PERSONNEL COMMITTEE
AGENDA

January 20, 2021, Following Finance
Virtual Meeting Held in Accordance with Public Act 254 of 2020
Zoom Virtual Meeting
Meeting ID: 399-700-0062 / Password: LCBOC
https://zoom.us/j/3997000062?pwd=SUdLYVFFcmozWnFxbm0vcHRjWkVIZz09

Pages

1. CALL MEETING TO ORDER

2. ROLL CALL

3. APPROVAL OF AGENDA

4. CALL TO THE PUBLIC

5. APPROVAL OF MINUTES 3

Minutes of Meeting Dated: December 16, 2020

Closed Meeting Minutes Dated: December 16, 2020

6. TABLED ITEMS FROM PREVIOUS MEETINGS

7. REPORTS

8. RESOLUTIONS FOR CONSIDERATION

8.1. Drain Commission 7

Resolution to Approve the Change of Title for Two Drain Positions.

8.2. Human Resources 14

Resolution Authorizing the Signing of the 2021 Administrative Services Agreement, Schedules, and Exhibits for Renewal Term January 2021 to December 2021 with Blue Cross Blue Shield of Michigan.

8.3. Board of Commissioners 53

Resolution Approving Appointments to Livingston County Boards and Committees.

9. ADJOURNMENT

PERSONNEL COMMITTEE

MEETING MINUTES

Livingston County

December 16, 2020, 8:00 am
Virtual Meeting Held in Accordance with Public Act 228 of 2020
Zoom Virtual Meeting
Meeting ID: 399-700-0062 / Password: LCBOC
https://zoom.us/j/3997000062?pwd=SUdLYVFFcmozWnFxbm0vcHRjWkVIZz09

Members Present:
William Green, remotely from Deerfield Township, Michigan
Wes Nakagiri, remotely from Hartland Township, Michigan
Douglas Helzerman, remotely from Handy Township, Michigan

1. CALL MEETING TO ORDER

The meeting was called to order by Commissioner Green at 8:01am

2. APPROVAL OF AGENDA

Motion to Approve the Agenda as presented.
Moved By: Wes Nakagiri
Seconded By: Doug Helzerman

Roll Call Vote: YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):** None

Motion Carried (3-0-0)

3. CALL TO THE PUBLIC

Bruce Hundley, Veterans Committee applicant, announced he was present if anyone had questions for him.
Commissioners spoke out regarding the Commissioner Wage Increase.

Doug Helzerman recommended adding a discussion in regards to Commissioner wage increases.

Elizabeth Hundley suggested following the 2016 procedures for Elected Officials.

4. APPROVAL OF MINUTES

Minutes of Meeting Dated: November 18, 2020
Closed Meeting Minutes Dated: November 18, 2020

Motion to Approve Minutes as presented.
Moved By: Doug Helzerman
Seconded By: Wes Nakagiri

Roll Call Vote: YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):** None

Motion Carried (3-0-0)

5. TABLED ITEMS FROM PREVIOUS MEETINGS

None

6. REPORTS

None

7. RESOLUTIONS FOR CONSIDERATION

7.1 DRAIN COMMISSION

Resolution Authorizing the Reclassification of the Wastewater Superintendent Drain Commissioner

Motion to Approve the above Resolution.

Moved By: Doug Helzerman
Seconded By: Wes Nakagiri
Roll Call Vote: YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None;
Absent(0): None

Motion Carried (3-0-0)

7.2 DRAIN COMMISSION

Resolution Authorizing the Creation of the Wastewater Technical Specialist Position

Motion to Approve the above Resolution.

Moved By: Doug Helzerman
Seconded By: Wes Nakagiri
Roll Call Vote: YES (2): D. Helzerman, W. Green; **NO (1):** W. Nakagiri; **Absent (0):**None

Motion Carried (2-1-0)

7.3 EMS

Resolution Approving the Tentative Agreement between the Livingston County Board of Commissioners and the Michigan Association of Fire Fighters Representing Paramedics

Motion to Approve the above Resolution and move to Finance.

Moved By: Doug Helzerman
Seconded By: Wes Nakagiri
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):**None

Motion Carried (3-0-0)

7.4 COUNTY ADMINISTRATION

Resolution Reauthorizing and Modifying Emergency Temporary COVID-19 Leave Benefits for Eligible County Employees--County Administration

Motion to Approve the above Resolution and move to Finance.

Moved By: Wes Nakagiri
Seconded By: Doug Helzerman
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):**None

Motion Carried (3-0-0)

7.5 BOARD OF COMMISSIONERS

Resolution Approving Appointments to Livingston County Boards and Committees

Motion to Approve the above Resolution and move to Board of Commissioners.

Moved By: Wes Nakagiri
Seconded By: Doug Helzerman
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):**None

Motion Carried (3-0-0)

8. Discussion

Commissioners would like to see Commissioner wages added to the Board Rules.

Cindy Catanach suggested including the discussion of Commissioner wages during the Yearly Budget Process Meeting.

9. CLOSED SESSION

- Labor Relations Update

Motion to go into Closed Session at 9:30am

Moved By: Doug Helzerman
Seconded By: Wes Nakagiri
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):** None

Motion Carried (3-0-0)

Motion to Return to Open Session at 9:53am.

Moved By: Wes Nakagiri
Seconded By: Doug Helzerman
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):** None

Motion Carried (3-0-0)

10. ADJOURNMENT

Motion to Adjourn Meeting at 9:53am

Moved By: Wes Nakagiri
Seconded By: Doug Helzerman
Roll Call Vote : YES (3): D. Helzerman, W. Nakagiri, W. Green; **NO (0):** None; **Absent (0):** None

Motion Carried (3-0-0)

Respectfully submitted by:

Pam Dinsmore

Recording Secretary

RESOLUTION **NO:** [Title]

LIVINGSTON COUNTY **DATE:** Click or tap to enter a date.

RESOLUTION TO APPROVE THE CHANGE OF TITLE FOR TWO DRAIN POSITIONS - Drain Commissioner

WHEREAS, currently, the Drain Commissioner's office has positions titled Sanitary Facilities Operator and Assistant Sanitary Facilities Operator; and

WHEREAS, the department is undergoing to review of its structure and operations and wishes to change these job titles to Wastewater Operator and Assistant Wastewater Operator, respectively, to better reflect operations and duties; and

WHEREAS, these position job descriptions have been updated by Municipal Consulting Services, LLC. and are attached; and

WHEREAS, the positions will remain at their current pay grades with no change in pay; and

WHEREAS, no change in the number of personnel employed in the Drain Commissioners office is proposed as part of this resolution; and

WHEREAS, the Personnel Sub-committee has reviewed and supports the recommendation.

THEREFORE BE IT RESOLVED that the Livingston County Board of Commissioners hereby approves the title change only of Sanitary Facilities Operator and Assistant Sanitary Facilities Operator to Wastewater Operator and Assistant Wastewater Operator, respectively.

# # #

MOVED:
SECONDED:
CARRIED:

LIVINGSTON COUNTY
JOB DESCRIPTION

ASSISTANT WASTEWATER OPERATOR

Supervised By: Wastewater Superintendent
Supervises: No supervisory responsibility
FLSA Status: Non-Exempt

Position Summary:

Under the supervision of the Wastewater Superintendent, is responsible for learning and performing duties associated with the operations and maintenance of the County's sanitary systems. Assists the Wastewater Superintendent and Wastewater Operators with the maintenance and repair of the system. This position has an opportunity to be promoted to Wastewater Operator after satisfactorily demonstrating that necessary skills have been achieved, as determined by the Deputy Drain Commissioner and Wastewater Superintendent.

Essential Job Functions:
An employee in this position may be called upon to do any or all of the following essential functions. These examples do not include all of the duties, which the employee may be expected to perform. To perform this job successfully, an individual must be able to perform each essential function satisfactorily.

1. Operates and maintains sanitary sewer collection system, treatment facilities, and on-site community wastewater systems.

2. Communicates professionally with landowners, regulatory agencies, developers, septic haulers, local units of government, and the general public with questions or concerns regarding the County's sanitary sewer systems.

   Performs preventative and emergency maintenance and repairs on sanitary systems and components.

   Performs inspections of various sanitary system components. Communicates findings to the Wastewater Superintendent.

3. Maintains inventory of equipment and supplies and communicates needs to the Wastewater Superintendent.

4. Responds to emergency requests on a 24-hour basis under the supervision of the Wastewater Superintendent or Wastewater Operators.

5. Locates and flags underground utilities in response to MISS DIG design and construction

staking requests.

6. Assists Wastewater Operators in the cleaning and televising of the sewer system.

7. Installs and/or replaces grinder pumps and related appurtenances.

8. Utilizes asset management software to document work through completion of work orders.

9. Assists in compliance with state of Michigan reporting requirements for sanitary sewer overflows as required under Part 31 of Public Act 451, as amended.

10. Follows standard operating procedures (SOPs) established by the department.

11. Performs other duties as directed.

Required Knowledge, Skills, Abilities and Minimum Qualifications:

The requirements listed below are representative of the knowledge, skills, abilities and minimum qualifications necessary to perform the essential functions of the position. Reasonable accommodations may be made to enable individuals with disabilities to perform the job.

Requirements include the following:

- High school diploma or GED and one year of experience working on wastewater collection systems or a similar field.

- The County, at its discretion, may consider an alternative combination of formal education and work experience.

- Understanding of the basic principles and practices of collection systems operations, onsite wastewater treatment operations, and maintenance and repairs of such facilities.

- Ability to obtain and keep current all applicable certifications and training, including forklift, vactor, overhead crane, confined space, first aid, and any other requirements necessary to perform the job duties.

- Ability to establish effective working relationships and use good judgment, initiative and resourcefulness when dealing with County employees, contractors, landowners, representatives of other governmental units, professional contacts, elected officials, and the public.

- Ability to assess situations, solve problems, work effectively under stress, within deadlines, and in emergency situations.

- Mechanical aptitude with knowledge of mechanical and electrical equipment.

- Ability to follow verbal and written instructions and pay explicit attention to detail.
- Skill in the use of office equipment and technology, including some knowledge of Microsoft Suite applications and ability to learn department-specific software.
- Ability to respond to emergencies or service needs on a 24-hour basis

Physical Demands and Work Environment:

The physical demands and work environment characteristics described here are representative of those an employee encounters while performing the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to stand, sit, walk, climb, use hands and fingers, talk, hear, and view and create written documents. The employee uses hand strength to grasp tools and may climb ladders or uneven terrain. The employee is frequently required to reach with hands and arms, such as to operate and repair vibrating machinery, use wrenches, hand tools, etc., and operate motorized equipment and vehicles. The employee must lift or push/pull objects of up to 75 lbs. without assistance. Accommodation will be made, as needed, for employees required to lift or move objects that exceed this weight.

While performing the duties of this job, the employee frequently works near moving mechanical parts and is exposed to fumes or airborne particles, toxic or caustic chemicals, and risk of electrical shock. The noise level in the work environment is usually moderate to loud.

LIVINGSTON COUNTY
JOB DESCRIPTION

WASTEWATER OPERATOR

Supervised By: Wastewater Superintendent
Supervises: No supervisory responsibility
FLSA Status: Non-Exempt

Position Summary:

Under the supervision of the Wastewater Superintendent is responsible for operating and maintaining the County's sanitary sewer treatment and collection systems. Takes a lead role in sanitary sewer system maintenance and repairs and assists the Wastewater Superintendent in training Assistant Wastewater Operators.

Essential Job Functions:

An employee in this position may be called upon to do any or all of the following essential functions. These examples do not include all of the duties, which the employee may be expected to perform. To perform this job successfully, an individual must be able to perform each essential function satisfactorily.

1. Operates and maintains sanitary sewer collection system, treatment facilities, and on-site community wastewater systems. Flags underground storm water and sanitary lines prior to digging or construction.

2. Communicates professionally with landowners, regulatory agencies, developers, septic haulers, local units of government, and the general public with questions or concerns regarding the County's sanitary sewer systems.

3. Assists the Wastewater Superintendent in communicating with property owners and developers seeking to connect to the County's sanitary sewer system.

4. Utilizes asset management software to document work through completion of work orders.

5. Maintains inventory of equipment and supplies and communicates needs to the Wastewater Superintendent.

6. Conducts sampling and prepares reports to comply with local, state, and federal regulatory requirements.

7. Serves as a lead responder to emergency requests on a 24-hour basis.

8. Locates and flags underground utilities in response to MISS DIG design and construction staking requests.

9. Conducts pump station drawdown tests.

10. Conducts sewer cleaning and televising following the NASSCO PACP and MACP condition rating assessment.

11. Installs and/or replaces grinder pumps and related appurtenances.

12. Complies with State of Michigan reporting requirements for sanitary sewer overflows as required under Part 31 of Public Act 451, as amended.

13. Follows standard operating procedures (SOPs) established by the department.

14. Performs other duties as directed.

Required Knowledge, Skills, Abilities and Minimum Qualifications:

The requirements listed below are representative of the knowledge, skills, abilities and minimum qualifications necessary to perform the essential functions of the position. Reasonable accommodations may be made to enable individuals with disabilities to perform the job.

Requirements include the following:

- High school diploma or GED supplemented by additional workshops or coursework related to operation and maintenance of wastewater collections, pumps, and electrical systems, and four years of experience as a wastewater collection systems operator.

- The County, at its discretion, may consider an alternative combination of formal education and work experience.

- Ability to obtain and keep current all applicable certifications and training, including forklift, vactor, overhead crane, confined space, first aid, and any other requirements necessary to perform the job duties.

- Michigan Commercial Driver's License Class A with tanker endorsement or the ability to obtain within a reasonable timeframe.

- NASSCO Pipeline Assessment and Manhole Assessment Certifications or ability to obtain certifications.

- Thorough knowledge of the principles and practices of wastewater treatment operations and maintenance and repairs of such facilities.

- Ability to establish effective working relationships and use good judgment, initiative and resourcefulness when dealing with County employees, contractors, landowners,

representatives of other governmental units, professional contacts, elected officials, and the public.

- Ability to assess situations, solve problems, work effectively under stress, within deadlines, and in emergency situations.

- Skill in the use of underground line locating equipment, confined space meters, toxic gas data loggers, electrical testing equipment, and sewage sampling meters.

- Mechanical aptitude with knowledge of mechanical and electrical equipment.

- Ability to follow verbal and written instructions and pay explicit attention to detail.

- Skill in the use of office equipment and technology, including some knowledge of Microsoft Suite applications and ability to learn department-specific software.

- Ability to respond to emergencies or service needs on a 24-hour basis

Physical Demands and Work Environment:

The physical demands and work environment characteristics described here are representative of those an employee encounters while performing the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is frequently required to stand, sit, walk, climb, use hands and fingers, talk, hear, and view and create written documents. The employee uses hand strength to grasp tools and may climb ladders or uneven terrain. The employee is frequently required to reach with hands and arms, such as to operate and repair vibrating machinery, use wrenches, hand tools, etc., and operate motorized equipment and vehicles. The employee must lift or push/pull objects of up to 75 lbs. without assistance. Accommodation will be made, as needed, for employees required to lift or move objects that exceed this weight.

While performing the duties of this job, the employee frequently works near moving mechanical parts and is exposed to fumes or airborne particles, toxic or caustic chemicals, and risk of electrical shock. The noise level in the work environment is usually moderate to loud.

RESOLUTION **NO:** [Title]

LIVINGSTON COUNTY **DATE:** Click or tap to enter a date.

RESOLUTION AUTHORIZING THE SIGNING OF THE 2021 ADMINISTRATIVE SERVICES AGREEMENT, SCHEDULES, AND EXHIBITS FOR RENEWAL TERM JANUARY 2021 TO DECEMBER 2021 WITH BLUE CROSS BLUE SHIELD OF MICHIGAN

WHEREAS, Livingston County contracts with Blue Cross Blue Shield of Michigan to administer health and dental benefits to its employees and retirees; and

WHEREAS, Livingston County has received the 2021 Administrative Services Agreement and various Schedules and Exhibits to renew Livingston County's contract with Blue Cross Blue Shield of Michigan for Administrative Services.

THEREFORE BE IT RESOLVED that the Livingston County Board of Commissioners hereby authorizes the Board Chair to sign the attached Blue Cross Blue Shield of Michigan Administrative Services Agreement, Schedules, and Exhibits, after review and approval as to form by legal counsel.

# # #

MOVED:
SECONDED:
CARRIED:

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

GROUP SIGNATURE PAGE

Effective 1/1/2021 **thru** 12/31/2021

Between Blue Cross Blue Shield of Michigan and

LIVINGSTON COUNTY - CID 106931

Group and Blue Cross Blue Shield of Michigan agree to sign the specified documents checked-off below ("Documents") using an electronic signature ("E-Signature"). Each party's E-Signature is the legal equivalent of a manual / handwritten signature on the specified Documents. By providing their E-Signatures below, the parties are legally bound by the terms and conditions in the Documents referenced. 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 Documents.

Documents Included:

- ☒ **Administrative Services Contract** →
- ☒ **Schedule A**
  - ☒ Exhibit 1 to Schedule A
  - ☒ Exhibit 2 to Schedule A
- ☒ **Schedule B**
  - ☒ Exhibit 1 to Schedule B
- ☒ **Stop-Loss Policy**
  - ☒ Stop-Loss Exhibit →
  - ☐ Amendment to Stop-Loss Insurance

Requires Group Selection: ***Customer Attestation***

Group Health Plan Type –	
Is Groups' Plan governed by ERISA?	☐ Yes ☒ No

Specific Stop-Loss Run-Out Coverage	
Group is electing "Run-Out" Coverage for their Specific Stop-Loss:	☒ Yes ☐ No

Upon E-Signature by the parties, this page will be electronically attached to applicable Documents and stored for reference and record. E-Signed copies of this fully executed ASC Contractual package will be shared with all parties upon completion.

AGREED AND ACCEPTED.

BLUE CROSS BLUE SHIELD OF MICHIGAN:	**GROUP CUSTOMER:**
By: (Signature)	**By:** (Signature)
Name: (Print)	**Name:** Jennifer Palambos (Print)
Title:	**Title:** Board Chairman
Date:	**Date:**

Blue Cross Blue Shield of Michigan

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

ADMINISTRATIVE SERVICES CONTRACT
WEEKLY INVOICE PROGRAM

Group Name: **Livingston County**

Address: **304 E Grand River Suite 205 Howell, Michigan 48843**

Customer ID: **106931** **Effective Date:** **01/01/2021**

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

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

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

BCBSM and Group agree as follows:

ARTICLE I
DEFINITIONS

A. **"BCBS Plan"** means a company that has been licensed by BCBSA other than BCBSM.

B. **"BCBSA"** means the Blue Cross and Blue Shield Association.

C. **"BlueCard Program"** means the national program established by BCBSA under which Claims are processed by BCBS Plans when Enrollees receive health care services outside of Michigan. BCBSA mandates the policies, procedures and disclosures of the BlueCard Program and amends them from time to time. Schedule B sets forth BCBSA's required disclosures for the BlueCard Program and is incorporated into this Contract. If BCBSA amends the disclosures, such amendments shall automatically become a part of this Contract upon BCBSM giving sixty (60) days prior written notice to Group.

D. **"Claim"** means, for the lines of business set forth in Schedule A, a payment request from a health care provider or an Enrollee for a health care service, product, or prescription drug provided to an Enrollee, with an incurred date during the term of this Contract. Claims billed to Group are negotiated rates paid to health care providers pursuant to BCBSM or a BCBS Plan's provider agreements, which may include both service-based and value-based reimbursement. Service-based reimbursement means a BCBSM or BCBS Plan fee for a health care service. Value-based reimbursement means a fee for Quality Programs, as more fully described in Exhibit 1 to Schedule A.

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

E. **"Contract"** means this administrative services contract and any schedules, parts, exhibits and addenda attached hereto and incorporated herein by reference as amended from time to time.

F. **"Contract Year"** means the period from the Effective Date to the first Renewal Date, or the period from one Renewal Date to the next Renewal Date. If termination occurs other than at the end of a Contract Year, Contract Year means that period from the Effective Date or the most recent Renewal Date to the termination date.

G. **"Coverages"** means the health care benefits set forth in the benefit design document or Part C of the Group Enrollment and Coverage Agreement and BCBSM's medical policies, which are incorporated into this Contract.

H. **"Employee"** means the following which are eligible and enrolled for Coverage under the terms of the Plan or as required by law: (i) employees as designated by Group; (ii) retirees and their surviving spouses as designated by the Group; and (iii) COBRA beneficiaries.

I. **"Enrollee"** means an individual that Group enrolled as an Employee, spouse or dependent in the Plan pursuant to *Article II.B*.

J. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended, 29 USC 1101, *et seq*, and regulations promulgated thereunder.

K. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, Public Law 104-191 of 1996, *et seq*, and regulations promulgated thereunder.

L. **"PPACA"** means the Patient Protection and Affordable Care Act, as amended, Public Law 111-148 of 2010, *et seq*, and regulations promulgated thereunder.

M. **"Quality Programs"** refer to BCBSM or BCBS Plan programs funded with value-based provider reimbursement. Quality Programs are governed by separate agreements with health care providers and are designed to improve health care outcomes and control health care costs.

N. **"Rebates"** means retrospective payments collected from drug manufacturers and paid to BCBSM that are attributable to Enrollee drug utilization.

O. **"Renewal Date"** means the date one (1) year after the Effective Date, and the same date of every subsequent year. The Renewal Date may be changed by mutual agreement of BCBSM and Group.

P. **"Transition Assistance Period" or "TAP"** means the period that begins on the Termination Date and concludes twenty-four (24) months thereafter, during which BCBSM shall provide those services, and Group shall perform those obligations, set forth in *Article IV.B*.

ARTICLE II
GENERAL RESPONSIBILITIES

A. **Claims Administrator Status.** Group delegates to BCBSM the responsibility and discretionary authority as claims administrator to make Plan interpretations and final benefit determinations. BCBSM's claims administrator responsibilities extend only to the full and fair review of claims and administrative appeals as set forth in ERISA §503. By assuming these specifically delegated responsibilities as claims administrator, BCBSM does not thereby assume any other duty of the Group as Plan administrator or any other fiduciary function Group performs on behalf of its Plan. Any determination or interpretation made by BCBSM pursuant to its claim determination authority is binding on the Enrollee, Group, and BCBSM unless it is demonstrated that the determination or interpretation was arbitrary and capricious. Group retains all other fiduciary responsibilities and duties under ERISA not specifically delegated to BCBSM in this Contract. BCBSM shall not be responsible for Group's failure to meet any of its financial obligations or Plan administrator responsibilities with respect to the Plan.

B. **Eligibility and Enrollment.** Prior to the Effective Date, Group shall notify BCBSM of all Enrollees that will be covered by the Plan. During the term of this Contract, following agreed upon procedures, Group shall notify BCBSM of all changes in Plan enrollment. Until BCBSM has been properly notified of changes to Group's Plan enrollment, BCBSM shall continue to process Claims for Enrollees as listed on BCBSM's computer membership programs. Group represents and warrants that any eligibility and status changes it requests are compliant with and permissible under applicable state and federal law, including PPACA.

C. **Claims Processing.** During the term of this Contract, Claims will be directly submitted to BCBSM and will be processed according to the Coverages and BCBSM's standard operating procedures for Claims. Notwithstanding the foregoing, Claims from out-of-state providers may, depending on the type of payment request, be directly submitted to the applicable out-of-state BCBS Plan and are processed and paid under the BlueCard Program as set forth in Schedule B. Claims from out-of-state providers are reported and billed to Group as they are received by BCBSM from a BCBS Plan and may include a BlueCard Access Fee for processing the Claim.

D. **Disputed Claims.** Group shall notify BCBSM in writing of any Claim that Group disputes within sixty (60) days of Group's access to a paid Claims listing. BCBSM shall investigate such Claim and respond to Group within a reasonable time period. Upon BCBSM's request, Group shall execute any reasonably necessary documents that will allow BCBSM to recover any amounts that may be owed by a third party with respect to such disputed Claim. If BCBSM recovers any amount from a third party or if BCBSM determines that the disputed Claim is not Group's financial responsibility or is incorrect, then BCBSM shall give Group a credit for the recovered or corrected amount (reduced by any stop loss credits given by BCBSM relating to such disputed Claim).

E. **Recoveries.**

1. Subrogation. BCBSM shall be subrogated to all of Group's, the Plan's, or an Enrollee's rights with respect to any Claim. BCBSM will use reasonable efforts to evaluate information provided by the Enrollee and other sources to identify Claims in which the Plan may have a subrogation or reimbursement interest. However, BCBSM is not obligated to pursue any subrogation or reimbursement claim, including commencing, becoming a party to, or intervening in any litigation. BCBSM will remit to Group the funds recovered from third parties less (a) any attorney fees resulting from recovery litigation undertaken by BCBSM, (b) any negotiated lien reduction, and (c) the percentage set forth on Schedule A. Group will reasonably assist in any BCBSM recovery efforts, including providing BCBSM with requested Plan documents.

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

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

1. Each party shall provide prompt written notice of the Litigation to the other party if served with such Litigation.

2. Group may request that BCBSM select counsel and defend litigation. BCBSM retains the right to deny this request and require Group to defend the Litigation.

3. Whenever Group or BCBSM is a party in any Litigation, regardless of who defends the litigation, Group and BCBSM each reserve the right, at their own cost and expense, to retain counsel to protect their own interests.

4. Regardless of who defends the litigation, Group and BCBSM shall reasonably cooperate with each other to provide all relevant information and documents within their respective control that are not subject to a privilege or confidentiality obligation; and to reasonably assist each other to defend, settle, compromise, or otherwise resolve the Litigation. Whenever either party is served with any Litigation, the party served shall take all steps necessary to prevent a default in the Litigation prior to determining which party will defend such Litigation.

5. BCBSM shall have full authority to settle or compromise such Litigation, without Group's specific consent, unless:

   a. $50,000 or more is at issue in the Litigation;
   b. State tax issues or mandated benefit issues are part of the Litigation and Group has requested BCBSM to defend the Litigation; or
   c. Settlement of the Litigation could have a material adverse impact on Plan costs or administration.

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

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

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

7. When BCBSM defends the Litigation, the cost and expenses of such defense shall be paid by BCBSM. However, Group shall pay for any judgment, award, settlement or payment of amounts due with respect to the underlying Litigation.

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

G. Group Audits.

1. Group, at its own expense, shall have the right to audit Claims incurred under this Contract; however, audits shall not occur more frequently than once every twelve months and shall not include Claims from previously audited periods or Claims paid prior to the last twenty-four (24) months.

2. Prior to any audit, Group and BCBSM must mutually agree upon any independent third-party auditor that Group wishes to perform the audit. BCBSM shall not unreasonably withhold its consent. Additionally, prior to audit, Group and any third-party auditor shall sign BCBSM's audit agreement.

3. All audits shall be conducted pursuant to BCBSM corporate policy and other requirements at the time of the audit. The parties acknowledge staffing constraints may exist in servicing concurrent Group initiated audits. Therefore, after notice from Group requesting an audit, BCBSM will have up to ninety (90) days to begin gathering requested documentation and to schedule the on-site phase of the audit.

4. Sample sizes shall not exceed two hundred (200) Claims and shall be selected to meet standard statistical requirements (i.e., 95% Confidence Level; precision of +/- 3%). If BCBSM agrees to any additional Claims above the 200, Group shall reimburse BCBSM for Claims documentation in excess of 200 Claims at fifty dollars ($50.00) per Claim.

5. Following the on-site activity and prior to disclosing the audit findings to Group, the auditor shall meet with BCBSM management and present the audit findings.

6. BCBSM shall have no obligation to make any payments or reimbursements in connection with audit findings to Group unless there has been a recovery from the provider, Enrollee, or third-party carrier, as applicable. No adjustments or refunds shall be made based on the auditor's statistical projections of sampled dollar errors. An audit error will not be assessed if the Claim payment is consistent with BCBSM policies and procedures, or consistent with specific provisions contained in this Contract or other written Group instructions agreed to by BCBSM.

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

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

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

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

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

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

K. **Coordination with Medicare.** Group shall timely notify BCBSM whether Medicare is the primary payer for Claims of any Enrollee. BCBSM shall change such Enrollee's eligibility record within fifteen (15) business days of BCBSM's receipt of Group's notice.

L. **Prescription Drug Benefits.** To the extent Group has engaged BCBSM to administer prescription drug claims for its Plan, BCBSM or its subcontractor shall process all prescription drug claims according to the Coverages, participating pharmacy contracts, and fees set forth on Schedule A. Payments to participating pharmacies may include prescription drug costs, dispensing fees, and incentive fees for dispensing a generic drug or compounding a prescription drug.

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

ARTICLE III
FINANCIAL RESPONSIBILITIES

A. **Group Responsibilities.** Group shall be responsible and liable for:

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

B. **Group's Weekly Wire and Other Payments.** Group shall make weekly payments of all amounts due to BCBSM within one (1) business day of the invoice issue date. In addition, Group shall pay to BCBSM any separately invoiced amounts within fifteen (15) days of invoice or settlement issue date. If Group's payment for any amount payable under this Contract is more than one (1) business day late, Group shall pay a late fee equal to two percent (2%) of any outstanding amount due or the maximum percentage permitted by law, whichever is less. BCBSM may cease processing Claims retroactive to the last date for which full payment was made.

C. **Interest and Float.** Group shall make payments of amounts due and owing to a designated BCBSM bank account, which funds other BCBSM accounts. To the extent any of those bank accounts are interest bearing, BCBSM retains any interest earned and will not pay or credit any interest to Group. Additionally, banks holding BCBSM accounts may retain float interest earned on transactions with the funds in those accounts.

D. **Schedule A Renewals.** At least thirty (30) days prior to each Renewal Date, BCBSM shall send Group a Schedule A for the new Contract Year with all pricing terms for a single or multiple Contract Year(s). Any renewal Schedule A shall be deemed fully executed and effective as of the Renewal Date if Group fails to sign it and makes any payment according to its terms.

E. **Settlements.**

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

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

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

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

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

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

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

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

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

ARTICLE IV
TERMINATION AND TERMINATION ASSISTANCE

A. Termination & Notice.

1. With or Without Cause. Either party may, with or without cause, terminate this Contract by providing the other party with at least ninety (90) days prior written notice of the termination date ("Termination Date").

2. Nonpayment, Partial Payment, Insolvency, or Bankruptcy. Notwithstanding any other Contract provisions, if Group fails to timely pay any amounts owed or becomes insolvent or files for bankruptcy protection, BCBSM may terminate this Contract by providing Group with at least five (5) days prior written notice of the Termination Date.

3. Termination within the First Contract Year. If Group gives notice of termination before the end of the first Contract Year or if BCBSM terminates under *subsection 2* above before the end of the first Contract Year, Group shall pay BCBSM twelve (12) months of the administrative fees as set forth in Schedule A multiplied by the average monthly Employee count (less the administrative fees paid prior to the Termination Date) to compensate BCBSM for its implementation costs.

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

1. End of Coverage. Notwithstanding any other provisions contained herein, neither BCBSM nor any BCBS Plan shall have any obligation for payment for any health care services which are incurred on or after the Termination Date.

2. Obligation to Pay. Notwithstanding any other provisions contained herein, Group is obligated to timely pay all amounts incurred under the Contract during the TAP.

3. Claims Processing. All Claims incurred, but not paid, prior to the Termination Date shall be processed by BCBSM or other BCBS Plans pursuant to the terms and conditions in this Contract. BCBSM may cease processing Claims if Group fails to timely pay BCBSM for amounts due and owing, is insolvent, or files for bankruptcy. Group represents and warrants that it will be solely liable for any Claims BCBSM does not pay as a result of Group's failure to make timely payment. Group will indemnify, defend, and hold BCBSM harmless for any Litigation or other adversary proceeding brought by an Enrollee whose claim was not paid as a result of Group's failure to timely pay BCBSM. This paragraph is independent of BCBSM's rights under *Article IV.A.2* above.

4. Administrative Fee and Claim Payments. For the first three (3) months of the TAP, Group shall pay the fixed administrative fees and shall continue to make Claim payments in the same manner as prior to the Termination Date. For the next twenty-one (21) months of the TAP, BCBSM will invoice Group for Claims each month. AAC, if any, will continue to be paid for the duration of the TAP.

5. Settlement – Last Contract Year. Within one-hundred eighty (180) days following the Termination Date, BCBSM shall prepare a settlement statement for the last Contract Year.

6. Final Settlement. Within ninety (90) days after the expiration of the TAP, BCBSM will prepare a final settlement and will refund any positive balance or invoice Group for any negative balance. Any negative balance will be due within ten (10) days of the date of invoice. The payment to Group or to BCBSM as provided in the immediately preceding sentence shall fully and finally settle, release, and discharge each party from any and all claims that are known, unknown, liquidated, non-liquidated, incurred-but-not-reported, adjustments, recoupments, receivables, recoveries, rebates, hospital settlements, and other sums of money due and owing between the parties and arising under this Contract.

7. Group Duty to Notify / Indemnity. Group shall notify BCBSM if, as a result of its insolvency or other status, another party is required by law to receive any refunds, payments, or returned funds from BCBSM under this *Article IV*. Group shall indemnify, defend, and hold BCBSM harmless for any liability, including attorney fees, resulting from Group's failure to notify BCBSM under this paragraph.

C. **Conversion to Underwritten Group.** If Group converts from a self-funded group to a BCBSM underwritten group, Group shall continue to be obligated for any balance due and Group shall timely pay the amounts due and owing under this Contract in addition to any premium payments as a BCBSM underwritten group.

ARTICLE V
GENERAL PROVISIONS

A. **Entire Agreement.** This Contract represents the entire understanding and agreement of the parties regarding matters contained herein. This Contract supersedes any prior verbal or written agreements and understandings between the parties and shall be binding upon the parties, their successors or assigns. Neither party has executed this Contract in reliance on any representations, warranties, or statements other than those expressly set forth herein.

B. **Indemnity.** Group agrees to indemnify, defend and hold BCBSM harmless from any claims resulting from Group's breach of any term of this Contract or breach of any obligation or duty not expressly delegated to BCBSM in this Contract, including, but not limited to, Group's obligation to manage eligibility and enrollment, benefit design, disclose Plan information to Enrollees, respond to requests for Plan documents, and to read and understand the terms of this Contract. The indemnity and hold harmless provisions of this Contract shall survive the termination of the Contract.

C. **Service Mark Licensee Status.** BCBSM is an independent licensee of BCBSA and is licensed to use the "Blue Cross" and "Blue Shield" names and service marks in Michigan. BCBSM is not an agent of BCBSA and, by entering into this Contract, Group agrees that it made this Contract based solely on its relationship with BCBSM or its agents. Group agrees that BCBSA is not a party to this Contract, has no obligations under this Contract, and that no BCBSA obligations are created or implied under this Contract.

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

If to Group:	If to BCBSM:
Address set forth above	Blue Cross Blue Shield of Michigan 600 Lafayette East, Mail Code B612 Detroit, Michigan 48226-2998

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

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

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

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

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

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

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

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

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

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

M. **Summary of Benefits and Coverage.** Group is solely responsible for the creation and distribution of the summary of benefits and coverage form.

N. **Plan Year.** Group's plan year is the one-year period beginning on the Effective Date and each Renewal Date thereafter unless Group notifies BCBSM at least six months in advance of a change thereto.

O. **Knowing Assent.** Group acknowledges that it has had a full opportunity to consult with such legal and financial advisors as it has deemed necessary or advisable in connection with its decision to knowingly enter into this Contract. Group acknowledges that it has an obligation, as Plan Fiduciary, to determine whether the financial arrangements set forth in this Contract and Schedules are an appropriate Plan expense and for the exclusive benefit of the Plan. Group acknowledges that it has had any questions about this Contract posed to BCBSM fully answered to Group's satisfaction.

Blue Cross Blue Shield of Michigan
SCHEDULE A – Renewal Term (Effective 01/01/2021 thru 12/31/2021)
Administrative Services Contract (ASC)

1. **Group Name** LIVINGSTON COUNTY
2. **Customer ID** 106931
3. **ASC Funding Arrangement** Weekly Invoice

4. Line(s) of Business and Products

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

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	Amount Per Contract Per Month	Estimated Monthly Contracts	Estimated Monthly Admin Fee	Effective Start Date	Effective End Date
i. 2021 Base Admin Fee	$74.37	569	$42,316.53	01/01/2021	12/31/2021

B. Variable Administrative Fees – *Not Applicable*

6. Data Feeds

A. Standard Data Feeds

Coverage	Sent/ Received	Vendor	Pricing Method	Fee Amount	Monthly Cap	Effective Start Date	Effective End Date
Membership Eligibility Data - Maintenance	Send to	Health Care Bluebook	Annual	$0.00	$0.00	01/01/2021	12/31/2021
Medical Claims Data - Maintenance	Send to	Health Care Bluebook	Annual	$0.00	$0.00	01/01/2021	12/31/2021

B. Custom Data Feeds – *Not Applicable*

C. Ad Hoc Data Feeds – *Not Applicable*

7. Hospital Advance

Category	Amount
Hospital Advance	$230,065.20

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

A. Late Payment Charge 2%
B. Health Care Provider Interest Charge 12%

11. Buy-Ups

A. Buy-Ups—Stand-Alone and Bundles

Program	Pricing Method	Unit Price	Unit Volume	Amount	Effective Start Date	Effective End Date
Online Visits	PCPM	$0.20	569	$113.80	01/01/2021	12/31/2021
Blue Cross Health & Well-being Access	PMPM	$1.50	569	$853.50	01/01/2021	12/31/2021
Physician Health Screening	PMPM	$1.00	569	$569.00	01/01/2021	12/31/2021
Health & Well-being - Plus	PMPM	$1.50	569	$853.50	01/01/2021	12/31/2021
Health Savings Account (HSA)	PCPM	$2.95	569	$1,678.55	01/01/2021	12/31/2021

B. Buy-Ups— Care Navigation Solutions – *Not Applicable*

12. Shared Savings Programs

BCBSM has implemented programs to enhance the savings realized by its customers. As stated below, BCBSM will retain as administrative compensation a percent of the recoveries or cost avoidance. Administrative compensation retained by BCBSM through the Shared Savings Program will be available through reports obtained on eBookshelf:

Program:	**BCBSM Retention of:**	
A. Pre-Payment Forensic Billing Review	30%	Cost avoidance of improper hospital billing identified by third party vendor(s) through forensic pre-payment billing review.
B. Advanced Payment Analytics	30%	Recoveries of claims overpayments identified by third party vendor(s) using proprietary data mining analytics and enhanced reviews.
C. Subrogation	30%	Recoveries of claims overpayments from subrogation efforts.
D. Provider Credit Balance Recovery	30%	Recoveries of claims overpayments obtained by third party vendor(s) through enhanced review of hospital patient accounting systems.
E. 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.
F. Rebate Service Fee for Medical Prescription Drugs	10%	Medical benefit drug rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee. The Rebate Administrator Fee is 5.25% of gross rebates for medical benefit drug Claims.
G. Rebate Service Fee for Pharmacy Prescription Drugs	10%	Pharmacy benefit rebates on Claims incurred in the renewal term net of the Rebate Administrator Fee charged and retained by the Rebate Administrator. The Rebate Administrator Fee is (i) 3% of gross rebates for BCBSM clinical formulary, custom formulary, and custom select formulary drug Claims, including specialty drug Claims and (ii) 7.7% of gross rebates for Part D formulary drug Claims, including Part D specialty drug Claims.

13. Pharmacy Pricing Arrangement

A. Traditional Prescription Drug Pricing and Administrative Compensation

BCBSM has negotiated pricing for prescription drugs with its pharmacy benefit manager ("PBM"). Group acknowledges and agrees the amount BCBSM pays PBM for a prescription drug may be more or less than the amount Group pays BCBSM for such prescription drug. Enrollee coinsurance will be calculated based on the amount Group pays BCBSM for the prescription drug.

In addition to any other administration compensation paid to BCBSM by Group, BCBSM shall retain as administrative compensation as follows for the above Traditional Prescription Drug Pricing arrangement ("Traditional Rx Drug Pricing Admin Fee"):

a. Up to one (1) percentage point of the aggregated AWP discount BCBSM receives from its PBM for drugs classified by BCBSM as retail (excluding mail order) brand drugs; and

b. Up to four (4) percentage points of the aggregated AWP discount BCBSM receives from its PBM for drugs classified by BCBSM as retail or mail order generic drugs.

BCBSM's actual Traditional Rx Pricing Admin Fee depends 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 amount retained by BCBSM as administrative compensation 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

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. Agent Fees

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

17. Medicare Contracts

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

18. Compensation Agreement with Providers

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

BCBSM Quality Programs may also include risk sharing arrangements with certain provider entities ("PE"), e.g., physician organizations, facilities, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside risk for a performance year. The PE's performance will be measured by comparing its total cost of care trend for attributed members to BCBSM's statewide total cost of care trend which may be equated to a per member per month amount. BCBSM will calculate each PE's performance approximately 11 months after the end of a performance year.

Notwithstanding the above, in the first two years of the program (2020-2021), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM may be used to offset any additional reimbursement earned by a PE in the following year. BCBSM will not retain any amounts resulting from such risk sharing arrangements. If the PE's performance results in a payment of additional reimbursement, Group may be invoiced an additional amount based on its attributed membership to that PE. If the PE's performance results in a return of reimbursement, Group may receive a credit based on its attributed membership to that PE. BCBSM will provide Group with supporting documentation for such amounts. Invoice or credit to Group will occur in conjunction with BCBSM's customer savings refund process as set forth in the administrative services contract.

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

19. Out-of-State Claims

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

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

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

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

BCBSM Quality Programs may also include risk sharing arrangements with certain provider entities ("PE"), e.g., physician organizations, facilities, health systems, or any combination thereof, that have contracted with BCBSM for upside and downside risk for a performance year. The PE's performance will be measured by comparing its total cost of care trend for attributed members to BCBSM's statewide total cost of care trend which may be equated to a per member per month amount. BCBSM will calculate each PE's performance approximately 11 months after the end of a performance year.

Notwithstanding the above, in the first two years of the program (2020-2021), BCBSM will not invoice Group for any additional reimbursement earned by a PE. Moreover, reimbursement returned to BCBSM may be used to offset any additional reimbursement earned by a PE in the following year. BCBSM will not retain any amounts resulting from such risk sharing arrangements. If the PE's performance results in a return of reimbursement, Group may receive a credit based on its attributed membership to that PE. BCBSM will provide Group with supporting documentation for such amounts. Invoice or credit to Group will occur in conjunction with BCBSM's customer savings refund process as set forth in the administrative services contract.

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.

BLUE CROSS BLUE SHIELD OF MICHIGAN
Exhibit 2 to Schedule A
For Effective 1/1/2021 – 12/31/2021

1. Group Name LIVINGSTON COUNTY
2. CID 106931

This Exhibit 2 to Schedule A modifies and/or supplements the 2021 Schedule A based on any non-standard arrangements with Group. If there is a conflict between the terms of the Schedule A and this Exhibit 2, the terms of this Exhibit 2 will control and govern the rights and obligations of the parties.

1. Modifications to Schedule A:

    a. Section 5 is modified to add the following:

    Base Admin Fee

    BCBSM agrees to hold the 2020 Base Administrative Fee of $74.37 PCPM for Year 2021 and Year 2022 contingent on LIVINGSTON COUNTY retaining the current Lines of Business, Medical, Prescription Drugs, Stop-Loss and current enrolled segments.

Schedule B
BlueCard Disclosures
Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

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

A. BlueCard® Program

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

1. Liability Calculation Method Per Claim – In General

a. Enrollee Liability Calculation

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

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

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

b. Group Liability Calculation

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

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

2. Claims Pricing

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

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

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

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

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

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

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

3. BlueCard Program Fees and Compensation

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

B. Negotiated Arrangements

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

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

1. Enrollee Liability Calculation

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

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

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

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

2. Group Liability Calculation

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

3. Claims Pricing

Same as in the BlueCard Program above.

4. Fees and Compensation

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

C. Special Cases: Value-Based Programs

Value-Based Programs Overview

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

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

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

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

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

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

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

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

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

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

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

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

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

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

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

Care Coordinator Fees

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

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

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

Value-Based Programs under Negotiated Arrangements

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

D. Return of Overpayments

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

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

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

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

F. Nonparticipating Healthcare Providers Outside BCBSM's Service Area

1. Enrollee Liability Calculation

a. In General

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

b. Exceptions

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

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

2. Fees and Compensation

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

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

1. General Information

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

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

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

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

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

Exhibit 1

BlueCard Program Access Fees may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in BCBSM's administrative fee, unless otherwise agreed to by Group. The BlueCard Access Fee is charged by the Host Blue to BCBSM for making its applicable Provider network available to Group's Enrollees. The BlueCard Access Fee will not apply to Nonparticipating Provider Claims. The BlueCard Access Fee is charged on a per-Claim basis and is charged as a percentage of the discount / differential BCBSM receives from the applicable Host Blue and is capped at $2,000.00 per Claim. The percentages for 2021 are:

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

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

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

Blue Cross Blue Shield of Michigan

STOP-LOSS INSURANCE POLICY
between

BLUE CROSS BLUE SHIELD OF MICHIGAN
a Nonprofit Mutual Insurer

Herein called "the Company"

and

LIVINGSTON COUNTY

Herein called "the Policyholder"

The Exhibit attached hereto and made a part of this Policy shall establish the Policyholder's Group Name, Customer ID, 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 contract between the Policyholder and the Company (herein called the "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.

This Policy is exempt from the filing requirements of Section 2236 of the Insurance Code of 1956, 1956 PA 218, MCL 500.2236.

SECTION I
DEFINITIONS

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

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

2. **"Aggregate Stop-Loss Coverage"** means the Amounts Billed during the Policy Period (less Specific Stop-Loss Claims, if any) that exceed the Aggregate Attachment Point. For any aggregate credits to be provided, a twelve-month Policy Period is required.

3. **"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 credited under this Policy.

4. **"Amounts Billed"** means paid Claims, including any adjusted and re-adjudicated 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 Covered specified on the Exhibit and in settlement of Claims for any benefits under the Plan, and are:

   (a) In the case of new coverage or existing customer adding stop-loss coverage: (i) incurred and paid during the Policy Period or (ii) incurred prior to and paid during the Policy Period for which Policyholder is not reimbursed or paid by the prior stop-loss carrier, 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.

5. **"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;

6. **"Aggregate Attachment Point"** means the dollar amount above which Aggregate Stop-Loss Coverage will apply. The Aggregate Attachment Point is the product of (a) the average number of Coverage Units per month for the Policy Period, (b) the expected Claims per Coverage Unit for the Policy Period and (c) the attachment point percentage listed in Item A.3. of the most current Exhibit to this Policy provided, however, that the Aggregate Attachment Point shall never be less than the Minimum Aggregate Attachment Point specified in Item A.4. of the most current Exhibit.

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

8. **"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.

9. **"Claim"** means "Claim" as that term is defined in the Contract.

10. **"Claims Covered"** means the coverage specified in Items A.1. and/or B.1. of the most current Exhibit.

11. **"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."

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

13. **"Effective Date of Policy"** means the Policy Period start date referenced in the Exhibit.

14. **"Employee"** means "Employee," as that term is defined in the Contract unless the 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 Contract.

15. **"Exhibit"** means the attached Exhibit to the Stop-Loss Coverage Policy or any subsequent replacement Exhibit supplied by the Company. 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.

16. **"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.

17. **"Minimum Aggregate Attachment Point"** is the minimum Claims amount shown in Item A.4 of the Exhibit that must be paid by the Policyholder before Aggregate Stop-Loss Coverage is credited. The Minimum Aggregate Attachment Point is 90 percent (90%) of a) the Aggregate Attachment Point as shown in Item A.3. of the Exhibit on a per Coverage Unit basis times b) the number of Coverage Units as shown in Item A.6. of the Exhibit.

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

19. **"Original Effective Date of Policy"** means the date the Policyholder became a Blue Cross Blue Shield of Michigan stop-loss insurance policyholder. If stop-loss coverage was terminated for any reason, the Original Effective Date of Policy means the start date of the most recent uninterrupted policy periods.

20. **"Plan"** shall mean the self-funded group health plan of the Policyholder.

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

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

23. **"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.

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

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

26. **"Run-Out Period"** means the 24-month period immediately following the termination of this Policy.

27. **"Specific Attachment Point"** means the dollar amount above which Specific Stop-Loss Coverage will apply as shown in Item B.3. of the Exhibit.

28. **"Specific Stop-Loss Coverage"** means the Amounts Billed during the current Policy Period in excess of the Specific Attachment Point and the Aggregating Specific Deductible in Item B.4. of the Exhibit, if applicable, per Policy Period.

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

    (a) If the Amounts Billed that have accumulated during the Policy Period for any Coverage Unit exceed the amount indicated in Item B.3. and the Aggregating Specific Deductible indicated in Item B.4., if applicable, 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 Stop-Loss Claims. A monthly review will occur to determine if such excess exists.

    (b) Specific Stop-Loss Coverage 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 Contract.

    (c) If, during the Run-Out Period, Run-Out Amounts Billed exceed the Specific Attachment Point and the Aggregating Specific Deductible indicated in Item B.4., if applicable, of the most current Exhibit, 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.

    (d) If, during the current Policy Period, aggregate Amounts Billed less Specific Stop-Loss Claims, if any, exceed 1) the Aggregate Attachment Point and 2) Minimum Aggregate Attachment Point indicated in Item A.4. of the most current Exhibit to the Policy, such excess, if any, shall be referred to in this Policy as Aggregate Stop-Loss Claims.

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

30. **"Stop-Loss Premium"** means the Monthly or annual premium, calculated by multiplying the number of Coverage Units for a particular Month by the premium rate indicated in Items A.5. and/or B.5. of the most current Exhibit, that is required by the Company for the risk assumed under the Policy as 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 by the date set forth on the Stop-Loss Premium invoice. 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:

    (a) 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;

    (b) 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;

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

(d) On any date the Company determines 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. and/or B.6. of the Exhibit.

SECTION II
POLICY PROVISIONS

1. **STOPLOSS CREDIT.** The Company hereby agrees to credit the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the Amounts Billed during the Policy Period which are in excess of the Aggregate Attachment Point or Specific Attachment Point. If the Policyholder selects an Aggregating Specific Deductible as part of its Policy, in addition to the Specific Attachment Point, a deductible of amount specified in Item B.4. in Amounts Billed must be met before any credit 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 credit be extended to, any claim or liability for extra-contractual, compensatory, or punitive damages, including interest, statutory penalties and attorney fees or any payments made as an exception to the Plan. 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.

2. **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.

3. **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

1. **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 Contract.

2. **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 Contract. A remittance will be considered received when actually delivered into the possession or control of the Company.

3. **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.

4. **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 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 the date of Termination of the Policy regardless of any "Run-Out" Coverage.

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.

5. **RUN-OUT STOP-LOSS PREMIUM.** If Run-Out Stop-Loss Insurance is selected by the Policyholder (only available for Specific Stop-Loss Coverage and only if selected at least twelve months prior to termination of the Contract), 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 Specific Stop-Loss Premium amount indicated in Item B.5. and shall be payable for the first three months after termination of the 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.

SECTION IV
SETTLEMENTS

1. **SPECIFIC STOP-LOSS SETTLEMENT.** The invoices or payment schedules provided under the Contract shall include the premium due under this Policy as well as any credits to the Policyholder for Specific 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. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

   If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Specific 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 Coverage shall not extend beyond the termination date of this Policy.

2. **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. If the Policyholder owes payment to the Company, the Company reserves the right to deduct amount(s) owed from any payment due the Policyholder as a result of the settlement.

3. **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 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 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

1. **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

litigation 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.

2. **TERMINATION.** This Policy will terminate upon the earliest of the following dates:

   (a) The end of the Policy Period.

   (b) The date specified in writing by the Policyholder provided that Company is notified at least 30 days in advance of the termination date.

   (c) The date mutually agreed to in writing by both parties.

   (d) The date specified in writing by Company following Policyholder's failure to timely pay amounts due provided that Policyholder is notified at least 5 days in advance of the termination.

   (e) The date the Plan terminates.

   (f) The date the 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 Coverage 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.

3. **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.

4. **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.

5. **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.

6. **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.

7. **LIABILITY.** The Company will have neither the right nor the obligation under this Policy (though such right or obligation may exist under the separate 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.

8. **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.

9. **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 U.S. 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 as shown in the Contract

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

10. **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.

11. **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.

12. **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.

Blue Cross Blue Shield Blue Care Network of Michigan

EXHIBIT TO THE STOP-LOSS COVERAGE POLICY

Policyholder:	**LIVINGSTON COUNTY**				
Customer ID:	106931	Policy Period:	01/01/2021	through	12/31/2021

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: (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.

A. AGGREGATE STOP-LOSS INSURANCE

Attachment Point percentage of the expected Claims for the Policy Period	125%
1. Claims Covered	Renewal of Existing Coverage: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.
2. Lines of Business Covered	Medical Claims and Outpatient Prescription Drug Claims covered by Stop-Loss Policy
3. Attachment Point (per Coverage Unit)	$16,457.57
4. Minimum Aggregate Attachment Point	$8,427,921.60
5. Monthly Premium (per Coverage Unit)	$5.49
6. Number of Coverage Units	569

B. SPECIFIC STOP-LOSS INSURANCE

1. Claims Covered	Renewal of Existing Coverage: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.
2. Lines of Business Covered	Medical Claims and Outpatient Prescription Drug Claims covered by Stop-Loss Policy
3. Specific Attachment Point (per Coverage Unit)	$150,000.00
4. Aggregating Specific Deductible	[N/A]
5. Monthly Premium (per Coverage Unit)	$149.82
6. Number of Coverage Units	569
7. Run-Out Coverage	*Group may elect "Run-Out" Coverage by checking the "Yes" box on the Group Signature Page. Unless checked "Yes", Group will not have Stop-Loss Run-Out coverage.* *"Run-Out" Coverage applies to claims incurred on or after the Original Effective Date of Policy and paid during the Run-Out Period*

C. ADDITIONAL PROVISIONS TO SPECIFIC STOP-LOSS INSURANCE

SECOND YEAR RATE CAP & NO-NEW LASER		
The Company will not change the Specific Premium rate in Item B.5 for the Second Year Policy Period by more than the percentage noted, as long as the Attachment Point remains the same in item B.3 and Aggregating Specific Deductible remains the same in item B.4 per Coverage Unit. The Company will not apply additional lasers in the Second Year Policy Period, referenced in this Section.	**Rate Cap:**	50%
	Second Year Policy Period:	01/01/2022
	Through	12/31/2022

RESOLUTION **NO:** [Title]

LIVINGSTON COUNTY **DATE:** Click or tap to enter a date.

Resolution Approving Appointments to Livingston County Boards and Committees - Board of Commissioners

WHEREAS, the terms of representatives on the following Livingston County Boards and Committees have expired and/or seats have been vacated; and

WHEREAS, the following appointments have been recommended:

Board of Public Works

Greg Tatara, MHOG Director ..... Term expires 12.31.2021

Community Corrections Advisory Board

David Reader, Prosecutor ..... Term expires 12.31.2024

Community Mental Health Authority Board

Suzanne Vandemergel ..... Term expires 12.31.2023

Livingston County Foundation

Ronald Van Houten ..... Term expires 12.31.2024

Meghan Reckling ..... Term expires 12.31.2023

THEREFORE BE IT RESOLVED that the Livingston County Board of Commissioners hereby approve the above referenced appointments and expiration dates.

# # #

MOVED:
SECONDED:
CARRIED:

From: Robert Spaulding
To: Natalie Hunt
Subject: DPW Appointments
Date: Thursday, October 29, 2020 8:52:33 AM

Good Morning Natalie

Hope all is well. Are you back in the office or still working from home?

I would like to proceed with the following appointments/terms for the Livingston County Department of Public Works:

Michael Arens	term expiring 12-31-2022	Application and Background check pending
Dale Brewer	term expiring 12-31-2021	Application and Background check pending
Dave Domas	term expiring 12-31-2022	Application and Background check pending
Arthur McCleer	term expiring 12-31-2022	Application and Background check pending
Greg Tatara	term expiring 12-31-2021	
Terry Wilson	term expiring 12-31-2022	Application and Background check pending

Can we do this resolution right now? Do you have the records of who we would need to do the background check on?

I still have some phone calls to members on the Solid Waste committee and Township Supervisors to make, but will have soon.

Thanks Natalie

Rob

LIVINGSTON COUNTY COMMUNITY CORRECTIONS
210 S. Highlander Way Howell 48843 Phone (517)540-7661 Fax (517)545-9637

January 15, 2021

Natalie,

The positions of County Prosecutor and County Commissioner on the Livingston County Community Corrections Advisory Board (LCCCAB) have been vacated. It is recommended that Prosecutor David Reader and Commissioner Carol Reader fill these positions.

Current Board membership is comprised of:

- Sheriff Michael Murphy (Chairperson)
- Chief of Police – Chief David S. Russell (Unadilla Township)
- Circuit Court Judge – Honorable Michael P. Hatty
- District Court Judge – Honorable Daniel B. Bain
- District Court Judge – Honorable Miriam A. Cavanaugh
- County Commissioner – Vacant
- Livingston County CMH Executive Director – Connie Conklin
- County Prosecutor – Vacant
- Criminal Defense – Karen Groenhout
- Business Community – Curtis Griffin
- Probation Supervisor – Tom Zahon
- Workforce Development – Dawn Awrey (MichiganWorks!)
- Communications Media – Vacant
- Member of Local Clergy – Carrie Skiles

If you have any questions, please contact me directly.

Sincerely,

Megan Kerekes
Community Corrections Manager

Community Mental Health Services
of Livingston County

December 10, 2020

Commissioner Carol Griffith
Livingston County Board of Commissioners
304 E. Grand River Ave.
Howell, Michigan 48843

Subject: Request for appointment to Livingston County Community Mental Health Authority Board: Suzanne Vandemergel

Dear Commissioner Griffith:

This letter is to request appointment of Suzanne Vandemergel to the Livingston County Community Mental Health Authority Board. As you can see from the attached letter she brings a depth of knowledge and expertise that will be an asset to our Board. Ms. Vandemergel will be replacing Mr.Jan Plas. He will be vacating his position after 20 years of service on December 31, 2020.

We ask for her three-year appointment to begin January 1, 2021 and end December 31, 2023. If you have any questions, please let me know. Thank you for your consideration.

Sincerely,

Constance Conklin
Executive Director

December 10, 2020

Carol Griffith
Livingston County
Board of Directors

Dear Ms. Griffith,

I recently met with Connie Conklin, Executive Director of Community Mental Health Services, regarding my interest in a board position.

I have lived in Livingston County for over forty years and retired from Brighton Area Schools where for 10 of those years I worked in the classroom as a para educator with emotionally impaired students. I feel my background working with these students would be an asset to the Livingston County Community Mental Health Authority board and the community.

Recognizing the important role of the organization and the impact it has on the members of the community in need of mental health services, I would be privileged to serve on the board.

Sincerely,

Suzanne Vandemergel
1856 Genoa Circle
Howell, Michigan 48843
810-599-2965

Natalie Hunt

From: Nathan Burd
Sent: Thursday, January 14, 2021 11:35 AM
To: Natalie Hunt
Cc: Jennifer Palmbos; Cindy Catanach
Subject: Foundation Resolution

Hi Natalie,

Cindy and I met with Meghan Reckling this morning regarding her interest in the Foundation Board. A resolution can be prepared for next week's Personnel Committee for her appointment.

Thanks,

Nathan Burd
Livingston County Administrator
(517) 540-8800
nburd@livgov.com
www.livgov.com