Blue Cross Blue Shield of Michigan

SCHEDULE A – Renewal Term (Effective 01/01/2019 thru 12/31/2019)

Administrative Services Contract (ASC)

1. **Group Name** CITY OF ANN ARBOR
2. **CID** 102815
3. **ASC Funding Arrangement** Weekly Wire

4. **Line(s) of Business and Products**

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

Products	Applicable
Flexlink	
CDH	

5. Administrative Fees

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

A. Fixed Administrative Fees

Fixed Administrative Fee	Administration Fee Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Administration Fee	Effective Start Date	Effective End Date
A. Base Administrative Fee	$60.32	1,525	$92,015.14	01/01/2019	12/31/2019
B. Third Party Pharmacy Vendor Fee	$0.00	1,525	$0.00	01/01/2019	12/31/2019

B. Variable Administrative Fees - Not Applicable

6. GlidePath - Not Applicable

7. Hospital Advance - Not Applicable

8. Advanced Deposit Monthly Cap Amount - Not Applicable

9. BCBSM Account

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

10. Late Payment Charges/Interest

A. Late Payment Charge	2%
B. Yearly Statutory Interest Charge (Simple Interest)	12%
C. Provider Contractual Interest	12%

11. Buy-Ups - Not Applicable

12. Shared Savings Programs

A. Payment Integrity - Not Applicable

B. Shared Pharmacy Rebate - Not Applicable

C. Traditional Prescription Drug Pricing and Administrative Compensation - Not Applicable

13. Medical Benefit Drug Rebates

The rebate administration fee charged and retained by Rebate Administrator is up to 5.5% of gross rebates for medical benefit drug Claims. Additionally, BCBSM will retain a Rebate Service Fee equal to 10% of medical benefit drug rebates on Claims incurred in the renewal term net of the above Rebate Administrator Fee. The amount of rebates retained by BCBSM as administrative compensation will be identified as a BCBSM Rebate Service Fee and reported to Group.

14. Enrollee Changes Disclaimer

If there is more than a percent 10% change in the number of Enrollees from the number stated above during any month of the Contract Year or a change in Coverages, BCBSM may immediately revise any affected pricing terms in this Schedule A to reflect such changes in Enrollment and/or Coverages. Any revisions will be effective beginning with the next invoice following thirty (30) day notification by BCBSM to the Group. The revised Schedule A will be treated as executed by Group and effective as of the date it is received by Group.

15. Third Party Stop Loss Fee

If Group obtains stop-loss coverage from a third-party stop-loss vendor, BCBSM will charge an additional fee of $8.00 per contract per month due to the additional costs and resources necessary for BCBSM to effectively manage Group's benefits.

16. Third Party Pharmacy Vendor Fee

See Above

17. Agent Fees

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

18. Consumer-Directed Health Disclaimer

If you have a Consumer-Directed Health (CDH) spending account, you may be billed a separate fee for the applicable contracts.

19. Diabetes Management and Prevention Programs

If Group purchases a Diabetes Management and/or Diabetes Prevention Buy-Up program, Group and BCBSM will execute a separate terms and conditions document for such program(s).

20. Medicare Contracts

If your group contains Medicare contracts and they are being separated from the current funding arrangement, all figures within the current funding arrangement will be adjusted.

21. Compensation Agreement with Providers

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

22. Out of State Claims

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

Exhibit 1 to the Schedule A

Value-Based Provider Reimbursement

As in prior years, the Claims billed to Group include amounts that BCBSM reimburses health care providers including reimbursement tied to value. BCBSM has adopted a provider payment model that includes both fee-based and value-based reimbursement. BCBSM does not unbundle Claims and does not retain any portion of Claims as compensation. Provider reimbursement is governed by separate agreements with providers, BCBSM standard operating procedures, and BCBSM Quality Programs.

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, for example, Pay-for-Performance (PFP) rates and Value Based Contracting (VBK) rates earned by hospitals and Patient Centered Medical Home (PCMH) rates earned by physicians.

Provider reimbursement rates also capture provider commitments to BCBSM Quality Programs. For example, hospitals participating in Hospital Collaborative Quality Initiatives (CQIs) agree to allocate a portion of their reimbursement to fund inter-hospital quality initiatives.

Providers may also receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement or collected from Group's Customer Savings Refund. Such allocations may be to a pooled fund from which value-based payments to providers are made. For example, pursuant to the Physician Group Incentive Program (PGIP), physicians agree to allocate a percentage of each Claim to a PGIP fund, which in turn makes reward payments to eligible physician organizations demonstrating particular quality and pays physician organizations for participation in collaborative initiatives. Starting in 2019, an additional portion of a provider's contractual reimbursement (the "Risk Allocation") on most claims will be allocated to a Risk Pool for payment to organized systems of care based on cost/quality performance.

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

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

Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Enrollees access healthcare services outside the geographic area BCBSM serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to BCBSM for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSM serves, Enrollees obtain care from Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Enrollees may obtain care from Providers in the Host Blue geographical area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. BCBSM remains responsible for fulfilling its contractual obligations to you. BCBSM's payment practices in both instances are described below.

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

    a. Enrollee Liability Calculation

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

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

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

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

b. Group Liability Calculation

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

2. Claims Pricing

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

(i) an actual price. An actual price is a negotiated payment in effect at the time a Claim is processed without any other increases or decreases, or

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

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

The Host Blue determines whether it will use an actual, estimated or an average price in its respective Provider agreements. The use of estimated or average pricing may result in a difference (positive or negative) between the price Group pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Enrollee and Group is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

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

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

3. BlueCard Program Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which BCBSM is obligated under the BlueCard Program to pay to the Host Blue, to the Blue Cross and Blue Shield Association (BCBSA), and/or to vendors of BlueCard Program related services. The specific Blue Card

Program fees and compensation that are charged to Group and which Group is responsible related to the foregoing are set forth in Exhibit 1 to this Schedule B. BlueCard Program Fees and compensation may be revised annually from time to time as described in H below.

B. Negotiated Arrangements

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

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

1. Enrollee Liability Calculation

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

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

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

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

2. Group Liability Calculation

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

3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and

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

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways, including but not limited to retrospective settlements, Provider Incentives, share of target savings, Care Coordinator Fees and/or other allowed amounts.

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

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

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

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

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

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

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

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

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

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

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

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

Care Coordinator Fees

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

1. PaMPM billings; or

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

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

Value-Based Programs under Negotiated Arrangements

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

D. Return of Overpayments

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

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

relationship with its Participating Providers, notwithstanding to the contrary any other provision of this agreement/contract.

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

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

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. Enrollee Liability Calculation

    a. In General

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

    b. Exceptions

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

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

2. Fees and Compensation

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

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

1. General Information

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

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

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

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

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

Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount/differential BCBSM receives from the applicable Host Blue. The percentages for 2019 are:

1. 4.14% for fewer than 1,000 PPO or traditional enrolled Blue contracts;
2. 2.31% for 1,000–9,999 Blue PPO or traditional enrolled Blue contracts;
3. 2.14% for 10,000–49,999 Blue PPO or traditional enrolled Blue contracts;

all capped at $2,000.00 per Claim.

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

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

Blue Cross Blue Shield of Michigan

EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder Group Name: CITY OF ANN ARBOR

Account Number: 102815

Effective Date of Policy 01/01/2019

Policy Period: These specifications are for the Policy Period commencing on 01/01/2019 and ending on 12/31/2019

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Exhibit is superseded in whole or in part by a later executed Exhibit. This Exhibit is to the Policy most recently submitted to the state insurance regulator as of the commencement date of the Policy Period stated above.

A. Aggregate Stop-Loss Insurance: ____ Yes __X__ No

If yes, the Attachment Point will be set at of the expected Claims for the Policy Period, and items 1 through 6 below should be completed.

1. Stop-Loss Coverage Period:

____ New Coverage: Claims incurred and paid during the Policy Period.

____ Standard: Claims incurred and paid during the Policy Period.

____ "Run-in" only applies to claims incurred under experience rated coverage provided to Group by Blue Cross Blue Shield of Michigan on or after and paid during the Policy Period.

____ Renewal of Existing Coverage: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

2. Aggregate Stop-Loss insurance shall apply to Amounts Billed for:

____ Medical Claims

____ Outpatient Prescription Drug Claims

____ All lines of covered business as identified in the Schedule A to the Administrative Services Contract

3. Attachment Point -The Attachment Point for Aggregate Stop-Loss coverage shall be the average of the number of Coverage Units for the Policy Period multiplied by the following amounts for each Coverage Unit

4. Aggregate Stop-Loss Coverage

Amounts Billed during the current Policy Period (less Specific (Individual) Stop-Loss Claims, if any) that exceed the Attachment Point. For any aggregate credits to be provided, a twelve-month period is required.

5. Premium: Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by the premium rate of for each Coverage Unit.

6. The number of current Coverage Units is 1525. If the number of Coverage Units varies by +/- 10% in any Month during the Coverage Period, the premium rate and Attachment Point may be revised at any time by Blue Cross Blue Shield of Michigan. Any revision will be effective retroactive to the beginning of the Policy Period.

B. Specific Stop-Loss Insurance __X__ Yes _____ No

If yes, complete items 1 through 7 below.

1. Stop-Loss Coverage Period:

____ New Coverage (Select one from below):

____ Standard: Claims incurred and paid during the Policy Period.

____ "Run-in" included: Claims incurred on or after and paid during the Policy Period

____ "Run-in" includes claims paid by Policyholder's prior claim administrator:

__X__ Renewal of Existing Coverage: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

__X__ "Run-Out" included: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

2. Specific (Individual) Stop-Loss Insurance shall apply to Amounts Billed for:

__X__ Medical Claims

____ Outpatient Prescription Drug Claims

3. Specific (Individual) Stop-Loss Coverage Attachment Point is:

$350.000.00 per contract unit

4. Specific (Individual) Stop-Loss Coverage – The Amounts Billed during the current Policy Period in excess of the Individual Attachment Point in B.3. above per Policy Period.

5. Run-Out Stop-Loss Insurance – The Amounts Billed during the Run-Out Period for Claims Incurred since the original Effective Date of Policy in excess of the Individual Attachment Point identified in B.3. above less any Specific (Individual) Stop-Loss Claims previously paid for Amounts Billed paid during the Run-Out Period.

6. Premium

If the Policyholder has selected Specific (Individual) Stop-Loss Coverage, the Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by the premium rate of $33.62 for each Coverage Unit.

If the Policyholder has selected Run-Out Stop-Loss Insurance, the Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for the final month before termination by the same amount described above for the Stop-Loss Premium and shall be payable for the first three months after termination of the Administrative Services Contract. However, if the number of Coverage Units in the final month is less than the number in the month exactly one year earlier, BCBSM shall calculate the Monthly Premium using the higher count from one year earlier.

7. The number of current Coverage Units is 1525. If the number of Coverage Units varies by +/- 10% in any month during the Coverage period, the premium rate and Attachment Point may be revised at any time by Blue Cross Blue Shield of Michigan. Any revision will be effective retroactive to the beginning of the Policy Period.

Additional Provisions:

The undersigned person represents that he/she is authorized and responsible for purchasing stop-loss coverage on behalf of the Policyholder. It is understood that the actual terms and conditions of coverage are those contained in this Exhibit and the Stop-Loss Coverage Policy into which this Exhibit shall be incorporated at the time of acceptance by Blue Cross Blue Shield of Michigan, a nonprofit mutual disability insurer ("BCBSM"). Upon acceptance, BCBSM shall issue a Stop-Loss Coverage Policy to the Policyholder. Upon acceptance of this Exhibit and issuance of the Stop-Loss Coverage Policy, the Policyholder Group shall be referred to as the "Policyholder."

Policyholder shall acknowledge its acceptance of the terms of the Stop-Loss Coverage Policy and this Exhibit by signature of a duly authorized representative through a means, electronic or otherwise, determined by the Company.

STOP-LOSS INSURANCE POLICY
between

BLUE CROSS BLUE SHIELD OF MICHIGAN
a Nonprofit Mutual Insurer

Herein called "the Company"
and

CITY OF ANN ARBOR

Herein called "the Policyholder"

The Exhibit attached hereto and made a part of this Policy shall establish the Policyholder's Group Name, Group Number, the Effective Date of Policy, and the Policy Period.

In consideration of the Exhibit attached hereto and in consideration of the payment made by the Policyholder of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Policy.

All definitions of the administrative services agreement between the Policyholder and the Company (herein called the "Administrative Services Contract") shall apply equally to this Policy unless otherwise specified in this Policy or the Exhibit.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Form 2019-1

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SECTION I
DEFINITIONS

Additional definitions applicable to this Policy are contained in the Administrative Services Contract.

"Additional Administrative Compensation" or "AAC" has the meaning as defined in the applicable Administrative Services Contract.

"Aggregating Specific Deductible" means a deductible, in addition to the specific Attachment Point, that must be satisfied during the Policy Period before Amounts Billed are reimbursable under this Policy.

"Amounts Billed" means paid Claims in addition to the combined amount of BlueCard Fees and AAC, if any. AAC and/or BlueCard Fees shall only be included as "Amounts Billed" where such AAC or fees are paid in association with the types of Claims specified on the Exhibit and in settlement of Claims for any benefits under the Plan, and are:

(a) In the case of new coverage: (i) incurred and paid during the Policy Period or (ii) incurred during the Stop-Loss Coverage Period and paid during the Policy Period, as specified on the Exhibit.

(b) In the case of a renewal of existing coverage, incurred on or after the original Effective Date of Policy and paid during the most current Policy Period, as specified on the Exhibit.

(c) Paid during the Run-Out Period, where applicable, in accordance with the provisions of this Policy.

Claims, AAC, and BlueCard Fees are considered "incurred" on the date the associated service or supply is furnished; Claims, AAC, and BlueCard Fees are considered "paid" on the date they are processed.

"Amounts Billed" shall not include:

(a) AAC or BlueCard Fees associated with claims incurred prior to the original Effective Date of Policy, except as specified on the Exhibit;

(b) AAC or BlueCard Fees associated with claims incurred after the termination date of this Policy;

(c) Extra-contractual damages of any nature, compensatory damages, punitive damages, or any similar damages however assessed (including as a result of settlement), or any payments made as an exception to the Plan; or

"**Attachment Point**" means the dollar amount above which Stop-Loss Insurance will apply as indicated in Items A.3. and/or B.3. of the most current Exhibit to this Policy provided, however, that the Attachment Point for Aggregate Stop-Loss Insurance shall never be less than the minimum specified in Item A.3. of the most current Exhibit. The Attachment Point may be revised by the Company on any date the Company determines that that there has been a change in Coverages or the number of Coverage Units has changed by an amount equal to 10% or more of total enrollment from the number shown in Items A.6. or B.7. of the Exhibit.

"BCBS Plan" means a company that has been licensed by the Blue Cross and Blue Shield Association ("BCBSA").

"BlueCard Fees" means the fees assessed under the national program established by BCBSA under which BCBS Plan Enrollee claims are processed by BCBS Plans when an Enrollee receives health care services outside of the area served by their BCBS Plan.

"Claim" means "Claim" as that term is defined in the Administrative Services Contract.

"**Coverage Unit**" means an Employee plus such person's eligible enrolled dependents. Those dependents are not counted separately but are included within the Employee's "Coverage Unit."

"**Enrollee**" means "Enrollee," as that term is defined in the Administrative Services Contract unless the Administrative Services Contract provides coverage for inmates of a penal institution, in which case "Enrollee" means "Inmate," as defined in such Administrative Services Contract.

"**Effective Date of Policy**" means the date specified on the Exhibit.

"**Employee**" means "Employee," as that term is defined in the Administrative Services Contract unless the Administrative Services Contract provides coverage for inmates of a penal institution or participants in a Trust Fund, in which case "Employee" means "Inmate" or "Participants," as defined in the relevant Administrative Services Contract.

"**Exhibit**" means the attached EXHIBIT TO THE STOP-LOSS COVERAGE POLICY or any subsequent replacement Exhibit supplied by the Company specifying the particulars of this Policy. The specifications or items of the Exhibit shall be applicable for the Policy Period indicated on the Exhibit, except that any item of the Exhibit may be changed in accordance with the provisions described in this Policy.

"**Final Policy Period**" means the period of time beginning on the first day of the Policy Period specified on the most current Exhibit and ending on the date the Policy is terminated.

"**Month**" means each succeeding calendar Month period beginning on the first day of the Policy Period.

"**Plan**" shall mean the self-funded Group Health Plan of the Policyholder.

"**Policy**" as used herein means this Stop-Loss Coverage Policy.

"**Policy Period**" means the period of time beginning and ending on the dates shown on the most current Exhibit.

"Proof of Loss" means evidence of the Plan's payment or liabilities of Amounts Billed by or on behalf of an Enrollee during the Policy Period.

"**Run-In Period**" means the period immediately prior to the initial Policy Period, if any, as specified in Items A.1 or B.1 of the Exhibit.

"**Run-Out Amounts Billed**" means those Amounts Billed that are incurred on or after the Effective Date of Policy but prior to termination and that are paid during the Run-Out Period.

"**Run-Out Period**" means the twenty-four-Month period immediately following the termination of this Policy.

"Stop-Loss Claims" means the Amounts Billed for which the Company assumes responsibility and risk.

(d) If the Amounts Billed that have accumulated during the Policy Period for any Coverage Unit exceed the amount indicated in Item B.3. of the most current Exhibit to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as **Specific (Individual) Stop-Loss Claims** and the coverage provided hereunder for such claims as **Specific Stop-Loss Insurance**. A monthly review will occur to determine if such excess exists.

(e) Specific Stop-Loss Insurance does not extend beyond the termination date of this Policy unless coverage for Run-Out Stop-Loss Insurance is elected at least twelve months prior to termination of the ASC.

(f) If, during the Run-Out Period, Run-Out Amounts Billed exceed the Attachment Point indicated in Item B.3. of the most current Exhibit to this Policy, such excess, if any, shall be referred to in this Policy as **Run-Out Stop-Loss Claims** and the coverage provided hereunder for such claims as **Run-Out Stop-Loss Insurance**.

(g) If, during the current Policy Period, aggregate Amounts Billed less Specific (Individual) Stop-Loss Claims, if any, exceed the Attachment Point indicated in Item A.3. of the most current Exhibit to this Policy, such excess, if any, shall be referred to in this Policy as **Aggregate Stop-Loss Claims** and the coverage provided hereunder for such claims as **Aggregate Stop-Loss Insurance**.

(h) Stop-Loss Claims may also include claims paid by the Policyholder's prior claim administrator as specified on the Exhibit.

"**Stop-Loss Coverage Period**" means the period specified in Items A.1. and/or B.1. of the most current Exhibit.

"**Stop-Loss Premium**" means the Monthly or annual premium, calculated in accordance with the formulas indicated in Items A.5. and/or B.6. of the most current Exhibit, that is required by the Company for the risk assumed for the Stop-Loss Insurance indicated in Item A.1. and/or B.1. of the most current Exhibit. The Policyholder shall pay to the Company the Stop-Loss Premium on the first date after it receives the Stop-Loss Premium invoice that Amounts Billed must be paid under the Administrative Services Contract. If the Policyholder's payment is more than one business day late, the Policyholder shall pay a late fee in the amount as described in this Policy.

The Stop-Loss Premium shall be subject to change by the Company (and the Aggregate Stop-Loss Attachment Point revised retroactive to the first month of the Contract Year) as follows:

(i) At the end of the Policy Period shown in the most current Exhibit, provided that thirty (30) days prior written notice is given by the Company;

(j) On the implementation date of any changes or benefit variances in the Policyholder's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;

(k) On any date changes imposed by governmental entities increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

(l) On any date the Company determines that that there has been a change in Coverages or the number of Coverage Units has changed by an amount equal to 10% or more of total enrollment from the number shown in Items A.6. or B.7. of the Exhibit.

SECTION II
POLICY PROVISIONS

INDEMNIFICATION OF RISK. The Company hereby agrees to indemnify the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the Amounts Billed pursuant to the Plan during the Policy Period which are in excess of the Attachment Point specified in Items A.3. and/or B.3. of the most current Exhibit. If the Policyholder selects an Aggregating Specific Deductible as part of its Policy, in addition to the Attachment Point specified in Item A.3, a deductible in the amount shown in Amounts Billed must be met before any indemnification is made by the Company. This additional deductible amount may be met on behalf of one or more Enrollees and must be an accumulation of Amounts Billed in excess of those applied to the specific Attachment Point within the Policy Period. The Company shall not be liable for, nor shall the indemnification be extended to, any claim or liability for extra-contractual, compensatory, or punitive damages, including interest, statutory penalties and attorney fees. Unless otherwise specified in the Exhibit, the Company shall not be liable for the cost of administration of a Plan, including any costs related to investigation, payment or other services provided by a third-party administrator or any other party.

ENTIRETY. This Policy, the most current Exhibit, and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Policy shall not create any right or legal obligation between the Company and any Enrollee under the Plan.

MODIFICATION. Except for the Exhibit to this Policy, which may be changed at any time in accordance with the provisions of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of Company and an authorized representative of the Policyholder.

SECTION III
PREMIUM PROVISIONS

PREMIUM PAYMENT. The premium amounts to be paid to the Company as consideration for the insurance provided hereunder shall be specified on the Exhibit and the method of payment shall be set forth in the Administrative Services Contract.

REMITTANCE. The Company shall bill the Policyholder for the Stop-Loss Premium amount due and the Policyholder shall remit payment as set forth in the Administrative Services Contract. A remittance will be considered received when actually delivered into the possession or control of the Company.

LATE FEE. A late fee shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Policyholder. This charge shall be an amount equal to the lesser of:

(a) 2.0% of any outstanding amount due; or

(b) The maximum rate permitted by state law.

NOTICE, SUBROGATION, AND PROOF OF LOSS. The Company shall reimburse the Policyholder as specified in the section of this Policy entitled SETTLEMENTS. Payment to the Policyholder in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements. The subrogation provisions of the Administrative Services Contract are hereby incorporated by reference except to the extent they conflict with a specific provision of this Policy.

No action at law or in equity shall be brought to recover on this Policy more than three (3) years from expiration of this Policy.

If any time limitation of this section of the Policy is less than that permitted by the state of Michigan at the time this Policy is issued, such limitation is hereby extended to agree with the minimum permitted by such law.

The books and records of the Policyholder which pertain to the Plan, including any Proof of Loss required by the Plan, shall be open to the Company and its representatives at all times during the usual business hours for inspection.

SECTION IV
SETTLEMENTS

SPECIFIC (INDIVIDUAL) STOP-LOSS SETTLEMENT. The invoices or payment schedules provided under the Administrative Services Contract shall include the premium due under this Policy as well as any credits to the Policyholder for Specific (Individual) Stop-Loss Claims existing at that time. To the extent that a true-up is needed to reflect corrections or adjustments based on the actual number of Employees covered at any one time during Policy Period or for other reasons, including but not limited to recovery of claims, the Company will provide, within 120 days after the end of each Policy Period during which this Policy is in effect, an annual settlement. Any deficit or surplus resulting from this settlement will be reflected in a subsequent bill. The Company reserves the right to deduct any amount(s) owed the Company by the Policyholder from any payment due the Policyholder as a result of the claim settlement.

If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Specific (Individual) Stop-Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Policy termination. Specific Stop-Loss Insurance shall not extend beyond the termination date of this Policy.

AGGREGATE STOP-LOSS SETTLEMENT. For any Aggregate Stop-Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within 120 days after the end of each Policy Period during which this Policy is in effect. The Company reserves the right to deduct any amount(s) owed the Company by the Policyholder from any payment due the Policyholder as a result of the claim settlement. Aggregate Stop-Loss Insurance shall not exceed the maximum indicated in Item A.3. of the most current Exhibit to this Policy in any Policy Period or any Final Policy Period.

If the settlement reflects that Claims for the Policy Period are less than 90% of expected Claims for the Policy Period, no Aggregate Stop-Loss benefit shall be payable to the Policyholder. If the settlement reflects that Claims for the Policy Period are equal to or greater than 90% of expected Claims for the Policy Period and exceed the Attachment Point for Aggregate Stop-Loss Insurance for that Policy Period, then Aggregate Stop-Loss Claims, to the extent funded by the Policyholder, minus any Specific (Individual) Stop-Loss Claims, shall be the responsibility of the Company. If the Attachment Point exceeds the Claims, then no Aggregate Stop-Loss benefit shall be payable to the Policyholder.

RUN-OUT PERIOD SETTLEMENT. If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Insurance and only if selected at least twelve months prior to termination of the Administrative Services Contract), credits shall be provided to the Policyholder for Run-Out Stop-Loss Claims under this Policy as part of the run-out process under

the Administrative Services Contract. Within 120 days following the Run-Out Period, the Company shall prepare a settlement statement that will include a final reconciliation of all Run-Out Stop-Loss Claims.

SECTION V
GENERAL PROVISIONS

LIMITATION OF LIABILITY. Liability for any errors or omissions by the Company (or its officers, directors, employees, agents, or independent contractors) in the administration of this Policy, or in the performance of any duty or responsibility contemplated by this Policy, shall be limited to the maximum benefits which should have been paid under the Policy had the errors or omissions not occurred (including the Company's share of any arbitration expenses incurred under the Policy), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence, or intentional breach of a duty by the Company.

TERM AND TERMINATION. This Policy shall continue in full force and effect from year to year unless terminated as provided herein.

This Policy may be terminated as follows:

(a) By either party at the end of any Policy Period following thirty (30) days prior written notice to the other.

(b) By both parties on any date mutually agreed to in writing.

(c) Notwithstanding any other provision of this Policy, if Policyholder fails to timely pay any amounts owed, the Company may, after five days' notice in writing, terminate the Policy.

This Policy will terminate automatically:

(d) On the date the most current Exhibit terminates as specified in the Exhibit, unless a replacement Exhibit for the period immediately following is executed by the Company and the Policyholder;

(e) On the date the Plan terminates; or

(f) On the date the Administrative Services Contract terminates.

In the event of termination of this Policy for any reason prior to the expiration of a Policy Period, no Aggregate Stop-Loss Insurance will exist for the Final Policy Period or Run-Out Period. The Policyholder will be required to fund all claims during the Final Policy Period and Run-Out Period. The Company shall have no obligation to determine a Claim settlement for the period during which coverage was not in effect nor shall the Company refund any portion of the premium(s) to the Policyholder.

ADVISORS. Each party acknowledges that it has had full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision knowingly to enter into this Policy. Neither party has executed this Policy in reliance on any representations, warranties, nor statements made by the other party hereto other than those expressly set forth herein.

ASSIGNMENT. No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.

GOVERNING LAW. This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Michigan without regard to any state choice-of-law statutes, and any applicable federal law.

INSOLVENCY. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Enrollees under a Plan.

LIABILITY. The Company will have neither the right nor the obligation under this Policy (though such right or obligation may exist under the separate Administrative Services Contract) to directly pay any Enrollee or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit an Enrollee to have a direct right of action against the Company. The Company will not be considered a party to the Plan or to any supplement or amendment to it by reason of this Policy.

NO WAIVER. The failure of either the Policyholder or the Company to insist upon strict performance of any of the terms of this Policy shall not be construed as a waiver of its respective rights or remedies with respect to any subsequent breach or default in any of the terms of this Policy.

NOTICES: Unless otherwise provided in this Policy, any notice required shall be given in writing and sent to the other party either by hand-delivery, electronic message to a designated representative of the other party, or postage-pre-paid US first class mail at the following address or such other address as a party may designate from time to time:

If to Policyholder: To the Policyholder's address for ASC purposes.

If to the Company: Blue Cross Blue Shield of Michigan
600 Lafayette East, Mail Code B612
Detroit, Michigan 48226-2998

OFFSET. Any payment or overpayment made to the Policyholder due to an error or mistake must be promptly refunded to the Company upon notice to the Policyholder of such error or mistake. The Company may offset any refund owed to the Policyholder for such payment or overpayment or any premium owed to the Company against any reimbursement due to the Policyholder.

SERVICE MARK LICENSEE STATUS. The Company is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. The Company is not an agent of BCBSA and, by entering into this Policy, Policyholder agrees that it did so based solely on its relationship with the Company or its agents. Policyholder agrees that BCBSA is not a party to this Policy, has no obligations under this Policy, and that no BCBSA obligations are created or implied under this Policy.

SEVERABILITY. In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

TAXES. Any taxes imposed, increased, or adjudged due by any lawful authority on or after the Effective Date of Policy, that directly pertain to this Policy, whether relating to fees, services, benefits, payments, or any other aspect of this Policy or the Plan and that the Company is required to pay or remit shall be reimbursed by the Policyholder as invoiced by the Company.

Blue Cross Blue Shield of Michigan
Group Signature Page

Group and Blue Cross Blue Shield of Michigan agree to sign the documents listed below ("Agreements") using an electronic signature ("E-Signature"). Each party's E-Signature is the legal equivalent of a manual/handwritten signature on the Agreements. By providing their E-Signatures below, the parties are legally bound by the terms and conditions in the Agreements. Group agrees that no certification authority or other third party verification is necessary to validate Group's E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of Group's E-Signature or the Agreements.

- ASC Contract Amendment
- Schedule A
- Schedule A, Exhibit 2 (if applicable)
- Stop Loss Exhibit
- Stop Loss Exhibit - Amendment (if applicable)

Upon E-Signature by the parties, this page will be electronically attached to the Agreements and stored for reference and record. Group may review this documentation by requesting a copy from their BCBSM salesperson or by submitting a request to BCSAGS@bcbsm.com.

Signatures

BLUE CROSS BLUE SHIELD OF MICHIGAN: **GROUP:**

By: (Signature)	**By:** (Signature)
Name: (Print)	**Name:** (Print)
Title:	**Title:**
Date:	**Date:**

THE GROUP:

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

THE GROUP:

BY: _____
(Signature)

NAME: _____
(Print)

TITLE: _____

DATE: _____

The parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall bind such party to this Agreement. The parties agree that any electronically signed document (including this Agreement) shall be deemed (i) to be "written" or "in writing," (ii) to have been signed and (iii) to constitute a record established and maintained in the ordinary course of business and an original written record when printed from electronic files. For purposes hereof, "electronic signature" means a manually-signed original signature that is then transmitted by electronic means; "transmitted by electronic means" means sent in the form of a facsimile or sent via the internet as a "pdf" (portable document format) or other replicating image attached to an e-mail message; and, "electronically signed document" means a document transmitted by electronic means and containing, or to whichthere is affixed, an electronic signature.