**Amendment to Administrative Services Contract for Consolidated Appropriations Act (2021) and Transparency in Coverage Final Rule Provision**

1. Group Name CITY OF ANN ARBOR
2. CID 102815

This amendment ("Amendment") to the Administrative Services Contract ("Contract") is between Blue Cross Blue Shield of Michigan ("BCBSM") and the undersigned group ("Group"), as the plan sponsor and administrator of its group health care plan, and relates to the Consolidated Appropriations Act ("CAA") passed on December 27, 2020 and Transparency in Coverage Final Rule.

In consideration of their mutual promises, the Contract will be amended as follows:

1. Article II, Section J is deleted in its entirety and replaced with the following:

   J. Confidentiality.

   The terms of this Contract and the items set forth below are confidential and shall not be disclosed or released to a third party without the prior written consent of BCBSM, unless required by law.

   1. Provider Proprietary Information. Health care provider names, addresses, tax identification numbers, and financial amounts paid to such providers.

   2. BCBSM and Other BCBS Plan Proprietary Information. BCBSM's or any other BCBS Plan's methods of reimbursement, amounts of payments, discounts and access fees; BCBSM's administrative fees and, if applicable, stop loss fees; those processes, methods, and systems developed for collecting, organizing, maintaining, relating, processing and transacting comprehensive membership, provider reimbursement and health care utilization data.

   Notwithstanding the foregoing, Group does not need BCBSM's consent and shall not be restricted from:

   1. Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the Group, Enrollees, or individuals eligible to become Enrollees.

   2. Electronically accessing de-identified claims and encounter information or data for each Enrollee, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, the amendments made by the Genetic Information Nondiscrimination Act of 2008 ("GINA"), and the Americans with Disabilities Act of 1990 ("ADA"), including, on a per claim basis:

      a. financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;
      b. provider information, including name and clinical designation;
      c. service codes; or
      d. any other data element included in claim or encounter transactions.

3. Sharing information or data described in subparagraph (1) or (2) above, or directing that such data be shared with a business associate (as defined in 45 CFR Section 160.103 "Business Associate" of Group or plan), consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, the amendments made by the GINA, and the ADA. BCBSM may place reasonable restrictions on a Business Associate related to the public disclosure of the information described in subparagraphs (1) and (2).

2. The following paragraph is added to Article V—General Provisions as a new item:

**Compliance Assistance.** To the extent the below requirements are applicable to Group, BCBSM will provide Group with reasonable support related to Group's compliance with:

a. 29 CFR 2590.715-2715A2 and 29 CFR 2590.715-2715A3 by providing the data necessary for Group to meet the individual and public disclosure requirements;

b. the Federal No Surprises Act (42 USC §300gg-111) and its implementing regulations;

c. the Mental Health Parity and Addiction Equity Act, including BCBSM providing Group with BCBSM's book-of-business comparative analysis under 42 USC §300gg-26(a)(8); and

d. cost reporting requirements under 29 USC 1185n (to the extent BCBSM maintains such information) and air ambulance reporting under 29 USC 1185l.

Except as set forth in this Amendment, all other terms and conditions of the Contract shall remain in full force and effect. If there is a conflict between the terms of this Amendment and the Contract, the terms of this Amendment shall prevail.

FOR THE CITY OF ANN ARBOR

By _____
Christopher Taylor, Mayor

By _____
Jacqueline Beaudry, City Clerk

Approved as to substance:

By _____
Milton Dohoney Jr., City Administrator

Approved as to form and content

By _____
Atleen Kaur, City Attorney

**Traditional Prescription Drug Guarantee Addendum**

This Prescription Drug Guarantee Addendum ("Rx Addendum") amends and is made part of the Administrative Services Contract ("ASC") between Blue Cross Blue Shield of Michigan ("BCBSM") and City of Ann Arbor ("Group"), as the plan sponsor and administrator of its group health care plan. The provisions of this Rx Addendum will override and control any conflicting provision of the ASC. All non-conflicting provisions of the ASC will remain in full force and effect.

Group and BCBSM have agreed to certain guarantees related to Group's prescription drug benefit plan ("Rx Plan") administered by BCBSM as set forth below**.**

BCBSM and Group agree as follows:

**1) DEFINITIONS.** The following definitions shall apply to this Rx Addendum. All capitalized terms not defined in this Rx Addendum shall have the meaning set forth in the ASC.

**a) 340B Claims** –means Paid Claims meeting any of the following criteria: (a) submitted to PBM with a submission clarification code of "20" or equivalent code under the applicable NCPDP format (or any successor format); (b) submitted to PBM by a pharmacy which is categorized as Type 39 in the NCPDP DataQ database; (c) identified as a 340B claim using the ESP Portal or similar industry resource for identification of 340B claims; or (d) identified as having been purchased by the dispensing pharmacy at a 340B discount, whether identified at the time of dispensing or subsequent to dispensing. PBM shall monitor the volume of Paid Claims identified as 340B Claims on the basis of having been rejected by a Drug Manufacturer as 340B in order to reasonably substantiate the accuracy of a Drug Manufacturer's rejection of Paid Claims. For the avoidance of doubt, Paid Claims meeting any one of the criteria provided herein will be regarded as 340B Claims, and identification of 340B Claims may occur at the time of adjudication or any time afterward.

**b) 90-Day Retail Network** – A network where claims are filled for commercial Enrollees for a three-month supply. Three-month supply shall mean equal to or greater than 84 days' supply per prescription/refill.

**c) Average Wholesale Price or AWP** – The average wholesale price of a Covered Drug on the date the order is dispensed as reflected by the information set forth in the BCBSM contracted Pharmacy Benefit Manager's ("PBM") claim processing system on the date the claim is processed, based on information received from Medi-Span's Master Drug Database ("MDDB"), at least once each seven (7) calendar days. The applicable AWP shall be based on the manufacturer's full eleven-digit NDC code of the actual package size and date from which the Covered Drug is dispensed by the Participating Pharmacy. If MDDB or other applicable reporting sources discontinue providing AWP or change the methodology for calculating AWP in a way that materially changes the economics of this Rx Addendum, the parties will discuss in good faith a reasonable modification to the program pricing terms to preserve the parties' relative economics before such changed methodology.

**d) Biosimilar Drug** – A "biosimilar" biological product as defined in the Biologics Price Competition and Innovations (BPCI) Act of 2009 at 42 U.S.C. section 262(i)(2) and approved under Section

351(k) of the Public Health Services Act.

**e) Brand Drug**-- For purposes of calculating retail, mail order and Specialty Drug guarantees, Brand shall be defined as drugs, products, and supplies with a valid NDC that meet all the following criteria:

(i) Medi-Span Multi-Source Code of "M", "N", or "O" and
(ii) Medi-Span Brand Name Code of "T" and
(iii) DAW Code that is not 3, 4, 5, or 6.

For adjudication purposes, BCBSM may, for select circumstances, override the brand status for benefit copay reasons or as dictated by the Drug list or Formulary.

**f) Compounded Drug** - A Paid Claim where two (2) or more U.S. Food and Drug Administration ("FDA") approved ingredients are mixed together and prepared by a pharmacist in a non-commercially available dose or dosage form to meet a Member's individual medical needs. The product will not be considered a Compound Prescription Claim if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added. Each ingredient contained in a Compound Prescription Paid Claim shall be billed and priced using the National Council on Prescription Drug Programs (NCPDP) D.0 standard.

**g) Cost Sharing Amount** – Such amounts that are required to be collected by Participating Pharmacy's and to be paid by an Enrollee for each prescription or authorized refill, which may include copayments, coinsurance or deductibles.

**h) Covered Drugs** – Drugs or supplies used to treat medical conditions which are set forth in the Drug List or Formulary selected by the Group.

**i) Dispensing Fee** – The fee that is paid by PBM on behalf of BCBSM to a Participating Pharmacy to dispense a Covered Drug.

**j) Device(s)** – Prescription claims for products included in the American Hospital Formulary Service (AHFS) therapeutic class code 94000000, except for insulin pumps, continuous glucose monitors (CGM), or diabetic test strips.

**k) Drug List or Formulary** – The list of Brand Drugs and Generic Drugs as set forth by BCBSM and which shall be dispensed through pharmacy providers to Enrollees. BCBSM shall develop formularies with identified preferred prescribed drug alternatives.

**l) Exclusive Limited Distribution** – Exclusive distribution Specialty Drugs which are only available through no more than two (2) pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.

**m) Generic Drug** –Generic Drug shall be defined as all drugs, products, and supplies with a valid 11-digit NDC that meet at least one of the following criteria:

(i) Medi-Span Multi-Source Code of "Y or

(ii) Medi-Span Brand Name Code of "B" or "G" or
(iii) DAW Code that is one of 3, 4, 5, or 6

**n) Incentive Fee** – The fee that is paid by PBM on behalf of BCBSM to a Participating Pharmacy to dispense a Generic Drug or to compound a prescription drug.

**o) Ingredient Cost** – The amount equal to the lowest of (i) the pharmacy's usual and customary price, as submitted ("U&C") less the Dispensing Fee, (ii) the applicable Maximum Allowable Cost ("MAC"), where applicable, (iii) AWP less the applicable AWP discount, or (iv) pharmacy submitted ingredient cost.

**p) Limited Distribution Drugs** – Specialty Drugs used to treat conditions affecting only a small number of patients with special requirements. The manufacturer, or as recommended by the FDA, may choose to limit the distribution of a drug to only a few pharmacies.

**q) Mail Order Pharmacy Program** – the program in which Enrollees may submit a prescription, as allowed by a Plan, PBM to dispense Covered Drugs to Enrollees via mail order by a non-specialty pharmacy owned or operated by PBM under lines of business as agreed between the parties.

**r) Maximum Allowable Cost or MAC** – The current maximum allowable cost of certain Covered Drugs as identified by BCBSM or PBM. MAC pricing will be applied to all distribution channels, including (if applicable) retail, 90-day retail maintenance, and mail order channels. The composition of the MAC lists will be the same across all distribution channels using the same industry standard data element for all lists. The MAC pricing that applies at the Mail Service Pharmacy shall be equal to or better (e.g., deeper discounts) than the MAC pricing that applies at retail Participating Pharmacies. Variation of MAC pricing among retail Participating Pharmacies shall be minimized to limit Member disruption.

**s) National Drug Code or NDC –** The 11-digit National Drug Code as assigned by the pharmaceutical drug manufacturer and as reported by Medispan or other agreed upon source.

**t) New to Market** – Specialty Drugs approved by FDA, available in market, and added by BCBSM to the Specialty Drug Price List. New to market designation applies for no more than six (6) months.

**u) Participating Pharmacies** – Entities which contract with BCBSM or its PBM to provide Covered Drugs to Enrollees.

**v) Rebates** – any discount, price concession or other direct or indirect remuneration BCBSM receives from drug manufacturers which are related to Group utilization, including, but not limited to, rebates, administrative fees, inflation protection payments, educational payments, data payments, reimbursements and other fees or compensation. Rebates do not include any discount, price concession or other direct or indirect remuneration BCBSM or PBM receives for the direct purchase of a prescription drug as a mail order pharmacy or specialty pharmacy or bona fide service fees at fair market value received by PBM for providing any products or services directly to drug manufacturers.

**w) Rx Claim** – A request for payment from (1) a pharmacy provider for providing a Covered Drug to

an Enrollee or (2) directly from an Enrollee for a Covered Drug. Rx Claims billed to Group include all amounts that BCBSM pays to PBM or directly to pharmacy providers or Enrollees for such claims, including Dispensing Fees, Incentive Fees, and Ingredient Cost, and any BCBSM fees disclosed on Group's Schedule A less any Cost Sharing Amount and Enrollee sanction, if applicable.

**x) Specialty Drug** – Biotech drugs, including high cost infused medications, oral and self-injectable drugs, products, supplies, services, and other drugs related to specialty disease categories or other categories, as included on the BCBSM Specialty Drug Price List.

**y) Standard Retail Network** – A network where claims are filled for commercial Enrollees, for a one-month supply. One-month supply shall mean 1-83 days' supply per prescription/refill.

**z) Subrogation Claims** – subrogation claims submitted by any state or a person or entity acting on behalf of a state or similar United States or state government health care programs, for which BCBSM is deemed to be the primary payor by operation of applicable federal or state laws.

**aa) Usual & Customary or U&C** – The usual and customary or retail price charged by a Participating Pharmacy for a Covered Drug in a cash transaction on the date the drug is dispensed.

**bb) Zero Balance Claims or ZBC** – Rx Claims where the Enrollee pays the full cost of the Covered Drug and Group is billed $0 (zero) dollars.

## 2) TERM AND TERMINATION.

The effective date of this Rx Addendum shall be 01/01/2026 and shall continue in full force and effect until 12/31/2026 (the "Term"), unless Group or BCBSM terminates the ASC prior to the end of the Term or Group or BCBSM terminate Group's prescription drug coverage by giving the other party at least thirty (30) days' prior written notice. Group acknowledges that BCBSM does not offer prescription drug benefit services separate from its administrative services for medical benefits.

If Group terminates prescription drug coverage before the end of the Term, Group shall pay BCBSM a $2.00 per contract per month (PCPM) fee multiplied by Group's average monthly contract count prior to termination multiplied by the remaining months in the Term in order to compensate BCBSM for the costs of setting up and implementing Group's Rx Plan. Furthermore, if the effective date of termination is prior to the end of or during a Contract Year, Section 3 covering the guarantees shall be null and void for that respective Contract Year.

Upon mutual agreement of terms and conditions of this Rx Addendum, Group must execute this Rx Addendum within 90 days of such mutual agreement ("Deadline"). If the Rx Addendum is executed after the Deadline, BCBSM reserves the right to not reconcile the guarantees for the impacted Contract Years. Additionally, if Group terminates the prescription drug coverage before [DATE], Group shall return to BCBSM all credits the Group received during the Term that are set forth in Group's Schedule A(s).

## 3) GUARANTEES

**a) AWP Discount and Dispensing Fee Guarantees**. BCBSM guarantees the average AWP discount ("Guaranteed AWP Discount") and Dispensing Fees ("Guaranteed Dispensing Fee") for the retail, mail order, and specialty Participating Pharmacies will be as follows:

i) **Retail-30 Network Discounts and Dispensing Fee Guarantees.**

| Contract Year | Type of Drug | Discount | Dispensing Fees |
|---|---|---|---|
| Year 1 | Brand | AWP – 19.40% | $0.55 |
| | Generic | AWP – 84.50% | $0.55 |

ii) **Mail Order Discounts and Dispensing Fee Guarantees.**

| Contract Year | Type of Drug | Discount | Dispensing Fees |
|---|---|---|---|
| Year 1 | Brand | AWP – 23.35% | $0.00 |
| | Generic | AWP – 91.00% | $0.00 |

iii) **Overall Specialty Drugs Network Discounts and Dispensing Fee Guarantees – Non - Exclusive.**

| Contract Year | Discount | Dispensing Fees |
|---|---|---|
| Year 1 | AWP – 19.40% | $0.00 |

iv) **AWP Discount and Dispensing Fee Guarantee Calculation.**

(1) Within ninety (90) days of the end of each Contract Year, BCBSM will calculate the actual average AWP discount ("Actual AWP Discounts") and Dispensing Fees ("Actual Dispensing Fee") for all Covered Brand Drugs, Generic Drugs, and Specialty Drugs (exclusive of Excluded Claims as defined below) dispensed and submitted by Participating Pharmacies for Enrollees, in the aggregate, for the applicable Contract Year.

(2) The retail and mail order guarantee calculations include ZBCs and U&C (applicable to retail) Rx Claims but exclude Specialty Drugs, Indian Health Service, Tribal/Urban Indian Health, Veteran/Military provider claims, vaccines, Compounded Drugs, COVID-19 antiviral drugs and OTC antigen at home test kits, direct Enrollee reimbursement claims, secondary payer coordination of benefit ("COB") claims, 340B Claims, and Subrogation Claims ("Excluded Claims").

(3) The Specialty Drug guarantee calculations exclude the Excluded Claims, Exclusive Limited Distribution products, Limited Distribution Drugs not dispensed by the Blue Cross preferred specialty pharmacy, New to Market Specialty Drugs, New to Market Biosimilar Drugs and New to Market Limited Distribution Drugs, but includes Specialty Drug Rx Claims including ZBC and U&C (if applicable).

(4) Specialty Drug AWP discounts are determined by the BCBSM Specialty Drug Price List, which is revised periodically as market conditions warrant.

**a) Claim Level Rebate Guarantees**. For each paid Covered Brand Drug dispensed by a pharmacy provider to an Enrollee, BCBSM guarantees that Group's average Rebates will be at least the following amounts net of the Rebate Administrator Fees and BCBSM Rebate Service Fee:

| | Contract Year | Average Rebate |
|---|---|---|
| Standard Retail | Year 1 | $355.65 |
| Mail Order | Year 1 | $714.15 |
| Specialty Drugs | Year 1 | $3,625.10 |

The Rebate Guarantees are based on the BCBSM Clinical Drug List (Formulary) and Group's benefit designs as of Group's Contract Year 1.

The Claim Level Rebate Guarantees exclude 340B Claims, Subrogation Claims, Indian Health Services, Tribal, and VA claims, direct claims, secondary payer coordination of benefit ("COB") claims, Devices, vaccines, consumer card or discount card program paid claims, COVID-19 antiviral drugs and OTC antigen at home test kits, hemophilia products, and paid claims submitted beyond 180 days from the date of service.

BCBSM retains as administrative compensation 7.50% of Rebates. Notwithstanding the foregoing, GROUP will receive the greater of the above Rebate guarantees or 92.50% of Rebates for 2026.

If the actual Rebates received by BCBSM from Rebate Administrators are less than the guaranteed amounts above, BCBSM will credit Group the difference.

Rebates will be passed to GROUP quarterly as an invoice credit based on actual Rebates received.

Most Rebates are received from the Rebate administrators approximately six (6) to nine (9) months after the end of the calendar quarter in which claims are incurred; therefore, annual reconciliation of Rebate guarantees to actual Rebates received will occur approximately six (6) to nine (9) months after the contract year.

BCBSM may apply a credit towards its achievement of the Rebate Guarantees ("Rebate Credit") due to a reduction in Rebates that may result from, but is not limited to (i) the introduction of a Biosimilar Drug or authorized Brand Drug alternative; (ii) WAC reduction on a Brand Drug subject to Rebates; (iii) WAC change of a Biosimilar Drug; (iv) utilization

shifts between Biosimilar Drugs, the originator biologic, or a low WAC alternative; or (v) the launch of a lower cost non-Generic Drug. The Rebate Credit does not apply to Generic Drugs that launch after the Brand Drug no longer has patent protection. The Rebate Credit is calculated as the difference between the expected Rebate revenue associated with the original rebated product or high wholesale acquisition cost ("WAC") alternative (e.g. an originator Brand Drug, originator biologic, or high WAC product) and the actual Rebates BCBSM receives.

**b) General Provisions Applicable to Section 3 Guarantees**.

i) **Offset**. BCBSM may use any surplus achieved on a guarantee to make up for, and offset, a shortfall in any other guarantee within the same channel as set forth in this Rx Addendum.
   (1) The channels shall be defined as:
      (a) Retail-30 (1-83 day supply)
      (b) 90-day (inclusive of retail-90 (84+ day supply) and mail order claims)
      (c) Specialty Drugs will be included in specialty channel (regardless if dispensed by retail or mail order specialty pharmacy)
      (d) Rebate guarantees

   If Group's guarantee shortfall is capped at a certain dollar amount, BCBSM shall perform any offsetting against the capped amount.

ii) **Credit**. Any shortfall on the AWP Discount and Dispensing Fee guarantees will be credited to Group within ninety (90) days following the end of the Contract Year if such shortfall is not offset by BCBSM against any surplus achieved in the other applicable guarantees. Any shortfall on the Rebate guarantees will be credited to Group within six (6) to nine (9) months following the end of the Contract Year if such shortfall is not offset by BCBSM against any surplus achieved in the other Rebate guarantees.

iii) **Modification of Guarantees**. BCBSM reserves the right to immediately revise or void, in its sole discretion, the above guarantees upon the occurrence of any of the following events:

   (1) Group fails to use BCBSM as Group's exclusive pharmacy benefit administrator;
   (2) Modification of Formulary content or benefit design;
   (3) Total contract enrollment or 90-day retail enrollment, if applicable, changes by more than 10 percent of the contract count as of the effective date of this Rx Addendum; or
   (4) Group fails to be responsible for more than 50 percent of the Covered Drug cost under the Rx Plan which is measured over the entire plan year.
   (5) Rebate revenue is materially decreased because Brand Drugs unexpectedly move off-patent to generic status, or if Generic Drugs, authorized Brand alternative drugs, low priced Brand Drugs or over-the-counter substitutes become available. BCBSM acknowledges that it has already taken into account the effect that scheduled Brand Drug patent expirations and Generic Drug availability will have on Rebates over the term of the Addendum.

(6) If a government action, change in law or regulation, change in the interpretation of law or regulation, or action by any drug manufacturer has a material effect on the availability of Rebates.

iv) **Annual Reporting**. BCBSM shall provide an annual report of Group's performance against the AWP Discount and Dispensing Fee Guarantees in a format determined by BCBSM within ninety (90) days following the end of the Contract Year. BCBSM shall also provide an annual report of Group's performance against the Claim Level Rebate Guarantees in a format determined by BCBSM within six (6) to nine (9) months after the end of the Contract Year.

v) **Market Check**

(1) At any time following the initial eighteen (18) months of the contract, Group may review the financial terms of the Rx Addendum to comparable financial offerings available in the marketplace ("market check"). Group may conduct the market check itself, or use an independent consultant who has executed a confidentiality agreement with BCBSM to perform the market check.

(2) This comparison must be related to groups of a similar type (ex. Municipalities private firms, etc.) and will take into account similar plan design, pricing structure, size, drug spend, formulary, clinical and trend programs, retail pharmacy, home delivery pharmacy, and specialty pharmacy mix and utilization, generic drug utilization, demographics, and other relevant factors necessary to provide an appropriate comparison. The comparison will be measured on the basis of a total, aggregate comparison of the pricing terms offered by a single vendor to a single plan.

(3) Should the Market Check result in a 3% or greater savings, Group or its consultant will provide a report of the Market Check findings to BCBSM. Group will set forth in its report the % index targets and measurements used in the analysis (whichwill be based on the channels of cost including but not limited to retail discount, mail order discount, 90 retail discount, dispensing fees, and rebates)] available from a single vendor, and not the best financial terms available from multiple vendors or a single vendor to multiple entities)

(4) There is an understanding due to confidentiality agreements common in the industry that specific terms or proprietary information (including bid materials) cannot be provided, however, a good faith effort will be made to provide all available and appropriate materials

(5) Upon receipt of such report, BCBSM will have reasonable time, as mutually agreed upon by both parties, to offer a comparable or better financial arrangement, Components in the financial proposal would be translated into an updated Rx Addendum and would be effective January 1st Contract Year 3.

(6) In the event the Market Check sets forth financial terms for a contract that would extend beyond year 3 of the Rx Addendum, BCBSM will have the right to match any such financial terms so that the end date of any revised Rx Addendum will be adjusted accordingly. In the event that the contract term is extended for more than one additional year, Group may conduct one (1) additional Market Check during the additional term.

(7) If BCBSM and Group are unable to agree to updated terms as a result of the Market Check, Group may terminate this Agreement, on ninety (90) days written notice to BCBSM.

vi) **Guarantee Audits**.

(1) Format. Group, at its own expense, shall have the right to audit ("Guarantee Audit") Group's performance against the guarantees once for each Contract Year following Group's receipt of the annual report from BCBSM for the applicable Contract Year. After notice from the Group requesting a Guarantee Audit, BCBSM will have up to 90 days to gather the Rx Claims data for the applicable Contract Year in a format determined by BCBSM and to schedule the Guarantee Audit.

(2) Auditor. Prior to a Guarantee Audit, Group and BCBSM must mutually agree upon any independent third party auditor that Group wishes to perform the audit. Additionally, Group and any third party auditor shall sign any documents BCBSM believes necessary to conduct the audit.

(3) Findings. Group (or its auditor) shall provide BCBSM with a written report of any findings if Group (or its auditor) disputes the results of BCBSM's calculations of Group's performance against the guarantees in the annual report. If Group's audit findings show a shortfall on any guarantee and BCBSM accepts such findings, in BCBSM's sole discretion, BCBSM will provide a credit to Group of such shortfall subject to the Offset provision specified above.

(4) Scope and Timing of Guarantee Audit. The rights and obligations contained in this Guarantee Audit section apply only to Group's review of BCBSM's calculations of Group's performance against the guarantees. Any Group audit for accuracy and adjudication of Rx Claims processed by BCBSM ("ASC Audit") is subject to the terms and conditions of the ASC "Group Audit" section. If Group is conducting an ASC Audit during a Contract Year, Group shall conduct a Guarantee Audit at the same time as the ASC Audit. Otherwise, Group shall be prohibited from conducting a Guarantee Audit at a different time than the ASC Audit during a Contract Year in which Group conducts an ASC Audit.

**IN WITNESS WHEREOF**, each party presents and warrants that the individual signing this Rx Addendum on its behalf is duly authorized to bind such party to all terms and conditions of this Rx Addendum. This Rx Addendum may be executed in any number of counterparts (by facsimile or otherwise), each of which shall be an original, but which together shall constitute one and the same instrument.

FOR THE CITY OF ANN ARBOR

By _____
Christopher Taylor, Mayor

By _____
Jacqueline Beaudry, City Clerk

Approved as to substance:

By _____
Milton Dohoney Jr., City Administrator

Approved as to form and content

By _____
Atleen Kaur, City Attorney

**Blue Cross Blue Shield of Michigan**
**SCHEDULE A – Renewal Term (Effective 01/01/2026 thru 12/31/2026)**
**Administrative Services Contract (ASC)**

**1. Group Name** CITY OF ANN ARBOR
**2. Customer ID** 102815
**3. ASC Funding Arrangement** Monthly Wire
**4. Line(s) of Business and Services**

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

| Services | Applicable |
|---|---|
| Prescription Drug Guarantee Addendum | X |
| Indemnification / Attestation Form(s) | X |

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

| A. Fixed Administrative Fees | Amount Per Contract Per Month | Estimated Monthly Contracts | Estimated Monthly Admin Fee | Effective Start Date | Effective End Date |
|---|---|---|---|---|---|
| i. 2026 Base Admin Fee | $69.40 | 1,721 | $119,437.40 | 01/01/2026 | 12/31/2026 |
| ii. 3rd Party Stop-Loss Vendor Fee | $0.00 | 1,721 | $0.00 | 01/01/2026 | 12/31/2026 |

***ADDITIONAL NOTES FOR FIXED ADMINISTRATIVE FEES:***

***3rd Party Stop-Loss Vendor Fee***
- *The 3rd Party Stop-Loss Vendor Fee is waived because the Group has Stop-Loss coverage with our preferred vendor partner.*

**B. Variable Administrative Fees – *Not Applicable***

**6. Data Feeds – *Not Applicable***

**7. Advance Deposit – *Not Applicable***

**8. Advance Deposit Monthly Cap / Level Payment Amount – *Not Applicable***

**9. BCBSM Account**

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

**10. Late Payment / Interest Charges**

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

**11. Buy-Ups**

Group has elected to implement the following Buy-Up programs. Please see the Buy-Up Exhibit for detailed description(s) of the programs, if applicable.

| A. Programs | Pricing Method | Unit Price | Unit Volume | Amount | Effective Start Date | Effective End Date |
|---|---|---|---|---|---|---|
| Virtual Care | PCPM | $0.20 | 704 | $140.80 | 01/01/2026 | 12/31/2026 |

***ADDITIONAL NOTES FOR BUY-UPS:***

***Virtual Care***

- *Group is offering Virtual Care to a partial population contracts in Subgroups: 0000, 0001, 0002, 0003, 0004, 0006, 0008, 0009, 0010, 0011, 0061, 0062, 0069, 0070, 0072, and 0083.*
- *The standard Virtual Care fee is **$0.20 PCPM** for **704 contracts** and is equal to **$140.80 per month**.*
- *The monthly amount of $140.80 will be pro-rated across the 1,721 total medical contracts and is equal to $0.08 PCPM for 2026.*
- *The pro-rated Virtual Care fee of **$0.08 PCPM** will be invoiced to the Group based on the actual total medical contracts each month.*
- *The Virtual Care will be billed as a separate line item on the invoices sent to the Group.*
- *($0.20 PCPM x 704 contracts = $140.80 / 1,721 total medical contracts = $0.08 PCPM).*

**12. Shared Savings Programs**

BCBSM has implemented programs to enhance the savings realized by its customers. BCBSM will charge a fee or retain a portion of the recoveries or cost avoidance at the percentages set forth below. BCBSM's administrative compensation obtained through the Shared Savings Program will be available through reports on eBookshelf:

| **Program**: | **BCBSM Compensation:** | **Compensation Methodology:** |
|---|---|---|
| A. Hospital Bill Review | 30% | Cost avoidance of improper hospital billing through line-by-line reviews of certain DRG outlier and/or percent-of-charge inpatient claims to identify defects and improprieties before the bill is paid. |
| B. Advanced Payment Analytics | 30% | Recoveries of overpayments using proprietary data mining analytics as a second pass review along with continual monitoring enabling up-to-date policy compliance. |
| C. Subrogation | 30% | Recoveries of money already paid through Blue Cross benefits that is the responsibility of non-health insurance carrier. |
| D. Hospital Credit Balance | 30% | Recoveries of claims through enhanced reviews of hospital patient accounting systems and identified credit balances from overpayments. |
| E. Advanced Editing | 30% | Cost avoidance through applied advanced algorithms and extensive analytic reviews of professional and outpatient facility Claims for adherence to medical, clinical and national coding guidelines. |
| F. Non-Participating Provider Negotiated Pricing | 30% | Cost avoidance for out-of-network, non-participating Claims equal to the difference between the amount that would have been paid pursuant to the Group's benefit design (before Enrollee cost-share is applied) and the amount actually paid for such Claims (before Enrollee cost-share is applied) as a result of third-party vendor negotiations or benchmark-based pricing. |

| | | |
|---|---|---|
| G. Home Infusion Therapy Medical Drugs | 30% | The difference between the BCBSM-managed home infusion therapy (''HIT'') network fee schedule and the improved negotiated pricing administered through a third party HIT vendor. BCBSM's HIT network fee schedule pricing is increased each calendar year by 0.77 percent for PPO claims. |
| H. Oncology Site of Care | 20% | BCBSM's approved amount for certain oncology drug Claims paid at the professional setting reimbursement rate to direct Enrollees to receive treatment at lower cost sites of care. |
| I. Rebate Service Fee for Medical Prescription Drugs | 7.5% | Medical benefit drug rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee. The Rebate Administrator Fee is up to 5.25% of gross rebates for medical benefit drug Claims. |
| J. Rebate Service Fee for Pharmacy Prescription Drugs | 7.5% | Pharmacy benefit manufacturer rebates on Claims incurred in the renewal term. |

## 13. Pharmacy Pricing Arrangement

### A. Traditional Prescription Drug Pricing and Administrative Compensation

Group acknowledges and agrees the amount BCBSM pays its contracted pharmacy benefit manager ("PBM") for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug, and BCBSM may retain the difference as administrative compensation as specified below, when the amount is less.

BCBSM shall retain the following administrative compensation ("Traditional Rx Drug Pricing Admin Fee"):

a. Up to 1.80 percentage points of the aggregated Average Wholesale Price ("AWP") discount BCBSM receives from its PBM for drugs classified as Brand Drugs; and

b. Up to four (4) percentage points of the aggregated AWP discount BCBSM receives from its PBM for drugs classified as Generic Drugs.

c. $0.05 of the dispensing fee for 30-day supplies of retail prescription drugs.

For purposes of this section, Brand Drugs and Generic Drugs shall be defined as follows:

a. **Brand Drugs** – drugs, products, and supplies with a valid 11-digit National Drug Code ("NDC") that meet all the following criteria:

   (i) Medi-Span Multi-Source Code of "M", "N", or "O", and

   (ii) Medi-Span Brand Name Code of "T", and

   (iii) Dispense as Written ("DAW") Code that is not "3", "4", "5", or "6"

b. **Generic Drugs** – drugs, products, and supplies with a valid 11-digit NDC that meet at least one of the following criteria:

   (i) Medi-Span Multi-Source Code of "Y", or

   (ii) Medi-Span Brand Name Code of "B" or "G", or

   (iii) DAW Code that is one of "3", "4", "5", or "6"

The actual Traditional Rx Drug Pricing Admin Fee paid by Group to BCBSM shall depend on Group's aggregated AWP discount referenced above, which is based on Group's prescription drug utilization, drug mix, pharmacy choice, and a pharmacy's usual and customary charges. BCBSM will credit Group with any amount that was collected during the Contract Year that exceeds the amounts specified in (a) and (b) above. The Traditional Rx Drug Pricing Admin Fee retained by BCBSM will be reported to the Group.

Group agrees to timely incorporate language into Group's Summary Plan Description or equivalent document that any Enrollee cost-sharing that is calculated as a percentage will be based upon the amount Group pays BCBSM for the prescription drug.

### B. Pharmacy Monitoring Fee (PMF) Pricing – *Not Applicable*

## 14. Additional Pharmacy Services and/or Programs

### A. 3rd Party Rx Vendor Fee

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

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

**15. 3rd Party Stop-Loss Vendor Fee**

Group's stop-loss coverage is administered by a preferred vendor. As a result, the 3rd Party Stop-Loss Vendor Fee is waived. See waived fee referenced in the **Administrative Fees** Section 5 above: *3rd Party Stop-Loss Vendor Fee.*

**16. Agent Fees**

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

**17. Medicare Contracts**

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

**18. Compensation Agreement with Providers**

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

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

**19. Out-of-State Claims**

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

**20. Credits and Fees – *Not Applicable***

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

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

BCBSM negotiates provider reimbursement rates on its own behalf and makes those rates available to customers through its products and networks. The reimbursement rates can, and often do, vary from provider to provider. Providers may qualify for higher reimbursement rates for satisfying requirements of certain BCBSM Quality Programs, including, but not limited to:

**A. Pay-for-Performance.**
Hospitals earn reimbursement for improving quality, cost efficiency and population health. This program recognizes both mid-to-large sized and small rural short-term acute care hospitals for quality improvements such as lower re-admission rates, participating in a statewide health information exchange, and performance in a varied portfolio of collaborative quality initiatives to address many of the most common and costly areas of surgical and medical care in Michigan.

**B. Value-Based Contracting.**
Hospitals earn reimbursement for improving quality, cost efficiency and population health. Hospitals work with physicians to provide cost-efficient care for a shared patient population, and earn rewards based on improved outcomes across that population.

**C. Collaborative Quality Initiatives ("CQIs").**
CQIs address many of the most common and costly areas of surgical and medical care in Michigan. In each CQI, hospitals and physicians across the state collect, share and analyze data on patient risk factors, processes of care and outcomes of care, then design and implement changes to improve patient care.

**D. Physician Group Incentive Program.**
The Physician Group Incentive Program connects approximately 40 physician organizations (representing about 20,000 physicians) statewide to collect data, share best practices and collaborate on initiatives that improve the health care system in Michigan. Participating physician organizations are evaluated and rewarded on transformation of health care delivery, quality metric performance, and performance enablement – all efforts designed to improve the overall value of care delivered while reducing total cost of care.

**E. Patient-Centered Medical Home ("PCMH").**
In the PCMH model of care, patients get the right care at the right time in the right setting. Since 2009, Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home designation program has fueled statewide movement of primary care into a team-based, proactive model of efficient, cost-effective care centered around the patient.

**F. Provider-Delivered Care Management.**
PCMH-designated practices increasingly provide personalized care management services for patients with chronic conditions or multiple, ongoing health needs. Patient care teams are assembled according to each patient's needs, and may include nurses, nutritionists, counselors, psychologists, respiratory therapists, asthma educators, certified diabetes educators, social workers, pharmacists and community health workers. Services are coordinated with the care patients are already receiving from their doctor.

**G. Blueprint for Affordability.**

The Blueprint for Affordability program combines quality outcomes with a shared financial risk contract that enables providers to manage the health of their patient population and their total cost of care. BCBSM contracting arrangements may also include risk sharing with certain provider entities ("PE"), e.g., physician organizations, physician hospital organizations, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside financial risk.

Providers may receive reward and incentive payments from BCBSM Quality Programs funded through an allocation from provider reimbursement. Such allocations may be to a pooled fund from which value-based payments to providers are made. If a provider's performance results in a payment of additional reimbursement, the reward payment is made from the pooled funding. For Blueprint for Affordability, if the PE's performance results in a return of reimbursement, the amount at risk is returned to the pooled fund to offset a portion other provider gains. BCBSM will not retain any amounts resulting from BCBSM Quality Programs.

As explained in the Blue Card Program disclosure (Schedule B to ASC), an out-of-state Blue Cross Blue Shield Plan ("Host Blue") may also negotiate fee-based and/or value-based reimbursement for their providers. A Host Blue may include all provider reimbursement obligations in Claims or may, at its election, collect some or all of its value-based provider (VBP) reimbursement obligations through a PaMPM benefit expense, as in, for example, the Total Care Program. All Host Blue PaMPM benefit expenses for VBP reimbursement will be consolidated on Group's 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.

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 Group's BCBSM account representative.

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

**Blue Cross Blue Shield of Michigan**
**Buy-Up Exhibit to Schedule A**
**Renewal Term (Effective 01/01/2026 thru 12/31/2026)**

1. Group Name CITY OF ANN ARBOR
2. CID 102815

This Buy-Up Exhibit describes the services, compensation and disclosures for the Buy-Ups set forth in the Schedule A.

- The **Virtual Care Buy-Up Solution** by Teladoc Health® (the "Solution") provides Urgent Care, Therapy, and Psychiatry to eligible BCBSM and BCN members via online, mobile app, or phone. The Solution includes:
  - **Urgent Care:** HMO and PPO Commercial members will receive virtual urgent care services that include 24/7 on-demand access to board-certified doctors via online, mobile app, or phone. Services include diagnosing common and routine ailments or conditions, recommending treatment, directing member to contact his or her primary care physician (if necessary and appropriate), recommend therapy, and prescribe medication based on clinical protocols and member's clinical needs.
    - Members will have access to acute care services that are available on-demand 24/7, 365 days per year for all ages.
    - For scheduled visits, members can request a visit for the same day or the following day, between 7 am to 9 pm local time, seven days a week, subject to availability.
    - Members 18 and over must have their own account.
    - Parent or legal guardian initiates and completes General Medical Visits for minors.
    - Members will not be able to request the same General Medical Provider for subsequent acute care visits.
    - Providers may prescribe medication based on clinical protocol and member's clinical needs.
  - **Therapy and Psychiatry:** HMO and PPO Commercial members will receive virtual mental health services that include, crisis support, and expert teletherapy and telepsychiatry via online, mobile app, or phone.
    - Members will have access to the mental health team seven days a week, Monday to Sunday, 7 am to 9 pm, local time by appointment.
    - Members will have access to the mental health team that includes board certified psychiatrists, psychologists, and other licensed clinicians. Family therapy sessions will not be offered.
    - Therapy services will be available to members ages 13 and older.
      - Therapy will be offered for ages 13 to 17, with a licensed therapist with parental consent. A parent or guardian must be present at the start of the adolescent's first therapy session.
      - Parent or legal guardian will need to request the visit and fill out the appropriate consent forms.
      - Once forms are completed the system will allow the parent or legal guardian to schedule the visit and select a mental health provider.
      - For subsequent visits, members ages 13 to 17 can schedule on their own sessions and the parent will be notified of the scheduled visit.
    - Psychiatry services will be available to members ages 18 and older, subject to change based on legal approval and clinical criteria to provide psychiatry to adolescent.
    - The mental health services include a customized formulary of commonly prescribed mental health medications.

        - The types of medications commonly prescribed within the mental health services include, but are not limited to, antidepressants, specific anxiolytics, and select antipsychotics.
    - Mental health practitioners will comply with current laws and regulations and will not prescribe DEA controlled substances or narcotics under the mental health services absent a change in the applicable laws and regulations.
        - In the event a mental health practitioner elects to prescribe a DEA controlled substance or narcotic, or any other medication that is outside of the mental health services' formulary, the mental health practitioner shall refer the Member for an in-person visit.

The Group will pay BCBSM **$0.20** per contract per month (PCPM) for the Solution.

Group may terminate its participation in the Solution by providing BCBSM with at least 90 days written notice. BCBSM will not enroll new members in the Solution following Group's termination notice, and all active members will be disenrolled from the Solution on the termination effective date.

**Schedule B**
**BlueCard Disclosures**
**Inter-Plan Programs**

**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 Programs." These Inter-Plan Programs 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 Programs. The Inter-Plan Programs 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 Programs and the fees that are charged in connection with Inter-Plan Programs. 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 Programs.

## A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Program. 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 handling all interactions with its providers, including contracting with Participating Providers. The financial terms of the BlueCard Program are described generally below.

### 1. Liability Calculation Method Per Claim – In General

a. Enrollee Liability Calculation

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

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

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

b. Group Liability Calculation

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

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

**2. Claims Pricing**

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

(i) 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) 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; or

(iii) 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.

The Host Blue will apply the actual, average or estimated price method consistent with its specific Provider contracts. The use of average or estimated 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 average or estimated 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. The Group has no ownership interest in any variance account. Variance accounts are notional bookkeeping accounts maintained by the Host Blue and no amounts are segregated or held for the benefit of the Group.

**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 **section 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. If BCBSM has entered into a Negotiated Arrangement with a Host Blue, Enrollee liability is the same as described under Section A, BlueCard Program.

Under certain circumstances, if BCBSM pays the participating or non-participating 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 recalculating Access Fees. The Host Blue initiates the settlement with BCBSM using the bulk settlement process. The Access Fee for the total cost of the claim (episode) must be recalculated. If the recalculated Access Fee is different than the total Access Fee charged on the episode related claims, adjustment for the Access Fee must be included in the bulk settlement charge/refund to BCBSM that BCBSM passes onto the 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. BlueCard Fees and Compensation**

Group understands and agrees to reimburse BCBSM for certain fees and compensation which we are obligated under applicable Inter-Plan Program requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Program-related services. Fees and compensation under applicable Inter-Plan Programs 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 administrative and/or a network access fees 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 A.2** 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 at the rate set by the Host Plan. The Host Blue may retain interest earned on funds held in variance accounts.

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

*Care Coordinator Fees*

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

1. PaMPM billings; or

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

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

*Value-Based Programs under Negotiated Arrangements*

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

**D. Return of Overpayments**

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

Unless the Host Blue agrees to a longer period of time for retroactive cancellations of membership, the Host Blue will provide BCBSM the full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, BCBSM will request such refunds for a period of up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding any conflicting provision found elsewhere in 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, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance 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 Program requirements to pay to the Host Blue, to the Blue Cross and Blue Shield Association, and/or to vendors of Inter-Plan Program-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 Programs may be revised from time to time as provided for in **section 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 Program requirements to pay to the Host Blue, to the Association and/or to vendors of Inter-Plan Program-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 Programs may be revised from time to time as provided for in **section H** below.

**H. Modifications or Changes to Inter-Plan Program Fees or Compensation**

Modifications or changes to Inter-Plan Program 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 Program fees or compensation describing the change and the effective date thereof and Group has the right to terminate the ASC without penalty by giving written notice of termination before the effective date of the change. If Group fails to respond to the notice and does not terminate the ASC during the notice period, Group will be deemed to have approved the proposed changes, and BCBSM will then allow such modifications to become part of the ASC.

**Exhibit 1**

**A. BlueCard Program Access Fees:**

Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at $2,000.00 per Claim. The percentages for 2026 are up to:

1. 3.21% for fewer than 1,000 BCBSM contracts;
2. 1.79% for 1,000–9,999 BCBSM contracts;
3. 1.66% for 10,000–49,999 BCBSM contracts;

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

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

FOR THE CITY OF ANN ARBOR

By _____
Christopher Taylor, Mayor

By _____
Jacqueline Beaudry, City Clerk

Approved as to substance:

By _____
Milton Dohoney Jr., City Administrator

Approved as to form and content

By _____
Atleen Kaur, City Attorney

**Blue Cross Blue Shield of Michigan**

# INDEMNITY/ATTESTATION FORM
## For Retiree-Only Plans

**Group Name:** CITY OF ANN ARBOR
**Customer ID:** 102815 **Renewal Term:** Effective 01/01/2026 thru 12/31/2026

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This Form covers the above group customer's ("Group") certification and agreement to the following:

1. Group is the plan sponsor and administrator for its health and welfare benefit plan(s) ("Welfare Plan").

2. Blue Cross Blue Shield of Michigan (BCBSM) is the claims processor for the Welfare Plan.

3. Group attests that its Welfare Plan is a legally distinct, retiree-only plan that provides health care coverage to retirees; has fewer than two participants who are current employees; and has a plan document that is separate and distinct from the plan document that covers active employees.

4. Group agrees that, because of its status as a retiree-only plan, Welfare Plan is not required to comply with certain aspects of the Affordable Care Act ("ACA") and the Mental Health Parity and Addiction Equity Act ("MHPAEA").

5. BCBSM will administer the Welfare Plan's benefits as instructed by Group and will rely on Group's attestation that it is a retiree-only plan to the extent that Group's benefit design does not comply with the ACA or MHPAEA.

6. Group agrees to indemnify and hold BCBSM harmless from any damages, fines, costs (including attorney fees) expenses, liabilities or financial penalties that are imposed on BCBSM for administering Group's benefit design.

7. BCBSM disclaims, and Group hereby releases BCBSM, from all liability related to the implementation, processing, and administration of the retiree benefit design.

8. To the extent Welfare Plan ceases to be a retiree-only plan, Group agrees to notify BCBSM immediately (i.e., within 30 days or less) and to update its benefit design as necessary to comply with applicable legal requirements.

**Blue Cross Blue Shield of Michigan**

# INDEMNITY/ATTESTATION FORM
# For Grandfathered Plans

**Group Name:** City of Ann Arbor
**Customer ID:** 102815 **Renewal Term:** Effective 01/01/2026 thru 12/31/2026

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This Form covers the above group customer's ("Group") certification and agreement to the following:

1. Group is the plan sponsor and administrator for its health and welfare benefit plan(s) ("Welfare Plan").

2. Blue Cross Blue Shield of Michigan (BCBSM) is the claims processor for the Welfare Plan.

3. Group attests that its Welfare Plan is a "grandfathered plan" under the Affordable Care Act.

4. Group agrees that, because of its status as a grandfathered plan, Welfare Plan is not required to comply with certain aspects of the Affordable Care Act ("ACA").

5. BCBSM will administer the Welfare Plan's benefits as instructed by Group and will rely on Group's attestation that it is a grandfathered plan to the extent that Group's benefit design does not comply with the ACA.

6. Group agrees to notify BCBSM as soon as the Welfare Plan ceases to qualify as a grandfathered plan and will update its benefit design as necessary to comply with applicable legal requirements.

7. Group agrees to indemnify and hold BCBSM harmless from any damages, fines, costs (including attorney fees) expenses, liabilities or financial penalties that are imposed on BCBSM for administering Group's benefit design.

8. BCBSM disclaims, and Group hereby releases BCBSM, from all liability related to the implementation, processing, and administration of the grandfathered benefit design.

**Blue Cross Blue Shield of Michigan**

# INDEMNITY/ATTESTATION FORM
# For Mental Health Parity/Behavioral Health (Other)

**Group Name:** CITY OF ANN ARBOR
**Customer ID:** 102815 **Renewal Term:** Effective 01/01/2026 thru 12/31/2026

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This Form covers the above group customer's ("Group") certification and agreement to the following:

1. Group is the plan sponsor and administrator for its health and welfare benefit plan(s) ("Welfare Plan").

2. The Welfare Plan is self-funded.

3. Blue Cross Blue Shield of Michigan (BCBSM) is the claims processor for the Welfare Plan.

4. Group understands that it is responsible for designing a plan that complies with the Mental Health and Addiction Equity Act ("MHPAEA") including performing Quantitative Treatment Limitation testing and ensuring that Group decisions to add or exclude a benefit do not violate non-quantitative treatment limitation requirements.

5. Group agrees to indemnify and hold BCBSM harmless from any damages, fines, costs (including attorney fees) expenses, liabilities or financial penalties that are imposed on BCBSM for administering benefits in accordance with Group's benefit design.

6. BCBSM disclaims all liability to Group and its Welfare Plan associated with the implementation, processing, and administration of the benefit design.

# BCS INSURANCE COMPANY

## CHANGE ENDORSEMENT

Policyholder: **City of Ann Arbor**
Group Number: **2100011-01**
Policy Number: **ESL-30386**
Endorsement Effective Date: **January 1, 2026**
Policy Period: From: **January 1, 2026** To: **December 31, 2026**

This Endorsement is hereby added to and forms a part of the policy to which it is attached. It does not change any of the provisions of the Schedule and/or policy except as stated below.

1. [ ] Benefit Period From ***n/a*** Benefit Period Through ***n/a***
2. [ ] Covered Expenses Specific/Aggregate ***n/a***
3. [ ] Specific Deductible per Covered Person ***n/a***
4. [ ] Aggregating Specific Deductible ***n/a***
5. [ ] Specific/Aggregate Rate(s) ***n/a***
6. [ ] Minimum Annual Aggregate Deductible ***n/a***
7. [ ] Monthly Aggregate Factor(s) ***n/a***
8. [ ] Covered Persons Employees, Dependents, COBRA, Retirees ***n/a***
9. [ ] Policyholder Name Change ***n/a***
10. [ ] Add or Remove business affiliate ***n/a***
11. [ ] Exclusion(s), Added ***n/a***
12. [ ] Exclusion(s), Removed ***n/a***
13. [ ] Policyholder Address Change ***n/a***
14. [ ] Endorsement(s), Add or Remove ***n/a***
15. [ **X** ] Special Limits:

    1. Within Section **III. CLAIMS PROVISIONS** of the Policy, the subsections titled **NOTICE OF AGGREGATE LOSS** and **NOTICE OF SPECIFIC LOSS** the time limits indicated in each subsection for provision to the Company of written proof of loss are deemed to be amended to be change the time limits in each section to: "*within three hundred sixty-five (365) days after the end of the Policy Period or the Benefit Period, whichever is later."*

# BCS INSURANCE COMPANY

2. Within Section **V. PREMIUMS** of the Policy, the subsection titled **GRACE PERIOD** is deemed to be amended to allow a Grace Period of sixty (60) days from any premium due date after the first premium due for payment of any subsequent premium owed. All other provisions of the Policy shall remain in force.

3. Section **VIII. Termination,** the subsection **Termination by the Company** is deemed to be amended to require the Company to provide sixty (60) days prior written notice of termination. All other provisions of the Policy shall remain in force.

4. In a case where the Policyholder's Plan does not contain one or both of the following exclusions within Section **IV. General Exclusions**, numbered 1) and 2) shown below:
   *1) Payments the Policyholder makes under the Plan Document as a result of declared or undeclared war, including resistance to armed aggression;*
   *2) Payments the Policyholder makes which are recoverable under the Plan Document's coordination of benefits provision;*

   The Policyholder's Plan coverage terms shall govern in lieu of either or both of the missing Policy exclusion(s).

BCS Insurance Company, by its President and Secretary, has caused this policy to be executed at its executive office in Oakbrook Terrace, Illinois.

PRESIDENT

SECRETARY

The provisions of this Endorsement are accepted:

Employer: **City of Ann Arbor**

Street Address: **301 E. Huron Street**

City, State, Zip Code: **Ann Arbor, MI 48107**

FOR THE CITY OF ANN ARBOR

By _____
Christopher Taylor, Mayor

By _____
Jacqueline Beaudry, City Clerk

Approved as to substance:

By _____
Milton Dohoney Jr., City Administrator

Approved as to form and content

By _____
Atleen Kaur, City Attorney