs and discovery expenses.

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

1.2 Mass Tort Recoveries.

1.2.1 BlueCross will perform mass tort recoveries on behalf of Employer. BlueCross will retain a fee of 29% of all mass tort recoveries received on or after July 1, 2017.

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

1.3 Class Action Recoveries.

1.3.1 BlueCross will perform class action recoveries on behalf of Employer. BlueCross will retain a fee of 29% of all class action recoveries received on or after July 1, 2017.

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

2. Audit Services. BlueCross will conduct audits in varying manners and forms, including but not limited to, pre-payment claims audits, post-payment claims audits, and provider audits. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross' right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 29% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial audit finding. BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.

3. Coordination of Benefit Services. BlueCross will conduct coordination of benefits activities. BlueCross, in its sole discretion, will determine when and how to conduct such activities and nothing in this Agreement shall limit BlueCross' right or authority to conduct such activities. When BlueCross identifies an overpayment or prevents an overpayment from occurring as a result of these activities, BlueCross will retain 29% of any such overpayment recoveries or overpayment prevention savings. Savings are determined at the time of the initial finding. BlueCross will credit Employer for any savings, less the BlueCross retention amount, as appropriate.

4. Medical Drug Rebates. BlueCross may receive Medical Drug Rebates. Unless otherwise stated herein, a "Medical Drug Rebate" is any payment BlueCross receives that is attributable to a claim for a Prescription Drug that is adjudicated under the Member's medical benefit.

4.1 Contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met are specifically excluded from the definition of Medical Drug Rebate and shall be retained by BlueCross.

4.2 For Medical Drug Rebates received by BlueCross on or after January 1, 2017, BlueCross retains 100% of Medical Drug Rebates.

5. Pharmacy Rebates. BlueCross may receive Pharmacy Rebates. Unless otherwise stated herein, a "Pharmacy Rebate" is any payment BlueCross receives that is attributable to a claim for a Covered Drug that is adjudicated under the Member's pharmacy benefit.

5.1 The following are specifically excluded from the definition of Pharmacy Rebate and shall be retained by BlueCross: (a) contractual obligations to BlueCross that require payment of a penalty or other amount to BlueCross if contractual obligations are not met; and (b) rebates attributable to Provider-administered Specialty Drugs.

5.2 For Pharmacy Rebates based on service dates occurring on or after July 1, 2017, Employer will receive 100% of Pharmacy Rebates.

Addendum to Administrative Services Agreement

City Contract #2017-0090

This addendum shall modify and supersede the attached Administrative Services Agreement effective at 12:01 A.M. July 1, 2017 (the "Agreement") between BlueCross BlueShield of Tennessee ("Vendor") and the City of Franklin, Tennessee ("City"). The Agreement together with this Addendum and the attached document(s) constitute the entire agreement ("Contract").

1. Assignment/Subcontracting. Neither party may assign any rights or obligations under this Contract or any Statement of Work without the prior written consent of the other party. This Addendum will be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns. Vendor may subcontract any portion of the work without the prior consent of the City, but such subcontracting will not relieve Vendor of its duties under this Addendum.

2. Waiver. Neither party's failure or delay to exercise any of its rights or powers under this Addendum will constitute or be deemed a waiver or forfeiture of those rights or powers. For a waiver of a right or power to be effective, it must be in writing signed by the waiving party. An effective waiver of a right or power shall not be construed as either (a) a future or continuing waiver of that same right or power, or (b) the waiver of any other right or power.

3. Severability. If any term or provision of this Addendum is held to be illegal or unenforceable, the validity or enforceability of the remainder of this Addendum will not be affected, unless the severance of that provision substantially deprives a party of the benefit of its bargain or increases the cost of performing its duties pursuant to this Agreement.

4. Precedence. In the event of conflict between the provisions of this Addendum and any contract, agreement or other document which this Addendum may accompany, the provisions of this Addendum will to the extent of such conflict take precedence unless such document expressly states that it is amending this Addendum.

5. Entire Agreement. This Addendum, including any contract, agreement or other document which this Addendum may accompany, constitutes the entire agreement between the parties and supersedes any prior or contemporaneous communications, representations or agreements between the parties, whether oral or written, regarding the subject matter of this Addendum. The terms and conditions of this Addendum may not be changed except by an amendment expressly referencing this Addendum by section number and signed by an authorized representative of each party.

6. Modifications. City agrees to reference this Addendum on any purchase order issued in furtherance of this Addendum, however, an omission of the reference to this Addendum shall not affect its applicability. In no event shall either party be bound by any terms contained in a City purchase order, acknowledgement, or other writings unless: (a) such purchase order, acknowledgement, or other writings specifically refer to this Addendum or to the specific clause they are intended to modify; (b) clearly indicate the intention of both parties to override and modify this Addendum; and (c) such purchase order, acknowledgement, or other writings are signed by authorized representatives of both parties.

7. Survival. These Terms and Conditions shall survive the completion of or any termination of any contract, agreement or other document which this Addendum may accompany as set forth herein.