The City of Muskogee encourages participation from all its citizens in public meetings. If participation is not possible due to a disability, notify the City Clerk, in writing, at least forty-eight hours prior to the scheduled meeting and necessary accommodations will be made (ADA 28 CFR/36).

Council Rules of Decorum limit citizen comments on agenda items and public hearings to five (5) minutes and general comments for non-agenda items to three (3) minutes. Any person desiring to address the Council during such period is required to sign in with the City Clerk prior to the Council meeting between 5:00 p.m. and 5:15 p.m. on the third floor of City Hall or anytime between 8:00 a.m. and 5:00 p.m. in the Office of the City Clerk. They shall provide their name, address and specify the agenda item they wish to address. Remarks shall be directed to the matter being considered and the speaker is allowed to speak only one time. If written materials are to be submitted twelve (12) copies should be made available, and may not be returned.

AGENDA
MUSKOGEE CITY COUNCIL
MARCH 26, 2018

REGULAR SESSION - 5:30 P.M., 3RD FLOOR, COUNCIL CHAMBERS MUNICIPAL BUILDING, 229 W. OKMULGEE, MUSKOGEE, OKLAHOMA

INVOCATION - WAYNE JOHNSON

FLAG SALUTE - MAYOR BOB COBURN

ROLL CALL - MAYOR BOB COBURN

APPROVAL OF MINUTES: CITY COUNCIL REGULAR SESSION MARCH 12, 2018.

CONSENT AGENDA

The following items are considered to be routine by the City Council and will not be read aloud. The Consent Agenda will be enacted with one motion and should discussion be desired on an item, that item will be removed from the Consent Agenda prior to action and considered separately prior to the Regular Agenda.

1. Approval of claims for all City departments March 1, 2018 through March 14, 2018.

2. Approval of accepting the lowest, best bid for chemical pump to Haynes Equipment in the amount of $51,141.00, or take other necessary action. (Greg Riley)

3. Approval of the use of the Muskogee-Davis Regional Airport South Apron for the April 28, 2018, Touch-A-Truck event fundraiser for the Muskogee Public Library Youth Services Department, or take other necessary action. (Mike Stewart)

4. Approval of the appointment of Councilor Ivory Vann to serve on the Purchasing Committee. (Mayor Bob Coburn)

5. Approval of the appointment of Councilor Derrick Reed as Chairman and Councilor Dan Hall as Vice-Chairman of the Finance Committee. (Mayor Bob Coburn)

6. Approval of the appointment of Councilor Wayne Johnson as Chairman and Councilor Marlon Coleman as Vice-Chairman of the Public Works Committee. (Mayor Bob Coburn)

7. Approval of the appointment of Blanca Lopez to serve a four (4) year term on the Parks and Recreation Board, beginning April 1, 2018, and ending March 31, 2022, replacing Jason George, or take other necessary action. (Councilor Ivory Vann)

REGULAR AGENDA

8. Consider approval of the Trust Indenture of the Roxy Theater Community Trust; approval of Ordinance No. 4043-A, establishing, recognizing and accepting a beneficial interest in said Trust; approval of Resolution No. 2714, authorizing the transfer of the Roxy Theater from the City to be held in Trust for the benefit of the City; approving an Assignment Agreement between the City and the Trust assigning the Management Agreement of September 1, 2015 with Oxford Productions, Inc., or take other necessary action. (Roy D. Tucker)

9. Receive update from NFP Corporate Services of Oklahoma on current plan savings, and consider approval of Resolution No. 2715 authorizing certain modifications to the medical plan benefits under the City of Muskogee Employee Benefit Plan, providing and directing said modifications be incorporated into the Plan Documents, Summary Plan Description and Benefit Summary Sheets, as well as, approval of Resolution No. 2716 approving and authorizing execution of the Mutual of Omaha renewal, the Blue Cross Blue Shield Exhibit to the Stop Loss Coverage Policy, the Blue Cross Blue Shield Administrative Services Agreement, the Blue Cross Blue Shield Benefits Program Application, the Blue Cross Blue Shield PBM Fee Schedule Addendum to the Benefit Program Application, and the HCSC COBRA Administrative Services Addendum, all to become effective on May 1, 2018, and authorizing the City Manager, or designee, to execute all documents, or take other necessary action. (Kelly Plunkett)

10. Receive report on City of Muskogee's 30-year designation as a Tree City USA. (Rick Ewing)

11. Consider the appointment of Patrick Cale to the Purchasing Committee, to serve a term commensurate with his term on City Council, replacing Deputy Mayor Janey Boydston, or take other necessary action. (Mayor Bob Coburn)

RECOGNIZE CITIZENS WISHING TO SPEAK TO THE MAYOR AND COUNCIL.

Council Rules of Decorum limit citizen comments to three (3) minutes. Any person desiring to speak is required to sign-in with the City Clerk, provide their name, address, and the particular issue they wish to address. Under Oklahoma law, the Council Members are prohibited from discussing or taking any action on items not on today's agenda. If written materials are to be submitted to the Council twelve (12) copies should be made available, and

may not be returned.

ADJOURN

Regular City Council
Meeting Date: 03/26/2018
Initiator: Ashley Wallace, Office Adm 1
Department: City Clerk
Staff Information Source:

Information

AGENDA ITEM TITLE:
APPROVAL OF MINUTES: CITY COUNCIL REGULAR SESSION MARCH 12, 2018.

BACKGROUND:

RECOMMENDED ACTION:

Fiscal Impact

Attachments

03-12-2018 ccmin

MINUTES

OF THE COUNCIL OF THE CITY OF MUSKOGEE, OKLAHOMA, MET IN REGULAR SESSION, IN THE COUNCIL CHAMBERS OF CITY HALL MONDAY, MARCH 12, 2018

The Council of the City of Muskogee, Oklahoma, met in Regular Session in Council Chambers of City Hall, Monday, March 12, 2018, at 5:30 p.m., with Mayor Coburn presiding.

Invocation was given by Mayor Bob Coburn

Flag Salute was led by Mayor Bob Coburn

Meeting was called to order by Mayor John R. Coburn and the City Clerk called the roll as follows:

Present:	Mayor John R. Coburn; Deputy Mayor James Gulley; Councilmember Janey Boydston; Councilmember Patrick Cale; Councilmember Marlon Coleman; Councilmember Dan Hall; Councilmember Wayne Johnson; Councilmember Derrick Reed; Councilmember Ivory Vann
Staff Present:	Mike Miller, City Manager; Mike Stewart, Assistant City Manager; Roy Tucker, City Attorney; Tammy L. Tracy, City Clerk; Gary Garvin, City Planner; Greg Riley, Public Works Director; Matthew Beese, Assistant City Attorney; Mark Wilkerson, Parks & Recreation Director; Michael O'Dell, Fire Chief; Kelly Plunkett, Human Resources Director; Rex Eskridge, Police Chief

APPROVAL OF MINUTES: SPECIAL CALL CITY COUNCIL FEBRUARY 20, 2018, CITY COUNCIL REGULAR SESSION FEBRUARY 26, 2018.

Motion was made by Councilmember Dan Hall, seconded by Councilmember Janey Boydston to approve minutes: Special Call City Council February 20, 2018, City Council Regular Session February 26, 2018.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

CONSENT AGENDA

Motion was made by Deputy Mayor James Gulley, seconded by Councilmember Dan Hall to approve Consent Agenda.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

The following items are considered to be routine by the City Council and will not be read aloud. The Consent Agenda will be enacted with one motion and should discussion be desired on an item, that item will be removed from the Consent Agenda prior to action and considered separately prior to the Regular Agenda.

1 Approval of claims for all City departments February 15, 2018 through February 28, 2018.

2 Approval of a contract with Midwest Employers for excess workers compensation insurance in the amount of $85,101.00, or take any other necessary action. (Roy D. Tucker)

3 Approval of a Preliminary and Final Plat of Sooner Addition, consisting of two (2) lots on 2.83 acres, located on the north side of Harris Road, east of Country Club Road, or take other necessary action. (Gary D. Garvin)

4 Approval of amended Council Policy 1-2, or take other necessary action. (Roy D. Tucker)

5 Approval of a contract with Cowan Group Engineering for the design of Water System Project A, Tank Mixing and Project B, Water Distribution Improvements or take other necessary action. (Greg Riley)

6 Approval of the appointment of Jaime Stout to serve on the War Memorial Trust Authority, commensurate with her term on the City Council, replacing Councilor James Gulley, or take other necessary action. (Councilor Janey Boydston)

7 Approval of the appointment of Stacy Alexander to serve a four (4) year term on the Parks and Recreation Board, beginning April 1, 2018, and ending March 31, 2022, replacing Edwynna Walker, or take other necessary action. (Councilor Patrick Cale)

8 Approval of the appointment of Justin Blake O'Neal to serve a three (3) year term on the Historic Preservation Commission, beginning March 1, 2018, and ending February 28, 2021, replacing Doug Buse, or take other necessary action. (Mayor Bob Coburn)

REGULAR AGENDA

9 Consider approval of Ordinance No. 4042-A amending the Muskogee Code of Ordinances, Chapter 2, Administration, Article II, Municipal Government Organization, Section 2-29 titled, "Council Participation Guidelines and Rules of Decorum;" Modifying meeting schedule; Providing for Repealer, Severability and Setting an Effective Date, or take other necessary action. (Roy D. Tucker)

City Attorney Roy Tucker stated several months ago, City Council modified the meeting schedule, changing Public Works and Finance meeting times to 5:30 P.M. from 4:00 P.M. the first and third Mondays of the month, and Council meetings to 5:30 P.M. from 7:00 P.M. on the second and fourth Mondays of the month. City Council Policy 1-2 (effective 2013) was not amended at the same time City Code 2-20 was modified. In reviewing the Policy, there were several items of clarification that were needed in the instant ordinance, which is attached as an exhibit to Council Policy 1-2. Specifically, the following items were modified:

- correcting the maximum speaking time for public hearing and agenda item comments to five (5) minutes, rather than the two (2) minutes listed in the ordinance;
- referencing the sign up time cutoff within the ordinance, rather than solely on the sign up form;
- correcting punctuation and grammatical mistakes.

Motion was made by Councilmember Dan Hall, seconded by Councilmember Janey Boydston to approve Ordinance No. 4042-A amending the Muskogee Code of Ordinances, Chapter 2, Administration, Article II, Municipal Government Organization, Section 2-29 titled, "Council Participation Guidelines and Rules of Decorum;" Modifying meeting schedule; Providing for Repealer, Severability and Setting an Effective Date.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

10 Consider and take possible action on a resolution supporting Marsy's Law for Oklahoma, SQ 794, or take other necessary action (Councilor Marlon Coleman).

Motion was made by Councilmember Marlon Coleman, seconded by Deputy Mayor James Gulley to approve to direct Staff to prepare a resolution supporting State Question 794, also known as Marsy's Law, for further consideration at a Special Call City Council meeting held on March 19, 2018.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

11 Consider approval of the appointment of Jefferson Crane, to serve a four (4) year term on the Parks and Recreation Board, beginning April 1, 2018, and ending March 31, 2022, replacing Jim Eaton, or take other necessary action. (Councilor Wayne Johnson)

Motion was made by Councilmember Wayne Johnson, seconded by Councilmember Patrick Cale to approve the appointment of Jefferson Crane, to serve a four (4) year term on the Parks and Recreation Board, beginning April 1, 2018, and ending March 31, 2022, replacing Jim Eaton.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

12 Consider approval of the appointment of Joshua Cotten to the Chamber of Commerce Committee for Convention and Tourism Board, to serve the remainder of the term vacated by Holly Rosser-Miller, ending on April 30, 2019 or take other necessary action. (Councilor Ivory Vann)

Motion was made by Councilmember Ivory Vann, seconded by Councilmember Marlon Coleman to approve the appointment of Joshua Cotten to the Chamber of Commerce Committee for Convention and Tourism Board, to serve the remainder of the term vacated by Holly Rosser-Miller, ending on April 30, 2019.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

13 Consider approval of the appointment of Pamela Hale to the Chamber of Commerce Committee for Convention and Tourism Board, to serve a two (2) year term, beginning April 1, 2018, and ending March 30, 2020, succeeding Mike Martin, or take other necessary action. (Mayor Bob Coburn)

Motion was made by Mayor John R. Coburn, seconded by Councilmember Patrick Cale to approve the appointment of Pamela Hale to the Chamber of Commerce Committee for Convention and Tourism Board, to serve a two (2) year term, beginning April 1, 2018, and ending March 30, 2020, succeeding Mike Martin.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

RECOGNIZE CITIZENS WISHING TO SPEAK TO THE MAYOR AND COUNCIL.

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Betty Baucom McConnell expressed concerns over her utility account and asked Council to review.

Stephen Ezell 6121 S. 6th Street East, Muskogee, Oklahoma, explained the history behind the American Legion and VFW Memorial area that was dedicated to Greenhill Cemetery. No person was to be buried at that site until 1921 when City Manager R.L. Simpson gave the American Legion and VFW permission to bury a single soldier for each organization within the memorial area.

Paul McKinstry, 3307 W. 46th St. South, Muskogee, Oklahoma, stated he is a Veteran of the United States Army. When he was attending a service at Greenhill Cemetery, he noticed the area dedicated by the American Legion and VFW was in need of repair. Mr. McKinstry is proposing the first ever picnic in the cemetery. Greenhill Cemetery has agreed to the picnic which will be held Veteran's Day, November 10, 2018. He stated he would like this to be the biggest Veteran's parade that Muskogee has ever seen and hopes the cemetery picnic will become an event the rest of United States will become aware of and the biggest event Muskogee has seen in fifty years. Mr. McKinstry would also like to clean up the cemetery at no cost to the City, but through donations and help from the Boy Scouts of America.

14 Consider an Executive Session to discuss and take possible action on the following:

Motion was made by Councilmember Wayne Johnson, seconded by Councilmember Dan Hall to approve an Executive Session.

AYE: Mayor John R. Coburn, Deputy Mayor James Gulley, Councilmember Janey Boydston, Councilmember Patrick Cale, Councilmember Marlon Coleman, Councilmember Dan Hall, Councilmember Wayne Johnson, Councilmember Derrick Reed, Councilmember Ivory Vann

Carried - Unanimously

A Pursuant to Section 307 B.7, Title 25, Oklahoma Statutes, consider convening in Executive Session to discuss the requested Disability Retirement from the Oklahoma Municipal Retirement fund for Mark Bolding, and if necessary take action in open session. (Kelly Plunkett)

B Pursuant to Section 307B.2, Title 25, Oklahoma Statutes, consider convening in Executive Session to discuss negotiations with the American Federation of State, County and Municipal Employees, Local #2465, and if necessary, take appropriate action in open session. (Kelly Plunkett)

Council reconvened from Executive Session at 6:03 p.m.

Pursuant to Section 307B.7, Title 25, Oklahoma Statutes, consider convening in Executive Session to discuss the requested Disability Retirement from the Oklahoma Municipal Retirement fund for Mark Bolding, and if necessary take action in open session. (Kelly Plunkett)

Motion was made by Councilmember Patrick Cale, seconded by Councilmember Dan Hall to approve the requested Disability Retirement from the Oklahoma Municipal Retirement fund for Mark Bolding.

AYE: Mayor Bob Coburn, Deputy Mayor James Gulley, Councilmembers; Janey Boydston, Patrick Cale, Marlon Coleman, Dan Hall, Wayne Johnson, Derrick Reed, and Ivory Vann
Carried-Unanimously

Pursuant to Section 307B.2, Title 25, Oklahoma Statutes, consider convening in Executive Session to discuss negotiations with the American Federation of State, County and Municipal Employees, Local #2465, and if necessary, take appropriate action in open session. (Kelly Plunkett)

Motion was made by Councilmember Marlon Coleman, seconded by Councilmember Dan Hall to approve negotiations with the American Federation of State, County and Municipal Employees, Local #2465.

AYE: Mayor Bob Coburn, Deputy Mayor James Gulley, Councilmembers; Janey Boydston, Patrick Cale, Marlon Coleman, Dan Hall, Wayne Johnson, Derrick Reed, and Ivory Vann
Carried-Unanimously

ADJOURN

_____
JOHN R. COBURN, MAYOR

_____
TAMMY L. TRACY, CITY CLERK

Regular City Council **1.**

Meeting Date: 03/26/2018
Initiator: Donnie Wimbley, Purchasing Director
Department: Purchasing
Staff Information Source:

Information

AGENDA ITEM TITLE:
Approval of claims for all City departments March 1, 2018 through March 14, 2018.

BACKGROUND:
Claims List for all City Departments.

RECOMMENDED ACTION:
Approve of the claims for all City Departments March 1, 2018 through March 14, 2018.

Fiscal Impact

Attachments

Claims List

CITY OF MUSKOGEE CLAIMS
MARCH 1, 2018 TO MARCH 14, 2018

CHECK NO	VENDOR NO	VENDOR NAME	CHECK DATE	CHECK AMOUNT
197292	121	BRYANT, TENA	3/1/2018	10.97
197293	121	GRAYSON, MELINDA K	3/1/2018	36.58
197294	121	GREAT LIFE INVESTMENTS	3/1/2018	90.00
197295	121	JRC SELF STORAGE	3/1/2018	13.41
197296	121	MUSTAIN, CARL D	3/1/2018	46.47
197297	121	PETTIT, JAROD	3/1/2018	3.86
197298	121	WILLIAMS, ANNETTE	3/1/2018	9.65
197299	121	WILLIS, TEDRA MICHELLE	3/1/2018	2.53
197300	155	ACECO RENTAL AND SALES	3/2/2018	797.00
197301	4906	ACS PLAYGROUND ADVENTURES INC	3/2/2018	28.70
197302	2461	ADVANCE AUTO PARTS 64771111001	3/2/2018	3,050.36
197303	3	AIRGAS USA LLC	3/2/2018	56.21
197304	6	AMERICAN INDUSTRIAL SUPPLY CO	3/2/2018	66.00
197305	3984	AMERICAN RED CROSS-HEALTH & SA	3/2/2018	144.00
197306	11	B & J OIL CO INC	3/2/2018	197.40
197307	5046	BANCFIRST	3/2/2018	76,080.48
197308	3928	BANK OF OKLAHOMA - VISA	3/2/2018	51.03
197309	1703	BEN E. KEITH	3/2/2018	50.21
197310	4543	VIDA BERRY	3/2/2018	916.66
197311	3833	BEST BUY BUSINESS ADVANTAGE AC	3/2/2018	24.99
197312	780	BG PRODUCTS INC	3/2/2018	0.00
197313	1064	BOARD OF TESTS FOR ALCOHOL	3/2/2018	144.00
197314	5290	JANEY C BOYDSTON	3/2/2018	75.00
197315	5077	BRANDON BOWDEN DBA BOWDEN STEE	3/2/2018	2,800.00
197316	117	BRENDA REGAN	3/2/2018	22.71
197317	3238	BROKEN ARROW ELECTRIC	3/2/2018	582.36
197318	2552	BROWN'S SHOE FIT CO #87	3/2/2018	115.00
197319	3640	CHARBONNEAU, BILLY JO	3/2/2018	36.00
197320	167	CINCINNATI RADIATOR SERVICE IN	3/2/2018	200.00
197321	3051	CITY OF TULSA - PARK DEPARTMEN	3/2/2018	240.00
197322	4738	CITYWIDE PROPERTY MAINTENANCE	3/2/2018	1,320.00
197323	4882	CIVIC CENTER OPERATING ACCOUNT	3/2/2018	5,484.33
197324	3626	CLARK EQUIPMENT	3/2/2018	440.00
197325	4300	CLIFFORD POWER SYSTEMS INC	3/2/2018	350.00
197326	4390	BOB COBURN	3/2/2018	75.00
197327	4838	MARLON COLEMAN	3/2/2018	75.00
197328	2733	COOK CEILING ENTERPRISES	3/2/2018	5,638.00
197329	4311	DAVID'S DISCOUNT TIRES INC	3/2/2018	1,561.00
197330	25	DEALERS ELECTRICAL SUPPLY	3/2/2018	395.36

197331	3024	DERRELL JONES	3/2/2018	39.00
197332	3991	DIRT WORK DONE RIGHT	3/2/2018	1,875.00
197333	4167	COLLEEN DURBIN	3/2/2018	825.00
197334	170	EAST CENTRAL ELECTRIC	3/2/2018	18.87
197335	4862	SARAH EATON	3/2/2018	90.00
197336	953	EXPRESS EMPLOYMENT PROFESSIONA	3/2/2018	1,780.68
197337	29	FASTENAL COMPANY	3/2/2018	470.17
197338	30	FEDEX	3/2/2018	67.72
197339	5308	MEGAN FILANDA	3/2/2018	72.00
197340	3509	FLEETPRIDE INC	3/2/2018	34.44
197341	4407	FRANKLIN DIGITAL, INC	3/2/2018	345.25
197342	339	GARVER ENGINEERS LLC	3/2/2018	24,000.00
197343	5247	NIKYA GIVENS	3/2/2018	234.00
197344	4819	HALL, DAN	3/2/2018	75.00
197345	40	HARRISON TIRE & SUPPLY	3/2/2018	10.00
197346	42	HOGLE COMPANY	3/2/2018	24,823.00
197347	289	HOLLOWAY UPDIKE AND BELLEN INC	03/02/2018	23,116.60
197348	4443	JASON CRAIG HOLT	3/2/2018	350.00
197349	1414	HOMELAND STORES INC	3/2/2018	106.31
197350	923	HORT & LANDSCAPE ARCHITECTURE	3/2/2018	85.00
197351	923	HORT & LANDSCAPE ARCHITECTURE	3/2/2018	85.00
197352	923	HORT & LANDSCAPE ARCHITECTURE	3/2/2018	85.00
197353	4902	IMPERIAL LLC	3/2/2018	224.25
197354	2256	IMPRIMATUR PRESS	3/2/2018	254.50
197355	125	JACAMBRIA TWILLEY	3/2/2018	390.00
197356	5103	JACK HOOPES	3/2/2018	50.94
197357	3024	JEFF KIZZIA	3/2/2018	137.33
197358	3024	JEFF WATKINS	3/2/2018	78.00
197359	779	JOHN DEERE FINANCIAL F.S.B.	3/2/2018	89.98
197360	5305	JOHN V TEDESCO DO PA	3/2/2018	2,000.00
197361	4984	WAYNE A JOHNSON	3/2/2018	75.00
197362	2551	KEMP STONE	3/2/2018	301.77
197363	4467	KEVIN HERON TOOLS - SNAP ON	3/2/2018	244.00
197364	4742	KAREN LAUDERDALE	3/2/2018	72.00
197365	3024	LEWIS BROCK	3/2/2018	78.00
197366	5310	PETER J. LIIMATTA	3/2/2018	190.00
197367	3024	LINCOLN ANDERSON	3/2/2018	24.00
197368	399	LOCKE SUPPLY CO	3/2/2018	83.04
197369	980	LOVE BOTTLING CO - #212455	3/2/2018	42.00
197370	56	LOWES	3/2/2018	875.82
197371	4246	MARVIN'S MOWERS AND OUTDOOR LL	3/2/2018	1,699.95
197372	4956	MEDNOW URGENT CARE LLC	3/2/2018	1,162.00
197373	194	MORGAN SERVICES COMPANY LLC	3/2/2018	100.00
197374	921	MOTION INDUSTRIES INC	3/2/2018	127.84
197375	5195	MUSCOGEE STAFFING SOLUTIONS, L	3/2/2018	157.50
197376	61	MUSKOGEE COMMUNICATIONS, INC.	3/2/2018	184.60
197377	195	MUSKOGEE COUNTY CLERK	3/2/2018	42.00

197378	1132	MUSKOGEE COUNTY ELECTION BOARD	3/2/2018	3,830.72
197379	62	MUSKOGEE COUNTY SHERIFFS DEPAR	3/2/2018	34,185.00
197380	63	MUSKOGEE DAILY PHOENIX	3/2/2018	266.40
197381	341	MUSKOGEE LOCK & KEY	3/2/2018	71.70
197382	5082	MUSKOGEE MANUFACTURING LLC	3/2/2018	311.62
197383	4476	MUTUAL OF OMAHA INSURANCE CO	3/2/2018	8,377.80
197384	3645	NATIONAL ASSOC OF LEGAL ASSIST	3/2/2018	455.00
197385	901	NATIONAL RECREATION AND PARK	3/2/2018	65.00
197386	5327	NEWGEN STRATEGIES AND SOLUTION	3/2/2018	12,027.90
197387	114	OFFICE DEPOT	3/2/2018	374.35
197388	67	OKLAHOMA NATURAL GAS	3/2/2018	2,093.07
197389	5089	OLSSON ASSOCIATES	3/2/2018	310.00
197390	2763	ONE SOURCE WATER LLC	3/2/2018	91.00
197391	70	OREILLY AUTO PARTS	3/2/2018	4,162.61
197392	73	PATE INDUSTRIAL SUPPLY INC	3/2/2018	164.08
197393	3666	PITNEY BOWES INC	3/2/2018	423.00
197394	4795	PREMIER TRUCK GROUP	3/2/2018	15.52
197395	4610	PRIME AUTOMOTIVE WAREHOUSE LLC	3/2/2018	661.70
197396	4801	DERRICK REED	3/2/2018	75.00
197397	3420	RIVERSIDE AUTOPLEX OF MUSKOGEE	3/2/2018	10.20
197398	149	ROSSON WHEEL SERVICE	3/2/2018	135.00
197399	1058	ROY'S UPHOLSTERY	3/2/2018	95.00
197400	496	ROYAL SIGN AND GRAPHIC INC	3/2/2018	310.00
197401	84	SADLER PAPER COMPANY	3/2/2018	702.12
197402	3024	SCOTT CROW	3/2/2018	39.00
197403	209	SIGNS FOR THE TIMES	3/2/2018	1,540.00
197404	3739	SLAPE, INETTE	3/2/2018	126.00
197405	92	STUART C IRBY CO	3/2/2018	837.78
197406	212	SUNSET CHEMICAL COMPANY	3/2/2018	200.00
197407	93	SUPERIOR LINEN SERVICE INC	3/2/2018	241.73
197408	3868	SUREEXPRESS	3/2/2018	100.00
197409	3024	TARA MOUTRAY	3/2/2018	89.39
197410	94	TECHNICAL PROGRAMMING SERVICES	3/2/2018	2,408.57
197411	5353	THERIOT, TANNER C	3/2/2018	150.00
197412	2859	TOTAL RADIO INC	3/2/2018	1,195.70
197413	97	UNIFIRST HOLDINGS LP	3/2/2018	822.52
197414	572	USA BLUEBOOK	3/2/2018	243.74
197415	796	UTILITY SUPPLY CO	3/2/2018	300.00
197416	4789	IVORY L VANN	3/2/2018	75.00
197417	471	WALKER COMPANIES	3/2/2018	105.00
197418	335	WARREN CAT	3/2/2018	481.31
197419	215	WASTE MANAGEMENT OF OKLAHOMA I	3/2/2018	765.02
197420	717	WAYMAN, CINDY	3/2/2018	184.00
197421	329	WELDON PARTS - MUSKOGEE	3/2/2018	473.07
197422	4901	LAURA WICKIZER	3/2/2018	54.00
197423	121	CALE, PATRICK	3/2/2018	58.69
197424	121	CAVIN, TAMARA	3/2/2018	100.00

197425	121	CONARD, STACY	3/2/2018	51.85
197426	121	CROUCH, RAY	3/2/2018	47.13
197427	121	DIAMOND CREEK, LLC	3/2/2018	59.80
197428	121	GRADY, GARY LEE	3/2/2018	13.88
197429	121	LOFTON, SHANNA C	3/2/2018	65.00
197430	121	MOORE, LARRY W	3/2/2018	27.28
197431	121	MORGAN, BENNY LEON	3/2/2018	14.43
197432	121	ORKIN EXTERMINATING CO	3/2/2018	40.00
197433	121	PETTIT, JARAD	3/2/2018	68.50
197434	121	PETTIT, JAROD	3/2/2018	51.85
197435	121	SPURLOCK, DENNIS	3/2/2018	61.85
197436	11	B & J OIL CO INC	3/2/2018	82.40
197437	780	BG PRODUCTS INC	3/2/2018	3,511.20
197438	125	HERNANDEZ-MONTES, NANCY &	3/5/2018	135.41
197439	331	LORI PAULSON	3/5/2018	1,700.00
197440	2923	CLARENCE MCBRIDE	3/5/2018	27.00
197441	2923	DANNY DUPONT	3/5/2018	27.00
197442	2923	DANNY GABLE	3/5/2018	27.00
197443	2923	DONNIE BENNETT	3/5/2018	27.00
197444	2923	GORDON LEE	3/5/2018	27.00
197445	2923	HELEN HULL	3/5/2018	27.00
197446	2923	JACOB IRELAND	3/5/2018	27.00
197447	2923	JEFF GULLETT	3/5/2018	27.00
197448	2923	JOEL EVERETT	3/5/2018	27.00
197449	2923	JOHN HOOPER	3/5/2018	27.00
197450	2923	KEVIN WARLICK	3/5/2018	27.00
197451	2923	LESLIE ARNOLD	3/5/2018	27.00
197452	2923	NICHOLAS FRAZEE	3/5/2018	27.00
197453	2923	ROBERT DOBBS	3/5/2018	27.00
197454	2923	RODNEY FAITH	3/5/2018	27.00
197455	2923	STORMIE RICE	3/5/2018	27.00
197456	2923	SUSAN ROSS	3/5/2018	27.00
197457	2923	TARAH MOUTRAY	3/5/2018	27.00
197458	3024	KEVIN HAMMONS	3/5/2018	258.00
197459	3024	THOMAS HUDGENS	3/5/2018	108.00
197460	4468	BLUECROSS/BLUE SHIELD OF OK	03/05/2018	19,117.79
197461	121	BARNEY, MIRANDA J	3/7/2018	36.28
197462	121	BOWLIN AND ROLLIN, LLC	3/7/2018	9.47
197463	121	BRAVO, JAVIER	3/7/2018	100.00
197464	121	CALDWELL, MARY F	3/7/2018	18.13
197465	121	CAREY, LINDSEY M	3/7/2018	15.86
197466	121	CARTER, DEANDRIA M	3/7/2018	4.75
197467	121	CARTER, TAMIA	3/7/2018	20.69
197468	121	ELLER, JAMES R	3/7/2018	156.20
197469	121	EVANS, WENDY L	3/7/2018	14.86
197470	121	FIRESTONE, CRYSTAL L	3/7/2018	60.00
197471	121	HART, BARBARA R	3/7/2018	24.05

197472	121	HERRIMAN, WAYNE	3/7/2018	48.15
197473	121	HUDSON, PAULA A	3/7/2018	7.87
197474	121	INHOFE LAND & CATTLE	3/7/2018	2.44
197475	121	JOHNSON, TERESSA M	3/7/2018	38.40
197476	121	JRC SELF STORAGE	3/7/2018	22.61
197477	121	LANDRUM, TYLER M	3/7/2018	55.50
197478	121	LINDSEY, JOSEPH LELSIE	3/7/2018	9.40
197479	121	MCLAIN, SARAH R	3/7/2018	57.58
197480	121	MEYER, DAN	3/7/2018	54.81
197481	121	MILES, DEREK EUGENE	3/7/2018	4.00
197482	121	MORIN, STEPHEN ANTHONY	3/7/2018	34.64
197483	121	PALMER, KAY	3/7/2018	9.62
197484	121	PAYTON, GREG	3/7/2018	1.28
197485	121	PETTIT, JAROD	3/7/2018	64.05
197486	121	PETTIT, JARROD	3/7/2018	56.28
197487	121	PETTIT, JARROD	3/7/2018	8.30
197488	121	POOR, BRANDI RENEE	3/7/2018	24.01
197489	121	RHYNE, JUDY	3/7/2018	48.70
197490	121	RIDDLE, ROBERT F	3/7/2018	17.18
197491	121	SCHEULEN, PHILLIP W	3/7/2018	16.08
197492	121	SELLERS, KATIE DANYELL	3/7/2018	7.49
197493	121	SPURLOCK, DENNIS	3/7/2018	40.73
197494	121	SPURLOCK, DENNIS R	3/7/2018	54.05
197495	121	STATON, SUE	3/7/2018	60.00
197496	121	WARDLOW, DONALD	3/7/2018	16.10
197497	121	WILLARD, JENNIFER Q	3/7/2018	31.48
197498	121	RITZ PKG STORE	3/8/2018	20.00
197499	3024	ABIGAIL WRIGHT	3/9/2018	12.00
197500	2	ACCURATE LABS & TRAINING CENTE	3/9/2018	860.00
197501	2713	ACTION GROUP STAFFING	3/9/2018	2,609.24
197502	2461	ADVANCE AUTO PARTS 64771111001	3/9/2018	1,150.73
197503	117	ALAN FOSTER	3/9/2018	100.00
197504	3990	ALL-IN-ONE SUPPLY LLC	3/9/2018	269.16
197505	6	AMERICAN INDUSTRIAL SUPPLY CO	3/9/2018	48.18
197506	158	ANCHOR AUTO GLASS	3/9/2018	75.00
197507	5166	ANIMAL MEDICAL CENTER #15597	3/9/2018	1,707.00
197508	4612	AT&T MOBILITY #918-577-2585 (C	3/9/2018	22.31
197509	52	AUFFENBERG CHEVROLET CADILLAC	3/9/2018	107.39
197510	11	B & J OIL CO INC	3/9/2018	16,298.06
197511	3746	B & R ELECTRIC SERVICE INC	3/9/2018	750.00
197512	4361	BANCFIRST	3/9/2018	13,125.00
197513	5032	BENNETT MACHINE WORKS LLC	3/9/2018	1,000.00
197514	2905	BETTY OUTHIER WILLIAMS LAW OFF	3/9/2018	35.00
197515	2072	BRAINERD CHEMICAL COMPANY INC	3/9/2018	4,680.00
197516	3669	BRANT & ASSOCIATES	3/9/2018	846.06
197517	3238	BROKEN ARROW ELECTRIC	3/9/2018	126.54
197518	2552	BROWN'S SHOE FIT CO #87	3/9/2018	115.00

197519	3912	BURTON POOLS AND SPAS, LLC	3/9/2018	225.00
197520	586	CAGLE'S FLOWERS & GIFTS	3/9/2018	227.80
197521	117	CALVIN BRAY	3/9/2018	71.50
197522	294	CDW GOVERNMENT INC	3/9/2018	1,683.57
197523	820	CHIEF FIRE & SAFETY	3/9/2018	309.00
197524	3024	CHRIS CUMMINGS	3/9/2018	107.47
197525	117	CHRISTON WARD	3/9/2018	60.00
197526	4738	CITYWIDE PROPERTY MAINTENANCE	3/9/2018	3,030.00
197527	1650	CORAL SWIMMING POOL SUPPLY CO	3/9/2018	84.50
197528	4418	CROP PRODUCTION SERVICES	3/9/2018	3,690.00
197529	101	CROWL OIL CO INC	3/9/2018	15,358.02
197530	3455	D & F SERVICES LLC	3/9/2018	1,000.00
197531	4311	DAVID'S DISCOUNT TIRES INC	3/9/2018	185.76
197532	25	DEALERS ELECTRICAL SUPPLY	3/9/2018	100.08
197533	26	DELL MARKETING LP	3/9/2018	12,058.24
197534	4263	DIRECTV LLC	3/9/2018	77.99
197535	3991	DIRT WORK DONE RIGHT	3/9/2018	4,295.00
197536	953	EXPRESS EMPLOYMENT PROFESSIONA	3/9/2018	507.65
197537	29	FASTENAL COMPANY	3/9/2018	624.60
197538	884	FERGUSON ENTERPRISES INC	3/9/2018	692.39
197539	678	FISHER SCIENTIFIC COMPANY LLC	3/9/2018	144.69
197540	133	FIVE STAR OFFICE SUPPLY	3/9/2018	187.39
197541	3509	FLEETPRIDE INC	3/9/2018	0.00
197542	4644	ANDRAE FREEMAN	3/9/2018	400.00
197543	3024	GARY REASNOR	3/9/2018	366.00
197544	5328	GLOBAL ENERGY SOLUTIONS, LLC	3/9/2018	1,052.48
197545	34	GRAINGER	3/9/2018	3,516.65
197546	337	HACH COMPANY	3/9/2018	1,017.04
197547	4955	ALLANTE' HALL	3/9/2018	157.50
197548	1793	HARBOR FREIGHT TOOLS	3/9/2018	139.99
197549	40	HARRISON TIRE & SUPPLY	3/9/2018	10.00
197550	554	HAYNES EQUIPMENT COMPANY	3/9/2018	1,630.28
197551	4902	IMPERIAL LLC	3/9/2018	70.60
197552	779	JOHN DEERE FINANCIAL F.S.B.	3/9/2018	79.62
197553	3109	THE JOURNAL RECORD PUBLISHING	3/9/2018	40.00
197554	3024	KAREN COKER	3/9/2018	12.00
197555	125	KIMBRA THOMAS	3/9/2018	25.00
197556	4537	KINSER MARINE REPAIR	3/9/2018	51.00
197557	5324	KYLE EDWARDS AUTO GROUP	3/9/2018	140.02
197558	53	LAKE REGION ELECTRIC COOPERATI	3/9/2018	637.00
197559	369	LAKELAND FLORIST	3/9/2018	212.00
197560	964	LOVE BOTTLING CO - #111902	3/9/2018	44.20
197561	56	LOWES	3/9/2018	0.00
197562	56	LOWES	3/9/2018	2,390.07
197563	2967	MAIN STREET MUSKOGEE, INC	3/9/2018	10,000.00
197564	5363	MAYHUGH, AARON DBA GREEN COUNT	3/9/2018	1,718.00
197565	194	MORGAN SERVICES COMPANY LLC	3/9/2018	100.00

197566	3591	MOSAIC CROP NUTRITION LLC	3/9/2018	6,294.72
197567	921	MOTION INDUSTRIES INC	3/9/2018	742.87
197568	508	MUNICIPAL CODE CORPORATION	3/9/2018	4,523.00
197569	1992	MUNICIPALH2O.COM	3/9/2018	125.00
197570	5195	MUSCOGEE STAFFING SOLUTIONS, L	3/9/2018	157.50
197571	110	MUSKOGEE CHAMBER OF COMMERCE	3/9/2018	51,541.66
197572	195	MUSKOGEE COUNTY CLERK	3/9/2018	39.00
197573	304	MUSKOGEE COUNTY EMS	3/9/2018	52.00
197574	63	MUSKOGEE DAILY PHOENIX	3/9/2018	0.00
197575	1696	MUSKOGEE READY MIX LLC	3/9/2018	170.00
197576	5182	NATIONAL SAFETY COUNCIL	3/9/2018	681.56
197577	495	NEWARK CORPORATION DBA	3/9/2018	43.66
197578	3652	NEWTON EQUIPMENT LLC	3/9/2018	43.14
197579	1944	OFFICE CONNECTIONS LLC	3/9/2018	586.26
197580	114	OFFICE DEPOT	3/9/2018	617.75
197581	521	OKLAHOMA CORRECTIONAL INDUSTRI	3/9/2018	2,005.15
197582	272	OKLAHOMA MUNICIPAL LEAGUE	3/9/2018	85.00
197583	272	OKLAHOMA MUNICIPAL LEAGUE	3/9/2018	0.00
197584	67	OKLAHOMA NATURAL GAS	3/9/2018	3,140.44
197585	2763	ONE SOURCE WATER LLC	3/9/2018	167.50
197586	70	OREILLY AUTO PARTS	3/9/2018	2,660.33
197587	978	PALMER CAP-CHUR & EQUIPMENT IN	3/9/2018	208.33
197588	73	PATE INDUSTRIAL SUPPLY INC	3/9/2018	838.51
197589	3578	PIED PIPER SERVICES	3/9/2018	846.00
197590	3420	RIVERSIDE AUTOPLEX OF MUSKOGEE	3/9/2018	1,570.80
197591	3024	RON BLADEN	3/9/2018	12.00
197592	4621	RON DRAKE CONSULTING LLC	3/9/2018	3,000.00
197593	149	ROSSON WHEEL SERVICE	3/9/2018	50.00
197594	2616	ROYSE PRINTING CO	3/9/2018	275.00
197595	84	SADLER PAPER COMPANY	3/9/2018	2,809.15
197596	2503	SAFETY FIRE EXTINGUISHERS	3/9/2018	1,188.40
197597	435	SAFETY-KLEEN SYSTEMS INC	3/9/2018	222.44
197598	117	SCOTT CROW	3/9/2018	39.82
197599	3954	SCOTT-MERRIMAN INC	3/9/2018	1,494.15
197600	92	STUART C IRBY CO	3/9/2018	767.42
197601	94	TECHNICAL PROGRAMMING SERVICES	3/9/2018	2,229.42
197602	108	THREE RIVERS MUSEUM	3/9/2018	4,166.66
197603	4572	TRANSUNION RISK & ALTERNATIVE	3/9/2018	111.00
197604	3636	TYLER TECHNOLOGIES INC	3/9/2018	400.00
197605	97	UNIFIRST HOLDINGS LP	3/9/2018	1,173.05
197606	4166	UNIVAR USA INC	3/9/2018	718.50
197607	3386	UTILITY TECHNOLOGY SERVICES IN	3/9/2018	19,612.27
197608	4525	ELIVATE	3/9/2018	447.94
197609	4978	WHATEVER IT TAKES	3/9/2018	208.00
197610	399	LOCKE SUPPLY CO	3/9/2018	5.05
197611	29	FASTENAL COMPANY	3/9/2018	104.14
197612	3509	FLEETPRIDE INC	3/9/2018	109.78

197613	117	GARY GARVIN	3/9/2018	347.51
197614	3024	CHAD FARMER	3/12/2018	128.00
197615	3024	REX ESKRIDGE	3/12/2018	108.00
197616	2923	TIM DOERNER	3/12/2018	27.00
197617	2325	UNITED FORD FLEET & COMMERCIAL	3/12/2018	49.54
197618	5272	BURLEY, BRANDON DBA LAZY B FLO	3/13/2018	250.00
197619	4468	BLUECROSS/BLUE SHIELD OF OK	3/13/2018	54,786.45
197620	121	ABIDING LIFE FELLOWSHIP	3/14/2018	50.00
197621	121	ALL CLEAN	3/14/2018	60.20
197622	121	ARANT, MARK E	3/14/2018	109.99
197623	121	BOWLIN & ROLLIN, LLC	3/14/2018	46.47
197624	121	C D BROWN CONSTRUCTION	3/14/2018	887.48
197625	121	DICK'S SPORTING GOODS	3/14/2018	2.83
197626	121	DOKE HOLDINGS	3/14/2018	57.03
197627	121	DOKE HOLDINGS, LLC	3/14/2018	90.00
197628	121	GRAY, VIRGIL ALVIN WAYNE	3/14/2018	0.18
197629	121	GREAT LIFE INVESTMENTS	3/14/2018	50.92
197630	121	LUNDBERG, FRANCIS L	3/14/2018	36.73
197631	121	PALMER, KAY	3/14/2018	4.42
197632	121	SCOTT, TERESA	3/14/2018	40.04
197633	121	SHIMP, REBEKAH	3/14/2018	62.29
197634	121	SWEET BERRIES	3/14/2018	48.15
197635	121	THRESHOLD ENTERPRISES	3/14/2018	51.48
197636	121	UNIVERSAL STEEL CONTRACTORS, L	3/14/2018	40.31
197637	121	VANDIVER, DELORES A	3/14/2018	34.04
197638	121	WOODSON, GARY	3/14/2018	42.07
197639	331	AMY RILEY-START UP FOR CIVIC CENTER	3/14/2018	5,000.00
197640	3024	DAN HURD	3/14/2018	497.00
197641	3024	GARY GARVIN	3/14/2018	297.00
197642	3024	LINDY BROWN	3/14/2018	374.00
197643	117	REGGIE COTTON	3/14/2018	465.00
197644	3024	REGGIE COTTON	3/14/2018	266.00

DRAFT

The City of Muskogee encourages participation from all its citizens in public meetings. If participation is not possible due to a disability, notify the City Clerk, in writing, at least forty-eight hours prior to the scheduled meeting and necessary accommodations will be made (ADA 28 CFR/36).

PURCHASING COMMITTEE AGENDA

CITY OF MUSKOGEE

March 19, 2018

CITY HALL 2ND FLOOR CONFERENCE ROOM, 5:00 P.M.

1. Consider approval of Purchasing Committee Minutes March 5, 2018.

2. Consider approval of claims for all city departments March 1, 2018 through March 14, 2018.

Regular City Council **2.**

Meeting Date:	03/26/2018		
Submitted For:	Greg Riley, Public Works	Initiator:	Christy Byrd, Office Administrator I
Department:	Public Works		
Staff Information Source:	Greg Riley, Director of Public Works; George Kingston, Assistant Public Works Director-Utilities, Stephen Morton, Water Plant Superintendent, Donnie Wimbley, Purchasing Director		

Information

AGENDA ITEM TITLE:

Approval of accepting the lowest, best bid for chemical pump to Haynes Equipment in the amount of $51,141.00, or take other necessary action. (Greg Riley)

BACKGROUND:

Bids were received for chemical pumps for the water treatment plant. After review of the bids we believe that Haynes Equipment was the best bid, and offers the most cost effective service overall. Brenntag Southwest was slightly lower, but their bid packet was incomplete as it did not include a bid bond. Also, the installation aspect of the job could get rather expensive, per their bid. Anything over a one (1) day install incurs a $3000.00 per day charge. It is likely to take longer than one (1) day to install. The other bids were much higher than the two (2) previously mentioned companies. The MMA budgeted $52,000.00 this year for this purchase.

Bids were as follows:
Haynes Equipment- $51,141.00
Brenntag Southwest- $49,500.00
JCI- $65,000.00
Hawkins- $92,918.00

RECOMMENDED ACTION:

Approve awarding the chemical pump bid to Haynes Equipment in the bid amount of $51,141.00.

Fiscal Impact

Attachments

Chemical pump bid

Tabulation Sheet

City of Muskogee

Bid Item: Chemical Feed Pumps & Skid

Date: 1/24/2018

Department: Water Plant

Approved by Purchasing: _____

Approved by City Council: _____

Vendors	PRICE	BONDS					
Haynes Equipment	51,141.00	yes					
Hawkins	92,918.00	yes					
Brenntag Southwest	49,500.00	no					
JCI	65,000.00	Rejected	Emailed				

Witnessed by:

Russ Audis

Tim DeLozier

Stephen Webb

Approved by:

Regular City Council **3.**

Meeting Date: 03/26/2018
Submitted For: Mike Stewart, Assistant City Manager
Initiator: Drew Saffell, Airport Manager
Department: Assistant City Manager
Staff Information Source: Drew Saffell

Information

AGENDA ITEM TITLE:

Approval of the use of the Muskogee-Davis Regional Airport South Apron for the April 28, 2018, Touch-A-Truck event fundraiser for the Muskogee Public Library Youth Services Department, or take other necessary action. (Mike Stewart)

BACKGROUND:

Touch-A-Truck is a Muskogee Public Library Youth Services Department fundraiser which has been held at Muskogee-Davis Regional Airport for several years. This event takes place on April 28, 2018, and allows the area's youth to see and experience the many vehicles and equipment used by organizations and businesses throughout our City. This item has been approved by the Airport Board.

RECOMMENDED ACTION:

Approve the use of the Muskogee-Davis Regional Airport south apron for the April 28, 2018, Touch-A-Truck event fundraiser for the Muskogee Public Library Youth Services Department, or take other necessary action.

Fiscal Impact

Attachments

No file(s) attached.

Regular City Council **4.**

Meeting Date: 03/26/2018
Initiator: Ashley Wallace, Office Adm 1
Department: City Clerk
Staff Information Source:

Information

AGENDA ITEM TITLE:

Approval of the appointment of Councilor Ivory Vann to serve on the Purchasing Committee. (Mayor Bob Coburn)

BACKGROUND:

RECOMMENDED ACTION:

Fiscal Impact

Attachments

No file(s) attached.

Regular City Council **5.**

Meeting Date: 03/26/2018
Initiator: Tammy Tracy, City Clerk
Department: City Clerk
Staff Information Source:

Information

AGENDA ITEM TITLE:

Approval of the appointment of Councilor Derrick Reed as Chairman and Councilor Dan Hall as Vice-Chairman of the Finance Committee. (Mayor Bob Coburn)

BACKGROUND:

RECOMMENDED ACTION:

Fiscal Impact

Attachments

No file(s) attached.

Regular City Council **6.**

Meeting Date: 03/26/2018
Initiator: Tammy Tracy, City Clerk
Department: City Clerk
Staff Information Source:

Information

AGENDA ITEM TITLE:

Approval of the appointment of Councilor Wayne Johnson as Chairman and Councilor Marlon Coleman as Vice-Chairman of the Public Works Committee. (Mayor Bob Coburn)

BACKGROUND:

RECOMMENDED ACTION:

Fiscal Impact

Attachments

No file(s) attached.

Regular City Council **7.**

Meeting Date: 03/26/2018
Initiator: Tammy Tracy, City Clerk
Department: City Clerk
Staff Information Source:

Information

AGENDA ITEM TITLE:

Approval of the appointment of Blanca Lopez to serve a four (4) year term on the Parks and Recreation Board, beginning April 1, 2018, and ending March 31, 2022, replacing Jason George, or take other necessary action. (Councilor Ivory Vann)

BACKGROUND:

The appointment of Ms.Blanca Lopez is to fill the vacancy of Jason George. Ms. Lopez's term will be for a period of four (4) years.

RECOMMENDED ACTION:

Recommend approval.

Fiscal Impact

Attachments

Blanca Lopez

APPLICATION FOR APPOINTMENT TO A BOARD OR COMMISSION

CITY OF MUSKOGEE
CITY COUNCIL

APPLICATION FOR CITY COUNCIL APPOINTMENT TO A BOARD OR COMMISSION

Application Instructions:

- Complete the entire application form (copies of the form are acceptable).
- Applicants are strongly encouraged to attach a current resume or biography.
- Specifically list the names of the boards or commissions to which you are applying (multiple selections are allowed). Paperwork cannot be appropriately processed unless specific boards or commissions are listed.
- Return application along with your resume to:
  Office of the City Clerk, 229 W. Okmulgee, Muskogee, OK 74403 or by fax 918-684-6395.
- This form can be obtained electronically at http://www.cityofmuskogee.com, or by calling the City Clerk's Office at: (918) 684-6270.

Board(s) or Commission(s) for which you would like to be considered:
Parks board

Your Full Legal Name: Blanca Esther Lopez
Your Preferred Name: Blanca Lopez

Business Name: Muskogee Head Start
Home Address: 406 N. 15th St

Job Title/Employment Date: Family Advocate
City Zip: Muskogee, OK, 74401

Business Address: 301 N. 6th St
Ward: 1 2 3 4

Muskogee, OK, 74401
Home Phone: _____

Business Phone: 918-687-6611
Cell Phone: _____

Fax: _____
Home Email: _____

Business Email: _____

Are you registered to vote in City of Muskogee Elections? Yes (No)
Are you a citizen of the United States? (Yes) No

Personal Information:
The Mayor and Council desire a broad representation of backgrounds on boards and commissions.

Education (high school, name and location of college or university, year graduated, and degree):
Muskogee High School - gratuated May 2009

APPLICATION FOR APPOINTMENT TO A BOARD OR COMMISSION

Current employment (job description, employment date, supervisor):
Muskogee County Head Start - Oct 2012 - Present ;
Supervisor Melissa Sloan - 918-687-6611

Previous employment or experience:

Professional Licenses Held (if applicable):

Professional References (name, title, contact phone number):
Melissa Sloan - Family Service manager - 918-687-6611
Jenny McMann - Site Coordinator - 918-687-6611

Memberships in professional or civic organizations (please include offices held and dates of terms):

Military Service Record (including awards, decorations, etc.):

Have you ever been elected or appointed to any public office, board or commission in the City of Muskogee? (No) Yes (If yes, please list with dates served)

Do you currently hold a public office? Public offices include elected or appointed officials of a municipality (it does not have to be Muskogee it could be any town or city), elected or appointed official of any county or the state or federal government, are a trustee of a public trust, are employed by any entity as a police officer, fire fighter, deputy sheriff, assistant district attorney or similar position or the member of a school board or appointed official of a school system or any other public or similar position.
NO

Do you have any financial or other interests that might present a conflict of interest, or the appearance of such a conflict, if you were to be appointed to the position for which you have applied? (No) Yes (If yes, please explain)

APPLICATION FOR APPOINTMENT TO A BOARD OR COMMISSION

Please list any special interests or characteristics which might be important to serve on a Board or Commission:
I would like to be on the board because I want to be involved in the community and help my community in any way that I can.

RELEASE OF INFORMATION

I authorize the use of any information contained in the **APPOINTMENTS APPLICATION** to verify my statements made in the Application. I authorize my past employers, all references, and any other persons to answer all questions asked concerning my ability, character, reputation and previous education or employment record. I release all such persons from any liability or damages on a ccount of having furnished such information. I consent to such investigations as Tammy Tracy, City Clerk or her authorized representatives may make regarding law enforcement records and my general background.

I certify under penalty of perjury under the laws of the State of Oklahoma, that the above information is true, complete and correct to the best of my knowledge.

Signature of Nominee

3-4-18
Date

Submitted by the Mayor for approval by the City Council this _____ day of _____, 20___

Signature of Sponsor

Regular City Council			**8.**
Meeting Date:	03/26/2018		
Submitted For:	Roy Tucker, City Attorney	**Initiator:**	Roy Tucker, City Attorney
Department:	City Attorney		
Staff Information Source:			

Information

AGENDA ITEM TITLE:

Consider approval of the Trust Indenture of the Roxy Theater Community Trust; approval of Ordinance No. 4043-A, establishing, recognizing and accepting a beneficial interest in said Trust; approval of Resolution No. 2714, authorizing the transfer of the Roxy Theater from the City to be held in Trust for the benefit of the City; approving an Assignment Agreement between the City and the Trust assigning the Management Agreement of September 1, 2015 with Oxford Productions, Inc., or take other necessary action. (Roy D. Tucker)

BACKGROUND:

In Committee, the City Council unanimously approved creating a Roxy Theater Community Trust. Staff, along with Counsel for the Management Company, has prepared the following documents for adoption:

- Trust Indenture creating the Roxy Theater Community Trust
- Ordinance establishing the Trust
- Resolution directing the Theater be transferred by Deed of Trust to the Roxy Theater Community Trust
- Assignment of Management Agreement with Oxford Productions, Inc. to the Trust

RECOMMENDED ACTION:

Approve the Trust Indenture, Ordinance 4043-A, Resolution 2714, and Assignment of Roxy Management Agreement to the Trust.

Fiscal Impact

Attachments

Trust Indenture

4043-A 03-26-2019 PUBLIC TRUSTS

Proposed Resolution

Assignment of Management Agreement

TRUST INDENTURE
OF THE
ROXY THEATER COMMUNITY TRUST

KNOW ALL MEN BY THESE PRESENTS:

THAT THIS TRUST INDENTURE is executed this _____ day of _____, 2018, by the City Council of the City of Muskogee, Trustor, and by Bob Coburn, Jaime Stout, and Marlon Coleman, who shall be known as the Trustees of the Roxy Theater Community Trust, for the purpose of preserving and enhancing the historic Roxy Theater for the benefit of current and future generations of residents of the City of Muskogee.

NOW THEREFORE, WITNESSETH:

That in consideration of the payment by the Trustors to the Trustees the total sum of One Dollar ($1.00), receipt of which is hereby acknowledged, and of the mutual covenants herein set forth, and other valuable considerations, the said Trustees agree to hold, manage, invest, assign, convey, and distribute as herein provided, authorized and directed, such property as the Trustors or other persons may from time assign, transfer, convey, give, bequeath, devise or deliver to the Trust herein created or to the Trustees thereof,

TO HAVE AND TO HOLD such property and the proceeds, rents, profits, and increases thereof unto the said Trustees and their duly appointed successors and assigns, but nevertheless in trust, for the use and benefit of the residents of the City of Muskogee, Oklahoma hereinafter referred to collectively as the Beneficiary, and upon the following trusts, terms, and conditions herein stated.

ARTICLE I
CREATION OF TRUST

The undersigned Trustors, hereby create and establish a trust for the use and benefit of the Beneficiary, to finance, operate, construct and administer, hold, and/or receive and administer, for the public purpose, the Trust Estate hereinafter set forth, in the manner provided in this instrument, or in the absence of any applicable provision herein, in the manner now or hereafter provided by law, and under the provisions of Okla. Stat. Tit., 60 Secs. 176-180, as may be amended from time to time and any other applicable laws of the State of Oklahoma.

The undersigned Trustors hereby contract with the above-named persons and the latter, as individuals and as holders of public office, do hereby declare and covenant, between themselves and unto the Trustors, the State of Oklahoma and the Beneficiary hereinafter described, that they and their successors do and will accept the rights, privileges, duties, and responsibilities of the office of Trustee within this Trust.

ARTICLE II
NAME

A. The name of this Trust shall be, and the Trustees thereof in their respective fiduciary capacity shall be designated as:

Roxy Theater Community Trust

Under that name, the Trustees shall, so far as practical, conduct all business and execute all instruments in writing, and otherwise perform their duties and functions in the execution of this Trust.

B. Any references to "Trust" or "Trustees" shall mean the said Roxy Theater Community Trust or the Trustees thereof.

C. Any references to "Theater," shall mean the said Roxy Theater.

ARTICLE III
PURPOSE

The purpose of this trust, for and on behalf of the Beneficiary as hereinafter described, are:

A. To encourage the involvement and cooperation of all interested individuals and community groups for the efficient operation of the Theater; to establish, encourage and further the mission and vision of the Theater; to provide for record-keeping by the Trust and for audits of the utilization of the funds provided for the operation of the Theater; to provide for the storage of records of the Trust's activities and for such office spaces as may be required for trust meetings, to provide for the ongoing management, maintenance, upkeep, development, and growth of the Theater;

B. To hold maintain and administer any leasehold rights in and to properties of the Beneficiary demised to the Trustees, and to comply with the terms and conditions of any lease providing said rights; to acquire by lease, purchase, or otherwise, and to hold, construct, reconstruct, extend, install, equip, repair, enlarge, remodel, furnish, maintain, and operate or otherwise deal with any and all physical properties, real or personal, improvements, building, and other facilities whether within or without the territorial boundaries of the Beneficiary, which may be helpful, needful, or convenient for utilization in executing or promoting the general purposes of the Trust and the area; to lease, rent, furnish, provide, relinquish, sell, or otherwise dispose of, or otherwise make provision for, any or all of the Trust purposes of in the event that any such property of facility shall no longer be needful for such purposes;

C. To provide and administer funds for the cost of financing, acquiring, constructing, installation, equipping, repairing, remodeling, improving, extending, enlarging, maintaining, operating, administering, and disposing, of or otherwise dealing with any of

the said physical properties and facilities, and for administrating the Trust for any or all of the said Trust purposes, and for all other charges, costs and expenses incidental thereto; and in so doing to incur indebtedness, either unsecured or secured by any part or parts of the Trust Estate and/or revenues thereof as allowed by law;

D. To expend all funds coming into the hands of the Trustees, as revenue or otherwise, in payment of the said costs and expenses, and in the payment of any indebtedness incurred by the Trustees for the purposes specified herein, and in the payment of any debt or obligation properly chargeable against the Trust Estate, and to distribute the residue and remainder of such funds to the Beneficiary for the payment of all or any part of the principal and/or interest of any bonded indebtedness of the Beneficiary and/or one or more authorized purposes of the Beneficiary as shall be specified by the Trustees.

This Trust shall have duration for the term of duration of the Beneficiary and/or until such time as the Trust's purposes shall have been fully executed and fulfilled or until it shall be terminated as herein provided.

ARTICLE V
TRUST ESTATE

The Trust Estate shall consist of:

A. The funds and property presently in the hand of the Trustees or to be acquired or constructed by the Trustees and dedicated or funded by the Trustor and others to be used for Trust purposes;

B. Any and all leasehold rights demised to the Trustees by the Beneficiary as authorized and empowered by laws of the State of Oklahoma;

C. Any and all monies provided to the Trust by the Beneficiary, or by grant, donation, income or other legal funding source.

D. Any and all property, (real, personal or mixed), rights, chose in action, contracts, leases, privileges, immunities, licenses, franchises, benefits, and all other things of value (whether or not above described) presently in or hereafter coming into hands or control of the Trustees, pursuant to the provisions of this Trust Indenture or by virtue of the Trusteeship herein declared or otherwise by the laws of the State of Oklahoma.

ARTICLE VI
TRUSTEES

A. The Trustees of this Trust shall be the citizens and residents of the Beneficiary. There shall be not less than three (3), nor a maximum of nine (9) Trustees selected by a majority of the City Council pursuant to nomination and confirmation methods effective at the time of the appointment. The original Trustees of this Trust shall be composed of the individuals who were selected as set forth in paragraph one of this Trust Indenture. The

City Manager of the City, and his successor, or at his option, his designee, shall serve as an ex-officio, non-voting Trustee. Each successor Trustee in office so appointed and confirmed, upon vacancy by the original trustee, shall without any further act, deed or conveyance become a Trustee of this Trust and become fully vested with all of the estate, properties, rights, powers, duties, and obligations of his or her predecessor with like effects as if originally named Trustee herein. The duration of all terms of the Trustees shall be established pursuant to a set of Bylaws adopted in accordance with Article VII, paragraph J.

B. Until the first meeting of the Trustees, the chairperson of the Trust shall be Jaime Stout. Thereafter, the Chairman of the Trustees shall be elected, and then annually by a majority vote of the Trustees. The Chairman of the Trustees shall preside at all meetings and perform other duties designated by a majority of the Trustees. At the first meeting of the Trustees, the Trustees shall select one or more of their members to be a Vice-Chairman who shall act in the place of the Chairman during the latter's absence or incapability to act as Chairperson.

C. Beginning at the first meeting of the Trustees, the Trustees shall elect annually, by majority vote of the Trustees, one or more of their members to be Secretary. The Secretary shall keep minutes of all meetings of the Trustees and shall maintain complete and accurate records of all their financial transactions, and all such minutes, books, and records shall be on file in the office of the Trust. The Trustees may elect Assistant Secretaries who may or may not be Trustees. The Assistant Secretary or Secretaries shall act in the place of the Secretary during the latter's absence or incapability to act.

D. Beginning at the Trustee's first meeting, and annually thereafter, the Trustees, by majority vote, shall elect a Treasure of the Trust who may or may not be a Trustee.

E. The Trustees may appoint a general manager for the Trust Estate and may, at their discretion, employ such other clerical, professional, legal, and technical assistance as may be deemed necessary in the discretion of the Trustees to properly operate the business of the Trust Estate, and may upon majority vote, fix their duties, terms of employment and compensation. All Trustees shall serve without compensation but may, upon majority approval from the Trustees, be reimbursed for reasonable expenses incurred in the performance of their duties hereunder. In the event a general manager is appointed by the Trustees, the said general manager shall administer the business of the Trust Estates as directed from time to time by the Trustees. The general manager shall assume responsibility for the employment of any subordinate employees of the Trust as necessitated by the needs of the Trust.

F. The Trustees are authorized to contract, in connection with the incurring of any funded indebtedness secured by the Trust Estate and/or its revenues, or any part of either or both, that in the event of a default in the fulfillment of any contract obligation undertaken on behalf of the Trust Estate, or in the payment of any indebtedness incurred on behalf of the Trust Estate, then a temporary trustee or trustees or receiver shall be appointed to succeed to the rights, powers, and duties of the Trustee then in office. Any such contract, if made,

shall set out terms and conditions under which such a temporary trustee or trustees or receiver shall be appointed and shall operate the Trust Estate, and provide for compensation to be paid, and provide for the said appointment(s) to be vacated and the permanent Trustees to be automatically reinstated upon the termination of all defaults by which the said appointment(s) was (were) authorized.

G. Bonds or other evidences of indebtedness to be issued by the Trustees shall not constitute any indebtedness of the State of Oklahoma, or of the Beneficiary, nor shall they be considered personal obligations of the Trustees of the Trust. Any such indebtedness shall constitute obligations of the Trustees as Trustees, payable solely from the Trust Estate.

H. The Trustees, the State of Oklahoma, and the Beneficiary hereof shall not be charged personally with any liability whatsoever by reason of any act or omission committed or suffered in good faith or in the exercise of their honest discretion on the performance of such Trust, or in the operation of the Trust Estate; but any act or liability for any omission or obligation of the Trustees on the execution of such Trust, or in the operation of the Trust Estate, shall extend to the whole of the Trust Estate or so much thereof as may be necessary to discharge such liability or obligation.

I. Notwithstanding any other provision of this Trust Indenture which shall appear to provide otherwise, no Trustee or Trustees shall have the power or authority to bind or obligate any other Trustee or the Beneficiary, in his or her or its capacity, nor can the Beneficiary bind or obligate the Trust or any individual Trustee.

J. All Trustees appointed hereunder shall qualify by executing written acceptances of all the terms of this instrument, filed in the office of the clerk of the City of Muskogee, and by subscribing and filing such oaths as shall be required by law of public officers of the State of Oklahoma.

K. The acceptance of the officers of Trustee of this Trust shall not constitute any agreement of the Trustees, or any of them, to be in any partnership or association each with the other, but each shall be an individual and wholly independent Trustee only.

L. All persons, firms, associates, trusteeships, corporations, municipalities, governments, and all agents, agencies, and instrumentalities thereof, contracting with any Trustee or Trustees shall take notice that all expenses and obligations, and all debts, damages, judgments, decrees or liabilities incurred by any Trustee or Trustees, and any of the foregoing incurred by agent, servant or employee of any such Trustee or Trustees, in the execution of the purposes of this Trust, whether arising from incident to, or growing out of the execution of this Trust, nor shall they, nor shall these, be liable for the acts or omission(s) of each other or any other such Trustee; PROVIDED, however, that the foregoing shall not apply to the individual Trustees for any willful or grossly negligent breach of trust of any said Trustee or Trustees.

M. All of the legal rights, powers, and duties of each Trustee shall terminate when he or she ceases to be a Trustee hereunder and all of such legal rights, powers, and duties shall

devolve upon his or her successor and successors, with full right and power of the later to do or perform any act or things which his or her predecessor could have done or performed.

ARTICLE VII
POWERS AND DUTIES OF TRUSTEES

Subject to and in full compliance with all requirements of law applicable to this Trust or to the Trustees thereof:

A. The Trustees, in the manner hereinafter set forth, shall do, or cause to be done, all things which are incidental, necessary, proper or convenient to carry fully into effect the purposes enumerated in Article III of this instrument, with the general authority hereby given and being intended to make effective the power of the Trustees under this instrument; and to effectuate the said purpose the Trustees are specifically authorized to conduct the following activities in a lawful manner (without excluding such other as may be authorized elsewhere in this Indenture or otherwise necessary to perform the required duties of Trustees):

1. To sue and be sued;

2. To enter onto and conduct and execute, apply for, purchase or otherwise acquire franchises, property (real or personal), contracts, leases, rights, privileges, benefits, chose in action, or other things of value, and to pay for the same in cash, with bonds or evidence of indebtedness, or otherwise, PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

3. To own, hold, manage, and in any manner to convey, lease, assign, liquidate, dispose of, compromise or realize upon any property, contract, franchise, lease, right, privilege, benefit, chose in action, or other thing of value, and to exercise any and all power necessary or convenient with respect to same, PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

4. To guarantee, acquire, hold, sell, transfer, assign, encumber, dispose of, and deal in the stocks, bonds, debentures, shares, or evidences of interest or indebtedness in or of any sovereignty, government, municipality, corporation, association, trusteeship, firm or individual, and to enter into and perform any lawful contract in relation thereto, and to exercise all rights and privileges in relation thereto, to the same extent as a natural person might or could do; and the foregoing shall include (without limitation by reason of enumeration), the power and authority to guarantee or assume, out of the distributive funds of the Trust, the payment of any part or all of the principal of and/or the interest on any bonded indebtedness;

5. To enter into, make and perform contracts of every lawful kind or character, including but not limited to management contracts, with any person, firm,

association, corporation, trusteeship, municipality, government, or sovereignty; and, without limit as to amount, to draw, make, accept, endorse, assume, guarantee, discount, execute, and issue, promissory notes, drafts, bills of exchange, acceptances, warrants, bonds, debentures, and any other negotiable or non-negotiable, or transferable or nontransferable, instruments, obligations, and evidences of secured or unsecured indebtedness, and if secured by all or any part or parts of the income of the Trust, in the same manner and to the same extent as a natural person might or could do; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

6. To promote contracts of every lawful kind of character, including but not limited to management contracts, with any person, firm, association, corporation, trusteeship, municipality, government, or sovereignty; and, without limit as to amount, to draw, make, accept, endorse, assume, guarantee, discount, execute, and issue promissory notes, drafts, bills of exchange, acceptances, warrants, bonds, debentures, and any other negotiable or non-negotiable, transferable or non-transferable, instruments, obligations, and evidence of secured or unsecured indebtedness, and if secured by mortgage, deed if trust, or otherwise, then secured by all or any part of the income of the Trust; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

7. To exercise all powers authorized under Title 60 of the Oklahoma Statutes, including such powers as may be authorized by subsequent amendments to the said Title.

B. The Trustees shall collect and receive all property, money, rents, and income of all kinds belonging to or due the Trust Estate and shall use all of the same solely for the purposes, and the furtherance of the purpose, set forth on Article III of this instrument, and otherwise. Without limiting the foregoing provisions of this paragraph, none of the net earnings or income derived from or accruing to the Trust Estate, nor any part of the Trust, in any instance beyond that necessary to pay the principal of and interest on the indebtedness incurred for purposes set forth in Article III of this instrument and to pay the costs and expenses of the implementation of the said purposes, shall insure to the benefit of any person or entity other than the Beneficiary.

C. The Trustees shall take and hold title to all property at any time belonging to the Trust in the name of the Trust and shall have and exercise exclusively the management and control of the same for the use and benefit of the Beneficiary as provided herein, in the execution of the purposes of this Trust; and the right of the Trustees to manage, control, and administer the said Trust and its property, assets and business shall be absolute and unconditional and free from any direction, control or management by the beneficiary; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

D. The Trustees may employ such agents, servants, and employees as they deem necessary, proper or convenient for the execution of the purposes of this Trust, and prescribe their

duties and fix their compensation, and may establish policies and procedures for hiring, position description, training, retention, supervision, compensation, benefits and any other related needs; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

E. The Trustees may contract for the furnishings of any services or the performances of any duties that the trustees deem necessary, proper or convenient to the execution of the purposes of this Trust, and shall pay for the same as they see fit to provide in such a contract; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees. Contracts for construction, labor, equipment, material or repairs in excess of $50,000.00 shall be let in accordance with 60 O.S. §176 (I), as may be amended from time to time; provided, in cases of an imminent emergency as defined by 60 O.S. §176(I), the Trustees may contract or otherwise make purchases, without notice or competitive bid, for goods and services not to exceed $75,000.

F. The Trustees, by Resolution, may divide the duties of the Trustees hereunder, delegating all or any part of such duties to one or another of the Trustees as they deem proper; but where a specific duty is not so delegated, a majority if the Trustees must act for the Trust. The Trustees are hereby authorized to adopt Bylaws and to change the same from time to time at any regular or special meeting of the Trustees at which at least two-thirds of the incumbent Trustees vote in favor of such amendment. PROVIDED, however, that the notice of any meeting at which an amendment to the Bylaws is to be made shall contain notice that such an amendment will be proposed, and the said notice shall be mailed to all Trustees at lease fifteen (15) days prior to the meeting. Bylaws may prescribe notice and quorum requirements for the meetings of the Trustees so long as the same does is not in conflict with the Oklahoma Open Meeting Act as set forth in Article VII section K of this indenture, the frequency of meetings, the duties of officers and any and all other matters normally prescribed by Bylaws consisted with the provisions of the Trust Indenture.

G. The Trustees shall in the name of the Trust hereinabove set forth or in their names as Trustees, bring any suit or action which in their judgment shall be necessary to properly protect the interest of the Trust or to enforce any claim, demand or contract for the Trust or for the benefit of the Trust; and they shall defend, in their discretion, any action or proceeding against the Trust or the Trustees or agents, servants or employees thereof; and the Trustees are expressly authorized, in their discretion, to bring, enter, prosecute or proceeding against the Trust or the Trustees or agents, servants or employees thereof; and the Trustees are expressly authorized, in their discretion, to bring, enter, prosecute or defend any action or proceeding in which the Trust shall be interested and to compromise and such action or proceeding, and discharge the same out of the Trust property and assets; and the Trustees also are expressly authorized to pay or transfer out of the Trust property or assets such money or property as shall be required to satisfy any judgment or decree rendered against them as Trustees, or against the Trust, together with all costs, including court costs, counsel and attorney fees, and also to pay out the Trust property and assets such sums of money, or transfer appropriate property or assets of the Trust, for the purpose of settling, compromising, or adjusting any claim, demand, controversy, action or proceedings, together with all costs and expenses connected therewith; and all

such expenditures and transfers shall be treated as proper expenses of executing the purposes of this Trust; PROVIDED, that no transaction shall be completed without the approval of a majority of the Trustees;

H. No bond shall be required of the Trustees, or any of them, unless they shall deem the same proper and shall provide therefore by Resolution.

I. All actions by the Trustees pursuant to the provisions of this Trust Indenture, except for the adoption and/or amendment of Bylaws provided above, shall be approved by the majority vote of at least a majority of the Trustees. All meetings of the Trustees shall be open to the public; all proceedings of the Trustees shall be in compliance with the laws of the State of Oklahoma and the Trustees shall make or cause to be made a written record of all their proceedings. All books, records and minutes of the Trust and of the meetings of the Trustees shall be considered to be public records and shall be available for inspection by any interested party during customary business hours in the same interested party during customary business hours in the same manner and under the same conditions as are public record of the Beneficiary.

J. At their first meeting, which shall occur within thirty (30) days of the execution of this Trust Indenture, the trustees shall designate the principal office of the Trust; and they also shall designate the time and place for regular meetings of the Trustees. The time and place for regular meetings shall not be changed unless at a meeting where all incumbent Trustees are present. No notice shall be required for the holding of a regular meeting of the Trustees other than such as is otherwise required by law. Special meetings may be held upon such call as shall be fixed by Resolution of the Trustees adopted at a meeting where all of the Trustees are present. The Trustees shall cause to be filed, in all places where this instrument is recorded, a certificate designating the principal office of the Trust and the time and place of regular meetings of the Trustees; and any changes therein shall be filed of record on the like manner. Within sixty (60) days of the first meeting, the Trustees shall adopt Bylaws for the governing of the Trust. The Trustees shall provide for an independent audit on an annual basis and set a date of the auditor to perform said audit. Said auditor shall be selected and employed from an affirmative vote of a majority of the Trustees. The Trustees shall ensure that financial documents and reports sufficient to demonstrate fiscal activity are filed annually with the City Clerk of the City of Muskogee.

K. The Trustees shall in all respect comply with the Open Meeting Act of the Statutes of the State of Oklahoma, Okla. Stat. Tit. 25, Secs. 301-314, and as amended or changed. Further the Trustees shall in all respects comply with the Oklahoma Open Records Act of the Statutes of the State of Oklahoma, Okla. Stat. Tit. 51, Secs. 24A.1 et seq.

ARTICLE VIII
BENEFICIARY

A. The term "Beneficiary" as used in this instrument, under and pursuant to Okla. Stat. Tit. 60, Secs. 176-180, inclusive as amended and supplemented, and other statutes of the State of Oklahoma presently in force and effect; shall denote the entity.

THE CITY OF MUSKOGEE, OKLAHOMA

Trustor now declares that this Trust Indenture shall not be subject to revocation, alteration, amendment, revision, or modification from and after the date indebtedness is incurred by the Trustees.

RESIDENTS OF THE CITY OF MUSKOGEE, OKLAHOMA

The Trustors now declare that this Trust Indenture shall not be subject to revocation, alteration, amendment, revision, or modification from and after the date that any indebtedness is incurred by the Trustees.

B. The Beneficiary shall have no legal claim or right to the corpus of the Trust Estate, or to any part thereof, against the Trustees or anyone holding under them; nor shall the Beneficiary, as such, have any authority, power, or right whatsoever to do or transact any business whatsoever for or on behalf of, or binding upon the Trustees or the Trust Estate; neither shall the Beneficiary have the right to control or direct the actions of the Trustees in respect of the Trust Estate, or any part thereof; nor shall the Beneficiary shall be entitled solely to the benefits of the Trust, as administered by the Trustees hereunder, and at the termination of the Trust, as provided herein, and then only, the Beneficiary shall receive the residue of the Trust Estate. Notwithstanding anything in the aforesaid appearing to be to the contrary, no provision in this instrument and/or of the Acceptance of the Beneficial Interests there under by the governing body of the said Beneficiary limiting, restricting, or denying any such be construed or interpreted, to effect a surrender, or to attempt to effect a surrender, of any of the sovereign governmental powers of the State of Oklahoma or of the Beneficiary; but any and all provisions of this Trust instrument are intended, and shall be applied, to relate solely and only to the proprietary rights and property interests of the said Beneficiary, in trust as distinguished from its sovereign governmental powers and authority. Moreover, it is further agreed that nothing contained in this Trust Indenture and/or in the Acceptance of the Beneficiary Interest there under shall be constructed, interpreted or applied as granting or intending to grant to the Trustees hereunder an exclusive franchise in relation to any powers, rights, or authority of the Trustees under this Trust Instrument.

ARTICLE IX
TERMINATION

A. This Trust shall become irrevocable upon the issuance of any debt by the Trustees and during the pendency of the same; provided, however, until such time as debt is incurred by the Trust, the Trust shall terminate upon any of the following conditions:

1. When the purpose set forth in Article III of this instrument shall have been fully executed and fulfilled as determined by the Trustees and concurred by the City Council of the City of Muskogee, State of Oklahoma;

2. In the event of the happening of any event or circumstance that would prevent the said purpose of this Trust from being executed and fulfilled as determined by the Trustees; PROVIDED, that all indebtedness of the Trust shall have been paid;

3. Upon an affirmative vote by a majority of the City Council of the City of Muskogee, as the elected representatives of the Beneficiary, that termination of this Trust is in the best interest of the citizens of the Beneficiary; PROVIDED, that all indebtedness of the Trust shall have been paid; or

4. In the manner provided by Okla. Stat. Tit., 60 Sec. 180; PROVIDED, however that all indebtedness of the Trust shall not be terminated by voluntary action if there be any outstanding indebtedness or fixed-term obligations of the Trustees, unless all owners of such indebtedness or obligations, or someone authorized by them so to do, shall have consented in writing to such termination.

B. Upon the termination of this Trust the Trustees shall proceed to wind up the affairs of the Trust and after payment of all debts and obligations of the Trust out of Trust assets, if any there be, to the Beneficiary hereunder as provided in Section III of this Instrument. Upon final distribution as aforesaid, the powers, duties, and authority of the Trustees hereunder shall cease.

ARTICLE X
PARTIAL INEFFECTIVENESS

The invalidity of ineffectiveness for any reason of any one or more words, phrases, clauses, paragraphs, sections, or subsections of this instrument shall not affect the remaining portions hereof so long as such remaining portions shall constitute upon its being valid and effective only, and this instrument shall be constructed as though such invalid or ineffective portion had not been inserted herein.

ARTICLE XI
COVENANT

The undersigned Trustees hereby accept the Trust herein created and agree to comply with all the provisions and requirements placed upon them by this Trust Indenture. The provisions hereof shall be binding upon the undersigned, their heirs, executors, administrators, and assigns:

IN WITNESS WHEREOF, the Trustors and the Trustees have hereunto set their hands, executing this Trust Indenture on this day of _____ day of _____, 2018.

_____ _____

John R. Coburn, Trustee Jaime Stout, Trustee

_____

Marlon Coleman, Trustee

STATE OF OKLAHOMA)
) SS
COUNTY OF MUSKOGEE)

Before me, the undersigned Notary Public in and for said state and county, on this _____ day of _____, 2018, personally did appear John R. Coburn, Jaime Stout, and Marlon Coleman, to me known to be the identical persons who executed the within and foregoing instrument and acknowledged to me that they executed the same as their free and voluntary act and deed for the uses and purposes therein set forth.

_____

Notary Public

Approval and Consent of Trustor

The City of Muskogee as Trustor of the Roxy Theater Community Trust hereby expressly approves and consents and agrees to the above and foregoing Trust Indenture, this _____ day of _____, 2018.

_____

John R. Coburn, Mayor

Attest:

_____

Tammy Tracy, City Clerk
(seal)

APPROVED as to form this _____ day of _____, 2018.

_____

Roy D. Tucker
City Attorney

ORDINANCE NO. 4043-A

AN ORDINANCE AMENDING THE CITY OF MUSKOGEE CODE OF ORDIANCES BY AMENDING CHAPTER 91, PUBLIC TRUSTS, ARTICLE I, ESTABLISHMENT AND RECOGNIZTION, BY ADDING A NEW SECTION 9-102, ROXY THEATER COMMUNITY TRUST; PROVIDING FOR CODIFICATION, REPEALER, AND SEVERABILITY.

BE IT ORDAINED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF MUSKOGEE, OKLAHOMA, AS FOLLOWS:

Section 1: Article 91 of the City of Muskogee Code of Ordinances is hereby amended by adding a new section as follows:

Section 91-102. – Roxy Theater Community Trust

The City Council of the City of Muskogee does hereby establish and recognize the Roxy Theater Community Trust.

Section 2: CODIFICATION. Section 91-102, Roxy Theater Community Trust, is hereby codified as Section 91-102, Roxy Theater Community Trust, of Chapter 91, Public Trusts, Article I, Establishment and Recognition of the City of Muskogee, Oklahoma Code of Ordinances.

Section 3: REPEALER. All ordinances or parts of ordinances in direct conflict herewith are hereby repealed to the extent of the conflict.

Section 4: SEVERABILITY. Should any section, subsection, sentence, provision, clause or phrase hereof be held invalid, void or unconstitutional for any reason, such holding shall not render invalid, void or unconstitutional any other section, subsection, sentence, provisions, clause or phrase of this ordinance, and the same are deemed severable for this purpose.

PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF MUSKOGEE, OKLAHOMA, THIS _____ DAY OF _____, 2018.

_____
JOHN R. COBURN, MAYOR

ATTEST:

_____
TAMMY L. TRACY, CITY CLERK

Approved as to form and legality, this _____ day of _____, 2018.

_____
ROY D. TUCKER, CITY ATTORNEY

RESOLUTION NO. 2714

A RESOLUTION AUTHORIZING THE TRANSFER OF CERTAIN REAL PROPERTY PRESENTLY IN THE POSSESSION OF THE CITY OF MUSKOGEE, GENERALLY DESCRIBED AS THE ROXY THEATER, TO THE ROXY THEATER COMMUNITY TRUST TO BE HELD IN TRUST, AND AUTHORIZING THE CITY MANAGER TO EXECUTE ALL DOCUMENTS RELATED TO THE TRANSFER OF SAID REAL PROPERTY.

WHEREAS, the City of Muskogee, Oklahoma has established the Roxy Theater Community Trust; and

WHEREAS, the City of Muskogee, Oklahoma has in its possession certain real property which the City Council had determined would be more beneficially held in Trust by the Roxy Theater Community Trust; and

WHEREAS, the City of Muskogee desires to transfer said real property into the corpus of the trust;

NOW, THEREFORE, BE IT RESOLVED BY THE MAYOR AND CITY COUNCIL OF THE CITY OF MUSKOGEE, OKLAHOMA:

Section 1: That property described as:

E6.33 LOT 6 & ALL LOT 7 & W9.66 LOT 8 BLOCK 5 of the Original Townsite

to the City of Muskogee, Muskogee County, Oklahoma, is hereby authorized to be transferred by properly executed Deed of Trust from the City of Muskogee, Oklahoma, to the Roxy Theater Community Trust, and City Council of the City of Muskogee hereby authorizes the City Manager to execute all documents related to the transfer of said real property.

PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF MUSKOGEE, OKLAHOMA, THIS _____ DAY OF _____, 2018.

_____
JOHN R COBURN, MAYOR

ATTEST:

_____
TAMMY L. TRACY, CITY CLERK

Approved as to form and legality, this _____ day of _____, 2018.

_____
ROY D. TUCKER, CITY ATTORNEY

ASSIGNMENT AGREEMENT

This ASSIGNMENT AGREEMENT ("Assignment Agreement") is entered into as of _____ day of _____, 2018, by and between the City of Muskogee, Oklahoma, a municipal corporation organized under the laws of the State of Oklahoma (the "Assignor"), and the Roxy Theater Community Trust, a public trust organized under the laws of the State of Oklahoma (the "Assignee").

WHEREAS, the Assignor wishes to transfer and assign to the Assignee all of the Assignor's rights and interests in and to, and obligations under, a Management Agreement between Assignor and Oxford Productions, Inc. (hereinafter, the "Manager") effective September 1, 2015, as it may be amended in accordance with its terms (hereinafter, the "Management Agreement"), and the Assignee wishes to be the assignee and transferee of such rights, interests and obligations;

WHEREAS, the Assignor may not assign any of its rights, interests or obligations under the Management Agreement, directly or indirectly, without the prior written approval of the Manager; and

WHEREAS, by its signature hereto, Manager provides its written approval to the assignment by the Assignor of all of its rights, interests and obligations in the Management Agreement to the Assignee.

NOW, THEREFORE, the parties hereto, intending to be legally bound, do hereby agree as follows:

1. Assignment and Assumption. The Assignor hereby transfers and assigns to the Assignee, and the Assignee hereby acquires from the Assignor all of the Assignor's rights, and interests in and to the Management Agreement, of whatever kind or nature, and the Assignee hereby assumes and agrees to perform all obligations, duties, liabilities and commitments of the Assignor under the Management Agreement, of whatever kind or nature.

2. Retention of Obligations. Notwithstanding anything in this Assignment Agreement to the contrary, the Assignor shall remain obligated, as a principal and not a guarantor, to Manager with respect to all of the Assignor's obligations, duties, liabilities and commitments under the Management Agreement, of whatever kind or nature.

3. Effectiveness. This Assignment Agreement shall be effective as of the date set first set forth above.

4. Governing Law; Binding Effect. This Assignment Agreement shall be governed by and construed in accordance with the laws of the State of Oklahoma applicable to contracts made and performed in such state without giving effect to the choice of law principles of such state that would require or permit the application of the laws of another jurisdiction.

5. Counterparts. This Assignment Agreement may be executed in one or more counterparts, including facsimile counterparts, each of which shall be deemed to be an original copy of this Assignment Agreement, and all of which, when taken together, shall be deemed to constitute one and the same agreement. Delivery of such counterparts by facsimile or electronic mail shall be deemed effective as manual delivery.

IN WITNESS WHEREOF, the Assignee and Assignor have executed this Assignment Agreement as of the date first set forth above.

ASSIGNEE:

ROXY THEATER COMMUNITY TRUST

By: _____
Name: _____
Title: _____

ASSIGNOR:

CITY OF MUSKOGEE

By: _____
Name: _____
Title: _____

MANAGER:

OXFORD PRODUCTIONS, INC.

By: _____
Name: _____
Title: _____

Approved as to form and legality on behalf of City of Muskogee on this ___ day of _____, 2018.

_____
Roy D. Tucker, City Attorney

Regular City Council **9.**

Meeting Date: 03/26/2018
Submitted For: Kelly Plunkett, Personnel
Initiator: Kelly Plunkett, Director of Human Resources
Department: Personnel
Staff Information Source: Kelly Plunkett

Information

AGENDA ITEM TITLE:

Receive update from NFP Corporate Services of Oklahoma on current plan savings, and consider approval of Resolution No. 2715 authorizing certain modifications to the medical plan benefits under the City of Muskogee Employee Benefit Plan, providing and directing said modifications be incorporated into the Plan Documents, Summary Plan Description and Benefit Summary Sheets, as well as, approval of Resolution No. 2716 approving and authorizing execution of the Mutual of Omaha renewal, the Blue Cross Blue Shield Exhibit to the Stop Loss Coverage Policy, the Blue Cross Blue Shield Administrative Services Agreement, the Blue Cross Blue Shield Benefits Program Application, the Blue Cross Blue Shield PBM Fee Schedule Addendum to the Benefit Program Application, and the HCSC COBRA Administrative Services Addendum, all to become effective on May 1, 2018, and authorizing the City Manager, or designee, to execute all documents, or take other necessary action. (Kelly Plunkett)

BACKGROUND:

The Employee Health Insurance Committee has met with NFP Corporate Services of Oklahoma to discuss plan savings and changes to the Employee Benefits Plan.

The insurance fund balance as of February 27, 2018, was $2,912,167.35; a decrease of $184,220.60 from March 13, 2017. For Plan year 2017/2018, numerous benefit changes were recommended and implemented due to the plan savings we have realized over the last several years. One of those changes was to reduce medical (only) premium contributions for the City and each employee tier by 13.97%; the Insurance Committee voted unanimously to continue the premium reduction or "premium holiday" for the 2018/2019 plan year due to the insurance fund balance. No other Plan changes that effect benefit value, deductibles or cost of service were recommended for Plan year 2018/2019; however, various plan modifications (plan language changes) will need to be implemented due to a change in law or network provider policy. Resolution has been drafted to continue the premium reduction or "premium holiday" and to accept other plan modifications required due to a change in law or network provider policy, where such modifications do not effect benefit value, deductibles or cost of service.

Stop-loss coverage (a layer of protection in cases where health insurance claims exceed a certain threshold—currently $100,000.00/participant) options were reviewed and continuation of the $100,000.00 stop-loss amount was discussed. In addition, our Mutual of Omaha (life insurance), BCBS Benefit Program Application and HCSC COBRA Administrative Services Addendum need to be renewed; therefore, a second resolution has been drafted to allow the City Manager, or designee to approve the following documents: Mutual of Omaha Renewal Information and Exhibits, Blue Cross Blue Shield Exhibit to the Stop Loss Coverage Policy, Blue Cross Blue Shield Administrative Services

Agreement, Blue Cross Blue Shield Benefit Program Application, Blue Cross Blue Shield PBM Fee Schedule Addendum to the BPA, and the HCSC COBRA Administrative Services Addendum, each effective May 1, 2018.

Changes to the Stop Loss Coverage document, Blue Cross Blue Shield Benefit Program Application, and the HCSC COBRA Administrative Services Addendum include:

A. Average claim value changed from $539.35 (per employee per month) for each employee/family coverage unit to $555.09 (per employee per month)
B. Maximum liability factor changed from $674.19 (per employee per month) for each employee/family coverage unit to $693.86 (per employee per month)
C. Aggregate point of attachment changed from $3,334,800.00 to $3,417,134.00.
D. Aggregate Stop Loss monthly premium rates increased from $2.50 for each employee coverage unit and $2.50 for each employee/family coverage unit to $2.72 for each employee coverage unit and $2.72 for each employee/family coverage
E. Individual stop loss monthly premium rates changed from $76.05 for each employee coverage unit and $76.05 for each employee/family coverage unit to $85.02 for each employee coverage unit and $85.02 for each employee/family coverage unit
F. Number of active members (subject to change based on enrollment)
G. Pharmacy Network changed to Traditional Select Network from Prescription Drug Card
H. Medical administration fee decreased from $37.25 per employee per month (composite-fee plus rebate credit for the Prescription Drug Program) to $33.70 per employee per month (composite-fee plus rebate credit for the Prescription Drug Program)
I. Administrative fees decreased from $55.75 per employee per month to $52.20 per employee per month (fee plus rebate credit for the Prescription Drug Program plus commissions)
J. Medical run-off administration charge changed from $45.88 per employee per month to $52.64 per employee per month

Tentatively, open enrollment and education meetings for all employees have been scheduled for April 10-13; however, the open enrollment period will be held April 1-30, as required.

RECOMMENDED ACTION:

Recommend approval of a resolution authorizing certain modifications to the medical plan benefits under the City of Muskogee Employee Benefit Plan, providing and directing said modifications be incorporated into the Plan Documents, Summary Plan Description and Benefit Summary Sheets, as well as, approve resolution approving and authorizing execution of the Mutual of Omaha renewal, the Blue Cross Blue Shield Exhibit to the Stop Loss Coverage Policy, the Blue Cross Blue Shield Administrative Services Agreement, the Blue Cross Blue Shield Benefits Program Application, the Blue Cross Blue Shield PBM Fee Schedule Addendum to the Benefit Program Application, and the HCSC COBRA Administrative Services Addendum, all to become effective on May 1, 2018, and authorizing the City Manager, or designee, to execute all documents, or take other necessary action. (Kelly Plunkett)

Fiscal Impact

Attachments

2715 RES 03-26-2018 Employee Benefit Modifications

2716 RES 03-26-2018 Contracts

Dental Renewal

Mutual of Omaha

Stop Loss

Administrative Services Agreement
Benefits Program Application
Fee Schedule Addendum
Cobra Addendum
Medical Renewal

RESOLUTION NO. 2715

A RESOLUTION AUTHORIZING CERTAIN MODIFICATIONS TO THE MEDICAL, DENTAL AND VISION BENEFITS UNDER THE CITY OF MUSKOGEE EMPLOYEE BENEFIT PLAN, PROVIDING AND DIRECTING SAID MODIFICATIONS BE INCORPORATED INTO THE PLAN DOCUMENTS, SUMMARY PLAN DESCRIPTION AND BENEFIT SUMMARY SHEETS EFFECTIVE MAY 1, 2018, AND AUTHORIZING THE CITY MANAGER, OR DESIGNEE, TO EXECUTE ALL DOCUMENTS.

WHEREAS, the City of Muskogee, through brokerage services of NFP Corporate Services of Oklahoma ("Consultant"), Third Party Administrator services through Blue Cross and Blue Shield ("TPA") and VSP ("Vision Service Provider"), and Contractual services through CareATC ("Clinic") to provide said services;

WHEREAS, upon recommendation of the Consultant, the City of Muskogee's Insurance Committee reviewed the City's current Employee Benefit Plan Documents and Summary Plan Description for compliance with the Patient Protection and Affordable Care Act, 42 U.S.C. §18001 et seq., and benefits industry best practices;

WHEREAS, the Insurance Committee has hereby issued certain recommendations to modify and address evolving changes of law that effect plan compliance;

WHEREAS, the City of Muskogee finds that the recommended modifications of the City of Muskogee Employee Benefit Plans are in the best interest of the City, and for a governmental purpose.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MUSKOGEE, MUSKOGEE COUNTY, OKLAHOMA:

Section 1. The City Council of the City of Muskogee approves the recommended modifications of the medical, dental and vision benefits under the City of Muskogee Employee Benefit Plan and directs the same to be incorporated into the Plan Documents, applicable Summary Plan Description and Benefit Summary Sheets:

A. Continue the previous year's reduction from the general fund to the medical plan (only) of 13.97% from $7,157.54/year to $6,157.54/year for May 1, 2018 through April 30, 2019. Dental and vision contributions will remain unchanged.
B. Continue the reduction of employee medical (only) premiums of 13.97% on each employee dependent tier level, for May 1, 2018 through April 30, 2019 as follows:
    -Employee & Spouse: $3,248.03/year
    -Employee & Child: $2,170.35/year
    -Employee & 2+Children: $2,548.59/year

-Employee, Spouse & Child: $3,626.27/year
-Employee, Spouse & Children: $3,895.80/year

Dental and vision contributions will remain unchanged.

C. Continue the reduction of retiree medical (only) premiums of 13.97% for May 1, 2018 through April 30, 2019 as follows:
-Employee: $6,157.54/year
-Employee & Spouse: $3,248.03/year
-Employee & Child: $2,170.35/year
-Employee & 2+Children: $2,548.59/year
-Employee, Spouse & Child: $3,626.27/year
-Employee, Spouse & Children: $3,895.80/year

Dental and vision contributions will remain unchanged.

D. Other plan modifications required due to a change in law or network provider policy, where such modifications do not effect benefit value, deductibles or cost of service.

Section 2. The City Council of the City of Muskogee does hereby authorize the City Manager, or designee, upon review and approval of the City Attorney in accordance with Council Policy 2-1, to execute revised City of Muskogee Benefit Plan Documents and Summary Plan Description, requiring the same to be in compliance, as presented to the City Council on March 26, 2018 and listed herein.

ADOPTED AND APPROVED THIS _____ DAY OF _____ 2018.

CITY OF MUSKOGEE

_____
Mike Miller, City Manager

Approved as to form and legality this _____ day of _____, 2018.

_____
Roy D. Tucker, City Attorney

RESOLUTION NO. 2716

A RESOLUTION APPROVING THE FOLLOWING AGREEMENTS: MUTUAL OF OMAHA RENEWAL; BLUE CROSS BLUE SHIELD EXHIBIT TO THE STOP LOSS COVERAGE POLICY; BLUE CROSS BLUE SHIELD ADMINISTRATIVE SERVICES AGREEMENT; BLUE CROSS BLUE SHIELD BENEFIT PROGRAM APPLICATION; BLUE CROSS BLUE SHIELD PBM FEE SCHEDULE ADDENDUM TO THE BENEFIT PROGRAM APPLICATION; AND HCSC COBRA ADMINISTRATIVE SERVICES ADDENDUM, EACH EFFECTIVE MAY 1, 2018, AND AUTHORIZING THE CITY MANAGER, OR DESIGNEE, TO EXECUTE ALL DOCUMENTS.

WHEREAS, the City of Muskogee, through brokerage services through NFP Corporate Services of Oklahoma ("Consultant") and Third Party Administrator services through Blue Cross Blue Shield ("TPA") to provide said services;

WHEREAS, the City of Muskogee would like to renew the Consulting Agreement for NFP Corporate Services of Oklahoma, and upon recommendation of the Consultant and discussion with the Insurance Committee, the City has approved a stop-loss proposal from Blue Cross Blue Shield, a Blue Cross Blue Shield Administrative Services Agreement, a Blue Cross Blue Shield Benefit Program Application (medical, dental and prescription), a Blue Cross Blue Shield PBM fee schedule addendum to the benefit program application, and an HCSC COBRA Administrative Services Addendum;

WHEREAS, the Insurance Committee has hereby discussed certain recommendations to renew and approve these changes;

WHEREAS, the City of Muskogee finds that the recommendation of staff and the Insurance Committee are in the best interest of the City, and for a governmental purpose.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MUSKOGEE, MUSKOGEE COUNTY, OKLAHOMA:

Section 1. The City Council of the City of Muskogee approves the recommended change to the Blue Cross Blue Shield Stop Loss Coverage Policy as follows:

A. Average claim value changed from $539.35 (per employee per month) for each employee/family coverage unit to $555.09 (per employee per month)
B. Maximum liability factor changed from $674.19 (per employee per month) for each employee/family coverage unit to $693.86 (per employee per month)
C. Aggregate point of attachment changed from $3,334,800 to $3,417,134.
D. Aggregate Stop Loss monthly premium rates increased from $2.50 for each employee coverage unit and $2.50 for each employee/family coverage unit to $2.72 for each employee coverage unit and $2.72 for each employee/family coverage

E. Individual stop loss monthly premium rates changed from $76.05 for each employee coverage unit and $76.05 for each employee/family coverage unit to $85.02 for each employee coverage unit and $85.02 for each employee/family coverage unit
F. Number of active members (subject to change based on enrollment)

Section 2. The City Council of the City of Muskogee approves the recommended changes to the Blue Cross Blue Shield Benefit Program Application as follows:

A. Pharmacy Network changed to Traditional Select Network from Prescription Drug Card
B. Medical administration fee decreased from $37.25 per employee per month (composite-fee plus rebate credit for the Prescription Drug Program) to $33.70 per employee per month (composite-fee plus rebate credit for the Prescription Drug Program)
C. Administrative fees decreased from $55.75 per employee per month to $52.20 per employee per month (fee plus rebate credit for the Prescription Drug Program plus commissions)
D. Medical run-off administration charge changed from $45.88 per employee per month to $52.64 per employee per month

Section 3. The City Council of the City of Muskogee approves the recommended changes to the HCSC COBRA Administrative Services Addendum as follows:

A. Number of active members (subject to change based on enrollment)

Section 4. The City Council of the City of Muskogee does hereby authorize the City Manager, or designee, upon review and approval of the City Attorney in accordance with Council Policy 2-1, to execute all documents attached hereto and any and all other documents necessary to facilitate and finalize the agreements identified herein.

ADOPTED AND APPROVED THIS _____DAY OF _____2018.

CITY OF MUSKOGEE

_____

Mike Miller, City Manager

Approved as to form and legality this _____day of _____, 2018.

_____

Roy D. Tucker, City Attorney

Dental Renewal Comparison

City of Muskogee

Plan Year 2018-2019

	Current	Renewal
Est. Current EE Count	456	456
Fixed Costs (PEPM)		
Admin Fees	$4.21	$4.21
Total Fixed Costs Annualized	$23,037	$23,037
Increase/Decrease from Current		***0.00%***
Projected Claims Liability		
Expected Factor (PEPM)	$44.82	$48.55
		$3.73
Expected Costs Annualized	$245,255	$265,666
		$3.73
		$20,411
Increase/Decrease from Current		***8.3%***
Total Plan Costs		
Expected Factor (PEPM)	$49.03	$52.76
		$3.73
Expected Costs Annualized	$268,292	$288,703
		$20,410.56
Increase/Decrease from Current		***7.6%***

Renewal Information and Exhibits

Prepared For:

City of Muskogee

Group ID: G000ASMX

Renewal Effective Date: May 1, 2018

Thank you for choosing Mutual of Omaha as City of Muskogee's benefits provider. It has been our pleasure to provide City of Muskogee with group benefits and services that are unique to its needs. Mutual of Omaha is committed to providing unparalleled service that will meet the needs of our customers.

Each renewal period, we analyze current benefit and rate structures to determine the appropriate rates for continued group insurance protection for your valued employees. This process includes recalculation of the premium rates to reflect factors like:

- Plan features
- Demographics
- Experience
- Any adjustments to our underlying rate structure

Based on our review, please find below the renewal rates for City of Muskogee's benefit plans. We appreciate your business and look forward to the continued opportunity to meet your group insurance needs.

Renewal Contact Information

Michelle Bruckner
Sr Renewal Executive
Dallas Group Office
972/702-2418
Michelle.Bruckner@mutualofomaha.com

CITY OF MUSKOGEE

LIFE AND AD&D

Rate Guarantee Period - May 1, 2018 to May 1, 2019
Additional Value Added Services Included - Travel Assistance/Identity Theft Assistance

Life

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$2,427.79	$2,427.79	$0.00

Class Description

All Eligible Employees subject to the Policyholder's eligibility requirement

All Other Eligible Employees

Employee Rate Basis - per $1,000

Lives	Volume	Current Rate	Renewal Rate
434	$15,931,550	$0.144	$0.144

Spouse & Child(ren) Rate Basis - per unit

Lives	Volume	Current Rate	Renewal Rate
135	N/A	$0.99	$0.99

AD&D

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$637.26	$637.26	$0.00

Class Description

All Eligible Employees subject to the Policyholder's eligibility requirement

All Other Eligible Employees

Employee Rate Basis - per $1,000

Lives	Volume	Current Rate	Renewal Rate
434	$15,931,550	$0.04	$0.04

CITY OF MUSKOGEE

VOLUNTARY LIFE

Rate Guarantee Period - May 1, 2018 to May 1, 2019

Voluntary Life

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$6,272.80	$6,272.80	$0.00

Class Description

All Eligible Employees subject to the Policyholder's eligibility requirement

All Other Eligible Employees

Employee & Spouse Rate Basis - per $1,000

Age of Employee	Lives	Volume	Current Rate	Renewal Rate
Less than 24	3	$135,000	$0.05	$0.05
25-29	20	$1,520,000	$0.05	$0.05
30-34	32	$2,640,000	$0.06	$0.06
35-39	41	$3,162,000	$0.09	$0.09
40-44	40	$3,025,000	$0.15	$0.15
45-49	48	$3,406,000	$0.27	$0.27
50-54	33	$2,535,000	$0.43	$0.43
55-59	44	$2,735,000	$0.70	$0.70
60-64	13	$775,000	$1.01	$1.01
65-69	7	$270,000	$1.28	$1.28
70-74	0	$0	$1.28	$1.28
75-79	1	$10,000	$1.28	$1.28
80-84	0	$0	$1.28	$1.28
85-89	0	$0	$1.28	$1.28
90-100	0	$0	$1.28	$1.28

Child(ren) Rate Basis - per $1,000

Lives	Volume	Current Rate	Renewal Rate
57	$1,140,000	$0.20	$0.20

BlueCross BlueShield of Oklahoma

[redacted]

EXHIBIT TO THE STOP LOSS COVERAGE POLICY

Employer Group Name:	City of Muskogee
Employer Group Address:	229 W. Okmulgee Avenue
City:	Muskogee **State of Situs:** OK **Zip Code:** 74401
Account Number:	142987
Employer Group Number(s):	142987
Current Effective Date of Policy	05/01/2018
Current Policy Period:	These specifications are for the Policy Period commencing on 05/01/2018 and ending on 04/30/2019
Claim Administrator:	Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

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

A. Aggregate Stop Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1. through 9. below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from _____ to _____

☐ Incurred with Run-Out: Claims incurred from _____ to _____

and Claims paid from _____ to _____

☐ Run-in coverage: Claims incurred from _____ to _____

and Claims paid from _____ to _____

☒ Renewal of Existing Coverage:

☐ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

☒ Incurred with Run-Out: Claims incurred from 05/01/2018 to 04/30/2019

and Claims paid from 05/01/2018 to 07/31/2019

3. Aggregate Stop Loss Coverage shall apply to:

☒ Medical Claims ☐ Vision Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

☐ Dental Claims

☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

☐ Other (please specify): _____

4. Average Claim Value: $555.09 : (per Employee per month)

☒ Includes Claim Administrator's Provider Access Fee
☐ Excludes Claim Administrator's Provider Access Fee

Attachment Factor: 125% of the Average Claim Value

5. Aggregate Attachment Claim Liability:

a. Employer's Claim Liability for each Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Coverage Units for each Month by the following factor(s):

$693.86 for each Coverage Unit

$693.86 for each Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed.

6. Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims: ☐ Yes ☒ No

Run-Off Attachment Claim Liability Factors:

Employer's Run-Off Claim Liability shall be an amount equal to 15% of the annualized Employer Claim Liability based on the participation of the two (2) calendar months immediately preceding termination. Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

7. Aggregate Stop Loss Claims

a. The amount of Paid Claims during the current Policy Period, less Individual (Specific) Stop Loss Claims if any, that exceed the Aggregate Point of Attachment. The Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in item A.5.a. above for the current Policy Period. However, for the current Policy Period the minimum Aggregate Point of Attachment shall be $3,417,134.

b. The following applies if the answer to item A.6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims):

In the event of termination at the end of the current Policy Period, Aggregate Stop Loss Coverage shall equal the amount of Final Settlement Paid Claims that exceed the Final Settlement Aggregate Point of Attachment. Final Settlement Paid Claims shall equal the sum of the Paid Claims during the Final Policy Period and the Paid Claims during the Run-Off Period, less Individual (Specific) Stop Loss Claims, if any. The Final Settlement Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in items A.5. and A.6. above. However, for the Final Settlement Period the minimum Aggregate Point of Attachment shall be the minimum Aggregate Point of Attachment in item A.7.a. above increased by 15%.

c. The amount of "Run-in" Claims that is excluded from Individual (Specific) Stop Loss Coverage in item B.2. is also not eligible for Aggregate Stop Loss Coverage.

8. Stop Loss Premium (Select one):

☐ Annual Premium (Due on the first day of the current Policy Period): $_____.

The following applies if the answer to item A.6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of the current Policy Period, an additional premium amount equal to 15% of the Annual Premium will be due within ten (10) calendar days of receipt of the billing.

☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by:

$2.72 for each Coverage Unit

$2.72 for each Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed.

The following applies if the answer to item A.6. above is "Yes." (Aggregate Stop Loss Coverage includes coverage of Run-Off Paid Claims):

In the event of termination at the end of the current Policy Period, an additional premium amount equal to 15% of the annualized Premium based on the participation of the two (2) months immediately preceding termination will be due within ten (10) calendar days of receipt of the billing.

9. The premium is based upon a current membership of 275 Employee Coverage Units and 181 Family Coverage Units.

B. Individual (Specific) Stop Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1. through 6. below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from _____ to _____

☐ Incurred with Run-Out: Claims incurred from _____ to _____

and Claims paid from _____ to _____

☐ Run-in coverage: Claims incurred from _____ to _____

and Claims paid from _____ to _____

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☐ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

☒ Incurred with Run-Out: Claims incurred from 05/01/2018 to 04/30/2019

and Claims paid from 05/01/2018 to 07/31/2019

3. Individual (Specific) Stop Loss Coverage shall apply to:

☒ Medical Claims ☐ Vision Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

☐ Dental Claims

☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims

☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Claims

For each other Covered Person:

a. The amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $100,000 per Covered Person. Such amount shall apply for the current Policy Period.

Point of Attachment: ☒ Includes Claim Administrator's Provider Access Fee
☐ Excludes Claim Administrator's Provider Access Fee

b. Employer's Claim Liability equals the sum of Paid Claims for a Covered Person during the current Policy Period up to the Point of Attachment specified in item b.4.a. above.

5. Individual Stop Loss Coverage includes coverage of Run-Off Paid Claims: ☐ Yes ☒ No

The following applies if the answer to item B.5. above is "Yes" (Individual (Specific) Stop Loss Coverage includes coverage of Run-Off Paid Claims):

a. In the event of termination at the end of the current Policy Period, Individual (Specific) Stop Loss Coverage shall equal the amount of Final Settlement Paid Claims that exceed the Point of Attachment specified in item B.4. above. Final Settlement Paid Claims shall equal the sum of Paid Claims for a Covered Person during the Final Policy Period and the Run-Off Period (beginning on _____ and ending on _____.

b. In the event of termination at the end of the current Policy Period, Employer's Final Settlement Claim Liability equals the sum of Paid Claims for a Covered Person during the Final Policy Period and Run-Off Period up to the Point of Attachment specified in item B.4.a. above.

Settlements for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

6. Stop Loss Premium (select one):

☐ Annual Premium (Due on the first day of the current Policy Period): $_____.
☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Coverage Units for a particular Month by:

$85.02 for each Coverage Unit

$85.02 for each Family Coverage Unit

The following applies if the answer to item B.5. above is “Yes” (Individual (Specific) Stop Loss Coverage includes coverage of Run-Off Paid Claims): In the event of termination at the end of the current Policy Period, an additional premium amount equal to 20% of the annualized Premium based on the participation of the two (2) months immediately preceding termination will be due within ten (10) calendar days of the billing.

7. The premium is based upon a current membership of 275 Coverage Units and 181 Family Coverage Units.

Additional Provisions:

Retirees Covered: Yes ☒ No ☐

The undersigned person represents that he/she is authorized and responsible for purchasing Stop Loss Coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Exhibit and the Stop Loss Coverage Policy into which this Exhibit shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (“HCSC”). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Exhibit and issuance of the Stop Loss Coverage Policy, the Employer shall be referred to as the "Policyholder."

Bruce Troy
Sales Representative

Signature of Authorized Purchaser

Ribar Said
Name of Underwriter

Title of Authorized Purchaser

Date

INTERNAL USE ONLY	Date Exhibit approved by Underwriting: Name of Underwriter:

BlueCross BlueShield of Oklahoma

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is May 1, 2018.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number: 142987

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**CITY OF MUSKOGEE**
By: 	By:_____
Title: Divisional Senior Vice President	Title:_____
Date: Effective Date of Coverage noted above	Date:_____

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This Agreement made as of the Effective Date specified on page one (1) of this Agreement, by and between **Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and Employer specified on page one (1) of this Agreement ("Employer"), for Employer Group Number(s) set forth on page one (1) of this Agreement, WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of the Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a separate self-insured group health plan component as defined by Section 160.103 of HIPAA ("the Plan"); and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA, this Agreement and all Exhibits and Addenda described in Section 1, below, collectively referred to hereinafter as the "Agreement", unless specified otherwise; and

WHEREAS, Employer on behalf of the Plan desires to retain Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, the parties agree that it is desirable to set forth more fully the obligations, duties, rights and liabilities of Claim Administrator and Employer, as sponsor of the Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: DEFINITIONS, EXHIBITS AND ADDENDA

Capitalized terms used in this Agreement shall have the meanings set forth in Section 24, unless otherwise provided in the Agreement. All Exhibits and addenda attached hereto and referenced herein are hereby adopted and incorporated by reference as if set out in full in the body of this Agreement.

SECTION 2: APPOINTMENT AND SERVICES

2.1 ***Appointment.*** Employer hereby retains and appoints Claim Administrator to provide Services as hereinafter defined in connection with the administration of the Plan.

2.2 ***Administrative Services.*** Claim Administrator will perform the Services set forth in Exhibit 1. Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, or any of its subsidiaries or affiliates, including any successor corporation(s), whether by merger, consolidation, or reorganization, without prior written approval by Employer.

SECTION 3: RESPONSIBILITIES OF EMPLOYER AND CLAIM ADMINISTRATOR

3.1 ***Employer responsibility.*** Employer retains full and final authority and responsibility for the Plan and its operation. Claim Administrator is empowered to act on behalf of Employer in connection with the Plan only as expressly stated in this Agreement or as otherwise mutually agreed to in writing by the parties hereto.

3.2 ***Claim Administrator responsibility.*** Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including, but not limited to, local, state or federal taxes, penalties, Surcharges or other fees or amounts regardless of whether payable directly by Employer or by or

through Claim Administrator. Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement.

3.3 ***Litigation.*** Employer shall, to the extent practical, advise Claim Administrator of any legal actions against it or the Claim Administrator that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either party under the Plan and this Agreement. Employer shall undertake the defense of such action and be responsible for the costs of defense, including but not limited to attorneys' fees and costs, external claim reviews, and other expenses; provided, however, that Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, in which event the fees and expenses of those attorneys shall be the responsibility of Claim Administrator. Provided that no conflicts of interest exist, each party shall reasonably cooperate with the other party's defense of any action arising out of or related to the Services. Some defense support, such as from an external reviewer, may require an additional fee.

3.4 ***Claim overpayments.*** Employer acknowledges that unintentional administrative errors may occur. When Claim Administrator becomes aware of a Claim overpayment to a Provider or Covered Person, Claim Administrator will follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

For purposes of this Section 3.4, an "Overpayment" is defined as a payment to a Provider or a Covered Person which was more than it should have been, or a payment that was made in error.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Sections (a) – (e) below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

(a) Reductions From Future Payments. Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) from Other Plans, up to an amount equal to the Overpayment ("Off-Set").

(b) Cross-Plan Offsets. Claim Administrator has the right to reduce Another Plan's payment to a Provider by the amount necessary to recover the Plan's Overpayment to the same Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Provider by the amount necessary to recover Another Plan's Overpayment to the same Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

(c) Division of Recovery for Multiple Plans. If Claim Administrator has made Overpayments to a Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively, against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount equally divided between the Other Plans that overpaid the Provider.

(d) Employer Authorization for Cross-Plan Offsets. Employer authorizes and directs Claim Administrator to perform any Cross-Plan Offsets.

(e) No Independent Right of Recovery. Subject to the exception(s) set forth in this Section 3.4, Employer agrees that Claim Administrator will recover Overpayments in accordance with its Recovery Process and

that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan.

3.5 ***Required Plan information.*** Employer shall furnish on a Timely basis to Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by Claim Administrator for the performance of its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

It is Employer's obligation to Timely notify Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by Employer to Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by Claim Administrator to effect such changes. It is also Employer's obligation to obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Agreement.

3.6 ***Grandfathered Health Plans.*** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's grandfathered health plan status or any representation regarding any Plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference into and become part of this Agreement, and Employer represents and warrants that such Form is true, complete and accurate.

3.7 ***Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans.*** If Claim Administrator provides Services for any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a Plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

3.8 ***Plan eligibility errors.*** Clerical errors in keeping or reporting data relative to benefits described in this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected by Claim Administrator subject to the terms and conditions of this Agreement and Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. Employer is liable for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination.

3.9 ***Summary of Benefits and Coverage ("SBC").*** Unless otherwise provided in the applicable ASO BPA, Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

3.10 ***Massachusetts Health Care Reform Act.*** The Massachusetts Health Care Reform Act requires certain employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through Employer's Plan(s) and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements. If elected on the applicable ASO BPA, Claim Administrator will provide such written statements and electronic reporting, based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3.11 ***Use and disclosure of Protected Health Information.*** The parties acknowledge and agree that they have entered into a Business Associate Agreement in accordance with HIPAA. The terms and conditions of the Business Associate Agreement shall govern the use and disclosure of Protected Health Information by the parties, except as otherwise provided in this Agreement.

3.12 ***Electronic exchange of information.*** In the event Employer and Claim Administrator exchange various data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data and other information to Employer in the electronic format mutually agreed to by the parties. In the event Employer is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, Claim Administrator is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 4: THIRD PARTY DATA RELEASE

4.1 ***Types of data.*** In the event Employer directs Claim Administrator to provide data directly to its third party consultant and/or vendor (the "Employer's Vendor"), and Claim Administrator agrees in its sole discretion, then Employer acknowledges and agrees, and will cause Employer's Vendor to acknowledge and agree:

- **a.** That the requested documents, records and other information (for purposes of this Section 4, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.
- **b**. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 4, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.
- **c.** To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.
- **d.** To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
- **e.** To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.
- **f.** To return or destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed 60 days thereafter.

4.2 ***Third party obligations.*** Employer's Vendor(s) shall execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator.

4.3 ***Employer obligations.*** Employer shall:

a. Provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose or exchange data. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the Business Associate Agreement between Claim Administrator and Employer.

b. Provide Claim Administrator in writing, the appropriate authorization and specific directions with respect to the release, disclosure or exchange of data with Employer's Vendor(s) identified under 4.3.a. If Employer's Vendor(s) perform services that involve the use, access or disclosure of Protected Health Information as defined by HIPAA, the information required in this Section will be documented in the Business Associate Agreement between Claim Administrator and Employer.

c. Indemnify, defend and hold harmless Claim Administrator and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought against Claim Administrator in connection with any claim based upon Claim Administrator's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Employer Vendor(s), if consistent with Employer's directions, of any information and/or documentation or breach by Employer's Vendor(s) of any obligation described in this Agreement. In lieu of defense by Employer, Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of Claim Administrator.

SECTION 5: CLAIMS/INQUIRIES

5.1 ***Claim Administrator's responsibilities****.* As provided in this Agreement, Claim Administrator will receive eligibility information, review and process properly filed Claims, respond to Covered Person's inquiries directed to Claim Administrator and conduct Claim reviews and appeals; however, Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan.

5.2 ***Claim appeals.*** After exhaustion of all internal claim review remedies and exhaustion of an Independent External Review, if applicable, offered by Claim Administrator, a Covered Person may appeal all adverse benefit determinations to Employer. Claim Administrator will cooperate in providing Claim information pursuant to Section 3 above.

5.3 ***Internal Claim Administrator reviews.*** Claim Administrator may deny all or part of submitted Claims. Upon properly submitted request for review from the Covered Person or the Covered Person's authorized representative, Claim Administrator will provide a review of any adverse determination of a Claim, or, in the case of a pre-service authorization request, any adverse determination when the Covered Person would have an adverse financial impact for failing to pre-authorize the service. Certain Claims, pre-service authorization requests for review, or inquiries where there is a question as to eligibility, rescission or clarity of Employer's Plan language will be referred to Employer for review and final determination. Covered Persons who choose to appeal adverse determinations with Employer after exhaustion of all remedies offered by Claim Administrator will also be referred to Employer. In addition, Claim Administrator may provide other types of reviews related to the Plan as mutually agreed to by the Claim Administrator and the Employer.

5.4 ***External Review Coordination*****.** Claim Administrator may coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

SECTION 6: INDEMNIFICATION

6.1 The parties acknowledge and agree that (a) Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder, and (b) Employer retains the ultimate responsibility for claims under or related to the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by Claim Administrator.

6.2 ***Claim Administrator indemnifies Employer.*** Claim Administrator hereby agrees to indemnify and hold harmless Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) which have been adjudged to be (i) grossly negligent, fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

6.3 ***Employer indemnifies Claim Administrator.*** Employer agrees to indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against Claim Administrator in connection with the design, operation, or administration of the Plan, including but not limited to (a) the Plan's grandfathered health plan status, if applicable, (b) the Plan's exempt plan status, if applicable, (c) any provision of inaccurate information to Claim Administrator, and (d) selection of Employer's Essential Health Benefits benchmark for the purpose of ACA; unless the liability therefor was the direct consequence of the acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) and the acts or omissions are adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

SECTION 7: AUDIT RIGHTS

7.1 ***Employer audits Claim Administrator.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all costs associated with the audit. Employer will reimburse Claim Administrator for any reasonable personnel time in excess of eighty (80) person-hours required to support audits conducted during the term of this Agreement. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information, and to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such information by executing an Audit

Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

7.2 ***Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days prior written notice to Employer, conduct reasonable audits of Employer's membership records with respect to eligibility.

SECTION 8: TERM AND TERMINATION OF AGREEMENT

8.1 ***Term.*** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein.

8.2 ***Termination.*** This Agreement may be terminated as follows:

- **a.** By either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with ninety (90) days prior written notice to the other party; or
- **b.** By both parties on any date mutually agreed to in writing; or
- **c.** By either party, in the event of conduct by the other party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 16 below; or
- **d.** By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA, upon the Employer's failure to cure the non-payment within ten (10) days of written notice of the nonpayment to Employer as provided in Section 7.1 of Exhibit 2 of this Agreement.

8.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 8, Employer agrees to notify all Covered Employees. The parties agree that Employer will give such notice because Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 9: RELATIONSHIP OF PARTIES

9.1 ***Regarding the parties.*** Claim Administrator is an independent contractor with respect to Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever.

9.2 ***Regarding non–parties.*** It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents.

9.3 ***Exclusivity.*** Employer agrees not to perform or engage any other party to perform the same services as Claim Administrator's Services while this Agreement is in effect, unless Employer terminates this Agreement pursuant to its terms.

9.4 ***Assignment.*** Except as otherwise permitted by Section 2 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both parties. Any such attempted assignment in the absence of the prior written consent of the parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates or successors to the parties to the Agreement.

SECTION 10: ERISA

10.1 ***In relation to the Plan.*** Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of Employer, Employer agrees that no allocation or delegation of any fiduciary or non–fiduciary responsibilities under the Plan or any other employee welfare benefit plan of Employer is effective with respect to or accepted by Claim Administrator.

10.2 ***In relation to the Plan Administrator/Named Fiduciary(ies).*** Claim Administrator is not the plan administrator of Employer's employee welfare benefit plan as defined under ERISA. Employer represents and warrants that (i) Employer has a named Plan Administrator and a Named Fiduciary within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of § 3(16)(A) of ERISA; and (iii) Claim Administrator is not a fiduciary of Employer, the Plan Administrator or of the Plan.

10.3 ***In relation to Claim Administrator's responsibilities.*** Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of Employer's Plan. As such, Claim Administrator is intended to be a service provider but not a fiduciary with respect to Employer's ERISA employee welfare benefit plan. Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of Employer's ERISA welfare benefit plan. Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

SECTION 11: PROPRIETARY MATERIALS

11.1 ***Business Confidential Information and Proprietary Marks.*** The parties acknowledge that Claim Administrator has developed acquired or owns certain Business Confidential Information. "Business Confidential Information" includes, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. "Business Confidential Information" also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence. Employer shall not use or disclose Business Confidential Information to any third party without prior written consent of Claim Administrator.

Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that Claim Administrator may include Employer in its list of clients.

11.2 ***Claim Administrator/Association ownership.*** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association. Employer agrees not to contest (i) the Blue Cross and Blue Shield Association's ownership of, or the license granted by the Blue Cross and Blue Shield Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

11.3 ***Infringement.*** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Blue Cross and Blue Shield Association and utilized by Claim Administrator under a license with the Blue Cross and Blue Shield Association.

11.4 ***Disclosures in Account Contracts***. Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between Employer and Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Claim Administrator to use the Blue Cross and Blue Shield Service Mark, and that Claim Administrator is not contracting as the agent of the Association. Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Claim Administrator and that no person, entity, or organization other than Claim Administrator shall be held accountable or liable to Employer for any of Claim Administrator's obligations to Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of Claim Administrator other than those obligations created under other provisions of this Agreement.

11.5 ***Administrative Services Only, Network Only.*** Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to claims liability; and disclose the nature of the services and/or network access Claim Administrator is providing. Such disclosures must be made to Employer, Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and explanation of benefits documentation.

SECTION 12: ELECTRONIC DOCUMENTS

Employer's consent/responsibilities. Employer consents that any documents exchanged between the parties that describe the benefits under, or the administration of, the Plan (including but not limited to benefit booklets) may be in the format of an electronic file or access to an electronic file. Employer further acknowledges and agrees that if Claim Administrator provides Employer, at Employer's request, an electronic file that describes the benefits under, or the administration of, the Plan, Employer will provide Covered Persons access, via the intranet, internet, or otherwise, to only the most current version of that electronic file. Employer also acknowledges and agrees that, in all instances, Claim Administrator may rely on the fact that the most current version of the electronic file Claim Administrator provides to Employer is the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from Employer's use or posting of the electronic file on the intranet and/or internet.

SECTION 13: RECORDS

All Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator are and shall remain the property of Employer upon termination of this Agreement. Claim Administrator shall return a copy of such property upon request in a form as agreed upon by the parties with the cost of preparing such property for transmittal to be borne by Employer. All such Claim records shall be retained by Claim Administrator until Claim Administrator receives a request from Employer for transmittal or for a period of eleven (11) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 14: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of Oklahoma without regard to any state choice–of–law statutes, and any applicable federal law. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Tulsa,

Oklahoma**.** Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

SECTION 15: ENTIRE AGREEMENT

15.1 ***Definition.*** This Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement, and any written amendments made pursuant to Section 15.3 (Amending) of this Agreement, shall prevail in the event of a conflict with any Prior Communications that either party or a third party asserts to be a component of the Agreement between the parties.

15.2 ***Components.*** The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - Recovery Litigation Authorization
- **d.** Exhibit 4 - ASO BPA
- **e.** Exhibit 5 - PBM Exhibit

15.3 ***Amending.*** This Agreement may be amended only by mutual written agreement of the parties. Employer acknowledges and agrees that the format of such changes shall be determined by Claim Administrator in its sole discretion, including, but not limited to, the use of a new form of agreement (that replaces this Agreement in its entirety). Notwithstanding the foregoing, any amendments required by law, regulation or order ("Law") or by Claim Administrator or the Blue Cross and Blue Shield Association may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the parties shall then engage in good faith negotiations to amend the amendment. If the parties cannot agree on terms of the amendment in a satisfactory manner, either party shall be allowed to proceed to dispute resolution, as set forth in Section 18.

SECTION 16: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (pursuant to Section 19 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party ninety (90) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified party the opportunity to make the necessary modifications within the agreed upon term.

SECTION 17: LIMITATIONS; LIMITATION OF LIABILITY

No action or dispute shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA.

As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, liability (whether in contract, tort, or under any other form of liability) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited in the aggregate to the

maximum benefits which should have been paid under this Agreement during the twelve (12) months preceding the incident which gave rise to the claim had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred); or, if the claim arises within the first twelve (12) months of the Agreement, the limit will be the aggregate of the total benefits which should have been paid in that first year of the Agreement had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of gross negligence, fraud or criminal actions by Claim Administrator.

SECTION 18: DISPUTE RESOLUTION/ARBITRATION

18.1 ***Initial notice and negotiation.*** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this Section 18, which shall be the sole and exclusive procedures for the resolution of any such disputes. Employer or Claim Administrator shall give written notice to the other party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the parties shall seek to resolve that dispute through informal discussions between authorized representatives of the parties with appropriate authority to approve any resolution. All negotiations pursuant to this Section 18 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

18.2 ***Confidential arbitration.*** In the event the parties fail to agree with respect to any matter covered herein and only after making good faith efforts to resolve any dispute under this Agreement under Section 18.1, Employer or Claim Administrator may submit the dispute to confidential, binding arbitration before the American Arbitration Association ("AAA"), subject to the following:

a. For matters in which the amount in controversy is $10,000 or less, Claim Administrator shall select an arbitrator. For matters in which the amount in controversy exceeds $10,000, the arbitration shall be conducted by a single arbitrator selected by the parties from a list furnished by the AAA. If the parties are unable to agree on an arbitrator from the list, AAA shall appoint an arbitrator.

b. Arbitration shall be held in Tulsa, Oklahoma.

c. Arbitration proceedings will be governed by the AAA Commercial Rules.

d. The arbitrator shall be required to issue a written opinion resolving all disputes in any matter in which the controversy exceeds $10,000 and designating one party as the prevailing party.

e. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction over the dispute.

f. The arbitrator's fees and any costs imposed by the arbitrator will be shared equally by the parties. All costs and expenses, including but not limited to reasonable attorney and witness fees shall be borne by the non-prevailing party or as apportioned by the arbitrator.

g. This provision precludes Employer from filing an action at law or in equity and from having any dispute covered by this Agreement heard by a judge or jury.

h. Except as may be required by law, neither a party nor an arbitrator may disclose the existence, content, or results of any arbitration pursuant to this Section without the prior written consent of both parties.

18.3 Except as provided otherwise in this Agreement, each party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

SECTION 19: NOTICES

All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party. Claim Administrator may also provide such notices electronically, to the extent permitted by applicable law.

SECTION 20: SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL

Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

Any delay or inconsistency by either party in the enforcement of any part of this Agreement shall not constitute a waiver by that party of any rights with respect to the enforcement of any part of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

Neither party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars, terrorism, cybersecurity crimes or restraints of government.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 3.3 "Responsibilities of Employer and Claim Administrator: Litigation"; Section 4 "Third Party Data Release"; Section 6 "Indemnification" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); Section 11 "Proprietary Materials"; Section 13 "Records"; Section 17 "Limitations; Limitation of Liability"; and Section 8 of Exhibit 2 "Financial Obligation Upon Agreement Termination".

SECTION 21: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the “Permitted Purposes” as defined herein). For purposes of this paragraph, “Permitted Purposes” means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and performance, including, but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, a “limited data set” has the meaning set forth in HIPAA and “de-identified” means both member de-identification (as defined by HIPAA) and Employer de-identification (unless the work is being done in connection with Employer’s Plan). Solely for the Permitted Purposes, Claim Administrator may release, or authorize the release of, a limited data set or de-identified data to a third party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for access to such data. Nothing in the paragraph is intended to expand or limit the terms and conditions of the Business Associate Agreement with respect to the permitted use or disclosure of PHI (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to Claim Administrator-assigned Employer Group and Identification number.

SECTION 22: THIRD PARTY RECOVERY VENDORS AND OUTSIDE ATTORNEYS

To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of healthcare Providers’ Claim coding or billing to identify discrepancies prior to Claim Payments. Third parties' fees associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

SECTION 23: NOTICE OF ANNUAL MEETING

Employer is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of Members of said Company, consistent with HCSC bylaws. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Section, the term "Member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan.

From time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 24: DEFINITIONS

24.1 "Accountable Care Organization" means a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

24.2 "Administrative Charge" means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

24.3 "Allowable Charge" means the charge that Claim Administrator will use as the basis for benefit determination for Covered Services a Covered Person receives under the Plan. Claim Administrator will use the following criteria to establish the Allowable Charge for Covered Services:

a. ***For Medical Covered Services.***

(i) ***For Network Providers*** **–** For a Provider who has a written Network agreement with Claim Administrator to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Network Provider"), the Allowable Charge means the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with the terms of the Provider contract.

(ii) ***For Providers other than Network Providers ("Non-Contracting Providers")*** **-** For a Provider who does not have a written Network agreement with Claim Administrator to provide care to a Covered Person at the time Covered Services for medical benefits are rendered (a "Non-Contracting Provider"), the Allowable Charge (the "Non-Contracting Provider Allowable Charge") will be the lesser of: **(1)** the Non-Contracting Provider's billed charges, or; **(2)** an amount determined by Claim Administrator in accordance with this Section. Except as otherwise provided in this Section, the Non-Contracting Provider Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by Claim Administrator. Such factor will not be less than 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount the Claims Administrator would have paid a Network Provider for the same services. For services for which a Medicare reimbursement rate is not available, the Non-Contracting Provider Allowable Charge will represent an average contract rate for Network Providers adjusted by a predetermined factor established by Claim Administrator and updated on a periodic basis. Such factor shall not be less than 90% of the average contract rate. Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Non-Contracting Provider Allowable Charge for a particular service. In the event Claim Administrator does not have any claim edits or rules, Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Non-Contracting Provider Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by Claim Administrator within one hundred forty-five (145) days after the effective date that such change is implemented by the Centers for Medicare and Medicaid Services, or its successor.

In the event the Non-Contracting Provider Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and deductible amount. This difference may be considerable. To find out an estimate of Claim Administrator's Non-Contracting Provider Allowable Charge for a particular service, the Covered Person may call the customer service number shown on the back of the Covered Person's Identification Card.

b. ***For Prescription Drug Benefits,*** the Allowable Charge is determined as follows:

(i) Participating Pharmacy – For a Provider which has a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered ("Participating Prescription Drug Provider"), the Allowable Charge for purposes of calculating the Employer Payment and the Covered Persons' required deductible and Coinsurance, shall be the cost mutually agreed upon by Employer and Claim Administrator within the PBM Fee Schedule Addendum to the BPA attached and incorporated herein by this reference.

(ii) Out-of-Network Pharmacy – For a Provider which does not have a written agreement with Claim Administrator, a Blue Cross and/or Blue Shield Plan or the entity chosen by Claim Administrator to administer its prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered, the Allowable Charge for purposes of calculating both the Employer Payment and the Covered Persons' required deductible and Coinsurance shall be the lesser of the charge which the particular Out-of-Network Pharmacy usually charges for Covered Services, or the amount Claim Administrator would reimburse Participating Prescription Drug Providers for the same service, minus 25% unless otherwise agreed upon by Claim Administrator and Employer.

c. ***For Covered Dental Services,*** if dental benefits coverage is elected on the most current ASO BPA, the Allowable Charge is determined in accordance with the type of dental benefits coverage elected:

(i) Network Dentist – For a Provider who has a written agreement with Claim Administrator to provide dental care to a Covered Person at the time Covered Services are rendered ("Network Dentist"), the amount the Dentist has agreed to accept as full payment for Covered Services.

(ii) Non-Contracting Dentist – For a Provider who does not have a written agreement with Claim Administrator to provide dental care to a Covered Person at the time Covered Services are rendered ("Non-Contracting Dentist"), please refer to Plan Summary/Summary Plan Description for criteria used to establish the Non-Contracting Dentist Allowable Charge.

24.4 "Alternative Provider Compensation Arrangements" means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.5 "Alternative Provider Compensation Arrangement Payments" means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Homes payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 15.4 of Exhibit 2.

If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 24.5, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for Expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 15.4 of Exhibit 2. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Members, unless an alternate calculation method is used (in the same manner as described in Section

15.4 of Exhibit 2. Expected Payment may vary from Member to Member. For the purposes of this Section 24.5, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons.

Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by the Employer's Covered Persons per month.

Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable Expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

24.6 "Blue Cross Blue Shield Global Core Access Vendor Fees" means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

24.7 "Care Coordination" means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

24.8 "Care Coordinator" means an individual within a Provider organization who facilitates Care Coordination for patients.

24.9 "Care Coordinator Fee" means a fixed amount paid by a BlueCross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

24.10 "Claim" means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

24.11 "Claim Charge" means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction**.**

24.12 "Claim Payment" means Claim Administrator's payments under this Agreement based on the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Charge**,** in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

24.13 "Coinsurance" means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

24.14 "Copayment" means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

24.15 "Covered Employee" shall have the same meaning as defined in Employer's Plan to the extent consistent with the BPA.

24.16 "Covered Person" shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

24.17 "Covered Service" means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

24.18 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

24.19 "Fee Schedule" means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2.

24.20 "Fee Schedule Period" means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

24.21 "Global Payment/Total Cost of Care" means a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as Outpatient, Physician, ancillary, Hospital services, and prescription drugs.

24.22 "HIPAA" means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

24.23 "Hospital" means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

24.24 "Host Blue" means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

24.25 "Inpatient" means the Covered Person is a registered bed patient and treated as such in a health care facility.

24.26 "Negotiated Arrangement" means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

24.27 "Network" means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

24.28 "Non-Participating Healthcare Provider" means a healthcare Provider that does not have a contractual agreement with a Host Blue.

24.29 "Outpatient" means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

24.30 "Participating Healthcare Provider" means a healthcare Provider that has a contractual agreement with a Host Blue.

24.31 "Patient-Centered Medical Home" means a model of care in which each patient has an ongoing relationship with a Primary Care Physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

24.32 "Physician" means a physician duly licensed to practice medicine in all of its branches.

24.33 "Plan" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

24.34 "Primary Care Physician" means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

24.35 "Provider" means any Hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services.

24.36 "Provider Incentive" means an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to, any measures or initiatives related to a particular population of Covered Persons.

24.37 "Services" means the services listed in Exhibit 1.

24.38 "Shared Savings" means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

24.39 "Supplemental Charge" means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule. A Supplemental Charge may be applied for any customized reports, forms or other materials or for any additional services or supplies not documented in the applicable Fee Schedule. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

24.40 "Surcharges" means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

24.41 "Timely" means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within 48 business hours of notification to Employer by Claim Administrator, monthly fees (e.g. administrative) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

c. With respect to all Plan information due Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

24.42 "Value-Based Program" means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care Providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care Providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer from listing below:

  a. ***Enrollment Materials.*** Implementation materials to be provided by Claim Administrator's Marketing Administration Division during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Provision of identification cards appropriate to health benefit Plan coverage(s) selected.

  c. ***Standard Provider Directories.*** Access to Network Provider directories and periodic updates to such, if applicable to the health benefit Plan coverage(s) under the Agreement.

  d. ***Customer Service.*** Access to a toll–free customer service telephone number.

  e. ***Medical Pre–notification Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require pre–notification, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical pre–notification helpline for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

- **EXTERNAL REVIEW COORDINATION (if applicable)**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator's coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan's determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

  Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased (or proposed to be purchased) from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service (IRS) 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND STATISTICAL**

  Determination of Claims projections and pricing of administrative services and stop–loss coverage.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 3.

- **EMPLOYER PORTAL (currently called BLUE ACCESS® FOR EMPLOYERS)**

  Provide Employer with an on-line resource that allows employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called BLUE ACCESS® FOR MEMBERS)**

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying claims status, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers including, if also applicable, Primary Care Physicians within the designated service area.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current ASO BPA)***

  Provide a program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by Employer and agreed to by Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING (*If elected on the most current ASO BPA)***

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING (RBP) (*If elected on the most current ASO BPA)***

  Assist Employer with establishing a maximum coverage amount for specified imaging, inpatient, and outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT *(if elected on the most current ASO BPA)***

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via i) interactive audio communication (via telephone or similar technology) and/or ii) interactive audio/video examination and communication (via online portal, mobile app or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE (SBC) *(if elected on the most current ASO BPA)***

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 2, Section 16 entitled "MEDICARE SECONDARY PAYER INFORMATION REPORTING", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over 365 days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, escheat such funds to state of payee's last known address on behalf of Employer or escheat amounts pursuant to such funds to Employer, as elected by Employer, less any amount(s) owed by payee to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law**.**

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge.

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations.

- **HEALTH ADVOCACY SOLUTIONS (*If elected on the most current ASO BPA*)**

  Provide a program that may include Holistic Health Management, Member Rewards, utilization management, access to clinical and non-clinical Health Advocates, or such other features as determined by Employer and agreed to by Claim Administrator.

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Exhibit. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA and the PBM Exhibit; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Exhibit; or iii) the date the Agreement is terminated (or in the case of the PBM Exhibit, the date such Exhibit is terminated).

Inter-Plan Arrangement Fees:

i. **BlueCard® Program/Network access fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable;

ii. **Negotiated Arrangement/Custom fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s);

iii. **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**Such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or $2,000 per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 24 AGREEMENT DEFINITIONS of the Agreement.

2.1 "Employer Payment" means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 "Employer Payment Method" means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 "Employer Payment Period" means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 "Medicare Secondary Payer ("MSP")" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 16 of this Exhibit titled "MEDICARE SECONDARY PAYER INFORMATION REPORTING.")

2.5 "Run–Off Claim" means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 "Run–Off Period" means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 "Termination Administrative Charge" means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the

Agreement or partial termination of Covered Employees, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** Employer will pay service charges to Claim Administrator, in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining service charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing service charges.*** Such service charges shall be subject to change by Claim Administrator as follows:

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that sixty (60) days prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the single/family mix, or the Medicare/Non-Medicare mix varies +/- 10% from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, producer/broker fees, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service charges upon termination.*** In the event the Agreement is terminated in accordance with the "TERM AND TERMINATION" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

3.5 ***Additional service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to Employer and/or any other fees for services mutually agreed upon by the parties in writing.

3.6 ***Effect of Plan enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."

4.3 ***Covered Person's certain liability.*** Under certain circumstances, if Claim Administrator pays the healthcare Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period**.**

5.2 ***Confirmation or notification of amount due and payment due date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

- **a.** ***If Employer Payment Method is by check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.
- **b.** ***If Employer Payment Method is other than check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties, of the amount due. Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by Claim Administrator. If any day on which an Employer Payment is due is a holiday, such payment will be made or obtained on the next business day.

5.3 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no condition will Claim Administrator be responsible for payment of Reinsurance Contributions.

5.4 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim settlement shall be determined for each Claim settlement period indicated in the Fee Schedule specifications of the most current ASO BPA. The Claim settlement shall reflect the sum of the following:

- **a.** Claim Payments paid by Claim Administrator in the particular Claim settlement period.
- **b.** Claim Payments paid by Claim Administrator in prior Claim settlement periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current ASO BPA of the Agreement and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the "Claim Settlement Total."

6.2 ***Employer underpayment.*** If, within the Claim settlement period, the Claim Settlement Total exceeds Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within sixty (60) days from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer overpayment.*** If, within the Claim settlement period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

b. Terminate the Agreement as of the effective date specified in such notice.

7.2 ***When Claim Administrator fails to Timely notify.*** Pursuant to Section 20 "SEVERABILITY; ENFORCEMENT; FORCE MAJEURE; SURVIVAL" of the Agreement, Claim Administrator's failure to provide Employer with Timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from Employer.

7.3 ***Late charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 8 of the Agreement, or on the date of a partial termination by Employer of more than 10% of Claim Administrator's projections of Covered Employees, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or partial termination, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the

processing of such Claims after the Agreement's termination date or date of partial termination. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments and the applicable service charges for such Extended Benefits.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

8.3 ***Final Settlement.*** A final settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old) will be escheated to the state of payee's last known address by Claim Administrator, on Employer's behalf, less any amount(s) owed by such funds' payees to Claim Administrator, in accordance with Claim Administrator's established procedures and/ or the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

Employer represents that it acknowledges and has communicated the substance of the provisions stated in each of the following sections of this Exhibit 2 (Sections 10 and after) to its Covered Persons, with modifications appropriate for communications with Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim Payment.*** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in 10.3, below. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

10.2 ***Claim dispute.*** Once Covered Services are rendered by a Provider, the Covered Person has no right to request Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

10.3 ***Invalidity of assignments.*** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage

under the Plan. However, if Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

11.1 ***Choosing a Provider.*** The choice of a Provider is solely the choice of the Covered Person and Claim Administrator will not interfere with the Covered Person's relationship with any Provider.

11.2 ***Claim Administrator's role.*** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service.

11.3 ***If point–of–service coverage applies.*** If coverage under a Network point–of–service managed care health benefits program is applicable to the Plan under the Agreement, the following apply:

a. ***Physician Selection.***

A Covered Person shall be entitled to select a Primary Care Physician through the Plan to act as the Covered Person's principal care giver and to provide or arrange for the provision of medical care.

b. ***Changing Physician Selection.***

Both the Covered Person and the Primary Care Physician may request a change from one Primary Care Physician to another by notifying Claim Administrator of the desire to change; provided, however, such a request by a Primary Care Physician shall not be based upon the type, amount or cost of services required by the Covered Person or the physical condition of the Covered Person except where reasonably necessary to provide optimal medical care.

11.4 ***Intent of terminology.*** The use of an adjective such as but not limited to, 'Approved,' 'Administrator,' 'Participating,' 'In–Network' or 'Network' in modifying the term 'Provider' shall in no way be construed as a recommendation, referral or statement as to the ability or quality of such Provider. Conversely, the omission, non-use or non-designation of the foregoing adjectives, or, alternatively, any similar modifier, or, alternatively, the use of a term such as 'Non-Approved,' 'Non-Administrator,' 'Non-Participating,' 'Out-of-Network,' or 'Non-Network' should not be construed as carrying any statement or inference, whether negative or positive, as to the ability or quality of such Provider.

11.5 ***Provider's role.*** Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (other than as an individual Covered Person) or the Plan.

SECTION 12: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non–Network professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's Fee Schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

13.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Charge, subsection (d)(i). All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the Allowable Charge, subsection (d)(ii) above.

13.2 Claim Administrator hereby informs Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers)" for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual Network savings achieved for Covered Persons will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

13.3 Employer understands that Claim Administrator may receive such discounts during the term of the Agreement. Neither Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator. For the mail-order pharmacy and specialty pharmacy program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

13.4 "Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34 day supply increments so a 1-34 days' supply is considered 1 weighted claim, a 35-68 days' supply is considered 2 weighted claims, and the pattern continues up to 6 weighted claims for 171 or more days' supply. Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

13.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the

Agreement. Additional information about these types of fees or the amount of these fees is available upon request.

SECTION 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

14.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC.

14.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to the Claim Administrator under the PBM's agreement with Claim Administrator. This negotiation is conducted by the PBM for the benefit of Claim Administrator and not for the benefit of the Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, the Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The Claim Administrator may provide the Employer with a Rebate Credit, the amount of which is set forth in the ASO BPA. The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates provided to Claim Administrator by the PBM. The Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM to Claim Administrator and consents to Claim Administrator's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

14.3 As of the Effective Date, the maximum that a Pharmacy Benefit Manager will receive from any pharmaceutical manufacturer for manufacturer administrative fees is four and one quarter percent (4.25%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to Pharmacy Benefit Manager at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed..

SECTION 15: INTER-PLAN ARRANGEMENTS

15.1 *Out-of-Area Services*

Claim Administrator 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 Association. Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below. Claim

Administrator's services under this Agreement are governed by and subject to the Inter-Plan Arrangements rules in effect during the term of this Agreement, and a Host Blue is neither the agent nor the subcontractor of Claim Administrator.

Typically, when accessing care outside the geographic area Claim Administrator serves, Covered Persons obtain care from Participating Healthcare Providers. In some instances, Covered Persons may obtain care from Non-Participating Healthcare Providers. Claim Administrator remains responsible for fulfilling its contractual obligations to Employer. Claim Administrator'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 the Inter-Plan Arrangements. Dental care benefits, when paid as stand-alone benefits, and prescription drug benefits or vision care benefits that may be administered by a third party contracted by Claim Administrator to provide the specific service or services, are not processed through Inter-Plan Arrangements.

15.2 *BlueCard® Program*

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its Participating Healthcare Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Claim Administrator's action will be consistent with the spirit of this description.

a. *Liability Calculation Method – In General*

(1) Covered Person Liability Calculation.

Unless subject to a fixed dollar Copayment, the calculation of the Covered Person's liability on Claims for Covered Services will be based on the lower of the Participating Healthcare Provider's billed charges for Covered Services or the negotiated price made available to Claim Administrator by the Host Blue.

(2) Employer's Liability Calculation.

The calculation of Employer's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may, for a particular service or services, exceed the billed charge in accordance with how the Host Blue has negotiated with its Participating Healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the Covered Person'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.

b. *Claims Pricing*

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

(1) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

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

(3) 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. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific Claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Covered Person and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

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

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

c. ***BlueCard Program Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Association, and/or to vendors of the BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in the most current ASO BPA. The specific BlueCard Program fees and compensation may be revised from time to time as described in Section 15.9 below.

Claim Administrator will charge these fees as follows:

(1) BlueCard Program Access Fees

The access fee is charged by the Host Blue to Claim Administrator for making its applicable Provider Network available to Employer.

A BlueCard Program access fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Covered Persons for amounts in excess of the negotiated payment. However, a healthcare provider may bill for non-covered healthcare services and for Covered Person cost sharing (for example, deductibles, Copayments, and/or Coinsurance) related to a particular Claim.

(2) How the BlueCard Program Access Fee Affects Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator 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, Claim Administrator will pay the Host Blue's access fee and pass it along to Employer as stated above even though Employer paid little or had no Claim liability.

15.3 ***Negotiated Arrangements***

With respect to one or more Host Plans, instead of using the BlueCard Program, Claim Administrator may process Employer's Covered Persons' Claims for Covered Services through a Negotiated Arrangement. Pursuant to such a Negotiated Arrangements, the Host Blue(s) has/have agreed to provide, on Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of Employer receiving Covered Services in the state and/or service area of the Host Blue(s). Pursuant to the

agreement between Claim Administrator and the Host Blue(s), Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on Claim Administrator's behalf for those Covered Persons of Employer receiving Covered Services in the state and/or service area of such Host Blue.

In addition, if Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare Provider Network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator'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 Covered Persons access such networks. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Employer, Employer's Plan or Employer's Covered Persons.

a. ***Covered Person and Employer Liability Calculation***

Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under 15.2.a., BlueCard Program) that the Host Blue makes available to Claim Administrator and that allows Employer's Covered Persons access to negotiated participation agreement Networks of specified Participating Healthcare Providers outside of Claim Administrator's service area.

Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under 15.2.a, BlueCard Program).

Employer acknowledges that pursuant to the Host Blue's contracts with Host Blues' Participating Healthcare Providers, under certain circumstances described therein, the Host Blue (i) may receive substantial payment from Host Blues' Participating Healthcare Providers with respect to services rendered to such Covered Persons for which the Host Blue was initially obligated to pay the Host Blues' Participating Healthcare Providers, (ii) may pay Host Blues' Participating Healthcare Providers more or less than their billed charges for services, by discounts or otherwise, or (iii) may receive from Host Blues' Participating Healthcare Providers other allowances under the Host Blue's contracts with them. One example of this is quality improvement programs/payments.

If charged by the Host Blue to Claim Administrator, Employer shall reimburse Claim Administrator for any payments made to the Host Blue, unless otherwise set forth in the Agreement's Fee Schedule, including "Claim-like" charges, which are those charges for payments to Host Blues' Participating Healthcare Providers on other than a fee for services basis which include, but are not limited to, incentive payments.

Employer acknowledges that, in negotiating the Administrative Charge set forth in the Agreement's Fee Schedule, it has taken into consideration that, among other things, the Host Blue may receive such payments, discounts and/or other allowances during the term of its agreement with Claim Administrator. Further, all amounts payable by Covered Person and Employer shall be calculated on the basis described in this subsection, irrespective of any separate financial arrangement between the Host Blue's Participating Healthcare Provider that rendered the applicable Covered Service and the Host Blue other than the negotiated price as described in this subsection.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as described in Section 15.9 below.

In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to Employer under Negotiated Arrangements are set forth in the most current ASO BPA.

15.4 ***Special Cases: Value-Based Programs***

a. ***Value-Based Programs Overview***

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

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

(1) ***Value-Based Programs Administration***

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these Provider payments to Claim Administrator, which Claim Administrator will pass on to Employer in the form of 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 a Host Blue:

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

b) ***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. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed as Per Member Per Month ("PMPM") billings for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Claim Administrator will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings.

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

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

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

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

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

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

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

(2) ***Care Coordinator Fees***

Host Blues may also bill Claim Administrator for Care Coordinator Fees for Provider services which Claim Administrator will pass onto Employer as follows:

a) PMPM billings; or

b) 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 US Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, Claim Administrator and Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

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

If Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted in BlueCard Program section.

15.5 ***Return of Overpayments***

Recoveries from a Host Blue or its Participating Healthcare Providers and Non-Participating Healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recoveries will be applied, in general, on either a claim-by-claim or prospective basis. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to Employer.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Claim Administrator may request the Host Blue to provide full refunds from Participating Healthcare 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, Claim Administrator may request such refunds for a period of only 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 Healthcare Providers, notwithstanding to the contrary any other provision of this Agreement.

15.6 ***Inter-Plan Arrangements: 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, Claim Administrator will include any such surcharge, tax or other fee to Employer, which will be Employer's liability.

15.7 ***Non-Participating Healthcare Providers Outside Claim Administrator's Service Area***

a. ***Covered Person Liability Calculation***

(1) In General

When Covered Services are provided outside of the Claim Administrator's service area by Non-Participating Providers, the amount(s) a Covered Person pays for such services will generally be calculated using the methodology described in the Agreement for Non-Contracting Providers located inside our service area. The Covered Person may be responsible for the difference between the

amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, Claim Administrator may, but is not required to, negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then Claim Administrator may make a payment based on the lesser of:

a. the amount calculated using the methodology described in Section 15.7(a)(1), above: or
b. the following:
    i. for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
    ii. for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, a Covered Person may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Claim Administrator will make for the Covered Services as set forth above.

b. ***Fees and Compensation***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangements requirements to pay to the Host Blues, to the Association, and/or to vendors of Inter-Plan Arrangements related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided in Section 15.9 below.

15.8 ***Blue Cross Blue Shield Global Core®***

a. ***General Information***

If Covered Persons are outside the United States, the Commonwealth of Puerto Rice and the U.S. Virgin Islands (hereinafter: "BlueCard Service Area"), the Covered Persons may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the BlueCard Service Area, the Covered Persons will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

(1) Inpatient Services

In most cases, if Covered Persons contact the Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require Covered Persons to pay for covered Inpatient services, except for their cost-share amounts/deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a Claim to obtain reimbursement for Covered Services. Covered Persons must contact Claim Administrator to obtain preauthorization/precertification for non-emergency Inpatient services, if Employer's Plan requires preauthorization or precertification for such services.

(2) Outpatient Services

Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard Service Area will typically require Covered Persons to pay in full at the time of service. Covered Persons must submit a Claim to obtain reimbursement for Covered Services.

(3) Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons 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 Claim Administrator, the Blue Cross Blue Shield Global Core Service Center or online at www.bluecardworldwide.com. If Covered Persons 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.

b. ***Blue Cross Blue Shield Global Core Program-Related Fees***

Employer understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core Program are available upon request. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 15.9 below.

15.9 ***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, Claim Administrator shall provide Employer with at least thirty (30) 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 Employer's right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change, which notice will be effective after ninety (90) days in accordance with Section 8.2(a) of the Agreement. If Employer fails to respond to the notice and does not terminate this Agreement during the notice period, Employer will be deemed to have approved the proposed changes, and Claim Administrator will then allow such modifications to become part of this Agreement.

SECTION 16: MEDICARE SECONDARY PAYER INFORMATION REPORTING

16.1 Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173) adds new mandatory reporting requirements for group health plan ("GHP") arrangements. The parties agree that Claim Administrator as the Responsible Reporting Entity ("RRE") under Section 111 requirements is required to report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules.

16.2 Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan.

16.3 Employer agrees that Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of Claim Administrator's files concerning Covered Persons and the number of individuals employed by Employer. Employer agrees to use its best efforts in responding promptly and accurately to Claim Administrator's requests for information.

16.4 Further, to assure the continuing accuracy of Claim Administrator's files, Employer agrees that it is Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute. Employer acknowledges and agrees that Claim Administrator will be using the information provided by Employer and Covered Persons to update Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

16.5 Disclosure Statement: Employer acknowledges that Claim Administrator has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 17: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA

17.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:

a. Claim Administrator on behalf of Employer has the right to reimbursement for all benefits Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the Provider's Allowable Charge for Covered Services for which Claim Administrator has provided benefits to the Covered Person.

b. Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

17.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

SECTION 18: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part). As part of the overall plan of benefits that Employer offers to a Covered Person, if the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator may (1) communicate directly with the Covered Persons and/or (2) provide the Host Blues whose service area covers the geographic area in which a Covered Person resides, with a Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which Employer has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

Employer hereby acknowledges and agrees that Claim Administrator may, at its election, pursue claims of Employer and/or the Plan, which are related to claims that Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

1. Claim Administrator shall have the right to select and retain legal counsel.

2. Any lawsuit filed or arbitration initiated by Claim Administrator will be done in the name of Claim Administrator for its own benefit, as well as on behalf of Employer and possibly other parties. Claim Administrator will not cause any litigation to be filed or arbitration to be initiated solely in the name of Employer and/or the Plan without Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of Employer and/or the Plan with attorneys identified as counsel for Employer or in the name of two or more parties, including Employer and Claim Administrator, with attorneys identified as counsel for Employer, Claim Administrator and possibly other parties.

3. The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including providing appropriate authority to communicate with Employer concerning issues pertaining to any class actions and pursuant to which Employer specifically declines representation by class litigation counsel.

4. Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

5. Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.

6. Any and all recoveries, net of all investigative and other expenses relating to the recovery made through any means pursuant to the provisions of this Exhibit, including any costs of settlement, mediation, arbitration, litigation or trial including attorney's fees, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by Claim Administrator on any reasonable basis it deems appropriate.

7. Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of Claim Administrator.

8. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

9. Nothing in the provisions of this Exhibit shall require Claim Administrator to assert any claims on behalf of Employer and/or the Plan.

10. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, Employer acknowledges that the efforts of Claim Administrator may not result in recovery or in full recovery in any particular case.

11. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require Claim Administrator to assert any claims on Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after Claim Administrator has asserted a claim on behalf of Employer and/or the Plan but before any recovery, Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

12. If Employer should desire to participate in a class or multi–district settlement rather than defer to Claim Administrator, Employer may revoke the grant of authority established herein for that specific matter by affirmatively opting into a class settlement and by notifying Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 19 NOTICES of the Agreement.

13. Employer further acknowledges and agrees that, unless it notifies Claim Administrator to the contrary in writing as provided for under Section 19 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes Claim Administrator, on behalf of Employer and/or the Plan, consistent with Section 2 above, to:

- **a.** Pursue, without advance notice to Employer, claims that Claim Administrator pursues on its own behalf in class action litigation, federal multi–district litigation, private lien resolution programs, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
- **b.** Opt out of any class action settlement or keep Employer and/or the Plan in the class, if Claim Administrator reasonably determines that it should do so;
- **c.** Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.

14. Employer further acknowledges and agrees that Claim Administrator's decision to pursue recovery in connection with particular claims shall be in Claim Administrator's sole discretion and Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of Employer and/or the Plan when, as, and if, Claim Administrator determines that such claims may be pursued in the common interest of the parties.

15. Employer is responsible for ensuring that the terms of its health benefit plan are consistent with the terms of this Exhibit.

16. The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail with respect to the subject matter hereof.

EXHIBIT 4
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

EXHIBIT 5
PHARMACY BENEFIT MANAGEMENT SERVICES

(GUARANTEED TRADITIONAL AGGREGATE PRICING ARRANGEMENT)
(FOR USE ONLY FOR 151+ EMPLOYEES)

EFFECTIVE DATE OF THIS EXHIBIT: JANUARY 1, 2018

1. **Pharmacy Management:** Claim Administrator has contracted with Prime Therapeutics LLC (Prime) and/or other pharmacy benefit manager(s), mail order pharmacies, specialty pharmacies or other pharmacies to furnish certain pharmacy benefit management and other prescription drug benefit programs, including Rebate management and fee schedule management, including but not limited to MAC List management. Other services Prime will provide may include certain account management, clinical management, Drug List management, and Utilization Management services as set forth in the agreement between Prime and Claim Administrator. Claim Administrator reserves the right to contract with other Pharmacy Benefit Managers and pharmacies for such services. Please see the Agreement for additional information regarding Claim Administrator's use of Pharmacy Benefit Managers.

The Employer acknowledges that Claim Administrator currently owns a significant portion of the equity of Prime. The Employer further understands and agrees that fees and compensation that Prime receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator, administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to Manufacturers. Currently, none of these fees are passed on to the Employer as expenses or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement or this Exhibit.

2. **Services:** Pharmacy Benefit Management services to be provided include Drug List/Rebate Management Services; management of the pharmacy networks for Members; Claims processing (electronic and paper); management of clinical management programs; reporting and account support services. Claim Administrator pays a fee to Prime for pharmacy benefit management services, which may be factored into the pricing set forth in the ASO BPA and the PBM Fee Schedule Addendum to the ASO BPA (the "BPA Addendum").

3. **Drug List Services:** Claim Administrator utilizes its own Drug List and Prime supports Claim Administrator in the development, maintenance and updating of such Drug List. Prime performs Drug List exception reviews in accordance with the agreement between Prime and Claim Administrator. Prime provides Drug List management services, in accordance with NCQA and URAC standards, to Claim Administrator in supporting the Claim Administrator Pharmacy and Therapeutics ("P&T") and Business Committees. Employer acknowledges and agrees that Claim Administrator may, in a manner consistent with the Benefit Plan, promote the dispensing of pharmaceuticals in a manner consistent with the designated Drug List selected by Employer.

4. **Rebate and Manufacturer Administrative Fee Management**

In Claim Administrator's agreement with Prime, Prime has agreed to negotiate with Manufacturers to obtain Rebates for Covered Prescription Drug Products and Services as described in the Agreement.

In addition, Prime has advised Claim Administrator that Prime receives Manufacturer Administrative Fees as compensation for bona fide administrative services performed by Prime for the Manufacturer. Prime contracts with Manufacturers for Rebates and Manufacturer Administrative Fees on its own behalf (or Claim Administrator's behalf, as applicable) and for its own benefit (or Claim Administrator's benefit, as applicable), and not on behalf of Employer. Accordingly, Prime (or Claim Administrator, as applicable) retains all right, title and interest to any and all actual Rebates and/or Manufacturer Administrative Fees received from manufacturers. Prime has advised Claim Administrator that Rebate arrangements are based on volume purchase discounts or other similar arrangements with Manufacturers. Employer will be provided with Rebate credits as set forth in the Section of this PBM Exhibit entitled Rebates and in the PBM Fee Schedule Addendum to the BPA but otherwise shall have no right, title or interest in Rebates received by Prime or Claim Administrator under its agreement with Prime. Employer shall have no right, title or interest in Manufacturer Administrative Fees. Prime may retain Manufacturers Administrative Fees or pass them along, in whole or in part, to Claim Administrator in accordance with Prime's agreement with Claim Administrator. As of the Effective Date, the maximum that Prime will receive from any Manufacturer for Manufacturer Administrative Fees is four and one quarter percent (4.25%) of the Wholesale Acquisition Cost ("WAC") for all products of such Manufacturer dispensed during any given calendar year to members of Claim Administrator, as applicable; provided, however, Claim Administrator will advise Employer if such maximum has changed.

5. **Disclosures:** All other disclosures set forth in the Agreement will apply to pharmacy benefit management services.

6. **Pharmacy Network**

a. **Network Establishment and Maintenance:** In Prime's agreement with Claim Administrator, Prime has agreed to provide and maintain a network of Network Participants for use by Members to obtain Covered Prescription Drug Products and Services. The Employer acknowledges that in negotiating the Agreement and this Exhibit, it has taken into consideration that Claim Administrator and/or Prime will keep all or a portion of the discounts and/or other allowances that Claims Administrator or its pharmacy benefits manager has negotiated with the Network Participant. Prime will implement the methodology described in the Allowable Charge when calculating the Copayment/Deductible, and Coinsurance amounts. Prime will reimburse Network Participants in accordance with the applicable Network Contract. Prime requires its Network Participants to not switch Covered Prescription Drug Products to a higher cost product unless requested to by the Member and/or the Member's physician.

b. **Non-Payment to Excluded Providers:** Prime will use commercially reasonable efforts to not make payments to providers that are not licensed as required by law or that have been debarred, suspended or otherwise excluded from a federal or state program.

c. **Prime Maximum Allowable Cost ("MAC") Lists:** Prime owns and will maintain proprietary database listings of multi-source pharmaceutical drug products and supplies that also identifies a recommended maximum allowable cost for drugs or supplies within specified categories, commonly referred to as Prime's MAC Lists. Prime's MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Employer after 30 days' prior written request submitted by Employer to Claim Administrator, and subject to Employer's execution of Prime's non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. Prime's MAC List will only be made available for viewing at Prime's corporate headquarters or another secured location designated by Prime. Prime's MAC Lists will be the same for all "'Groups with the Pricing Arrangement' and Network" as described in the BPA Addendum.

d. **Pharmacy Locator:** Prime will provide a means, either toll-free telephone line or electronic, to enable Members to identify Network Participants in a particular area.

e. **Mail Service:** Prime will provide or cause to be provided a mail order prescription drug service through which Members may receive Covered Prescription Drug Products and Services through the mail ("Mail Service"). Upon termination of the Agreement between Claim Administrator and Employer, Prime agrees to provide or cause to be provided mail order open refill and prior authorization files for purposes of transition to any new vendor selected by Employer at Prime's standard rate. Mail Service and specialty pharmacies operate through an affiliate partially owned by Prime Therapeutics LLC.

f. **Pharmacy Network Audit Services:** Prime will perform or cause to be performed pharmacy Claims audits to promote Network Participant contract integrity.

g. **Audits:** In addition to the audit rights available elsewhere in the Agreement, Employer may request that Claim Administrator inspect and/or audit Prime's records, pursuant to the terms and conditions of the agreement between Claim Administrator and Prime, as they relate to the Claims under the Agreement. Employer may also audit Prime's records as they relate to the aforementioned Claims by coordinating such audit through Claim Administrator and executing an audit agreement with Prime as a party. Audits will be performed during normal business hours and are subject to providing Claim Administrator and Prime with reasonable advance written notice. Prime will make available records, as they relate to the Claims, unless Prime is legally or otherwise contractually prohibited from doing so. No material shall be copied or removed from Claim Administrator or Prime without prior written approval by Prime or Claim Administrator as applicable. Employer will bear its own cost and expenses for all such audits.

h. **Specialty Pharmacy:** Claim Administrator and Prime have contracted with specialty pharmacies and/or vendors to provide Members with access to in-network benefits for covered Specialty Drugs.

7. Claims Processing

a. **Adjudication of Prescription Drug Claims from Network Participants:** Prime will process Claims for Prescription Drugs Products and Services electronically submitted by Network Participants through the Claims Adjudication System, according to Benefit Plan benefit and eligibility information submitted by Claim Administrator to Prime and will pay eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Prime will also process and pay Paper Claims received from a Member at the benefit level set forth in the Benefit Plan, and based on the Allowable Charge, in accordance with the terms of the Benefit Plan, provided that the Benefit Plan allows such reimbursement.

b. **Material Change to AWP:** If after the Effective Date: (i) changes to the formula, methodology or manner in which AWP is calculated or reported by Medi-Span take effect or (ii) Medi-Span ceases to publish AWP for the Covered Prescription Drug Services under this Exhibit, then the financial terms of this Exhibit shall be automatically adjusted at the time of such change to return the parties to their respective economic positions as they existed under the Agreement immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Exhibit shall immediately and automatically be converted to an alternative pricing benchmark determined by Prime. Claim Administrator shall inform Employer in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services, and give Employer a reasonable opportunity to review such new benchmark. Thereafter, Employer will be deemed to have approved the designation, which will become part of this Agreement, unless Employer terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract.

c. **Statement of Account:** Prime will furnish to Claim Administrator, at least weekly, a statement of account of the amount of payments that have become due for Claims processed by Prime.

d. **NDC File:** Prime will maintain a National Drug Code (NDC) File for prescription drugs and required elements for each NDC.

e. **Help Desk Service:** Prime will provide help desk service for pharmacist Claim and Benefit Plan inquiries.

8. Benefit Plan Design:

In the event the Employer wishes to implement Benefit Plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the BPA Addendum may no longer be applicable. If such Benefit Plan design changes impact the existing pricing, new BPA Addendum pricing must be negotiated. If the parties cannot agree on the terms of the new BPA Addendum pricing, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Agreement or (b) terminate this Exhibit with 90 days' prior written notice to the other party. Failure to reach agreement on the new Addendum pricing shall not be a breach of contract.

9. Term This PBM Exhibit will be in effect for the term of the Agreement or the Term as stated in the BPA Addendum, whichever is shorter (the "Term").

10. Termination

This Exhibit may be terminated as follows:

a. By either party at the end of any twelve-month period of the Prescription Drug Program under this PBM Exhibit upon ninety (90) days prior written notice to the other party; or

b. By both parties on any date mutually agreed to in writing; or

c. By termination of the entire Agreement by either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA upon ninety (90) days prior written notice to the other party; or

d. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Exhibit, upon written notice as provided in the "Notices" section of the Agreement; or

e. By Claim Administrator, upon the Employer's failure to pay all amounts due under the Agreement or this Exhibit including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current ASO BPA and BPA Addendum.

11. Program Pricing Terms

The pricing terms for Pharmacy Benefit Management services are as follows, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan:

a. **Retail Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the retail pharmacy program based on the pricing set forth in the BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible and/or Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the retail pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

b. **Mail Service Pharmacy Program Claims**

1. (a) Employer will reimburse Claim Administrator for Claims submitted under the mail pharmacy program based on the pricing set forth in the BPA Addendum.

(b) Payment by Employer is subject to applicable Copayment/Deductible, Coinsurance or other coverage features set forth in the Benefit Plan designated by Employer under the mail order pharmacy program.

In each case, if applicable, Employer will pay Claim Administrator the price set forth in subsection (a) above, plus any Provider Taxes and any federal, state, or local sales, use or other tax or assessment related to any Prescription Drug Products and Services less the Member's cost share as established by Employer.

In no event will Employer be charged if the Member Copayment/Deductible or Coinsurance covers 100% of the Covered Prescription Drug Products and Services. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes. Zero balance logic is not employed.

2. **Direct Claims:** The Member reimbursement terms applicable to direct reimbursement of Paper Claims submitted by Members are determined by the benefit design.

c. **Specialty Drug Claims**

If covered under Employer Benefit Plan, notwithstanding anything to the contrary in Sections a and b above and elsewhere in the Agreement, Employer will reimburse Claim Administrator for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the pricing set forth in the BPA Addendum, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other specialty pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims under the Specialty Drug program is not included in the retail and mail pharmacy pricing described in the BPA Addendum. Member Deductible and Coinsurance will be calculated as described in the Agreement, and Member is also responsible for the applicable Copayment plus applicable taxes.

d. **Copayments/Deductibles/Coinsurance**

The Brand Drug Copayment/Deductible and Coinsurance will apply to all Brand Drugs as indicated in the applicable Drug List and Benefit Plan for the Employer group. The Generic Drug

Copayment/Deductible and Coinsurance will apply to all generic drugs as indicated in the applicable Drug List and Benefit Plan for Employer.

e. **Rebates**

Rebate credits are paid prospectively to the Employer as a credit on the monthly billing statement and shall not continue after termination of the Prescription Drug Program or the PBM Exhibit. Additional information about rebates and rebate credits are included in the Agreement and the ASO BPA.

12. DEFINITIONS

Certain terms are defined in the Administrative Services Agreement, but the following terms and phrases will have the meaning set forth below, for purposes of the services described in this Exhibit.

1. "Average Wholesale Price" or "AWP" means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the actual NDC-11 of the dispensed product. AWP discounts do not include savings from DUR or other clinical or medical management programs.

2. "Benefit Plan" means the benefit plan document that describes the Covered Prescription Drug Products and Services reimbursement for which an applicable Member of that Benefit Plan is entitled.

3. "Brand Drug" means, except as otherwise designated in the Additional Provisions of the BPA Addendum, a drug that may be protected by a patent and/or marketed under a trade name which the Pricing Source designates as a Brand Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Brand Drugs as M, N or O in their multi-source code indicator.

4. "Claim" or "Claims" means requests for payment submitted by Network Participants or Members for Prescription Drug Products and Services.

5. "Claim Administrator" has the meaning set forth in the Agreement.

6. "Claims Adjudication" means the determination of whether a given Claim is entitled to reimbursement pursuant to the terms and conditions of a Benefit Plan and the amount payable to or by a Network Participant or Member pursuant to such Benefit Plan, the applicable Network Contract and any other applicable factors, including any Copayment/Deductible or Coinsurance payable by a Member, as well as drug utilization review. Claims Adjudication shall accommodate any e-prescribing procedures that may be adopted after the date hereof.

7. "Compound Drug" means a prescription product composed of two or more medications mixed together, with at least one of the component medications being a Federal Legend Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring or sodium chloride solutions are added.

8. "Coinsurance" means that portion of the amount claimed for Covered Prescription Drug Products and Services, calculated as a percentage of the Allowable Charge (or its substitute) for such services, which is to be paid by Members pursuant to Member's Benefit Plan.

9. “Copayment/Deductible” means a fixed dollar portion of the amount claimed for Covered Prescription Drug Products and Services that is to be paid by Members pursuant to Member’s Benefit Plan.

10. “Covered Prescription Drug Products and Services” means the pharmaceuticals and associated services available to Members and eligible for reimbursement pursuant to the Member’s Benefit Plan, subject to any Copayment/Deductible or Coinsurance.

11. “Dispensing Fee” means the fee required to be paid to the Network Participant for the professional service of filling a prescription and is added to the Ingredient Cost for the prescription.

12. “Drug Utilization Review” or “DUR” means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored and acted upon consistent with the Member’s Benefit Plan. DUR can be prospective, concurrent or retrospective.

13. “Drug List” means a list of pharmaceutical products which is available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of individual pharmaceutical products.

14. “Extended Supply Network” or “ESN” means claims for Covered Prescription Drug Products and Services for which the quantity of medication is at least an Thirty-Five (35) days’ quantity supply of medication, provided that the Member’s Benefit Plan provides for an ESN benefit.

15. “Foreign Claim” means a Claim for a prescription product or service obtained outside the United States which prescription product or service has an equivalent FDA approved version available for dispensing inside the United States. Prescription products or services that do not have equivalent FDA approved versions are not eligible for reimbursement.

16. “Generic Drug” means, unless otherwise designated in the Additional Provisions of the BPA Addendum, a drug that is not protected by a patent nor marketed under a trade name which the Pricing Source designates as a Generic Drug. The Pricing Source used on the effective date of this Exhibit, Medi-Span, typically designates Generic Drugs as Y in their multi-source code indicator.

17. “Ingredient Cost” means the amount required to be paid to a Network Participant for a prescription drug and which, when combined with the applicable Dispensing Fee, constitutes the full amount payable to such Network Participant for the given prescription drug and the professional service of dispensing such drug.

18. “Legend Drugs” means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating “Caution — Federal Law Prohibits Dispensing Without a Prescription,” and which are approved by the FDA for a particular use or purpose.

19. "MAC List" means the list of unit prices established by Prime for multi-source Covered Drugs, each such unit price specified by Generic Product Identifier ("GPI") and including the dates for which such price was in effect. The MAC List is maintained by Prime and updated from time to time in accordance with this Exhibit and the BPA Addendum. Prime’s MAC Lists applicable to this Exhibit will be available for viewing by authorized representatives of Employer after 30 days’ prior written request submitted by Employer to Claim Administrator, and subject to Employer’s execution of Prime’s non-disclosure agreement(s). Such requests shall be made no more frequently than four (4) times per calendar year. Prime’s MAC List will only be made available for viewing at Prime’s corporate headquarters or another secured location designated by Prime.

20. “Mail Service” means the service through which Members may receive Covered Prescription Drug Products and Services through the mail.

21. “Manufacturer” means a company that manufactures, and/or distributes pharmaceutical drug products.

22. “Manufacturer Administration Fee” means all fixed fees received by Prime from any given Manufacturer relating to administration of Rebates under a Manufacturer Agreement.

23. “Maximum Allowable Cost” or “MAC” means the highest Ingredient Cost at which a Benefit Plan will reimburse any Network Participant or Member for a specific drug for products present on the MAC List at the time of service.

24. “Member” or “Members” means an individual who is eligible to receive Covered Prescription Drug Products and Services as a beneficiary at the time of service under a Benefit Plan.

25. “Network Contract” has the meaning set forth in the definition of “Network Participant.”

26. “Network Participant” means each individual pharmacy, chain or Pharmacy Services Administrative Organizations (PSAO) that has entered into an agreement(s) with Prime or Claim Administrator (“Network Contract”) to provide Covered Prescription Drug Products and Services to Members, as may be amended.

27. “Paper Claims” means Claims for prescription drug services that are submitted to Prime for Claim Adjudication through the use of a paper claim form, generally by a Member, subsequent to the point of sale.

28. “Pricing Source” means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and Claim Administrator may designate, which establishes and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for Covered Prescription Drug Products and Services. Claim Administrator shall inform Employer in writing, in advance if practicable, of any conversion to an alternative pricing benchmark for Covered Services, and give Employer a reasonable opportunity to review such new benchmark. Thereafter, Employer will be deemed to have approved the designation, which will become part of this Agreement, unless Employer terminates this Exhibit in accordance with its terms. Failure to reach agreement on the new benchmark shall not be a breach of contract. Claim Administrator will only use a single nationally recognized pricing source at any given time.

29. “Provider Tax” means any tax on a Covered Prescription Drug Product and Service required to be collected or paid by a pharmacy provider for a Covered Prescription Drug Product and Service.

30. “Rebate(s)” means compensation or remuneration of any kind received or recovered by Prime from any Manufacturer which is directly or indirectly attributable to purchase or utilization of Covered Prescription Drug Products and Services by Members. Rebates do not include Manufacturer Administration Fees which Prime is entitled to retain pursuant to the Agreement and this Exhibit unless otherwise required by law.

31. “Rebate Management Services” means the services which Prime is obligated to provide pursuant to Section 4.

32. “Specialty Drugs” means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are for serious or chronic conditions, have special handling or storage requirements, are infused medications, oral medications and/or that. In addition, patient support and/or education may be

required for these drugs. The list of Specialty Drugs is determined by Prime or Claim Administrator and subject to change.

33. "Usual and Customary" or "U&C" means the price, including any Dispensing Fee, that a Network Participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

34. "Utilization Management" means clinical management services designed to encourage proper utilization of prescription drugs in order to enhance (or not diminish) Member outcomes while managing drug benefit costs, directly and/or indirectly, for Benefit Plan and Members. Such services include, but are not limited to the following: drug list exception, prior authorization, step therapy, quantity limits and DUR.

35. "Zero Balance Due Claim" means any Claim where the Member cost share covers 100% of the Allowable Charge for such Claim.

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 142987

Group Number(s): 142987, 142988

Section Number(s): 1000, 1001, 9900, 2000, 2001, 9901

Legal Employer Name: City of Muskogee

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: Plan Administrator's Address:

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/Day/Year) 05 / 01 / 2018

Anniversary Date: (Month/Day/Year) 05 / 01 / 2019

Account Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 736005340

Address: 229 W. Okmulgee Avenue

City: Muskogee State: OK ZIP: 74401

Administrative Contact: Kelly Plunkett Title: HR Director

Email Address: kplunkett@muskogeeonline.org Phone Number: 918-684-6220 Fax: 918-684-6223

Wholly Owned Subsidiaries:

Affiliated Companies:

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Blue Access for Employers (BAE) Contact: Maggie Eaton

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: mleaton@muskogeeonline.org Phone Number: 918-684-6222 Fax Number: 918-684-6223

☒ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

Producer of Record

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISION

Effective: 05/01/2014

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Are commissions to be paid? ☒ Yes ☐ No

Producer or Agency to whom commissions are to be paid*: NFP Corporate Services (OK), LLC

Tax ID Number (TIN) of ☐ Producer or ☒ Agency: 820557866 Producer #: 002340000

NPN:

Address: 4811 Gaillardia Pkwy, Suite 300

City: Oklahoma City State: OK ZIP: 73142

Phone: 405-359-0594 Fax: Email: brady.ayala@nfp.com

Is Producer/Agency appointed with HCSC in Oklahoma? ☒ Yes ☐ No

Commissions:

☒ PCPM $18.50 Does a Monthly Cap Apply ☐ Yes ☒ No $ (If cap is annual, divide by twelve)
☐ Flat $ Does a Monthly Cap Apply ☐ Yes ☐ No $ (If cap is annual, divide by twelve)
☐ Percentage of Stop Loss: % Fees ☐ Single: $ ☐ Family: $ ☐ Aggregate: $

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Additional Comments: _____

Schedule of Eligibility ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

1. Eligible Person means:
   - ☒ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of:_____ *(name of union)*
   - ☐ Other:_____

   Are any classes of employees to be excluded from coverage? ☐ Yes ☐ No
   If yes, please identify the classes and describe the exclusion: _____

2. Employee Definition

   Full-Time Employee means:
   - ☒ A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - ☒ The date such person ceases to meet the definition of Eligible Person.
   - ☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan? (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted applicable by law)
   - ☐ The date of employment.
   - ☐ The day of employment.
   - ☐ The day of the month following month(s) of employment.
   - ☐ The day of the month following days of employment.
   - ☐ The day of the month following the date of employment.
   - ☒ Other: 1st of the month following or coinciding with completion of 30 days employment.

   Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No
   Are there multiple new hire waiting periods? ☐ Yes ☒ No
   If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered: ☐ Yes ☒ No

   If yes: a Domestic Partner is eligible to enroll for coverage
   If yes, are Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No
   If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☐ Yes ☐ No
   If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. Limiting Age for covered children: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

7. Are unmarried step-children under the limiting age eligible for coverage? ☒ Yes ☐ No
   If yes, is residency with the employee required? ☐ Yes ☒ No

8. Are unmarried grandchildren eligible for coverage?
   ☒ No ☐ Yes (answer the question below)
   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made?
   ☐ Yes ☐ No

9. Termination of coverage upon reaching the Limiting Age:
   ☒ The last day of coverage is the day prior to the birthday.
   ☐ The last day of coverage is the last day of the month in which the limiting age is reached.
   ☐ The last day of coverage is the last day of the billing month.
   ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee?
   ☐ Yes ☐ No
   However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements*.

10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

    ☐ Yes (specify number of days below) ☐ No

    Temporary Layoff: days Disability: days Leave of Absence: days

    However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

11. Enrollment:

    Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

    An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

    Specify Open Enrollment Period: 04/01 - 04/30

☒ Annual/open enrollment – late applicant may apply during open enrollment
☐ Annual/open enrollment

12. * Does COBRA Auto Cancel apply? ☒ Yes ☐ No
Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

***Not recommended for accounts with automated eligibility*

Lines of Business (Check all applicable services)	☒ **NO CHANGES** ☐ ***See Additional Comments***
Medical Plan Services: ☐ Blue Choice PPO ☐ Blue Traditional (In and Out of Network Benefits) ☒ BlueOptions ☐ BlueOptions Select PPO ☐ Blue Preferred ☐ **Out of Area** (Traditional) **Additional Services:** ☒ Blue Care Connection® ☐ Wellness Incentives ☐ Well onTarget® ☐ Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)* ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other	**Consumer Driven Health Plan:** ☐ Blue Edge (HCA) *(If selected, complete separate HCA BPA)* ☐ Blue Edge (HSA) (vendor:) ☐ Blue Edge FSA (vendor: ConnectYourCare) **Prescription Drugs:** *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA)* Pharmacy Network: ☒ Traditional Select Network ☐ Advantage Network ☐ Preferred Network ☐ Elite Network ☐ Network on PBM Fee Schedule Addendum Drug List: Basic Drug List Other (please specify): _____ **Ancillary Services:** ☒ Dental Plan Services ☐ Vision Plan Services ☒ Stop Loss Coverage *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)* ☐ Dearborn National Life Insurance *(if selected, complete separate Life application)* ☒ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum)*

FEE SCHEDULE

Payment Specifications ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Employer Payment Method: ☒ **Online Bill Pay** ☐ **Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: ☒ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi Monthly** ☐ **Monthly**

Claim Settlement Period: ☒ **Monthly**

Run-Off Period: Employer payments are to be made for 12 months following end of Fee Schedule Period.
Standard is twelve (12) months.

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: Months.

Administrative Per Employee per Month (PEPM) Charges

	Composite	Composite		
Administrative Fee	**$$52.13**	$_____	$_____	$_____
Dental	$_____	**$4.21**	$_____	$_____
Claims Fiduciary	$_____	$_____	$_____	$_____
*Rebate Credit for the Prescription Drug Program	**$(18.43)**	$_____	$_____	$_____
Commissions	**$18.50**	$_____	$_____	$_____
Outpatient Imaging Management Services	$_____	$_____	$_____	$_____
Management of the Virtual Visits Program	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	**$52.20**	**$4.21**	$_____	$_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager (PBM) to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____

Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	**$**_____
	Total:	**$**_____

Other Service and/or Program Fee(s) ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Not applicable to Grandfathered Plans

External Review Coordination: ☒ Yes ☐ No If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Federal Affordable Care Act external review process.

Reimbursement Service: ☒ Yes ☐ No

If yes*:* The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services):

Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for Covered Services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☐ Yes ☒ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category *(per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Service	**Composite**			

Medical Run-off Administration Charge:	**$52.64**	**$____**	**$____**	**$____**
Dental Run-off Administration Charge	**$____**	**$____**	**$____**	**$____**
Miscellaneous	**$____**	**$____**	**$____**	**$____**
Miscellaneous	**$____**	**$____**	**$____**	**$____**
Total:	**$52.64**	**$____**	**$____**	**$____**

Other Provisions

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:

   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC):

   ☒ Yes. Please answer question b. The SBC Addendum is attached.
   ☐ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

   b. Will Claim Administrator distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

   ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.
   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.
   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

   If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. Case Management Program: ☒ Yes ☐ No *The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, and other health care management programs.*

4. Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("EHB") Election:

   Employer elects EHBs based on the following:

   ☒1. EHBs based on a HCSC state benchmark: ☐ Illinois ☒ Oklahoma ☐ Montana ☐ Texas ☐ New Mexico

   ☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: ___

   ☐ 3. Other EHB, as determined by Employer

   In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Oklahoma benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation

The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: The following language replaces #C of Additional Provisions above as well as # 7 of Summary of Benefits and Coverage Addendum to ASO Benefit Program Application (ASO BPA): The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in the Administrative Services Agreement by the Claim Administrator. Without waiving any rights of sovereign immunity, and only to the extent permitted under Oklahoma law, and within the limits and protections of the Oklahoma Government Tort claims Act, the Employer agrees to indemnify and hold harmless the Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands,settlements or judgments brought against the Claim Administrator in connection with the design or administration of the Plan, unless the liability therefor was the direct consequence of the acts of omissions of the Claim Administrator or its directors, officers or employees and is adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of the Administrative Services Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 of the Administrative Services Agreement, the Claim Administrator shall be responsible for the correction of the Claim Payment errors by the Claim Administrator.

Employer agrees and acknowledges that it remains responsible for claims and liabilities arising in connection with the design and administration of the Plan.

REHIRE PROVISION - If coverage terminates due to layoff or reduction in working hours and Full-Time Regular Employment resumes within ninety (90) days, coverage will be reinstated on the first day of the month following the return to work. Reinstatement shall apply only to coverage initially provided. An Employee returning to work directly from coverage through the Plan's COBRA continuation option will have coverage effective immediately upon return to active Full-Time employment for the same coverage provided by the COBRA continuation.

RETIREE COVERAGE - A Retiree shall be entitled to continue participation in the Plan provided such election is made within thirty-one (31) days from the date Full-Time Regular Employment terminated. A Retiree shall also be entitled to continue participation for any Dependents who were participating in the Plan at the time employment ceased, provided the election is made within the same thirty-one (31) day period.
Effective May 1, 2016, Retirees are entitled to participate in open enrollment and make changes through qualifying events to also include adding new dependents.

TERMINATION OF A RETIRED PARTICIPANT'S COVERAGE: The Retired Participant's and (if applicable) Dependent Participant's coverage will terminate on the earliest of the following dates:
1. the first day of the month during which the Participant attains the age of sixty-five (65); or
2. the first day of the month for which the required monthly contribution for coverage is not received by the Plan Administrator; or
3. the date of termination of the Plan

Signature

Bruce Troy

Sales Representative

403 Phone: 405-316-7152
Fax: 405-549-2365

District Phone & FAX Numbers

Brady Ayala

Producer Representative

NFP Corporate Services (OK), LLC

Producer Firm

4811 Gaillardia Pkwy, Suite 300
Oklahoma City, OK 73142

Producer Address

Phone: 405-359-0594 Fax: 405-359-0679

Producer Phone & FAX Numbers

brady.ayala@nfp.com

Producer Email Address

820557866

Tax I.D. No.

Signature of Authorized Employer Representative

Print Name

Title

Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: 142987, 142988

By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: City of Muskogee

Address: 229 W. Okmulgee Avenue

City: Muskogee State: OK ZIP: 74401

Dated this _____ day of _____
Month Year

PBM Fee Schedule Addendum to the Benefit Program Application

City of Muskogee	
Term: 05/01/2018-04/30/2019	**Employees:** 456
Guaranteed Traditional Aggregate Pricing Arrangement D[1]* **Traditional Select Network and Basic Drug List**	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
17.50%	78.50%
DISPENSING FEE	
Brand	**Generic**
$1.15	$1.15
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
20.50%	82.50%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
19.75%	79.00%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 16.00%
DISPENSING FEE:	$0.00

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	$18.43

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

[1] Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

a. "Brand" products include "Brand Drugs" as defined in the PBM Exhibit and also include generic products that are available from no greater than three (3) generic manufacturers; and

b. "Generic" products include all products not defined in (a), above, as "Brand" products.

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer's Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

Signature of Authorized Purchaser

Print Name

Title

Date

HCSC COBRA ADMINISTRATIVE SERVICES ADDENDUM

(If applicable, attach to Benefit Program Application)

☐ NO CHANGES	ACCOUNT INFORMATION
Employer Name: City of Muskogee	
Employer Account Number(s): 142987	

COBRA Services

COBRA Administrative Billing Services Only: ☒ Yes ☐ No	
COBRA Administrative Full Services: ☒ Yes ☐ No	
Notification Services included: (Full Services) ☒ Yes ☐ No	
Conversion Rights included: (Full Services) ☒ Yes ☐ No	
Monthly Reports* included: ☒ Yes ☐ No *If Yes:* Email Address: mleaton@muskogeeonline.org AND kplunkett@muskogeeonline.org	
*Paper reports provided by mail/electronic reports via email	
Effective date(s) of services if different from ASO Effective Date of Coverage:	

COBRA Service Charges

Billing Services Fee per Participant per month: $10.00
If Notification Services included (Full Services)
Notification Fee [per Participant, per notification]: $10.00
Monthly Administrative Fee: $75.00 (to be paid by NFP Corporate Services (OK), LLC)
The Employer will pay HCSC a sum of One Hundred Dollars *($100.00)* per hour for any system programming costs associated with non-standard administration services.

COBRA Membership

Number of Active Members*: 456	
Number of current COBRA participants/members*:	
Number of current COBRA retiree participants/members*:	
**Full Service Unit (FSU) set-up of participants/members in BlueStar required*	
FSU Location: Tulsa	
FSU Contact: Oklahoma Membership	Email Address: OklahomaMembership@hcsc.net
Is all COBRA participant census information attached? ☐ Yes ☒ No	
Is all COBRA participant coverage(s) and level elected information attached? ☐ Yes ☒ No	
Is all dependent census information attached? ☐ Yes ☒ No	

COBRA Coverage		
Are rates (SINGLE/FAMILY or TIERED) for all coverages attached? ☒ Yes ☐ No		
Is 2% included in attached rates? ☒ Yes ☐ No		
Does Employer have any non-HCSC coverage? ☒ Yes ☐ No		
If Yes, Other Carrier(s): Name: VSP		
Address: 3333 Quality Drive		Email Address:
City: Rancho Cordova	State: CA	Zip: 95670
Administrative Contact: Wan Jankowski	Phone Number: 800-216-6248	Fax Number: 916-463-3928
Name:		
Address:		Email Address:
City:	State:	Zip:
Administrative Contact:	Phone Number:	Fax Number:
COBRA coverage begins: ☒ On date of Qualifying Event ☐ First of month following date of Qualifying Event		
Should 150% of the COBRA premium be charged to participants eligible for disability extension for the remaining 11 months of COBRA? ☐ Yes ☐ No *(Extension is from 18 months to 29 months when deemed disabled by Social Security)*		
Is contract provided and signed? ☐ Yes ☐ No		
Prior COBRA administrator info: Name:		
Address:		Email Address:
City:	State:	Zip:
Administrative Contact:	Phone Number:	Fax Number:

Stop-loss Renewal Comparison

City of Muskogee

2018-2019 Plan Year Renewal

BCBS Renewal

	BCBS Current	BCBS Renewal
Contract Terms		
Specific Contract Basis	**(12/15)**	**(12/15)**
Individual Ded Limit	**$100,000**	**$100,000**
Individual Lifetime Payment	Unlimited	Unlimited
Aggregating Specific	$0	$0
Aggregate Limit	125%	125%
Benefits Applied	Med/Rx	Med/Rx
Est. Current EE Count	456	456
Single	275	275
Family	181	181
Administration Costs		
Admin Fees (PEPM)	$55.75	$52.20
Total Admin Costs Annualized	**$305,064**	**$285,638**
Stop-Loss		
Stop-Loss Rates (Ind. & Agg.)		
Single	$78.55	$87.74
Family	$78.55	$87.74
Total Annual Stop-loss Premium	**$429,826**	**$480,113**
Claims Liability		
Expected Factor (PEPM)		
Single	$539.35	$555.09
Family	$539.35	$555.09
Expected Claims Annualized	**$2,951,323**	**$3,037,452**
Max Liability Factor (PEPM)		
Single	$674.19	$693.86
Family	$674.19	$693.86
Max Claims Liability Annualized	**$3,689,168**	**$3,796,802**
Total Plan Costs		
Expected Costs Annualized	**$3,686,213**	**$3,803,204**
Difference Compared to Current-		3.2%
Max Liability Annualized	**$4,424,057**	**$4,562,554**
Difference Compared to Current-		*3.1%*

Guardian
Option 1
(12/15)
$100,000
Unlimited
$0
125%
Med/Rx
447
274
173
$52.20
$280,001
$69.94
$69.94
$375,158
$744.93
$744.93
$3,995,805
$931.16
$931.16
$4,994,742
$4,370,963
18.6%
$5,649,901
27.7%

Regular City Council **10.**

Meeting Date: 03/26/2018

Submitted For: Mike Miller, City Manager **Initiator:** Marsha Wiseman, Admin Assistant

Department: City Manager

Staff Information Source:

Information

AGENDA ITEM TITLE:

Receive report on City of Muskogee's 30-year designation as a Tree City USA. (Rick Ewing)

BACKGROUND:

The City of Muskogee was recognized by Oklahoma Forestry Services and the Oklahoma Urban and Community Forestry Council for achieving national certification from the Arbor Day Foundation. Communities, universities and utility companies can earn this special recognition by accomplishing specific criteria related to planting and caring for trees, woodlands and community forests. Muskogee was among 21 cities recently honored at the state Arbor Week Kickoff celebration held at the Oklahoma History Center in Oklahoma City on March 13th. Oklahoma celebrates Arbor Week March 25 – 31 this year.

Communities earn Tree City USA status by meeting core standards of sound community forestry management; maintaining a tree board; having a community tree ordinance and spending at minimum of two dollars per capita on community forestry activities and celebrating Arbor Week. The TreeLine USA program exists to recognize best practices in public and private utility arboriculture, demonstrating how trees and utilities can co-exist for the benefit of communities and citizens.

The City of Muskogee, through the Parks & Recreation Department's *Forestry Division*, has achieved Tree City USA certification for 30 years. Muskogee is exceeded in the number of years of certification by only 4 other Oklahoma communities.

The Parks & Recreation Department's Forestry Division will be hosting Muskogee's Arbor Week celebration this Saturday, March 31st at 10:00am at the C. Clay Harrell Arboretum in Honor Heights Park.

RECOMMENDED ACTION:

Receive report.

Fiscal Impact

Attachments

Arbor Foundation Award Photo

TREE CITY USA®
Arbor Day Foundation™

30 Years

Regular City Council			**11.**
Meeting Date:	03/26/2018		
Submitted For:	Roy Tucker, City Attorney	**Initiator:**	Roy Tucker, City Attorney
Department:	City Attorney		
Staff Information Source:			

Information

AGENDA ITEM TITLE:

Consider the appointment of Patrick Cale to the Purchasing Committee, to serve a term commensurate with his term on City Council, replacing Deputy Mayor Janey Boydston, or take other necessary action. (Mayor Bob Coburn)

BACKGROUND:

Deputy Mayor Boydston has requested Councilor Cale replace her on the Purchasing Committee.

RECOMMENDED ACTION:

Approve the appointment of Patrick Cale to the Purchasing Committee, replacing Deputy Mayor Janey Boydston.

Fiscal Impact

Attachments

No file(s) attached.