MURFREESBORO CITY COUNCIL
Special Meeting Agenda
Murfreesboro Police Headquarters – Community Room
October 14, 2020 – 11:30 AM

Action Items

1. Airport Terminal MTSU Signage (Airport)
2. Agreement for Employee Medical Benefits (Human Resources)
3. FY21 Budget Amendment (Administration)
    a. City Budget Amendment Ordinance 20-O-31 (1st Reading)
    b. Water Resources Fund Budget Amendment Resolution 20-R-22
    c. Stormwater Management Fund Budget Resolution 20-R-23
4. FY21 Community Investment Program (Administration)

Workshop Items

5. August 2020 Financial Dashboard Information (Administration)
6. Report of New Debt Obligation (Finance)

Licensing

7. Wine Sales Certificate of Compliance – RaceTrac #2527 (Finance)
8. Wine Sales Certificate of Compliance – RaceTrac #2554 (Finance)
9. Wine Sales Certificate of Compliance – RaceTrac #2559 (Finance)

Payment of Statements

Other Business

Adjournment

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: MTSU Interior Signage Addendum to Transient Use Agreement

Department: Airport

Presented by: Chad L. Gehrke, Airport Manager

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☒
Direction	☐
Information	☐

Summary

Interior Sign Addendum to Transient Use Agreement with MTSU.

Staff Recommendation

Approve the Interior Sign Addendum to Transient Use Agreement with MTSU.

Background Information

MTSU's Aerospace Project is one of the premier degree-granting flight and airport management programs in the country. Having the University at the Airport is a significant benefit to the Airport and to the City. On September 19, 2019, Council approved a Transient Use Agreement with MTSU for approximately 22,000 square feet in the new Terminal at the Airport. MTSU desires to incorporate signage into the its space and in the Terminal's common area, which is consistent with the University tenancy in a portion of the building. The proposed amendment furthers the strong working relationship the University and City, particularly at the Airport.

Council Priorities Served

Improve economic development

The signage standard established at the Airport assures appropriate use of space within the building and can assist with promoting the City and community.

Fiscal Impact

The marginal cost to create and purchase two small exterior signs, An estimated $1,500 will be absorbed within the Airport's current budget through expense reductions.

Attachments

Interior Sign Addendum to Transient Use Agreement

INTERIOR SIGNAGE ADDENDUM TO

TRANSIENT USE AGREEMENT

As an Addendum to the Transient Use Agreement dated ___ for the use by MTSU of certain facilities within the Murfreesboro Municipal Airport Terminal, MTSU and the City of Murfreesboro agree as follows:

1. MTSU may paint and / or install interior signage substantially as shown on the attached four pages in and on:

   a. The interior of the Classroom,

   b. The Classroom Hallway and interior Doors,

   c. The VIP Lounge and Office, and

   d. The Southwest corner of the Terminal Lobby.

2. At the termination (for whatever reason and by whatever means) of MTSU's use and occupancy of any portion of the Terminal, MTSU, at its sole cost and expense, will repair and repaint to the extent reasonably necessary to return that space to the condition prior to MTSU's use and occupancy, including but not limited to repainting to eliminate "shadows" from any attached signage.

3. MTSU will not use the term "Airport Campus" on and signage / logos / facilities that are not physically located within the MTSU Aerospace Airport Campus area of the Airport.

4. The City will create and install exterior "wayfinding" signage at the south wing of the Terminal for the MTSU Classroom VIP Waiting Room utilizing, to the extent reasonably practicable, the wording requested by MTSU.

5. A request for approval of Temporary Directional or other Temporary Signage for a special event, or for any other temporary purpose, at the Airport must be delivered to the Airport Manager not less than 48 hours before the event. The request must include an illustration showing all proposed Temporary Signage and a drawing showing the proposed location(s).

6. This Addendum shall be deemed to be effective as of the date of approval by the Murfreesboro City Council.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto:

OWNER: CITY OF MURFREESBORO

BY:_____
Name: Shane McFarland
Title: Mayor
Date:

ATTEST:

_____
Melissa Wright, City Recorder

APPROVED AS TO FORM:

_____
Adam F. Tucker, City Attorney

USER: MIDDLE TENNESSEE STATE UNIVERSITY

BY:_____
Name: Alan Thomas
Title: VP, Business & Finance
Date:

RECOMMENDED BY MURFREESBORO AIRPORT COMMISSION: October ____, 2019

APPROVED BY MURFREESBORO CITY COUNCIL: _____

Classroom Interior

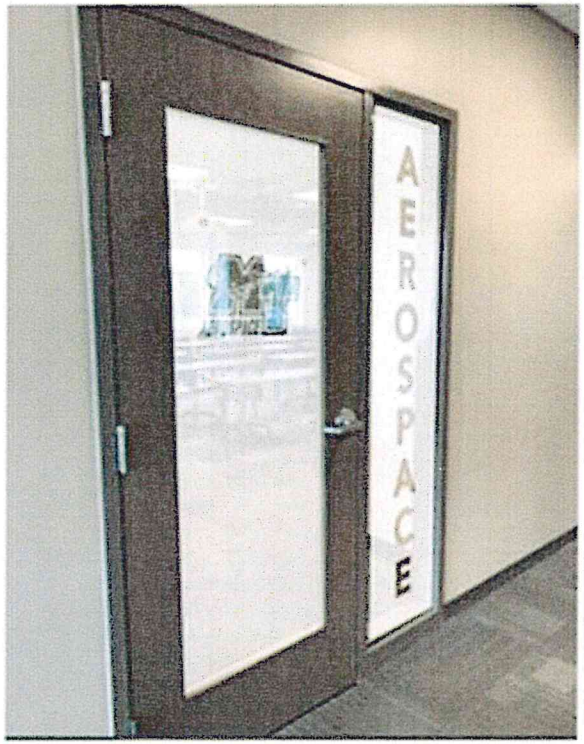
Murfreesboro Airport

- Logos and large-format photos will be vinyl materials, which will allow easy installation and change.
- Flip frames installed throughout room for faster change of topical images.

Classroom Hallway

Murfreesboro Airport

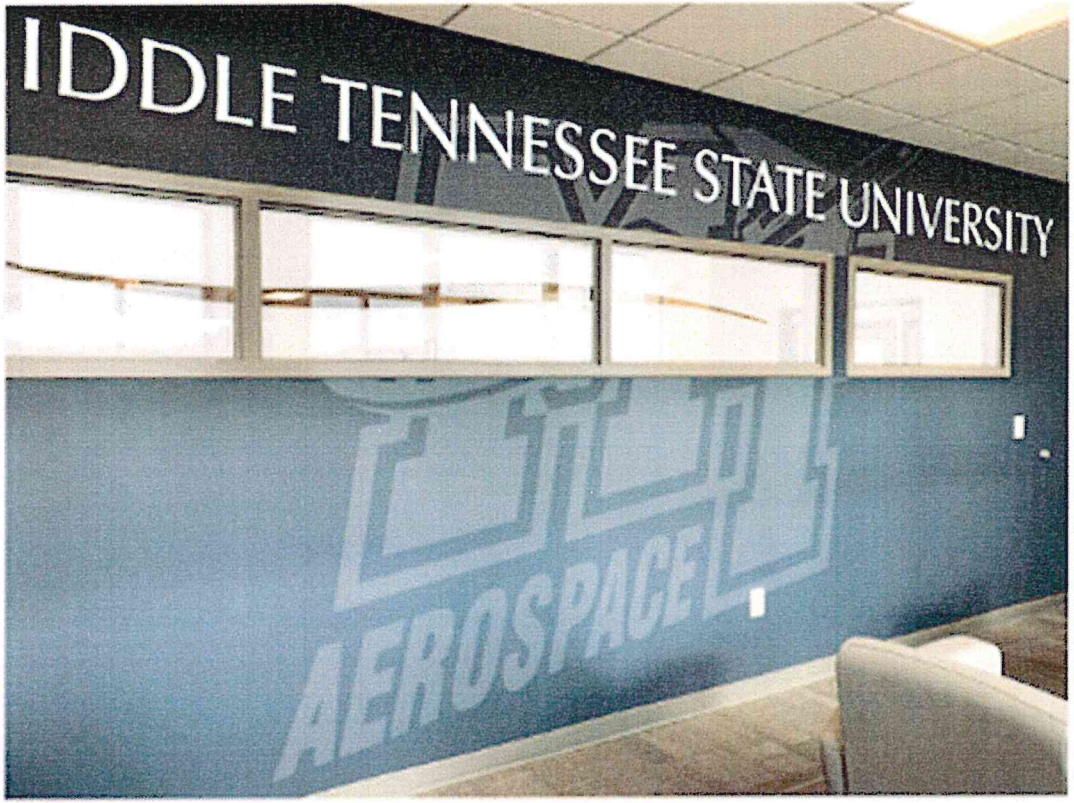
- Windows to the classroom will be frosted, with the logos remaining transparent to allow quick viewing if needed. Pedestrian signs will be placed outdoors at hallway entrances.



VIP Lounge & Office

Murfreesboro Airport

- Windows in between lounge and classroom will be frosted; logos will be vinyl treatments.



Terminal Lobby

Murfreesboro Airport

- Four "flip frames" allow easy change of static images and, if needed, welcome signs.
- Literature rack will be in corner to the right of our display

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: Agreement for Employee Medical Benefits

Department: Human Resources

Presented by: Pam Russell, Human Resources Director

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☒
Direction	☐
Information	☐

Summary

Agreements for employee medical benefits.

Staff Recommendation

Approve new agreements for Medical, Dental, and pharmacy employee benefits. Also approve the Flexible Spending Account (FSA) and MED Supplemental Insurance plan. All agreements are subject to final approval of the City Attorney.

Background Information

Proposals were solicited for medical, dental, and pharmacy employee benefits for a three-year term with an option to extend annually for an additional two years. The City's benefits consultant, Mercer, and the HR team conducted an in-depth analysis of the proposals that were received. Staff recommends the City continue with its current providers, Blue Cross Blue Shield of Tennessee, Delta Dental and Elixir Pharmacy Benefits Manager (formerly Envision). These vendors have provided good service and presented the strongest proposals.

The City also requests an extension of the current FSA and Supplemental Insurance plan administered by Wage Works and Benistar. Wage Works administers the FSA and supplement plan for City employees. Benistar provides health insurance for MED retirees.

Council Priorities Served

Responsible budgeting

Provide a strong employee benefit package which allows the City to hire and retain effective employees and avoid some of the significant expenses associated with hiring and training.

Fiscal Impact

Funds for these agreements are currently budgeted. The City will see an annual rate reduction of 6% for medical, 12% for dental, 3% for PBM and no increase for FSA. Benistar is being renewed with an approximately 2% rate increase, about $4,000 annually.

Attachments

1. Wage Works Extension
2. Benistar Extension
3. Blue Cross Blue Shield Agreement
4. Delta Dental Agreement
5. Elixir Agreement

WageWorks

AMENDMENT

Client:

City of Murfreesboro
111 W Vine St
PO BOX 1139, Murfreesboro, TN 37133-1139

This Amendment ("Amendment") to the Order Form by and between City of Murfreesboro ("Client") and WageWorks, Inc. ("WageWorks"), shall be effective as of 1/1/2021.

For good and valuable consideration, the receipt of which is hereby acknowledged, the parties hereby agree to amend the Order Form as set forth below. Unless otherwise modified herein, all other terms and conditions set forth in the Order Form shall remain in full force and effect.

This amendment may be executed in counterparts and exchanged by facsimile or electronically scanned copy. Each such counterpart shall be deemed to be an original and all such counterparts together shall constitute one and the same instrument.

Terms and Conditions of Service:

1. Term: The term of the Order Form shall be extended through December 31, 2022 ("Extended Term").

2. Fees: Client shall pay all Fees via Wire/ACH Credit or Check. All payments are due net 30 days from the date of invoice.

3. The Services shall be provided to the City of Murfreesboro and the City of Murfreesboro Water & Sewer Department as set forth below. For clarity, WageWorks shall invoice both entities separately.

City of Murfreesboro (WageWorks employer ID 33875):

Service Name	Fee Type	Fee	Description
HRA	Admin Fee	$3.50 PAPM	Per Account Per Month
HRA	Monthly Minimum	$150.00	
Amended and Restated Plan Document and SPD	Additional Service Fee	$0.00	Amended and Restated Plan Document and SPD. Priced per plan.
FSA	Admin Fee	$3.50 PPPM	Per Participant Per Month
FSA	Monthly Minimum	$150.00	
FSA	Implementation Fee	$0.00	
Amended and Restated Plan Document and SPD	Additional Service Fee	$0.00	Amended and Restated Plan Document and SPD. Priced per plan.

City of Murfreesboro Water & Sewer Department (WageWorks employer ID 34072):

Service Name	Fee Type	Fee	Description
FSA	Admin Fee	$3.60 PPPM	Per Participant Per Month

WageWorks

FSA	Monthly Minimum	$150.00	
Amended and Restated Plan Document and SPD	Additional Service Fee	$0.00	Amended and Restated Plan Document and SPD. Priced per plan.
HRA	Admin Fee	$3.50 PAPM	Per Account Per Month
HRA	Monthly Minimum	$150.00	
HRA	Implementation Fee	$0.00	
Amended and Restated Plan Document and SPD	Additional Service Fee	$0.00	Amended and Restated Plan Document and SPD. Priced per plan.

For Client:

By: _____

Name: _____

Title: _____

Date: _____

For WageWorks, Inc.

By: DocuSigned by: Darcy Mott E21A568E93874E0...

Name: Darcy Mott

Title: EVP & CFO

Date: 09/29/2020

Approved as to form:

Adam F. Tucker, City Attorney

BENISTAR
GROUP RETIREE HEALTH SOLUTIONS

9/30/2020

RE: City of Murfreesboro
Retiree Medical Plan - UA
Retiree Prescription Drug Program – ESI

Dear Alden Davenport:

Please be advised that there will be a combined 2.22% rate increase for the Retiree Medical Plan and the Express Scripts Group Medicare Part D Program. The rate increase is effective January 1, 2021. You will find the renewal rates below:

Retiree Medical Plan	$254.00
Group Medicare Part D Plan	$160.00
Combined Total	$414.00

This plan will automatically renew unless you notify Benistar of the group's plans to change plan design or terminate coverage. If this group intends to term coverage or make any plan design changes, please let us know no later than October 31st.

We would be more than happy to discuss this renewal with you in greater detail. You can contact me at 847-304-9500 ext. 4207.

Sincerely,
Kate Johnson
Case Manager

PLEASE NOTE: This template is subject to change before the contracting process begins.

An Independent Licensee of the Blue Cross and Blue Shield Association

ADMINISTRATIVE SERVICES AGREEMENT BETWEEN BLUECROSS BLUESHIELD OF TENNESSEE, INC. AND ABC, INC

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

Employer has established a self-funded Employee Welfare Benefit Plan, as the Employee Retirement Income Security Act of 1974 ("ERISA") defines that term, for its eligible Employees and their eligible Dependents ("Plan"). Employer's benefit documents, which summarize the benefits of the Employee Welfare Benefit Plan, are attached as Exhibit A ("Benefit Documents"). The eligible Employees and their eligible Dependents are collectively referred to as "Members", and that term is further defined in the Benefit Documents. All non-defined, but capitalized terms included in this Agreement are defined in the Benefit Documents. In consideration of the parties' mutual promises, the sufficiency of which are hereby acknowledged, the parties agree as follows:

ARTICLE I – RESPONSIBILITIES OF THE PARTIES

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

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

1.3. ERISA Fiduciary Responsibility. Employer is solely responsible for complying with all applicable provisions of ERISA. This includes the fiduciary responsibilities of administering its Plan and maintaining adequate funding to support the Plan. Employer is also responsible for, among other things, preparing and providing its covered employees with copies of Benefit Documents. Employer acknowledges that BlueCross is acting in a ministerial capacity and is not the "Administrator," the "Claims Fiduciary," nor the "Named Fiduciary" of Employer's Plan, as that term is defined in ERISA. For purposes of ERISA, the "Plan Administrator" is Employer.

1.4. Confidentiality. The parties acknowledge that this Agreement and information provided to the other party that is identified as confidential information, including, but not limited to, reimbursement information, group membership lists, marketing information and information obtained from and/or about the Blue Cross and Blue Shield Association and its programs ("Confidential Information") shall be treated as confidential, proprietary or trade secret information. A party may release Confidential Information to providers or its affiliates, or their respective directors, partners, officers, employees, advisors and other representatives (its "Representatives") who: have a need to know such Confidential Information, for purposes of their participation in or oversight of matters within the scope of this Agreement; and are under a duty or obligation of confidentiality at least as restrictive as those set forth in this Agreement. Each party shall advise its Representatives of their obligation to maintain the confidentiality of such information. Each party is responsible if its Representative breaches this Section. Neither party shall otherwise release nor disclose such Confidential Information to third parties without the other party's prior written consent, except as required by law. If legally compelled to release this Agreement or information included herein, Employer shall make every attempt to keep BlueCross proprietary information confidential, and shall provide written notice to BlueCross before releasing information. This paragraph shall survive the termination of this Agreement.

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

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

BlueCross reserves the right to refuse to release Confidential Information if BlueCross determines, in its sole discretion, that such release has the potential to damage BlueCross' competitive position in the market.

ARTICLE II – PAYMENT OF APPROVED CLAIMS AND ADMINISTRATIVE SERVICES FEES

2.1. Claims Funding. Employer shall pay the invoiced amount for claims processed and approved for payment by BlueCross in accordance with this Agreement ("Approved Claims.") Greater detail regarding this process is contained in Exhibit B. Nothing in this Agreement shall obligate or shall be deemed to obligate BlueCross to use its funds to satisfy any of Employer's obligations pursuant to this Agreement or Plan benefits.

Employer's assets and amounts contributed by Members, if applicable, are the only source or sources of payment of Approved Claims or any other benefit provided under the Plan.

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

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

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

ARTICLE III – TERM AND TERMINATION

3.1. Term. This Agreement becomes effective at 12:01 A.M. January 1, 2019 (the "Effective Date") and shall remain in effect until the earliest of the following events:

3.1.1 Until December 31, 2019, unless Employer and BlueCross agree to extend the term prior to December 31, 2019;

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

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

3.1.3 Any of the events specified in Section 3.2.

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

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

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

3.2.3 Employer ceases to maintain the Plan;

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

3.2.5 At any time Employer otherwise materially breaches this Agreement.

3.3. Termination for Invalid use of Information. Employer will use any information BlueCross makes available solely for the purpose of administering Employer's Plan under this Agreement and in accordance with applicable law. Employer agrees to hold BlueCross harmless for any claim, action or loss that may arise at any time in the future out of Employer's unauthorized or unlawful use of any such information. Furthermore, if Employer uses the information for another purpose, BlueCross will consider that action a material breach. This Agreement will then be subject to immediate termination.

3.4. BlueCross' Right to Reinstate. BlueCross has the sole discretion to decide to reinstate this Agreement if it was terminated pursuant to Subsections 3.2 or 3.3. If BlueCross

elects to reinstate this Agreement, Employer shall be responsible for reinstatement fees, which shall be $1,000.00.

3.5. Termination by Employer. Employer may terminate this Agreement upon giving BlueCross Thirty (30) days advance written notice if the following occurs:

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

3.5.2 If BlueCross materially breaches its duties under this Agreement.

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

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

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

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

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

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

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

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

and distinct administrative fee for BlueCross providing administrative services to pay run out claims. This is set out in Exhibit B.

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

ARTICLE IV – DISPUTE RESOLUTION

4.1. Binding Arbitration. Any dispute related to this Agreement that the parties are unable to resolve through informal discussion shall be resolved through binding arbitration or some other mutually acceptable dispute resolution procedure (e.g., mediation). The American Arbitration Association in Chattanooga, Tennessee, shall conduct such arbitration or mediation, unless the parties mutually agree in writing upon some other dispute resolution agency or venue.

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

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

ARTICLE V – LIABILITY AND INDEMNIFICATION

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

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

or resulted from the direction given by Employer or its directors, officers, employees or agents in the administration of the Plan.

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

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

5.2. Employer. Employer is responsible for making eligibility and benefit determinations in connection with the Plan, paying all claims for covered services and paying any other expenses related to or arising in connection with the Plan. Employer hereby agrees to indemnify, defend and hold harmless BlueCross, its directors, officers, employees and agents against any and all liability, actions, claims, lawsuits, settlements, judgments, costs, interest, penalties, expenses and taxes, including but not limited to, attorneys' fees and court costs, resulting from or arising directly or indirectly out of, or in connection with, any actions or decisions relating to the administration of the Plan unless the cause of such liability was the result of BlueCross' or any of its directors', officers', employees' or agents' failure to uphold the standard of care established in subsection 5.1.1. Further, Employer agrees to indemnify and hold harmless BlueCross for any Taxes or Penalties, as specified in Exhibit E to this Agreement.

ARTICLE VI – MISCELLANEOUS PROVISIONS

6.1 **Acceptance by Payment of Fees. BlueCross expects that Employer will demonstrate its acceptance of the terms of this Agreement by signing below. In the event that Employer has not signed the Agreement by January 1, 2019, this Agreement will be considered accepted by and binding upon both parties if and when Employer makes a payment to BlueCross in order to receive the services described in this Agreement.**

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

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

6.3 Assignment. This Agreement may be assigned to a subsidiary or affiliate of Employer upon Ninety (90) days prior written notice to, and with the express written consent of, BlueCross. BlueCross shall not unreasonably withhold its consent to any such assignment by Employer.

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

6.5 Impossibility of Performance. If an act or omission by a third party, including governmental entities, Network Providers or vendors, renders the performance of this

Agreement illegal, impossible or impractical, the affected party shall notify the other of the nature of that act or omission (the "Adverse Event.") The parties shall meet and, in good faith, attempt to negotiate a modification to this Agreement that minimizes the Adverse Event. Notwithstanding any other provision of this Agreement, if the parties fail to reach a negotiated modification concerning the Adverse Event, then the affected party may immediately terminate this Agreement upon giving written notice to the other party.

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

6.7 Entire Agreement. This Agreement, including the Exhibits and any Attachments hereto, contains the entire agreement between BlueCross and Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect. The Exhibits and Attachments to this Agreement include the following:

6.7.1 Exhibit A – Benefit Documents

6.7.2 Exhibit B – Administrative Services Fees

6.7.3 Exhibit C – Duties of and Services Provided by BlueCross

6.7.4 Exhibit D – Medical Management Services Provided by BlueCross

6.7.5 Exhibit E – Duties of Employer

6.7.6 Exhibit F – Automated Clearinghouse (ACH) Authorization Agreement

6.7.7 Exhibit G – Inter-Plan Arrangements

6.7.8 Exhibit H – COBRA Administration Agreement

6.7.9 Exhibit I – Reserved

6.7.10 Exhibit J – Reserved

6.7.11 Exhibit K – Reserved

6.7.12 Exhibit L – Reserved

6.7.13 Exhibit M – Online Enrollment Specifications

6.7.14 Exhibit N – Grievance Services

6.7.15 Exhibit O – Reserved

6.7.16 Exhibit P – Pharmacy Services

6.7.17 Exhibit Q – Business Associate Agreement

6.7.18 Exhibit R – Reserved

6.7.19 Exhibit S – Reserved

6.7.20 Exhibit T – Reserved

6.7.21 Exhibit U – Reserved

6.7.22 Exhibit V – Reserved

6.7.23 Exhibit W – Shared Savings

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

6.9 Inconsistencies.

6.9.1 If the provisions of this Agreement are in any way inconsistent with the provisions of the Benefit Documents, then the inconsistencies shall be resolved in accordance with the requirements of ERISA.

6.9.2 If the provisions of this Agreement are in any way inconsistent with the provisions of the Exhibits and Attachments hereto, then the provisions of Exhibits and Attachments shall prevail and the inconsistent provisions of this Agreement shall be deemed modified to the extent necessary to give effect to such provisions.

6.10 Independent Contractors.

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

6.10.2 On behalf of itself and its participants, Employer hereby acknowledges its understanding that this Agreement constitutes a contract solely between Employer and BlueCross which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting BlueCross to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that BlueCross is not contracting as the agent of the Association.

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

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

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

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

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

6.14 Benefit Documents. It is Employer's obligation to ensure all Benefit Documents, whether produced by BlueCross or Employer, meet the requirements of applicable laws. Employer agrees that all BlueCross and BlueShield Association mandated language shall be included in its Benefit Documents. BlueCross shall not be responsible for administering any Benefit Document that has not been reviewed and approved by BlueCross.

6.15 Severability. If any provision of this Agreement is declared illegal, void or unenforceable, the remaining provisions shall remain in force and effect, unless the severance of that provision substantially deprives a party of the benefit of its bargain or increases the cost of performing its duties pursuant to this Agreement.

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

6.17 Survival. The rights and obligations of the parties as set forth herein shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

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

6.19 Waiver of Breach. Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

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

6.21 Stop Loss Coverage. Employer has entered into a stop loss arrangement with a Stop Loss Vendor. BlueCross' duties with regard to this stop loss arrangement are in Exhibit C.

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

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives. The undersigned persons hereby warrant that they are duly authorized to bind each of their represented parties to the terms of this Agreement.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.		ABC, INC.	
By:		By:	
Print Name:	John Maki	Print Name:	
Title:	Vice President, Sales and Account Management	Title:	
Date:		Date:	
Address:	1 Cameron Hill Circle Chattanooga, TN 37402	Address:	
		Employer ID No.	

EXHIBIT A TO THE ADMINISTRATIVE SERVICES AGREEMENT

BENEFIT DOCUMENTS

Exhibit A consists of the following Benefit Documents

EXHIBIT B TO THE ADMINISTRATIVE SERVICES AGREEMENT

ADMINISTRATIVE SERVICES FEES (ASFS) AND CLAIMS FUNDING METHODOLOGY

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

1.1 Medical ASF

Rates effective as of:	January 1, 2019	January 1, 2020	January 1, 2021
Medical ASF	$_____ per Subscriber per month	$_____ per Subscriber per month	$_____ per Subscriber per month
Medical Main ASF	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**
Medical Guaranteed ASF	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**
Medical Total ASF	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**	**$_____ per Subscriber per month**

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

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

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

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

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

1.1.2 If Employer terminates this Agreement prior to _____ ___, 20___, Employer agrees that BlueCross will not receive certain additional income it had anticipated. As liquidated damages for this termination, Employer agrees that it will pay BlueCross an amount equal to one month's Medical Total ASF, based on the last fee paid by Employer.

1.2 Dental ASF

Rates effective as of:	January 1, 2019	January 1, 2020	January 1, 2021
Dental ASF	$_____ per Dental Subscriber per month	$_____ per Dental Subscriber per month	$_____ per Dental Subscriber per month

Dental ASF	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**
Dental Guaranteed ASF	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**
Dental Total ASF	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**	**$_____ per Dental Subscriber per month**

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

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

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

1.2.1.3 Fluctuation of the number of Dental Subscribers by more than _____% percent by location, state and/or in aggregate. Calculation of the Dental Total ASF was based on _____ Dental Subscribers; or

1.2.1.4 Fluctuation of the Member to Subscriber ratio by +/- _____. The Dental Total ASF was based on a Member to Subscriber ratio of _____.

1.2.2 If Employer terminates this Agreement prior to _____ ___, 20___, Employer agrees that BlueCross will not receive certain additional income it had anticipated. As liquidated damages for this termination, Employer agrees that it will pay BlueCross an amount equal to one month's Dental Total ASF, based on the last fee paid by Employer.

1.3 Vision ASF

Rates effective as of:	**January 1, 2019**	**January 1, 2020**	**January 1, 2021**
Vision ASF	$_____ per Vision Subscriber per month	$_____ per Vision Subscriber per month	$_____ per Vision Subscriber per month

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

Access Fees	The Access Fee is charged by the Host Blue to BlueCross for making its applicable provider network available to Employer's Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential BlueCross receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged, BlueCross passes the Access Fee directly on to Employer.	x.xx% of network savings, capped at $2,000.00 per claim
Administrative Expense Allowance (AEA) Fee	The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to BlueCross for administrative services the Host Blue provides in processing claims for Employer's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, BlueCross passes the AEA Fee directly on to Employer.	$x.xx per claim professional and $xx.xx per claim institutional
Nonparticipating Provider Fee		$3.00 per claim
Blue Cross Blue Shield Global® Core Fee		$3.75 per claim Member-submitted, $4.75 per claim professional, and $17.00 per claim institutional

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

3. Reports. Employer will have access to BlueCross' standard reporting and interactive reports. Any additional reports requested will be billed separately. Upon termination of this Agreement, Employer must pay charges for the cost of producing any report in advance of receiving the requested report.

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

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

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

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

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

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

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

4.2 Funding. On the 20th day of each month, BlueCross shall notify Employer of amounts that BlueCross estimates will be needed to pay BlueCross' ASFs for the following calendar month, and funds necessary to complete any adjustments to Approved Claims, fixed, previously agreed-upon charges, previous ASFs and any due late fees. Such payments shall be made in accordance with the Direct Debit Authorization Agreement, which is an Automated Clearinghouse (ACH) Authorization Agreement, attached to this Agreement as Exhibit F. Employer will transfer the amount specified by BlueCross into Employer's account so such funds shall be available for ACH debit by the first day of the following month (the "due date"). If the full amount specified by BlueCross pursuant to this paragraph is not received by BlueCross within that time period, BlueCross may immediately suspend payment of all Approved Claims on behalf of Employer, regardless of the date claims were incurred, until all amounts due are received by BlueCross. If BlueCross elects to not suspend claim payments on behalf of Employer, Employer shall pay a late fee of 1% per month on all amounts that are due and unpaid to BlueCross, pro-rated for each day that such amounts remain outstanding.

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

5.1 Cost of printing non-standard Member material.

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

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

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

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

5.6 Cost of non-standardized Member mailings.

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

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

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

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

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

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

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

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

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

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

EXHIBIT C TO THE ADMINISTRATIVE SERVICES AGREEMENT

DUTIES OF AND SERVICES PROVIDED BY BLUECROSS

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

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

   2.1. BlueCross shall furnish to Employer, for distribution to Members, forms to be used for enrollment and submission of any other forms determined to be necessary by BlueCross for the administration of the Benefit Documents under this Agreement.

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

   2.3. Once Employer has notified BlueCross in writing that a Member should be terminated as no longer eligible for coverage, BlueCross shall update its systems to reflect that change in the Member's coverage.

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

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

   2.4. RESERVED.

   2.5. BlueCross will supply identification cards.

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

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

2.6. BlueCross will provide Provider Directories through online access.

2.7. BlueCross will not conduct certification and verification of incapacitated dependent information.

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

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

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

3.3. BlueCross shall furnish each Member claiming benefits with an explanation of each claim that is paid, denied or rejected.

3.4. BlueCross shall give Members a reasonable opportunity to appeal a denied claim or any portion of a claim within the time frames specified by ERISA, according to the appeals procedure defined in the Benefit Documents.

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

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

3.6.1. If Employer's Benefit Documents include coverage for pharmacy benefits that are paid by BlueCross' pharmacy vendor, claims paid after a Member's termination cannot be recovered from the provider. BlueCross will attempt recovery from the Member on these claims. If Employer does not wish BlueCross to attempt recovery from a specific Member, Employer must direct BlueCross accordingly in writing.

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

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

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

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

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

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

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

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

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

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

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

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

higher than the provider's normal billing rate for that service, and BlueCross will pay the negotiated rate.

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

4.4.4. BlueCross may negotiate a settlement of a reimbursement dispute with a provider as part of its internal administrative procedures.

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

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

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

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

5.2. When a Member receives services from a Network Provider, he or she will be responsible for payment of the Deductible, Coinsurance and/or Copayment, as well as charges for any non-covered services. A Member's Coinsurance for Covered Services received from a Network Provider will be based on the provisions of the Network Provider's contract, and the lesser of (i) the Network Provider's pre-negotiated payment allowance, or (ii) charges for Covered Services at the time such Services are provided. BlueCross will not recalculate

Coinsurance in the event it recovers a discount or savings with respect to Covered Services after a claim for such Services is paid. Rather, Employer will receive a payment or credit for such savings or discounts.

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

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

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

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

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

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

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

7. Claims Payments Adjustments.

7.1. Whenever BlueCross becomes aware that a claims payment to a provider or Member is less than the amount to which the provider or Member is entitled, BlueCross shall promptly adjust the underpayment to reflect the proper amount that should be remitted.

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

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

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

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

7.2.2.2. all reasonable means of recovery under the circumstances have been exhausted; and

7.2.2.3. BlueCross' acts or omissions were not undertaken at the express direction of Employer.

7.2.3. BlueCross is not liable for interest on recovered overpayments.

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

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

7.3. The parties acknowledge that Employer may not contact Network Providers directly or indirectly regarding rates or charges for services provided to Members. All such contact with Network Providers must be by and through BlueCross.

7.4. In the event that BlueCross becomes aware that a claims payment to a provider or Member was or might have been the result of a fraud, BlueCross shall:

7.4.1. Notify the Plan as soon as possible about the alleged fraudulent claims;

7.4.2. Provide reasonable assistance to the Plan in recovering the alleged fraudulent claims; and

7.4.3. Report the suspected fraud to the appropriate law enforcement agency.

8. Annual Renewal Claims Analysis.

8.1. BlueCross will provide an annual renewal analysis of Employer's claims experience. BlueCross will also provide assistance in benefit design.

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

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

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

9. Legal Actions.

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

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

9.1.2. Subject to the indemnity provisions of the Agreement, Employer shall indemnify and defend BlueCross in any such Action, and shall be responsible for the defense costs for BlueCross.

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

9.1.4. Subject to the indemnity provisions of the Agreement, Employer shall remain liable for the full amount of any benefits paid as a result of such Action, in addition to all costs of legal fees, penalties, interest and other expenses recovered by a Member or provider in connection with the Action. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider as a result of any Action, or any legal fees or costs recovered by a Member or provider in connection therewith.

9.2. If an Action is brought against Employer:

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

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

9.2.3. Subject to the indemnity provisions of the Agreement, Employer shall be liable for the full amount of any benefits paid as a result of such Action, as well as any legal fees, penalties, interest and costs recovered by a Member or provider in connection therewith. In no event will BlueCross be liable for any amount of benefits paid to a Member or provider as a result of such Action, or any legal fees or costs recovered by a Member or provider in connection therewith.

10. Records and Reports. BlueCross will establish, maintain and provide to Employer, in its standard reporting package, records and reports generated as a result of the Services performed under this Agreement. BlueCross will not provide any information with regard to BlueCross' provider pricing agreements or any other information that is of a confidential or proprietary nature, as determined by BlueCross, unless it is subject to an agreement that protects the confidential and proprietary nature of the information. The required agreement shall be determined by BlueCross based on the intended use of the information.

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

12. Duties with regard to BlueRe of Tennessee Stop Loss Coverage. Employer has stop loss coverage with BlueRe of Tennessee ("BlueRe"). BlueCross will perform and provide the following on behalf of Employer:

12.1. Provide any records needed for the proper administration of stop loss coverage to BlueRe.

12.2. Provide Employer the following information at renewal:

Census	
Age/ Gender	Subscriber Count by age/gender
Zip Codes	Subscriber Count by LOB, State, Zip
Plan Design Summary/ Plan Document	Evidence of Coverage
Trigger Reports:	
50% of Specific Report	50% Report (Includes Diagnosis Only)
Medical & Rx	
Aggregate Claim Reports	Monthly Aggregate Report (excluding claims over specific)
By Month	(included in report)
Enrollment Included	(included in report)
Large Claims Amounts Included	(included in report)

12.3. Coordinate payment to brokers, and any other commission, as may be directed by Employer.

12.4. Provide monthly Claimants at 50% of Specific Attachment Point Reports.

13. RESERVED.

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

15. Distribution of Materials.

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

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

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

15.3.1. electronic access shall be limited to Employer's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;

15.3.2. they will replace any hard-copy Forms that have been modified by BlueCross;

15.3.3. the hard-copy documents on file with BlueCross shall control in the event of any discrepancy; and

15.3.4. Employer remains solely responsible for the content of the Documents and all other legal requirements pertaining to them (e.g., distribution).

15.4. BlueCross will create a draft Summary of Benefits and Coverage ("SBC"), based on services provided by BlueCross, and provide to Employer. Employer shall

review SBC, and revise or supplement as required, prior to distribution. Employer remains solely responsible for SBC content and all other legal requirements pertaining to SBC (e.g., distribution). BlueCross shall not charge Employer for draft SBC. BlueCross may charge Employer for translation of SBC to any language other than English.

16. Member Outreach. BlueCross shall have the right to contact Members to perform services under this Agreement, or as otherwise required by law, a regulatory body, or an accrediting agency. Employer warrants that the contact information included in its enrollment data was obtained directly from the applicable Member and that Members are aware they may be contacted via that information for non-telemarketing calls, emails, and/or text messages.

EXHIBIT D TO THE ADMINISTRATIVE SERVICES AGREEMENT

MEDICAL MANAGEMENT SERVICES PROVIDED BY BLUECROSS

Employer has selected several of BlueCross' Medical Management programs for use by Employer in administering its Plan. All services utilize current medical guidelines and standards. While these services are described below, they may be updated from time to time.

MEDICAL MANAGEMENT

1. Inpatient Review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. RESERVED

11. RESERVED

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

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

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

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

12.4. Case Management. BlueCross' Behavioral Health Case management process identifies high risk Members in facility based levels of care and assesses

opportunities to coordinate and manage the Member's total behavioral health care to ensure the best outcomes while the Member remains in facility based levels of care.

EXHIBIT E TO THE ADMINISTRATIVE SERVICES AGREEMENT

DUTIES OF EMPLOYER

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

   1.1 Provide BlueCross with a current, detailed description of the Benefit Documents and any subsequent changes, for approval by BlueCross;

   1.2 Provide BlueCross with the necessary Subscriber and Member eligibility information;

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

   1.4 Provide electronic enrollment and status change data, as detailed in Exhibit L.

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

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

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

   2.3 Notice by Employer can be effectuated through Employer's entering of data online, as detailed in Exhibit K.

3. Final Authority. Except as otherwise specifically stated in this Agreement, Employer retains all final authority and responsibility for the Plan including, but not limited to, the benefit design of the Plan, claims payment decisions, cost containment program decisions, eligibility and benefit determinations, compliance with the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), compliance with the requirements of ERISA, compliance with reporting and remitting abandoned property funds (except as referenced in Exhibit C, Section 5) if required by law, and compliance with any other state and federal laws or regulations applicable to Employer or the administration of the Plan. The phrase "eligibility and benefit determinations" means that Employer determines who is eligible to participate, (i.e., who are employees or dependents) and generally what medical procedures are included or excluded as identified in the Benefit Documents, but does not include the ultimate responsibility for making medical necessity determinations.

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

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

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

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

   4.1 Employer shall be responsible for providing each Subscriber with a copy of any required documents.

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

5. Financial Obligations.

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

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

6. Assessments.

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

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

   6.3 Employer will pay these additional amounts even if the validity of Assessments has not been finally determined. If it is finally determined that such Assessments were not valid, to the extent such Assessments are refunded or otherwise returned to BlueCross by the appropriate Federal, state or local governmental entity, BlueCross will refund to Employer an amount equal to those additional

amounts previously paid by Employer plus interest, if any, determined in accordance with BlueCross' regular procedures then in effect, less a pro rata share of any expenses incurred by BlueCross in contesting the validity of such Assessments.

7. Use of Names and Service Marks. Employer agrees to allow BlueCross to use Employer's name and service mark on I.D. cards and other forms necessary to implement this Agreement, and to promote Employer's relationship with BlueCross to potential or existing providers. BlueCross shall not use Employer's name or service mark for any other purpose without the prior written consent of Employer.

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

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

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

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

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

   8.3 Employer may perform a simple audit of BlueCross once during the calendar year while this Agreement is in force without any charge by BlueCross. A "simple audit" is one that requires less than Fifty (50) person hours of work by BlueCross

employees to assist in the audit. Employer must negotiate the cost, parameters, etc. with BlueCross for an audit that does not fit this definition.

8.4 The parties agree that Employer shall not hire a third party to conduct a contingent fee audit, where the third party's compensation is based on a percentage of errors (or savings, or "uncovered recoveries", etc.), which may be found by the third party in its audit. Should Employer err and so contract with a third party to perform such contingent fee audit, BlueCross has no obligation under the terms of this Agreement to cooperate with said third party in the conduct of such contingent fee audit.

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

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

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

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

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

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

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

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

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

EXHIBIT F TO THE ADMINISTRATIVE SERVICES AGREEMENT

DIRECT DEBIT AUTHORIZATION AGREEMENT

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

EXHIBIT G TO THE ADMINISTRATIVE SERVICES AGREEMENT

INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services

Overview

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

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

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

1.1 BlueCard® Program

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

1.1.1 Liability Calculation Method Per Claim – In General

1.1.1.1 Member Liability Calculation

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

1.1.1.2 Employer Liability Calculation

The calculation of Employer's liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to BlueCross by the Host Blue under the contract between the Host Blue and the provider. Sometimes, this negotiated price may be greater for a given

service or services than 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 Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge.

1.1.2 **Claims Pricing**

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

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

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

1.1.2.3 An average price. An average price is a percentage of billed charges 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 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 Member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or

average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, Employer will not receive a refund or charge from the variance account.

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

1.1.3 **BlueCard Program Fees and Compensation**

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

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

1.2.1 *Value-Based Programs Overview*

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

1.2.2 *Value-Based Programs under the BlueCard Program*

1.2.2.1 *Value-Based Programs Administration*

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

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

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

- 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.

- 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 follows:

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

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

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

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

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

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

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

1.2.3 *Care Coordinator Fees*

Host Blues may also bill BlueCross for Care Coordinator Fees for provider services which we will pass on to Employer as follows:

1.2.3.1 PMPM billings; or

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

As part of this Agreement/contract, BlueCross and Employer will not impose Member cost sharing for Care Coordinator Fees.

1.2.4 *Value-Based Programs under Negotiated Arrangements*

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

As part of this Agreement, BlueCross and Employer may agree to waive Member cost sharing for care coordinator fees.

1.2.5 *Value-Based Programs Definitions*

Accountable Care Organization (ACO): 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.

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific groups of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

Negotiated Arrangement a.k.a., Negotiated National Account Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Patient-Centered Medical Home (PCMH): 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.

Provider Incentive: 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 agreed-upon procedural and/or outcome measures for a particular group of covered persons.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

1.3 Return of Overpayments

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

1.4 Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BlueCross will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability. See also Exhibit E, paragraph 6.

1.5 Nonparticipating Providers Outside BlueCross' Service Area

1.5.1 Member Liability Calculation

1.5.1.1 In General

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

1.5.1.2 Exceptions

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

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

1.5.2 Fees and Compensation

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer are set forth in Exhibit B. Fees and compensation under applicable Inter-Plan

Arrangements may be revised from time to time as provided for in section 1.7 below.

1.6 Blue Cross Blue Shield Global® Core

1.6.1 General Information

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of 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 Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

1.6.1.1 Inpatient Services

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

1.6.1.2 Outpatient Services

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

1.6.1.3 Submitting a Blue Cross Blue Shield Global Core Claim

When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from BlueCross, the service center, or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

1.6.2 Blue Cross Blue Shield Global Core-Related Fees

Employer understands and agrees to reimburse BlueCross for certain fees and compensation which we are obligated under applicable Inter-

Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Employer under Blue Cross Blue Shield Global Core are set forth in Exhibit B. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section 1.7 below.

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

Modifications or changes to Inter-Plan arrangement fees are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, BlueCross 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 Employers right to terminate this Agreement without penalty by given written notice of termination before the effective date of this change. 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 BlueCross will then allow such modifications to become part of this Agreement.

EXHIBIT H TO THE ADMINISTRATIVE SERVICES AGREEMENT

COBRA ADMINISTRATION PROVIDED BY BLUECROSS

In the event that any Member is entitled to continuation of their benefits under the Benefit Documents, BlueCross will continue to perform its duties under this Agreement with regard to that Member as outlined below. That Member shall be charged the amount allowed by law (currently, 102% of the premium equivalent charged to active Subscribers, and 150% if the Member is disabled.) BlueCross' and Employer's obligations under this Exhibit shall terminate at the same time this Agreement ends.

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

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

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

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

   1.4 Collect all necessary payments and premium equivalents from said Member after the initial payment is submitted by Employer, in such amounts as directed by Employer, for all benefits selected to be continued by the Qualified Beneficiaries. If BlueCross does not receive the necessary payments from a Qualified Beneficiary, BlueCross will:

      1.4.1 place a stop-pay on the Qualified Beneficiary's benefits; and

      1.4.2 cancel the Qualified Beneficiary's coverage at the end of the grace period.

   1.5 Provide claims processing services;

   1.6 Provide access to the Blue Network(s);

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

   1.8 Terminate the COBRA continuation coverage at the appropriate time.

   1.9 When a notification of termination is generated, (i.e., for failure to submit the enrollment form and pay the applicable premium during the statutory election and/or grace period, non-payment of premium charges or expiration of the applicable eligibility period for COBRA continuation coverage) BlueCross will:

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

      1.9.2 Notify Employer of any termination of coverage;

      1.9.3 Mail information regarding any available conversion coverage to the terminated Qualified Beneficiary.

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

   1.11 If Employer terminates its Plan, BlueCross shall not send out Termination of Coverage letters.

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

   2.1 Notify Subscribers and/or Dependents of their COBRA rights initially;

   2.2 Provide the eligibility information for all Qualified Beneficiaries to BlueCross with the monthly eligibility information;

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

   2.4 Send the eligibility notification letter to the Qualified Beneficiaries;

   2.5 Collect the initial monthly premium equivalent from the Eligible COBRA Participant;

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

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

3. As consideration for the above-referenced services:

   3.1 For Qualified Beneficiaries who have BlueCross administered health benefits:

      3.1.1 Employer shall pay BlueCross the ASF included in Exhibit B;

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

4. Payment for COBRA administration services is as follows:

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

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

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

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

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

5. BlueCross will provide COBRA administration for all Members covered under Employer's Plan.

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

7. "Qualified Beneficiary" means each individual person who is eligible for COBRA continuation coverage, whether formerly covered under the BlueCross administered plan as a Subscriber or a dependent, or covered under another of Employer's benefits plans. "Eligible COBRA Participant" means the group of a Subscriber and/or Dependents,

whether formerly covered under the BlueCross or another of Employer's benefit plans, that have elected to be covered together as a family unit and are issued one invoice for COBRA Continuation Coverage by BlueCross.

EXHIBIT I TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT J TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT K TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT L TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVES

EXHIBIT M TO THE ADMINISTRATIVE SERVICES AGREEMENT

ONLINE ENROLLMENT SPECIFICATIONS THROUGH BLUECROSS SECURED WEBSITE

BlueCross' Duties and Responsibilities:

1. BlueCross will provide a PIN for website access.
2. BlueCross will provide instruction upon Employer's request. Such instruction may be done by telephone or personal contact.
3. BlueCross will accept data and process enrollment, status change and termination requests in accordance with the eligibility guidelines.
4. BlueCross has the right to audit Employer's data transmissions for accuracy and completeness.

Employer's Duties and Responsibilities:

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

EXHIBIT N TO THE ADMINISTRATIVE SERVICES AGREEMENT

GRIEVANCE SERVICES

This Exhibit describes duties regarding grievance services:

1. First Level Grievance.

   1.1 BlueCross shall conduct the first level grievance on Employer's behalf. For purposes of handling the first level Grievance, BlueCross is a limited fiduciary under ERISA.

   1.2 BlueCross shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.

   1.3 A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.

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

   1.5 First level grievance is the only mandatory level of grievance.

   1.6 If Employer's Plan includes vision benefits, first level grievance is the only grievance service performed for Members appealing an adverse benefit determination related to vision benefits.

2. Second Level Grievance.

   2.1 BlueCross shall conduct the second level grievance for Employer. For purposes of handling the second level Grievance, BlueCross is a limited fiduciary under ERISA.

   2.2 BlueCross shall have full discretionary authority to make eligibility, benefit, claim, or any other applicable benefit determinations.

   2.3 A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.

   2.4 Member shall have the opportunity to present oral testimony and to provide additional information to BlueCross.

3. External Review.

   3.1 BlueCross shall coordinate the external review procedure on Employer's behalf. For purposes of handling the external review process, BlueCross is a limited fiduciary under ERISA.

   3.2 BlueCross' external review procedure shall be based on and follow the external review procedure set forth in the Tennessee Code Annotated.

   3.3 A written decision concerning the grievance shall be sent to Member within the timeframe set forth in the Benefit Documents.

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

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

6. Nothing shall establish a grievance process that contradicts any statement in this Exhibit.

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

EXHIBIT O TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT P TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT Q TO THE ADMINISTRATIVE SERVICES AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

EXHIBIT R TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT S TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT T TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT U TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT V TO THE ADMINISTRATIVE SERVICES AGREEMENT

RESERVED

EXHIBIT W TO THE ADMINISTRATIVE SERVICES AGREEMENT

SHARED SAVINGS

BlueCross will perform recovery services in the identified areas and, as compensation for these services, BlueCross will retain a percentage of any recovery ("Shared Savings") as identified below. Shared Savings will be taken in accordance with BlueCross' administrative processes. Shared Savings will be reconciled via reporting updated on a weekly basis.

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

   1.1 Subrogation Recoveries.

      1.1.1 BlueCross will enforce Employer's subrogation rights. For all subrogation recoveries received on or after January 1, 20XX, BlueCross will retain a fee of ___% of the gross subrogation recovery. Employer is responsible for payment of: (a) any outside attorneys' fees incurred in enforcing Employer's subrogation rights; and (b) any other expenses arising in connection with litigation to enforce its subrogation interest, including, but not limited to, court costs and discovery expenses.

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

   1.2 Mass Tort Recoveries.

      1.2.1 BlueCross will perform mass tort recoveries on behalf of Employer. BlueCross will retain a fee of ___% of all mass tort recoveries received on or after January 1, 20XX.

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

   1.3 Class Action Recoveries.

      1.3.1 BlueCross will perform class action recoveries on behalf of Employer. BlueCross will retain a fee of ___% of all class action recoveries received on or after January 1, 20XX.

      1.3.2 For any recoveries received before the Process Conclusion Date, BlueCross will deduct its fee, the attorneys' fee (if any) and any other

litigation expenses from each recovery amount received. This net recovery is the amount that Employer will receive as a credit.

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

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

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

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

   4.2 For Medical Drug Rebates received by BlueCross on or after January 1, 20XX, BlueCross retains 100% of Medical Drug Rebates.

5. Pharmacy Rebates.

   5.1 For Pharmacy Rebates based on service dates occurring on or after January 1, 20XX, Employer will receive ___% of Pharmacy Rebates (as defined in Pharmacy Services Exhibit).

GROUP ADMINISTRATIVE SERVICES CONTRACT

ACCEPTANCE
AND
CONTRACT

The issuance of this signed CONTRACT by DDTN acknowledges acceptance of the GROUP's application for coverage. The coverage detailed in this CONTRACT is extended to the GROUP at the rates stated in and upon the terms and conditions set out in this CONTRACT including all schedules, endorsements and amendments.

So long as GROUP pays the PREMIUM as agreed, DDTN agrees to provide the BENEFITS described in this CONTRACT. BENEFITS will start at 12:01 AM Standard Time on the EFFECTIVE DATE. This CONTRACT will continue for the period of time shown on the Declaration Page and after that will be extended as described in this CONTRACT, unless ended in accordance with ARTICLE 7. If DDTN does not receive payments in accordance with this CONTRACT, it may suspend payment of claims.

Any changes to the rates, terms or conditions of this CONTRACT will only be effective when issued in writing by DDTN. No agent or broker or other employee of GROUP has the authority to change or waive any provisions of this CONTRACT.

This CONTRACT is issued on this the 1st day of January, 2020, by,

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
615-255-3175

Philip A. Wenk, D.D.S.

President & Chief Executive Officer
Title

ARTICLE 1. DEFINITIONS

As used in this CONTRACT:

1.01 **"BENEFITS"** means the amounts that DDTN will pay for dental services under this CONTRACT.

1.02 **"BENEFIT YEAR"** is the period from January 1 to December 31 of the same calendar year, unless otherwise defined on the Declaration Page. No BENEFITS will be allowed before the EFFECTIVE DATE of the MEMBER'S coverage.

1.03 **"CLAIM FORM"** is the standard Attending Dentist Statement form used to file a claim or request predetermination of BENEFITS. CLAIM FORM also includes claims filed with DDTN electronically.

1.04 **"COBRA-MEMBER"** is a MEMBER who ceases to be eligible as a SUBSCRIBER or DEPENDENT, but chooses to continue coverage as allowed under 29 USC § 1161 et seq. or an applicable state continuation of coverage provision.

1.05 **"CONTRACT"** is this agreement between DDTN and GROUP, including the Application, Declaration Page, all Schedules and all Endorsements and Amendments as issued by DDTN.

1.06 **"CONTRACT TERM"** is the time starting with the EFFECTIVE DATE and ending 12 months later, plus any renewals or extensions unless noted otherwise on the Declaration Page. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.

1.07 **"CONTRACT YEAR"** is the 12 months starting on the EFFECTIVE DATE and each subsequent 12 months while the CONTRACT is in effect.

1.08 **"DDTN"** is Delta Dental of Tennessee, a Tennessee Not-for Profit Corporation. As used in this contract, DDTN may refer to Delta Dental of Tennessee acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association.

1.09 **"DEDUCTIBLE"** is the amount the MEMBER must pay for services in any BENEFIT YEAR before BENEFITS will be paid by DDTN, subject to limitations shown on the Declaration Page.

1.10 **"DENTIST"** is a person licensed to practice dentistry when and where services are performed. DENTIST may also apply to auxiliary personnel legally authorized to perform services under the supervision of a person licensed to practice dentistry.

1.11 **"DEPENDENT"** is a Dependent of a SUBSCRIBER who is enrolled in this GROUP program.

1.12 **"EFFECTIVE DATE"** is 12:01 AM at the GROUP's address on the date the CONTRACT begins, as shown on the Declaration Page.

1.13 **"EMPLOYEE"** is an employee of the GROUP who is eligible for enrollment in the GROUP program.

1.14 **"GROUP"** is the employer, association or trust named in the Application.

1.15 **"MAXIMUM PLAN ALLOWANCE"** is the maximum fee DDTN will pay for a single procedure.

1.16 **"MEMBER"** is a SUBSCRIBER or a DEPENDENT who is enrolled in this GROUP's dental program.

1.17 **"NON-PARTICIPATING DENTIST"** is any DENTIST who is not a member of DDTN or any other organization that is a member of Delta Dental Plans Association.

1.18 **"OPEN ENROLLMENT PERIOD"** is the last month of each CONTRACT YEAR. During this period, EMPLOYEES may change DEPENDENT coverage to be effective on the first day of the next CONTRACT YEAR

1.19 **"PARTICIPATING DENTIST"** is a licensed DENTIST who is a member of DDTN or any other organization that is a member of Delta Dental Plans Association, and who has agreed to abide by their rules and regulations.

1.20 **"PREMIUM"** is the monthly amount paid by GROUP to DDTN to provide coverage under this CONTRACT. PREMIUM will refer to the administrative fees as well as reimbursement for claims paid.

1.21 **"PREVAILING FEE"** is the fee for a single procedure which satisfies the fee of most PARTICIPATING DENTISTS.

1.22 **"SUBSCRIBER"** is an EMPLOYEE who is enrolled in this GROUP's dental program.

ARTICLE 2. MONTHLY PREMIUMS

2.01 GROUP will pay PREMIUMS to DDTN at the address shown in ARTICLE 6 or to any other address as directed by DDTN. GROUP will make timely payments of PREMIUMS in the amount and manner shown on the Declaration Page or on a subsequently issued endorsement or amendment. Payment of PREMIUMS indicates the acceptance of this CONTRACT, its attachments, and subsequent endorsements and amendments.

PREMIUMS for COBRA-MEMBERS will be the same as for MEMBERS with the same coverage. GROUP will pay monthly PREMIUMS for COBRA-MEMBERS to DDTN. GROUP may charge COBRA-MEMBERS for their coverage as permitted by 29 USC § 1162.

2.02 DDTN will administer the dental benefits for GROUP'S self insured dental benefit plan in accordance with this contract. Weekly, each Tuesday, DDTN will transmit via fax or electronic mail, a notification showing the total of the claims payments processed the previous week. GROUP will issue payment by electronic transfer payable to DDTN so that it arrives at the address designated by DDTN, before the end of that week. Alternatively, GROUP may allow DDTN to issue an electronic debit of the GROUP's account before the end of that week. Monthly, DDTN will mail GROUP a report showing all claims payments. Should any of these days fall upon a holiday, the next business day will be substituted.

Before the first of each month, DDTN will invoice GROUP for the administrative fee for this dental program. Payment for this is due by the Delinquent Date stated on the Declaration Page and may be made by check, wire, or ACH.

At least quarterly, DDTN will give GROUP credit for voided checks and refunds received by DDTN on behalf of GROUP.

If any payment by GROUP is made by wire or ACH, a fax confirming the date and amount

of the transfer should be forwarded to DDTN at (615) 244-8108, ATTENTION: Accounts Receivable.

Since GROUP is self insured and will be funding the claim payments with a week's delay, DDTN will not require a deposit for the purpose of prepaying claims. This will allow DDTN to continue to use its normal claims payment process for issuing checks. If payment is not received on a timely basis, DDTN may require a deposit. If a deposit is required, it will act as an imprest fund from which claims will be paid and then replenished. If a deposit is required, it shall be based upon group size and experience. At the end of the contract, any unused portion of this deposit will be applied toward run out claims with any balance being returned to the GROUP. If a deposit is requested, it will be due within one week and should be sent to Delta Dental Plan of Tennessee, Finance Department, ATTN: Accounts Receivable, 240 Venture Circle, Nashville, Tennessee 37228.

Should DDTN not receive reimbursement for the claims paid or any administrative fee within five (5) calendar days of their due date, DDTN may suspend any further payment of claims. Should DDTN not receive payment within 10 calendar days of its due date, DDTN may cancel its contract with GROUP immediately and pursue collections of all monies owed to DDTN by GROUP plus reasonable collection fees, attorney fees and/or court costs.

2.03 DDTN may change the rate of monthly PREMIUMS whenever the CONTRACT is amended or renewed.

2.04 Terms and conditions governing membership enrollment will be found in Schedule C.

ARTICLE 3. LIMITATIONS AND EXCLUSIONS FOR ALL BENEFITS

3.01 DDTN will only pay the BENEFITS stated for each type of dental service described in the schedule or schedules of benefits. Not all dental services are BENEFITS under this contract. BENEFITS will only be provided for MEMBERS who are enrolled on the date of treatment. BENEFITS will be determined based on the date services were completed. To be a paid BENEFIT, services must be provided by a DENTIST or properly licensed employee of DENTIST. Services must be necessary and customary. Services must be provided by generally accepted dental practice standards, as determined by the dental profession. DDTN will pay allowable BENEFITS based upon the percentages shown on the Declaration Page. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE or the fees the DENTIST charges for the service. The MAXIMUM PLAN ALLOWANCE for in state NON PARTICIPATING DENTISTS is limited to the PREVAILING FEE. Out of state NON PARTICIPATING DENTISTS are paid in accordance with each state's local business rules from information provided from the National Provider File, or in the case of an ERISA contract, in accordance with the GROUP'S ERISA plan.

DDTN will administer this plan as a Delta USA program. A Delta USA program is a program whereby DDTN and other Participating Plans have agreed to provide to MEMBERS the BENEFITS described in the CONTRACT. DDTN shall be the Control Plan for the CONTRACT and may act for itself and on behalf of each Participating Plan, for the purposes herein cited.

3.02 **OPTIONAL SERVICES**

a) In cases where alternate or optional methods of treatment exist, BENEFITS are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the DENTIST's treatment plan or to recommend which treatment should be provided. It is a determination of BENEFITS under terms of the MEMBER's coverage. The DENTIST and MEMBER should decide the course of treatment. If the treatment rendered is

other than the covered BENEFIT, the difference between DDTN's allowance and the DENTIST's fee, up to the approved amount, for the actual treatment rendered is collectable from the MEMBER.

b) Payment made by DDTN for any surgical service will include charges for routine post-operative evaluations or visits.

c) In the event a MEMBER transfers from one DENTIST to another during the course of treatment, BENEFITS will be limited to the amount that would have been paid had only one DENTIST rendered the service.

3.03 **EXCLUSIONS**

DDTN does not pay BENEFITS for:

a) Treatment of injuries or illnesses covered by Workers' Compensation or Employer's Liability Laws.

b) Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.

c) Cosmetic surgery or procedures for purely cosmetic reasons.

d) Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations. This does not exclude those services provided under Orthodontic BENEFITS, if covered.

e) Treatment to restore tooth structure lost from wear.

f) Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.

g) Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).

h) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the DENTIST for treatment in any such facility.

i) Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.

j) Services by a DENTIST beyond the scope of his license.

k) Dental services for which the MEMBER incurs no charge.

l) Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.

m) General Anesthesia or I.V. Sedation is a BENEFIT only when administered by a properly licensed DENTIST in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.

3.04 No change in BENEFITS will become effective during a CONTRACT TERM unless GROUP and DDTN agree in writing.

ARTICLE 4. DEDUCTIBLE, MAXIMUM AND COORDINATION OF BENEFITS

4.01 DDTN will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied. The annual DEDUCTIBLE per MEMBER and per family is shown on the Declaration Page. The DEDUCTIBLE will apply for the calendar year unless noted otherwise on the Declaration Page.

4.02 The DEDUCTIBLE applies to the benefit categories as shown on Declaration Page. Only fees a MEMBER pays for services covered under the benefit schedules included in this CONTRACT will count toward satisfying the DEDUCTIBLE.

4.03 Unless otherwise indicated on the Declaration Page, the DEDUCTIBLE and MAXIMUMS apply each CALENDER YEAR.

4.04 **MAXIMUM**
DDTN will pay up to the Maximum Amount shown on Declaration Page.

4.05 **COORDINATION OF BENEFITS**
If a MEMBER is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CONTRACT will be subject to the following conditions:

a) If the other program is not primarily a dental program, this program is primary.

b) If the other program is for dental coverage, the following rules are applied:

1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.

2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e. stepparent) will be primary.

3. If there is a court decree stating that one parent has financial responsibility for a child's health care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

c) When primary coverage cannot be determined according to a) and b), the program which has covered the patient for the longer period will be primary.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage.

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 **CHOICE OF DENTIST.** DDTN does not furnish covered services directly. DDTN pays for licensed DENTISTS to provide these services. A MEMBER may choose any DENTIST. MEMBERS should determine for themselves the professional qualification of the DENTIST they select. In Tennessee, participation in DDTN is open to all DENTISTS who are licensed in Tennessee unless they have previously had their participation in DDTN terminated for cause. Whether a DENTIST is a PARTICIPATING or NON-

PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST'S ability.
DDTN shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, DDTN cannot ensure your DENTIST'S use of precautions against the spread of such diseases, nor can DDTN compel your DENTIST to be tested for HIV or to disclose test results to DDTN or to you. DDTN informs its PARTICIPATING DENTISTS about the need for clinical precautions as recommended by recognized health authorities on this issue. But if you have questions about your DENTIST'S health status or use of recommended clinical precautions, you should discuss them with your DENTIST.

DDTN is not responsible for any injuries or damages suffered due to the actions of any provider. DDTN is also not liable for a DENTIST's refusal or failure to provide services.

5.02 **CLINICAL EXAMINATION.** Before approving a claim, DDTN may obtain from any DENTIST or hospital such information and records DDTN may require to administer the BENEFITS. DDTN may require a MEMBER be examined by a dental consultant, retained by DDTN, in or near his community or residence. Such information and records will be kept confidential.

5.03 **CLAIM FOR BENEFITS.** To make a claim for BENEFITS, the CLAIM FORM must be properly completed and submitted to DDTN. Electronic claims may be accepted but require supporting documentation be maintained by the DENTIST.

5.04 **PREDETERMINATION.** A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDTN then will predetermine the BENEFITS payable under this CONTRACT. Payment will only be made for predetermined services if the MEMBER remains eligible and has not exceeded his or her annual maximum BENEFITS. A CLAIM FORM requesting a predetermination may be submitted electronically.

5.05 **PROOF OF LOSS.** Proof of loss must be furnished to DDTN within 15 months after completion of treatment for which BENEFITS are payable. Any claim filed after this period will be denied.

5.06 **FIRST AND SECOND LEVEL REVIEW OF CLAIMS DENIAL.** After a claim is processed, DDTN will send an Explanation of Benefits (EOB) to the SUBSCRIBER. If any payment for services was denied, the EOB will give the reason why. A SUBSCRIBER has 180 days after receiving an EOB to request a first level review. All requests for review must be submitted to DDTN in writing. All requests for review must give reasons the denial was wrong. The SUBSCRIBER may also ask to look at any records to aid his or her review. DDTN will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the subscriber within 30 days after DDTN receives the request for review.

If the SUBSCRIBER does not agree with the first level review decision, he or she may refer the request for review to the Professional Relations Advisory Committee of DDTN. This second level review must be in writing and received by DDTN within a reasonable time after the SUBSCRIBER receives the first level review decision. Unless unusual circumstances arise, a decision will be sent to the SUBSCRIBER within 30 days after DDTN receives the request for second level review.

If the subscriber does not agree with the second level review decision, he or she may file civil action in court.

GROUP, in its roll as the fiduciary for this program, will have the responsibility for final decisions relating to the payment of all benefits.

5.07 **TERMINATION OF BENEFITS ON LOSS OF ELIGIBILITY.** DDTN will not pay BENEFITS for any services received by a patient who is not eligible at the time of treatment. GROUP will repay DDTN for any payments made because of errors or delay in reporting required of the GROUP.

5.08 **TO WHOM BENEFITS ARE PAID.** BENEFITS provided under this CONTRACT will be paid as follows:

a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.

b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER unless assigned to the DENTIST.

ARTICLE 6. GENERAL PROVISIONS

6.01 **ENTIRE CONTRACT: CHANGES.** This CONTRACT, including Schedules, the Application, Declaration Page and any Endorsements or Amendments issued by DDTN make up the entire agreement between the parties. No agent has authority to change this CONTRACT or waive any of its provisions. No change in this CONTRACT will be valid unless made by written amendment signed by an Officer of DDTN or by written endorsement issued by DDTN.

6.02 **SEVERABILITY.** If any part of this CONTRACT or any amendment is found to be illegal, void or not enforceable, all other portions will remain in full force and effect.

6.03 **CONFORMITY WITH STATE LAWS.** The laws of the State of Tennessee will govern this CONTRACT. Any part of this CONTRACT which, on its EFFECTIVE DATE, conflicts with the laws of Tennessee is hereby amended to conform to the minimum requirements of such laws.

6.04 **LEGAL ACTIONS.** No action at law or in equity will be brought before 60 days after proof of loss has been filed as required by this CONTRACT. Any action must be brought within 3 years from the time proof of loss is required by this CONTRACT. In any case, action may only be brought after a MEMBER has exercised all the review and appeal rights available under this CONTRACT.

6.05 **CHOICE OF JURISDICTION.** All litigation related to the terms or conditions of this CONTRACT will be in a court of competent jurisdiction in Davidson County, Tennessee.

6.06 **DOES NOT REPLACE WORKERS' COMPENSATION.** This CONTRACT does not affect any requirements for coverage by Workers' Compensation Insurance.

6.07 **CERTIFICATE OF COVERAGE.** DDTN will supply Certificates of Coverage for distribution by the GROUP to SUBSCRIBERS. Such booklets will describe available BENEFITS and claims review and appeals procedures. Should the wording of this CONTRACT and the Certificates of Coverage or other marketing materials conflict, the CONTRACT will in all cases govern.

6.08 **APPLICATION CONFLICTS.** The terms of the CONTRACT, Schedules of Benefits and Declaration Page, along with any Amendments or Endorsements issued by DDTN, will, in all cases, be controlling. Should the wording of this CONTRACT, Schedule of Benefits or Declaration Page, along with any Amendments or Endorsements issued by DDTN, conflict with the Group Application or proposal, the CONTRACT, Schedules of Benefits and Declaration Pages along with any Amendments or Endorsements issued by DDTN will govern.

6.09 **PROFESSIONAL RELATIONSHIP.** GROUP and DDTN agree to permit and encourage the professional relationship between DENTIST and patient to be maintained without interference.

6.10 **NOTICE: WHERE DIRECTED.** All notices under this CONTRACT must be in writing. Notices for DDTN will be addressed to:

Delta Dental of Tennessee
240 Venture Circle
Nashville, Tennessee 37228-1699

Notices to the GROUP will be sent to the address shown on the Declaration Page. All notices will be effective 48 hours after deposit in the United States mail with fully prepaid postage. If agreed to in writing by the GROUP, DDTN may send notices electronically to the electronic mail address listed on the Group Application or other electronic mail address as requested by the GROUP.

6.11 **RIGHT TO RECOVERY.** Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDTN will have the right to recover any excess. DDTN will recover the excess from any persons to whom the payment was made, insurance companies or other organizations involved. Any MEMBER covered under this CONTRACT will execute and deliver any necessary documents and do whatever is necessary to secure such rights to DDTN.

6.12 **SUBROGATION.** DDTN assumes the MEMBER'S legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDTN has the right to recover from the MEMBER any payments made by or for the other party. In such cases, DDTN has the right to recover amounts equal to the BENEFITS paid by DDTN plus all collection cost.

DDTN has the right to make the recovery by suit, settlement or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source such as third party motorist coverage.

The MEMBER must help DDTN make a recovery. They must give requested information and sign necessary papers. If the MEMBER fails to help DDTN, or settles any claim without DDTN's written consent, DDTN may recover from the MEMBER. DDTN will be entitled to any recovery received by the MEMBER and reasonable and necessary attorney's fees and court costs.

6.13 **AMENDMENTS.** This CONTRACT may be amended or canceled by agreement between DDTN and GROUP without the approval of MEMBER.

6.14 **COLLECTIONS.** Should any payment owed DDTN by GROUP be due for more than 30 days, DDTN may pursue any and all collection efforts it deems necessary to collect such payment. GROUP will be responsible for all cost of such collection efforts including but not limited to collection fees, court cost and reasonable legal fees.

6.15 **SUBCONTRACTOR(S) AND AGENT(S).** DDTN may subcontract certain functions or appoint an agent or agents to act on DDTN's behalf and fulfill expressed, limited duties under this contact. Such agent(s) have no authority to change or modify this agreement.

6.16 **USE OF E-COMMERCE TOOLS.** DDTN may provide GROUP access to its internet-based E-Commerce Tools (such as E-Billing and Benefit Manager Toolkit). Only the employees or representatives (Users) designated by GROUP to DDTN will have access to E-Commerce Tools. GROUP will ensure assigned account names and/or log-ins and

passwords will be protected and not shared among Users or any other persons. GROUP will notify DDTN immediately if a User becomes terminated or should no longer have access to its E-Commerce Tools. To ensure continued access to DDTN's E-Commerce Tools, the GROUP agrees to pay premium invoices as billed. Failure to pay as billed may result the termination of access to the E-Commerce Tools. DDTN may revoke access or discontinue its E-Commerce Tools at any time.

ARTICLE 7. RENEWAL AND CANCELLATION

7.01 At the end of CONTRACT TERM, DDTN must give the GROUP 30 days notice of any change of PREMIUM or BENEFITS. Such notice will renew the CONTRACT unless GROUP provides written notice of cancellation

7.02 This CONTRACT may be canceled only as follows:

a) By GROUP with at least 15 days written notice at the end of a CONTRACT TERM.

b) By DDTN with at least 30 days written notice at the end of a CONTRACT TERM.

c) By DDTN, if GROUP:

1) does not furnish DDTN a listing of all EMPLOYEES as required under Schedule E; or,

2) does not permit DDTN to inspect GROUP'S records as called for under Schedule E; or,

3) does not pay PREMIUM, as required by ARTICLE 2; or

4) misrepresents any information required in the CONTRACT; or

5) does not meet the underwriting guidelines established for the program described on the Declaration Page.

7.03 DDTN must give GROUP 10 days written notice to cancel the CONTRACT because GROUP did not pay PREMIUM. Cancellation for any other reason requires 30 days written notice.

If the CONTRACT is canceled, GROUP will owe DDTN all unpaid PREMIUMS due prior to cancellation. Should GROUP fail to pay DDTN PREMIUMS through the cancellation date within 10 days of cancellation, DDTN may collect the greater of any unpaid premium or the reimbursement for any claim payments made plus an administrative fee equal to 12% of the claim payments.

7.04 DDTN will not continue to pay BENEFITS for services performed after the cancellation date of this CONTRACT.

ARTICLE 8. ATTACHMENTS

These documents are attached to this CONTRACT and made a part of it:

SCHEDULE A - SCHEDULE OF BENEFITS, LIMITATIONS, AND EXCLUSIONS.

SCHEDULE B - (If covered as a benefit) – ORTHODONTIC BENEFITS, LIMITATIONS, AND EXCLUSIONS.

SCHEDULE C – ELIGIBILITY AND ENROLLMENT

Group Application

Declaration Page

DELTA DENTAL OF TENNESSEE
SCHEDULE A
SCHEDULE OF BENEFITS, LIMITATIONS AND EXCLUSIONS

In addition to the benefits, limitations and exclusions listed below, the General Limitations and Exclusions found in Article 3 of this CONTRACT apply to this plan.

A. Diagnostic & Preventive Benefits, Limitations & Exclusions

1) Oral examinations and cleanings (prophylaxis).
   a) Oral exams and cleanings, to include periodontal maintenance procedures, are limited to two times in any 12 month period.
   b) Members with high risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any 12 month period. Eligible members include:
      (1) Diabetics with periodontal disease
      (2) Pregnant women with periodontal disease
      (3) Individuals with renal failure/dialysis
      (4) Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
      (5) Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertropic cardiomyopathy, or mitral valve prolapse)
   c) Adult prophylaxis for members under 14 years of age is not allowed.
   d) Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
2) X-rays.
   a) One set of bite-wing x-rays are covered in a 12 month period.
   b) Full mouth x-rays are covered once within 3 years, unless special need is shown.
3) Fluoride. Topical application of fluoride is covered for members up to 19 years of age.
4) Space maintainers. Space maintainers are covered for members 14 years of age and under.

B. Sealant Benefits, Limitations & Exclusions

Sealants – resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth.

1) A sealant is a benefit only on the unrestored, decay free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars.
2) Sealants are only a benefit on members under 16 years of age.
3) Only one benefit will be allowed for each tooth within a lifetime.

C. Basic Benefits, Limitations & Exclusions

1) Simple extractions.
2) General Anesthesia & I.V. Sedation is covered only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions.
3) Minor Restorations – amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.
   a) Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.
   b) The replacement, by the same dentist or dental office, of amalgam or composite restorations within 24 months is not allowed.
   c) The replacement, by the same dentist or dental office, of a stainless steel crown within 24 month of the initial placement is not allowed.
4) Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.

5) Denture Repairs – services to repair complete or partial dentures.

D. Oral Surgery Benefits, Limitations & Exclusions.

Oral Surgery – complex extractions and other surgical procedures (including pre- and post operative care).

E. Endodontic Benefits, Limitations & Exclusions

Endodontia – treatment of the dental pulp (root canal procedures).

1) Payment for root canal treatment includes charges for x-rays and temporary restorations.
2) Root canal treatment is limited to once in a 24 month period by the same dentist or dental office.

F. Periodontic Benefits, Limitations & Exclusions

Periodontia – treatment of the gums and bones that surround the tooth.

1) Payment for periodontal surgery shall include charges for three months post operative care and any surgical re-entry for a three year period.
2) Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
3) Scaling and root planing procedures are allowed once within 24 months.

G. Major Restorative Benefits, Limitations & Exclusions

Cast Restorations. Crowns and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.

1) Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
2) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
3) Procedures for purely cosmetic reasons are not benefits.
4) Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.

H. Prosthodontic Benefits, Limitations & Exclusions

1) Prosthodontics. Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
    a) Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
    b) Payment for a complete or partial denture shall include charges for any necessary adjustment within a six month period.
    c) Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
    d) Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit.
    e) A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
    f) Temporary partial dentures are a benefit only when upper anterior teeth are missing.
2) Complete or Partial Denture Reline and Rebase procedures. Payment for a reline or rebase of a partial or complete denture is limited to once in a three year period and includes all adjustments required for six months after delivery.

I. Implant Benefits, Limitation and Exclusions

Implants. The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.

1) Replacement of implants or abutments received in the previous five years is not a benefit.
2) The removal of an implant is allowed once per lifetime.
3) Specialized techniques are not benefits (ie. bone grafts, guided tissue regeneration, precision attachments, etc.)
4) Implant maintenance procedures are allowed once in a 12 month period.

DELTA DENTAL OF TENNESSEE
SCHEDULE B
ORTHODONTIC BENEFITS, LIMITATIONS AND EXCLUSIONS

In addition to the benefits, limitations and exclusions listed below, the General Limitations and Exclusions found in Article 3 of this CONTRACT apply to this plan.

A. Orthodontic Benefits, Limitations & Exclusions

1) Orthodontics. Procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.
   a) Orthodontic benefits are limited to members shown on the Declaration Page. DDTN shall make regular payments for orthodontic benefits.
   b) If orthodontic treatment began prior to enrolling in this plan, DDTN will begin benefits with the first payment due the dentist after the subscriber or covered dependent becomes eligible.
   c) Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
   d) Benefits are not paid to repair or replace any orthodontic appliance received.
   e) Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under other benefits of this plan.
   f) The initial payment (initial banding fee) made by DDTN for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
   g) Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum.

DELTA DENTAL OF TENNESSEE
SCHEDULE C
ELIGIBILITY AND ENROLLMENT

A. All permanent full time EMPLOYEES of GROUP on the EFFECTIVE DATE will be eligible to enroll in this GROUP dental program. Other EMPLOYEES will be eligible on the first of the month after they have worked full time for the number of months shown on the Declaration Page.

B. DEPENDENTS will become eligible along with the EMPLOYEE or as soon after that as they become DEPENDENTS. The following family members of the EMPLOYEE may be considered DEPENDENTS:

a) Lawful husband or wife;

b) Children from birth to the Dependent Age Limit stated on the Declaration Page. "Child" includes a natural child, step child, adopted child, foster child or a child for which the SUBSCRIBER is legal guardian.

A child reaching the Dependent Age Limit may continue to be eligible. The child must not be able to support them self because of mental incapacity or physical handicap. Such disabling condition shall have begun before reaching the Dependent Age Limit. Proof of these facts must be given to DDTN or GROUP within 31 days if requested. Proof will not be required more than once a year.

C. DEPENDENTS in military service are not eligible.

D. A Qualified Life Status Change will be defined by current Federal law.

E. Any EMPLOYEE who does not elect coverage, before entering the group, must satisfy all eligibility requirements to enter the GROUP. The application for coverage is subject to DDTN'S approval. Such EMPLOYEE may only enter the GROUP during an OPEN ENROLLMENT PERIOD except in the event of a related Qualified Life Status Change.

F. Any MEMBER who drops coverage may only re-enter the GROUP during the first OPEN ENROLMENT PERIOD after having been out of the plan for 12 consecutive months except in the event of a related Qualified Life Status Change.

G. For coverage to be in effect, DDTN must have received the enrollment information and the payment of that month's PREMIUM. The monthly PREMIUM for a MEMBER must have been paid for coverage to be in effect for that month. A MEMBER with an EFFECTIVE DATE on or between the 1st and 15th of the month will be billed for that month. A MEMBER with an EFFECTIVE DATE on or between the 16th and the last day of the month will not be billed for that month.

H. GROUP will be responsible for enrolling all MEMBERS. Enrollment information must be furnished to DDTN in a timely manner. Retroactive additions and terminations will be allowed only at the discretion of DDTN. Enrollment must be reported using one of DDTN's standard formats. If special programming is needed to accommodate GROUP's eligibility format, the cost may be billed to the GROUP.

I. By the EFFECTIVE DATE of the program, GROUP will furnish eligibility information for all EMPLOYEES. This information shall include the EMPLOYEE'S name, social security number, date of birth, date of hire, DEPENDENT coverage information and location code. GROUP may submit this information by electronic media or by completing enrollment forms provided by or

approved by DDTN. GROUP will report EMPLOYEES hired after the EFFECTIVE DATE and COBRA- MEMBERS as described above.

J. Unless eligibility is reported by electronic media or DDTN has agreed to allow the GROUP to self bill, DDTN will provide to GROUP each month a paper listing or electronic file of EMPLOYEES as reported to DDTN. GROUP will confirm continued eligibility of EMPLOYEES and return the paper listing or electronic file to DDTN by the 10th day of the month. DDTN will not pay BENEFITS for an EMPLOYEE or his or her DEPENDENTS if the EMPLOYEE is not on the listing or file

K. DEPENDENTS may be enrolled under the following rules:

a) DEPENDENTS must enroll at the time the SUBSCRIBER becomes eligible, or as soon after that as they become DEPENDENTS. Otherwise DEPENDENTS may only enroll during an OPEN ENROLLMENT PERIOD. DEPENDENTS from birth to age 3 may enroll at any time.

b) After enrollment, DEPENDENT coverage shall continue while the SUBSCRIBER has coverage. DEPENDENT coverage shall cease if they no longer meet the definition of DEPENDENT or the SUBSCRIBER chooses to drop DEPENDENT coverage. If DEPENDENT coverage is dropped, DEPENDENTS may re-enter the GROUP during the first OPEN ENROLLMENT PERIOD after having been out of the plan for 12 consecutive months.

L. The GROUP will be allowed to continue BENEFITS during a MEMBER'S unpaid leave of absence as determined by the policy of the GROUP. If it is the policy of the GROUP not to continue BENEFITS for an unpaid leave of absence, the MEMBER will not have coverage during this leave. Coverage will resume on the first day of the month after the EMPLOYEE returns to work. MEMBERS may continue coverage under 29 USC ' 1161 et seq. or an applicable state continuation of coverage provision when the EMPLOYEE is on strike or layoff.

M. If it is the policy or legal responsibility of the GROUP to continue coverage during a leave of absence, the GROUP will be responsible for the timely payment of all PREMIUMS due to DDTN for the EMPLOYEE on leave of absence. The employer must continue to consider the person a permanent EMPLOYEE and all other GROUP benefits, including dental, must be continued.

N. An EMPLOYEE loses coverage when employment benefits are terminated by the GROUP at the end of employment or at the end of the CONTRACT. DEPENDENTS lose coverage along with the EMPLOYEE, or earlier if they lose their DEPENDENT status. Subscribers lose coverage at the end of the month. The termination effective date will be the end of the month for which PREMIUM has been paid.

O. Possession of an I.D. card does not guarantee a MEMBER is eligible for BENEFITS. Eligibility is based upon information reported to DDTN by the GROUP. Eligibility may be confirmed by calling DDTN's Customer Service Representatives.

P. DDTN will not continue to pay BENEFITS for any MEMBERS when they lose eligibility. As provided by 29 USC ' 1161 et seq. or an applicable state continuation of coverage provision, coverage may continue for up to 18 months where the EMPLOYEE'S coverage ends as a result of a reduction in work hours or termination of employment. Coverage may not continue if the termination is as a result of gross misconduct.

Under 29 USC ' 1161 et seq. or an applicable state continuation of coverage provision, DEPENDENTS may continue coverage under this CONTRACT for up to 36 months. To continue coverage, the DEPENDENT must be a:

(1) surviving spouse or child of a deceased EMPLOYEE,
(2) separated or divorced spouse,

(3) DEPENDENT ineligible for Medicare who reaches the limiting age or otherwise ceases to meet the definition of DEPENDENT.

In any case, coverage shall end if the MEMBER fails to pay the required PREMIUM, becomes eligible for Medicare, obtains other group coverage or the GROUP cancels group dental coverage.

MEMBERS must choose whether or not to continue their coverage. MEMBERS have 60 days to make such an election. The 60-day period shall start at the earlier of the date the MEMBER'S coverage would otherwise end or the date the MEMBER receives notice of his rights.

EMPLOYEE is responsible for notifying the GROUP within 60 days of any change(s) in eligibility. EMPLOYEE should tell GROUP of changes in DEPENDENT status, divorce, or eligibility for Medicare.

Q. As plan administrator, it will be the GROUP'S responsibility to tell EMPLOYEES and DEPENDENTS of their rights under this CONTRACT.

R. GROUP will let DDTN inspect GROUP'S records to verify that the listing of EMPLOYEES is correct and to confirm compliance with ARTICLE 2. DDTN will give GROUP reasonable written notice before the date of the inspection.

This is a sample only and does not constitute an offer to contract. Actual terms and conditions may differ.

PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This Pharmacy Benefit Management Services Agreement (hereinafter this "Agreement") is entered into by and between Envision Pharmaceutical Services, LLC, an Ohio Limited Liability Company (hereinafter "Envision"), and _____, a[n] _____[Corporation/Limited Liability Company/Health and Welfare Fund] (hereinafter "Plan Sponsor"). This Agreement is effective _____, **20**__ (hereinafter the "Effective Date").

BACKGROUND

Envision is a URAC accredited Pharmacy Benefit Management (PBM) company providing comprehensive pharmacy benefit management services nationwide to various employers, unions, and Plan Sponsors that establish and fund health benefit plans covering outpatient prescription medications. Plan Sponsor has established one or more health benefit plans providing coverage for prescription medications to covered individuals and desires to engage Envision to provide pharmacy benefit management services in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises and agreements herein contained, Plan Sponsor and Envision hereby agree as follows:

1. DEFINITIONS

1.1 "Administrative Fee" means the amount that Envision charges Plan Sponsor for included services under this Agreement as set forth in Exhibit 1.

1.2 "Benefit Plan" means the Plan Sponsor's group insurance plan, prescription drug plan, or other benefit plan established and funded by Plan Sponsor that covers the cost of Covered Drugs dispensed to Covered Individuals.

1.3 "Benefit Specification Form" or "Benefit Specification Change Form" means the forms, as modified from time to time, that are completed by Plan Sponsor that specify the terms and provisions of the Benefit Plan and the configuration of System edits, such as which Prescription Drugs are covered by Plan Sponsor (including, for example Limited Distribution Drugs or Specialty Drugs), any limitations or exclusions, the Benefit Plan's tier structure and Cost Share requirements, and any conditions associated with the specific services to be rendered by Envision under this Agreement (i.e. Clinical Prior Authorizations, Drug Therapy Management, etc.). If there is any inconsistency between the terms of this Agreement and the Benefit Specification Form or any Benefit Specification Change Form submitted in connection with the services to be provided under this Agreement, then the provisions of the most recent signed Benefit Specification Form or Benefit Change Form shall control. A separate Benefit Specification form shall be provided by Plan Sponsor for each unique Benefit Plan, which Benefit Plan shall be identified by a unique group number.

CONFIDENTIAL SAMPLE

1.4 "Brand Drug" means a Prescription Drug designated as a branded drug product by Medi-Span as indicated by the multisource (i.e. MONY) code attached to the 11 digit NDC for such drug.

1.5 "Claim" means an invoice or transaction (electronic or paper) for a Covered Drug dispensed to a Covered Individual that has been submitted to Envision by the dispensing pharmacy or a Covered Individual (including transactions where the Covered Individual paid 100% of the cost). A "340B Claim" is a Claim which has been processed under Section 340B of the Public Health Service Act.

1.6 "Claims Adjudication System" or "System" means Envision's on-line computerized claims processing system.

1.7 "Contract Year" means the complete twelve month period commencing on the Effective Date and each consecutive complete twelve month period thereafter that this Agreement remains in effect.

1.8 "Cost Share" means the amount of money that a Covered Individual must pay to the Participating Pharmacy to obtain a Covered Drug in accordance with the terms of the Benefit Plan. The Cost Share may be a fixed amount (co-payment) or a percentage of the drug cost (co-insurance), or a deductible that must be satisfied before drugs are covered under the Benefit Plan.

1.9 "Covered Drug" means a Prescription Drug or other permitted drug (OTC), medical supplies (e.g. diabetic testing strips), or a medical device (e.g. blood glucose monitoring device) which is dispensed to a Covered Individual and meets the requirements for coverage under the Benefit Plan as communicated to Envision by Plan Sponsor.

1.10 "Covered Individual" or "Member" means each individual (including the Eligible Employee [Eligible Participant] and each of his or her dependents) who has been identified by Plan Sponsor on the Eligibility File as being eligible to receive Covered Drugs.

1.11 "Eligibility File" means that electronic communication supplied to Envision by Plan Sponsor (or Plan Sponsor's agent) which identifies the Covered Individuals covered under Plan Sponsor's Benefit Plan, along with other eligibility information necessary for Envision to provide PBM Services hereunder. Plan Sponsor acknowledges that eligibility begins on the first day the Covered Individual is reported by Plan Sponsor (or its designee) to be effective and continues through the last day the Covered Individual appears on the Eligibility File.

1.12 "Eligible Employee" ["Eligible Participant"] means an active employee [participant] or a Retiree of Plan Sponsor covered under Plan Sponsor's funded Benefit Plan. For purposes of this Agreement, a Retiree is a retired individual who is covered, primarily, by Plan Sponsor and not Medicare Part D. [For purposes of calculating the Administrative Fee, the Per Employee [Eligible Participant], per month (PEPM) amount stated in Exhibit 1 includes the Eligible Employee's [Eligible Participant's]/Retiree's eligible dependents. If, however, a dependent is also an Eligible Employee [Eligible Participant] of Plan Sponsor, such dependent shall be deemed to be an Eligible

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Employee [Eligible Participant] for purposes of calculating the total Administrative Fee.]

1.13 "Formulary" means an index of Prescription Drugs and supplies developed by Envision's pharmacy and therapeutics committee, which is hereby adopted by Plan Sponsor, and shall be used in conjunction with the Benefit Plan as a guide in the selection of Covered Drugs. The Prescription Drugs and supplies on the Formulary will be modified by Envision from time to time as a result of factors including, but not limited to, medical appropriateness, manufacturer arrangements and patent expirations. Additions and deletions to the Formulary are hereby adopted by Plan Sponsor.

1.14 "Generic Drug" means a Prescription Drug that is not a Brand Drug.

1.15 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

1.16 "Limited Distribution Drugs" means Prescription Drugs that are distributed by manufacturers through a limited number of pharmacies and wholesalers which have been selected by the manufacturer based on approved participation criteria.

1.17 "Mail Order Pharmacy" means Orchard Pharmaceutical Services, LLC d/b/a EnvisionPharmacies.

1.18 "Manufacturer Derived Revenue" means retrospective Formulary rebates, discounts, administrative fees, and other revenue payable by pharmaceutical manufacturers that are received by Envision pursuant to the terms of a formulary rebate contract negotiated independently by Envision with a pharmaceutical manufacturer, and which is directly attributable to Claims that comply with the utilization and benefit design requirements of such pharmaceutical manufacturer rebate contracts and that otherwise meet the terms and conditions hereunder.

1.19 "MAC List" means a proprietary list of Prescription Drugs for which Envision establishes a maximum price ("MAC Price") payable to the dispensing pharmacy. Envision utilizes the same MAC List to both determine the negotiated price payable to the dispensing pharmacy and the price charged to Plan Sponsor. Plan Sponsor will be charged the exact amount paid by Envision to the dispensing pharmacy for the Claim without any markup or spread. Envision updates the MAC List from time-to-time as Prescription Drugs come on the market or come off the market, or as their availability changes due to market circumstances.

1.20 "Participating Pharmacy" means a pharmacy (including the designated Mail Order or Specialty Pharmacy) that has entered into a negotiated pricing agreement with Envision to dispense Covered Drugs to Covered Individuals and participates in the Network selected by Plan Sponsor.

1.21 "Plan Sponsor" means the entity (identified above as Plan Sponsor) which (i) has established and underwrites the Benefit Plan on behalf of its Covered Individuals; (ii) has determined the rules by which the Benefit Plan is to be administered; and (iii) is financially responsible for the payment of Administrative Fees, Fees for Additional Services and Miscellaneous Expenses (as set forth in Exhibit 1), and Covered Drugs dispensed to Covered Individuals hereunder.

ORIGINAL SAMPLE

1.22 "Point-of-Sale" means the location and time that a Covered Drug is dispensed to a Covered Individual, and the corresponding Claim is submitted by the dispensing pharmacy for adjudication by the Claims Adjudication System.

1.23 "Prescriber" means a licensed health practitioner with independent prescribing authority in the state in which the dispensing pharmacy is located.

1.24 "Prescription Drug" means a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease which is dispensed by a duly licensed pharmacy and required by federal law to be dispensed only upon the authorization of a Prescriber. For purposes of this Agreement, over-the-counter medications, medical supplies, and medical devices are not Prescription Drugs, whether or not ordered by a Prescriber.

1.25 "Retail Pharmacy" means a state licensed retail community pharmacy that dispenses prescription medications at its physical location as well as Envision's owned and operated Specialty Pharmacy when dispensing non-Specialty Drugs. Unless otherwise determined by Envision, a Retail Pharmacy does not include a pharmacy that dispenses medications to patients primarily through mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, or clinics.

1.26 "Specialty Drug" means a drug on the Specialty Drug List that is typically a high-cost biotech, injectable, infused, oral, or inhaled Prescription Drug, and/or Prescription Drug that requires special storage, handling, and/or close monitoring of the patient's drug therapy to ensure appropriate use and clinical outcome.

1.27 "Specialty Drug List" means the standard list of Specialty Drugs and their reimbursement rates applicable to Plan Sponsor under the applicable (exclusive or open) option maintained and updated by Envision from time to time. The Specialty Drug List is available to Plan Sponsor upon request.

1.28 "Specialty Pharmacy" means Orchard Pharmaceutical Services, LLC d/b/a EnvisionPharmacies.

1.29 "Usual and Customary Price" or "U&C Price" means the retail amount the pharmacy charges its cash paying customers for the drug dispensed, as reported to Envision by the dispensing pharmacy.

2. STANDARD PBM SERVICES

Envision shall perform the following pharmacy benefit management services ("PBM Services").

2.1 Welcome Material: If requested by Plan Sponsor, Envision shall provide standard Welcome Material which may include plan benefit information and a Member identification card ("ID Card"). The standard Welcome Material will be mailed directly to Covered Individuals or to Plan Sponsor (by request). For any materials mailed directly to Covered Individuals, Plan Sponsor

shall reimburse Envision the cost of production and postage. Additional ID Cards or replacement ID Cards (i.e. for lost or stolen ID Cards) will be provided at a cost of production and postage. Additional charges may apply if Plan Sponsor desires to re-design and/or re-issue ID Cards, requires special graphics, additional logos (beyond Plan Sponsor logo), and/or special materials outside standard Welcome Materials.

2.2 Claims Processing: During the term of this Agreement, Envision shall accept, process, and adjudicate Claims for Covered Drugs (i) submitted electronically by Participating Pharmacies; (ii) submitted by Plan Sponsor's owned pharmacies or Plan Sponsor's contracted pharmacies, if any, (not including 340B Claims, unless such claims are included under a separate 340B Agreement); (iii) submitted by Covered Individuals as Direct Member Reimbursements (DMRs, as defined below); or (iv) received from third parties, such as Medicaid, for reimbursement by Plan Sponsor. Claims shall be checked for eligibility, benefit design, Cost Share requirements, and exclusions to determine which Claims are successfully processed, pended for prior authorization, or rejected for ineligibility or other factors in accordance with Plan Sponsor's specifications as set forth in Plan Sponsor's Benefit Specification Form (incorporated herein by this reference).

For Claims that must be processed manually or require special handling, including, without limitation, (i) DMRs, (ii) Claims received from third parties, such as Medicaid, for reimbursement by Plan Sponsor for ineligible payments, or (iii) paper Claims, Plan Sponsor will be charged a Manual Claims Processing fee as set forth in Exhibit 1. After termination of this Agreement, Envision shall process Claims received for dates of service on or before the effective date of termination for a period of ninety (90) days ("Run-Out Period"), subject to the following. Plan Sponsor shall deposit and maintain, with Envision, an amount equal to the last Claims invoice prior to termination. At the end of the Run-Out Period, the balance of the deposit shall be promptly refunded to Plan Sponsor and, thereafter, any Claims received by Envision shall be rejected.

2.2.1 Direct Member Reimbursement (DMR): Envision shall provide, via its website, a form for use by Covered Individuals to obtain reimbursement for amounts paid out-of-pocket (other than Cost Share) for Covered Drugs (e.g. Covered Drugs dispensed at a non-Participating Pharmacy) ("DMR Form"). Envision shall accept and process DMR Claims within thirty (30) calendar days of receipt of the DMR form, invoice Plan Sponsor for the Claim, and reimburse the Covered Individual until receipt of funds from Plan Sponsor.

2.2.2 Claims from Non-Participating Pharmacies: Unless otherwise directed by Plan Sponsor, Envision shall accept and process Claims received from non-participating government owned or operated pharmacies (e.g. Veterans Administration).

2.2.3 Claims Adjudication System Edits: Plan Sponsor's Benefit Plan may contain additional rules which determine the way in which Claims are to be adjudicated. These rules may include coverage limitations or exclusions, application of clinical intervention (e.g. step therapy, drug therapy management), application of dispensed as written (DAW) codes (e.g. to determine what portion of a Claim is payable by Plan Sponsor and what portion is payable by Members), and administrative overrides to authorize the dispensing of Covered Drugs in certain circumstances (e.g. requests for lost or stolen drugs, vacation supplies, certain package sizes, dosage changes, invalid days' supply). For this purpose, Envision shall program edits into the Claims Adjudication

System which are applied to Claims during the adjudication process as specified in the Benefit Specification Form. The Claims Adjudication System will provide the dispensing pharmacy with the appropriate messaging to advise the pharmacy of the applicable limitation, program, rule, or override.

Envision shall also program edits into the Claims Adjudication System which are applied to Claims during the adjudication process to identify the following drug utilization conditions: duplicate prescriptions; over-utilization/refill too soon; under-utilization; drug interactions; pediatric warnings; geriatric warnings; acute/maintenance dosing; therapeutic duplication; drug inferred health state; drugs exceeding maximum dose; and drugs below minimum daily dosage, as specified in the Benefit Specification Form. The Claims Adjudication System will provide the dispensing pharmacy with the appropriate messaging to advise the pharmacy of drug utilization issues.

2.3 Clinical Services

2.3.1 Clinical Prior Authorizations: If Plan Sponsor has elected to receive Clinical Prior Authorization services from Envision, for those Covered Drugs and circumstances specified by Plan Sponsor in the Benefit Specification Form, Envision will contact the prescriber and verify that the requested drug is appropriate for the diagnosis in the judgment of the prescriber. Plan Sponsor will be charged for Clinical Prior Authorizations as specified in Exhibit 1. If additional internal appeals (redeterminations) and/or the services of an Independent Review Organization are to be provided under this Agreement, such services shall be included in a separate or attached coverage determination and appeals process addendum.

2.3.2 Drug Therapy Management (DTM) Programs: Envision offers clinical programs such as Drug Therapy Care Gap Management and Medication Adherence and Persistency. If clinical programs are to be provided under this Agreement, such services and any additional charges shall be set forth in a separate or attached clinical programs exhibit.

2.4 Pharmacy Network: Envision shall arrange for the dispensing of Covered Drugs to Covered Individuals pursuant to contracts with one or more networks of Participating Pharmacies (each referred to herein as a "Network"). The Network designated for Plan Sponsor to be used by Covered Individuals hereunder shall be specified in the Benefit Specification Form. Plan Sponsor acknowledges that the pharmacies participating in a Network may be changed from time to time by Envision, including the designated Mail Order Pharmacy and/or Specialty Pharmacy provider. Contact information for Participating Pharmacies is constantly updated to reflect any changes and is accessible via Envision's website. Plan Sponsor acknowledges that (i) orders exceeding a thirty day supply are not available at all Retail Pharmacies; (ii) Covered Drugs shall not be dispensed to Covered Individuals without a prescription order by a Prescriber; and (iii) the availability of drugs are subject to market conditions and that Envision cannot, and does not, assure the availability of any drug from any Participating Pharmacy.

2.4.1 Plan Sponsor Owned Pharmacies. If Plan Sponsor desires to include one or more of its owned or affiliated pharmacies in the network of pharmacies authorized to dispense Covered Drugs to Plan Sponsor's Covered Individuals, it shall indicate same on the Benefit Specification Form. If Plan Sponsor desires its pharmacy to be available to other Envision clients using one or

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more of Envision's Networks, such pharmacy shall enter into an Envision Participating Pharmacy Agreement (PPA). If the pharmacy will be for the use of Plan Sponsor's employees only, such pharmacy shall complete an Envision-supplied form indicating the amounts to be invoiced to Plan Sponsor for Claims processed. In either case, the pharmacy shall submit all Claims to Envision for processing. Unless indicated otherwise in the Benefit Specification Form, Envision shall invoice Plan Sponsor for Claims received from Plan Sponsor's owned pharmacy. If the pharmacy is a Participating Pharmacy, Claims shall be adjudicated at the Network rates included in the PPA. Envision reserves the right to modify any guarantees or rates in the event of a modification or termination of the PPA.

2.5 Customer Service: Envision shall maintain and operate a customer service center with toll-free customer service numbers and adequately staffed trained personnel 24 hours a day, 7 days a week, 365 days a year, for the use of Plan Sponsor, Covered Individuals, Prescribers, and Participating Pharmacies.

2.6 Records: Envision shall maintain such business records as may be required by applicable law or regulation, or as may be necessary to properly document the delivery of, and payment for, Covered Drugs and the provision of services by Envision under this Agreement. Upon termination of this Agreement, Envision agrees to provide only industry-standard transfer files to a subsequent pharmacy benefit manager at Plan Sponsor's written request. Plan Sponsor agrees to pay or reimburse Envision for any cost charged by a vendor or pharmacy related to the transfer of files from or to such vendor or pharmacy at any time during this Agreement or connected with the termination of this Agreement.

2.7 Reports: Envision shall provide Plan Sponsor with access to a web-based report generator through which Plan Sponsor may create and download a variety of standard and customized reports. Envision shall provide training for a Plan Sponsor designated individual on the capabilities of Envision's web-based reporting program. Plan Sponsor represents that the designated individual has received training and has knowledge of the HIPAA privacy and security regulations. Any reports that are to be provided by Envision to Plan Sponsor without cost (other than those available from Envision's web-based reporting program) shall be mutually determined prior to the configuration of Plan Sponsor's Benefit Plan in the Claims Adjudication System and shall be specified in the Benefit Specification Form. Plan Sponsor shall be charged a fee for any other reports requested by Plan Sponsor.

Included in the web-based reports described above, or provided separately, Envision shall supply Plan Sponsor with reports of retrospective reviews to determine the drug utilization patterns of Members (e.g. high cost/high utilization of a particular drug class, therapeutic appropriateness of drug for a particular disease state).

2.7.1 Access to Third Parties: If Plan Sponsor desires Envision to provide one or more third parties access to web-based or other reports, Plan Sponsor shall complete and submit an Envision provided authorization form. Plan Sponsor acknowledges that any reports to be provided to Plan Sponsor's authorized third parties which are not accessible via the web-based reports generator, shall be provided via a secure FTP server.

2.8 Retiree Drug Subsidy (RDS) Reports: For Plan Sponsors which submit requests for drug subsidies under the Medicare RDS program, Envision shall provide Plan Sponsor with quarterly reports summarizing Claims paid by Plan Sponsor for Medicare Part D drugs dispensed to Covered Individuals who Plan Sponsor has identified on the appropriate form as Medicare eligible retirees. Plan Sponsor acknowledges that any estimated Manufacturer Derived Revenue which has been passed-through to Plan Sponsor will have been deducted from the Claim amounts reported. Unless otherwise specified herein or included under an addendum to this Agreement, Envision shall not be responsible or liable to Plan Sponsor for any RDS services or subsidies. Any assistance requested by Plan Sponsor and/or provided by Envision shall be solely consultative and shall not be deemed to be an acceptance by Envision of any responsibility or liability for the completion or submission of any RDS application or request for subsidies under Medicare Part D.

2.9 Additional Services: Any services to be rendered under this Agreement which are not included in the Administrative Fee as specified in this Section 2 shall be itemized in the Exhibits and Addendums hereto along with any associated costs or charges.

3. PRICING AND PASS-THROUGH METHODOLOGY

3.1 Pass-Through of Discounts and Dispensing Fees: The amount invoiced to Plan Sponsor shall be the exact drug ingredient cost and applicable dispensing fee which is paid to the dispensing pharmacy when the Claim is adjudicated without any reclassification, mark up, or spread by Envision, in accordance with the following:

3.1.1 For Ingredient Cost: Envision shall invoice Plan Sponsor the lower of:

(a) The calculated negotiated amount payable to the Participating Pharmacy based on the 11 digit NDC number of the drug dispensed; or

(b) If included on the then current Envision MAC List, the MAC Price for the drug dispensed; or

(c) The Participating Pharmacy's U&C Price (except for drugs dispensed by the Mail Order Pharmacy or Specialty Pharmacy); less any applicable Manufacturer Derived Revenue and/or any applicable Covered Individual Cost Share.

3.1.2 For Dispensing Fees: Envision shall invoice Plan Sponsor the actual dispensing fee amount paid to the Participating Pharmacy.

3.2 Manufacturer Derived Revenue

3.2.1 Pass-Through of Manufacturer Derived Revenue: Envision shall pass through to Plan Sponsor one hundred percent (100%) of all Manufacturer Derived Revenue earned by Plan Sponsor for eligible Claims. Prescription Drugs eligible for Manufacturer Derived Revenue are included in the Formulary provided by Envision. Plan Sponsor acknowledges that the Manufacturer Derived Revenue earned by Plan Sponsor is dependent on certain factors including, without limitation, the following: (i) the effect of terms and conditions of Plan Sponsor's Benefit Plan on the application of the Formulary; (ii) the structure of Plan Sponsor's Benefit Plan, including but not limited to Cost Share requirements and coverage rules such as Prior

Authorizations, Quantity Limits, and Step Therapy (as defined in the Benefit Specification Form); and (iii) the drug utilization patterns of Covered Individuals. Plan Sponsor further acknowledges that Plan Sponsor's portion of market share rebates is based on (i) Plan Sponsor's ability to meet and earn market share rebate levels by pharmaceutical manufacturer and (ii) the ratio of Plan Sponsor's Claims for a particular rebated drug to the total number of Claims for such drug for all Envision clients, as adjusted for the effect of Plan Sponsor's Benefit Plan (e.g. tier structure and Cost Share differentials) on the overall yield of market share rebates. No Manufacturer Derived Revenue shall be payable to Plan Sponsor for 340B Claims, Claims from any Plan Sponsor owned or affiliated pharmacy which is not a Participating Pharmacy, Claims for which Envision has not been paid in full, and other Claims not eligible for Manufacturer Derived Revenue.

3.2.2 Pass-Through Methodology: Manufacturer Derived Revenue shall be advanced to Plan Sponsor by adjusting the Claim for an eligible Prescription Drug by an estimated amount for applicable Manufacturer Derived Revenue using Envision's patented Point-of-Sale Technology. Envision's Point-of-Sale Technology generates a Claim that will be invoiced to Plan Sponsor at the net price after applying a credit for estimated Manufacturer Derived Revenue. (Plan Sponsor acknowledges that, unless otherwise indicated by Plan Sponsor on the Benefit Specification Form, if a Covered Individual pays a percentage of the drug cost (i.e. co-insurance) under the Benefit Plan, a proportional amount of the Manufacturer Derived Revenue will be passed on to the Covered Individual at the Point-of-Sale).

3.2.3 Sole Source: Plan Sponsor represents and warrants to Envision that, at no time during or after the term of this Agreement, is Plan Sponsor receiving rebates and other revenues from pharmaceutical manufacturers other than through Envision, either directly or indirectly (through a Group Purchasing Organization, drug wholesaler, or otherwise) for Claims processed by Envision under this Agreement. Plan Sponsor agrees that it shall not, at any time, submit Claims which have been transmitted to Envision to another pharmacy benefit manager or carrier for the collection of rebates and other revenues from pharmaceutical manufacturers or create a situation which would cause a pharmaceutical manufacturer to decline payments to Envision. Envision reserves the right to recover from Plan Sponsor, and Plan Sponsor shall refund to Envision, any Manufacturer Derived Revenue, including any related penalties and fees, advanced to Plan Sponsor by Envision which is connected with any Claims for which Plan Sponsor received rebates and other revenues from pharmaceutical manufacturers from any other source or for amounts advanced to Plan Sponsor by Envision which have been withheld by a pharmaceutical manufacturer as a result of such Claims not meeting conditions for rebates, the ineligibility of Claims for Manufacturer Derived Revenue (i.e. 340B Claims), or breach of this Agreement by Plan Sponsor.

4. PLAN SPONSOR RESPONSIBILITIES

4.1 Implementation: No later than thirty (30) days prior to the Effective Date, Plan Sponsor shall provide Envision with an executed Benefit Specification Form and such data as reasonably necessary for Envision to set up the Claims Adjudication System and commence the provision of PBM Services as of the Effective Date. Such data includes, without limitation, prior utilization reports, pharmacy transfer files, and eligibility.

4.2 Eligibility Data: Plan Sponsor shall provide Envision (either directly or through an authorized third party administrator) with an Eligibility File, at least monthly, in the HIPAA 834 standard transaction code set format, or such other format as has been previously agreed to by Envision. Plan Sponsor shall provide timely eligibility updates (for example, additions, terminations, change of address or personal information, etc.) to ensure accurate determination of the eligibility status of Covered Individuals. Plan Sponsor acknowledges and agrees that (i) Envision provides such eligibility data to the Participating Pharmacies and understands that Envision and Participating Pharmacies will act in reliance upon the accuracy of data received from Plan Sponsor; (ii) Envision will continue to rely on the information provided by Plan Sponsor until Envision receives notice that such information has changed; and (iii) Envision shall not be liable to Plan Sponsor for any Claims or expense resulting from the provision by Plan Sponsor (or its designee) of inaccurate, erroneous, or untimely information. In addition, if Envision must create or update eligibility by manually entering Covered Individual data, Plan Sponsor will be charged a data entry fee as specified in Exhibit 1. In lieu of the Eligibility File, Plan Sponsor may provide eligibility information by updating the Claims Adjudication System directly (except for the initial Eligibility File, which must be provided to Envision during the initial implementation), provided Plan Sponsor continues to meet Envision's conditions and specifications for direct eligibility updates.

4.3 Benefit Plan: Plan Sponsor shall provide Envision with complete information concerning the Benefit Plan. Plan Sponsor understands and agrees that Envision shall rely on the terms and provisions provided by Plan Sponsor on the Benefit Specification Form. The Benefit Specification Form may be changed from time to time by Plan Sponsor by providing Envision with a replacement Benefit Specification Form or a Benefit Specification Change Form; provided, however, that the form must be signed by Plan Sponsor to be effective and the form provided to Envision at least thirty (30) days before any such change shall be implemented. If, however, Plan Sponsor provides Envision with an unsigned Benefit Specification Form or Benefit Specification Change Form, Envision shall not be bound by such form and Plan Sponsor shall hold harmless Envision for any consequences resulting from any changes not implemented. The most recent executed Benefit Specification Form shall supersede any prior dated form.

Plan Sponsor shall have sole authority to determine the terms of the Benefit Plan and the coverage of benefits thereunder, however, Plan Sponsor understands and agrees that any change in the Benefit Plan or System configuration (e.g. mandatory generic program, coverage of over-the-counter drugs or medications, source of Covered Drugs, use of Plan Sponsor Owned pharmacies, etc.) may affect yields in Manufacturer Derived Revenue and/or average drug pricing. Plan Sponsor agrees that Envision shall not be liable to Plan Sponsor for any reduction of such yields or increase in pricing which result from any such change. Further, any change to the Benefit Plan that affects a material term of this Agreement will require an amendment hereto. Plan Sponsor agrees to execute an amendment, at Envision's request, before implementing the change to the Benefit Plan.

4.4 Formulary: Plan Sponsor hereby adopts and shall adhere to the Formulary identified in the Benefit Specification Form. Plan Sponsor acknowledges the formulary may be modified by Envision from time to time. Any customization of the Formulary by Plan Sponsor or use by Plan Sponsor of an alternate Formulary must be approved, in writing, by Envision. Plan Sponsor

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acknowledges that adherence to the Formulary is necessary to maximize yields in Manufacturer Derived Revenue. Plan Sponsor agrees that Envision shall not be liable to Plan Sponsor for any reduction in yields of Manufacturer Derived Revenue or increase in drug pricing resulting from Plan Sponsor's failure to adhere to the Formulary or a change to the Benefit Plan that affects the application of the Formulary.

4.5 Payment: Plan Sponsor shall timely pay, or cause its designee to timely pay, Envision for services rendered hereunder in accordance with Section 5 below and Exhibit 1.

4.6 Cooperation: Plan Sponsor shall promptly provide Envision with all information (both verbal and written) that is requested by Envision and reasonably necessary for Envision to complete its obligations hereunder. Any information required to be provided by Plan Sponsor in order for Envision to perform a function under this Agreement shall be deemed to be untimely if not received by Envision at least five (5) business days prior to its due date. Further, Plan Sponsor shall not obfuscate, delay, impede, or otherwise fail to cooperate with Envision.

5. TERMS OF PAYMENT

5.1 Fees: Plan Sponsor hereby accepts the fees specified in Exhibit 1.

5.2 Payments for Claims: Envision shall invoice Plan Sponsor twice each month for Claims incurred. Plan Sponsor shall pay Envision's invoices via ACH/wire transfer no later than 12:00 p.m. Eastern time on the tenth (10th) calendar day from receipt of said invoices. Invoices shall be deemed to have been received by Plan Sponsor upon the earliest delivery of the invoice by mail, e-mail, fax, or courier.

5.2.1 Prompt Pay Requirements: Plan Sponsor agrees that, to the extent a state in which a Participating Pharmacy is located requires Claims to be paid within a specified time frame, Envision reserves the right to collect and maintain a commensurate prepay amount from Plan Sponsor, based on the utilization of Covered Individuals, in order for such prompt pay requirements to be met. Envision shall refund to Plan Sponsor any amount of prepayment remaining at the termination of this Agreement once all pending Claims are paid.

5.3 Payment of Administrative Fee: Beginning with the first month under this Agreement, Envision shall provide Plan Sponsor with an invoice of Administrative Fees on or about the first day of each month. Plan Sponsor shall pay Administrative Fees via ACH/wire transfer within seven (7) calendar days of receipt of Envision's invoice. The monthly Administrative Fee is calculated by multiplying the number of Eligible Employees [Eligible Participants] [Members] who are eligible to receive services hereunder at any time during the prior month (as reflected in the Claims Adjudication System) by the Administrative Fee amount set forth in Exhibit 1 (except for the initial invoice which is based on Plan Sponsor's initial Eligibility File). [Plan Sponsor agrees that the Administrative Fee set forth in Exhibit 1 shall be added to the invoiced amount for each Invoiced Claim and shall be paid by Plan Sponsor in conjunction with the payment of Claims as set forth in Section 5.2. For purposes of this Section, an "Invoiced Claim" shall be a Claim payable by Plan Sponsor under this Agreement, but shall not include transactions for Claims which have been rejected under the specifications of the Benefit Plan, transactions for previously paid

Claims which have been reversed (e.g. as a result of a reversal of a Claim by a Participating Pharmacy or by Envision as a result of an audit), or transactions for reprocessed Claims (e.g. to correct a previously paid Claim).]

5.4 Fees for Additional Services and Miscellaneous Expenses: Plan Sponsor agrees to reimburse Envision via ACH/wire transfer for Additional Services and Miscellaneous Expenses (e.g. postage) specified in Exhibit 1 hereunder, within seven (7) calendar days of receipt of an invoice.

5.5 Retroactive Disenrollment or Termination: Retroactive termination or disenrollment of a Covered Individual shall not release Plan Sponsor of its obligation to pay Claims incurred, at any time, on behalf of a Covered Individual or Administrative Fees due to Envision during any period for which services were renderable hereunder based on the then current eligibility. Further, termination of coverage of prescription drugs or the entering into a policy of insurance that covers prescription drugs shall not constitute a permitted termination of this Agreement.

5.6 Financial Responsibility: Plan Sponsor shall be and remain responsible for the payment of all invoices for Administrative Fees, Additional Services, Miscellaneous Expenses, and Claims (along with any associated dispensing fees, taxes, assessments and fees, and Cost Share not ultimately paid by Members). Plan Sponsor acknowledges that Envision will not pay pharmacies for Plan Sponsor's Claims, nor be obligated to pay pharmacies for Claims, unless and until adequate funds are received from Plan Sponsor.

5.6.1 Untimely Payments: If Plan Sponsor should fail to timely pay any amounts due Envision hereunder for any reason, including, but not limited to, insolvency, bankruptcy, termination of business, sale, or rebuff, Envision reserves the right to (i) suspend the provision of services; (ii) offset such amounts owed to Envision by any amounts owed by Envision to Plan Sponsor and/or (iii) collect from Plan Sponsor, in addition to such unpaid amounts, interest at a rate of 1.5% per month on the outstanding balance (or, if lower, the rate of interest permitted under the law of Plan Sponsor's state of domicile). If Envision suspends the provision of services, Covered Individuals will be required to pay 100% of the drug cost and any dispensing fees (or the U&C Price, if lower) to receive Covered Drugs. In addition, as a condition of continuing to perform services under this Agreement, Plan Sponsor shall deposit with Envision additional amounts to ensure the timely payment of future invoices. Envision may also discontinue advancing Manufacturer Derived Revenue to Plan Sponsor. Plan Sponsor further agrees that Envision shall not be liable for any consequences resulting from the untimely payment of Participating Pharmacies due to the failure of Plan Sponsor to timely pay Envision as required under this Agreement.

5.6.2 Financial Viability: Plan Sponsor acknowledges that Envision will periodically conduct a credit check of Plan Sponsor. If such credit check reasonably indicates that Plan Sponsor is not financially viable, Envision may require Plan Sponsor to deposit with Envision a reasonable amount to ensure the timely payment of future invoices.

5.7 Financial Audit by Plan Sponsor: Plan Sponsor may, at its sole expense, conduct a financial audit of Envision's records related to the adjudication of Plan Sponsor's Claims for any

complete Contract Year hereunder and is limited to one audit per audit scope. Envision shall make financial records available to Plan Sponsor's auditor as reasonably necessary for auditor to verify the financial terms hereunder have been met. Plan Sponsor agrees to not use as its auditors, any person or entity which, in the sole discretion of Envision, is a competitor of Envision, a pharmaceutical manufacturer representative, or any other person or entity which has a conflict of interest with Envision. Plan Sponsor's auditor shall execute a conflicts of interest disclosure and confidentiality agreement with Envision prior to the audit. Audits shall only be made during normal business hours following thirty (30) days written notice, which is to include the audit scope and time period under examination, be conducted without undue interference to Envision's business activity, and be conducted in accordance with Envision's standard audit policy, a copy of which may be made available to Plan Sponsor and its auditor upon request. Plan Sponsor agrees to disclose the findings and methodologies of a completed audit, and provide Envision with a reasonable period of time to respond to such findings and methodologies, before finalizing any amounts due to Plan Sponsor. Upon final settlement of audit, Envision shall remit any funds agreed to be due to Plan Sponsor within thirty (30) calendar days in the form of a credit memo to Plan Sponsor. The audit provisions hereunder shall survive the termination of this Agreement for twelve (12) months following the effective date of termination.

5.8 Financial Audit by Envision: Envision may, at reasonable intervals, request Plan Sponsor to provide records for Envision's inspection which provide supporting documentation for the information contained in the Eligibility File and the data provided by Plan Sponsor (or its designate) upon which the financial terms herein were based. Plan Sponsor agrees to provide such supporting documentation to Envision within ten (10) business days of such request. In addition, and if warranted, Envision may, at its own expense, inspect and audit, or cause to be inspected and audited, once annually, the books and records of Plan Sponsor directly relating to the existence and number of Covered Individuals. Audits shall only be made during normal business hours following thirty (30) days written notice, be conducted without undue interference to Plan Sponsor's business activity, and in accordance with reasonable audit practices. Envision agrees to execute a confidentiality agreement with Plan Sponsor prior to the audit.

6. TERM AND TERMINATION

6.1 Term: The term of this Agreement shall commence on the Effective Date and shall remain in full force and effect for an initial term of three (3) years ("Initial Term") unless earlier terminated as provided herein. Upon the expiration of the Initial Term, and each subsequent renewal term, this Agreement shall renew automatically for an additional term of one year; unless, at least ninety (90) days prior to the end of such term, either party hereto notifies the other, in writing, that this Agreement will terminate at the end of the current term.

6.2 Termination: This Agreement may be terminated as follows:

6.2.1 For Cause: By either party hereto in the event the other party breaches any of its material obligations hereunder; provided, however, that the defaulting party shall have thirty (30) days to correct such breach after written notice is given by such non-breaching party specifying the alleged breach;

6.2.2 For Insolvency: By either party hereto in the event the other party (i) is adjudicated insolvent, under state and/or federal regulation, or makes an assignment for the benefit of creditors; (ii) files or has filed against it, or has an entry of an order for relief against it, in any voluntary or involuntary proceeding under any bankruptcy, insolvency, reorganization or receivership law, or seeks relief as therein allowed, which filing or order shall not have been vacated within sixty (60) calendar days from the entry thereof; (iii) has a receiver appointed for all or a substantial portion of its property and such appointment shall not be discharged or vacated within sixty (60) calendar days of the date thereof; (iv) is subject to custody, attachment or sequestration by a court of competent jurisdiction that has assumed all of or a significant portion of its property; or (v) ceases to do business or otherwise terminates its business operations, is declared insolvent or seeks protection under any bankruptcy, receivership, trust deed, creditors arrangement or similar proceeding;

6.2.3 For Failure to Pay: By Envision, in addition to any other remedy available to Envision hereunder, in the event Plan Sponsor fails to pay Envision according to terms of this Agreement.

6.3 Notices: All notices required in this Section 6 shall be reasonably specific concerning the cause for termination and shall specify the effective date and time of termination.

6.4 Effect of Termination: Termination of this Agreement for any reason shall not release any party hereto from obligations incurred under this Agreement prior to the date of termination. Except as otherwise agreed, in writing, no services shall be provided by Envision after the effective date of termination. Envision reserves the right to suspend advancing Manufacturer Derived Revenue to Plan Sponsor upon Plan Sponsor's notification of termination. In the event that Plan Sponsor terminates this Agreement prior to completion of the Initial Term, Plan Sponsor shall refund any prorated amounts outstanding for any amount of money that Envision has funded to or on behalf of Plan Sponsor, including but not limited to allowances, credits and fees as set forth herein.

7. CONFIDENTIAL INFORMATION

7.1 Confidentiality: Except as otherwise stated herein or required by law, neither party hereto shall disclose any information of, or concerning the other party which has either been provided by one party to the other or obtained by a party in connection with this Agreement (including this Agreement and the terms of this Agreement) or related to the services rendered under this Agreement, all of which information is deemed confidential information. All data, information, and knowledge supplied by a party hereto shall be used by the other party exclusively for the purposes of performing this Agreement. Upon termination of this Agreement, each party shall return to the other party or destroy (if such destruction is certified) all confidential information provided including, without limitation, all copies and electronic magnetic versions thereof. Notwithstanding any of the foregoing to the contrary, "confidential information" shall not include any information which was known by a party prior to receiving it from the other party, or that becomes rightfully known to a party from a third party under no obligation to maintain its confidentiality, or that becomes publicly known through no violation of this Agreement.

7.2 Protected Health Information: Plan Sponsor will have access to Protected Health Information (PHI) (as defined by HIPAA) contained in reports provided by Envision or accessed by Plan Sponsor via Envision's website. Plan Sponsor agrees, for itself and its employees, that PHI shall not be used for any impermissible purpose, including, without limitation, the use of PHI for disciplinary or discriminatory purposes, and any user names and passwords assigned to designated individuals shall not be shared with non-designated individuals. In addition, Plan Sponsor, for itself and its Covered Individuals, authorizes Envision to use and share PHI as necessary to carry its obligations hereunder. Envision and Plan Sponsor shall execute a HIPAA Business Associate Agreement.

8. INDEMNIFICATION

8.1 Limited Indemnification by Envision: Envision hereby agrees to indemnify, hold harmless, and defend Plan Sponsor and its employees, officers, directors, trustees, shareholders, and agents from and against any and all liabilities, actions, damages, costs, losses and expenses (including without limitation, reasonable costs of investigation and attorneys' fees) incurred in connection with any and all third party claims which were caused by or arising out of (i) any act or omission by Envision in the performance of the services provided under this Agreement; or (ii) any breach of any representation, covenant, or other agreement of Envision contained in this Agreement.

8.2 Limited Indemnification by Plan Sponsor: Plan Sponsor hereby agrees to indemnify, hold harmless, and defend Envision and its employees, officers, directors, shareholders, affiliates and agents from and against any and all liabilities, actions, damages, costs, losses and expenses (including without limitation, reasonable costs of investigation and attorneys' fees) incurred in connection with any and all third party claims which were caused by or arising out of (i) the provision by Plan Sponsor or its designee of untimely, incomplete, or erroneous information; or (ii) Plan Sponsor's failure to comply with state or federal law in the operation of its Benefit Plan.

8.3 Limitation of Liability: Except in the case of fraud, the rights of the parties hereto for indemnification relating to this Agreement or the transactions contemplated hereby shall be strictly limited to those contained in this Section 8, and such indemnification rights shall be the exclusive remedies of the parties with respect to any matter arising under or in connection with this Agreement. Notwithstanding the indemnification obligations set forth above (i) each party's liability to the other hereunder will in no event exceed the actual proximate losses or damages caused by breach of this Agreement; and (ii) in no event will either party or any of their respective affiliates, directors, employees or agents, be liable for any indirect, special, incidental, consequential, exemplary or punitive damages, or any damages for lost profits relating to a relationship with a third party, however caused or arising, whether or not they have been informed of the possibility of their occurrence.

8.4 Survival: This Section 8 shall survive the expiration or termination of this Agreement for any reason.

9. RELATIONSHIP WITH CONTRACTED PHARMACIES

SAMPLE

Plan Sponsor acknowledges that Envision is neither an operator of pharmacies nor exercises control over the professional judgment used by any pharmacist when dispensing drugs or medical supplies to Covered Individuals. Nothing in this Agreement shall be construed to usurp the dispensing pharmacist's professional judgment with respect to the dispensing or refusal to dispense any drugs or medical supplies to Covered Individuals. Plan Sponsor agrees that it shall not hold Envision responsible, nor shall Envision be liable to Plan Sponsor or Covered Individuals, for any liability arising from the dispensing of drugs or medical supplies to Covered Individuals by any pharmacy.

10. GENERAL

10.1 Acknowledgement: Plan Sponsor acknowledges and agrees that it retains the sole responsibility for the terms and conditions of its Benefit Plan; its compliance with applicable law, and that of its Benefit Plan, including, without limitation, the interpretation and applicability of any state or federally mandated requirements; and determinations of coverage under the Benefit Plan; and shall not rely on any advice or recommendations of Envision as a substitute for obtaining its own independent accounting, tax, legal, or regulatory advice. Unless otherwise agreed in writing, Plan Sponsor shall also be responsible for the disclosing or reporting of information regarding the Benefit Plan or changes in the Benefit Plan (e.g., calculation of co-payments, deductibles; or creditable coverage) as may be required by law to be disclosed to governmental agencies or Covered Individuals.

10.2 Independent Contractors: Envision and Plan Sponsor are independent contractors. Notwithstanding anything herein to the contrary, neither party hereto, nor any of its respective employees, shall be construed to be the employee, agent, fiduciary, or representative of the other for any reason, or liable for any acts of omission or commission on the part of the other. Plan Sponsor acknowledges that, notwithstanding anything herein to the contrary, Envision negotiates contracts with pharmacies, pharmaceutical manufacturers, and vendors on its own behalf and not specifically or exclusively for Plan Sponsor.

10.3 Exclusivity: During the term of this Agreement, Envision shall be the sole provider of PBM Services to Plan Sponsor, including, without limitation, the exclusive contractor of rebates with pharmaceutical manufacturers for Plan Sponsor's Claims.

10.4 Assignment: Except as follows, this Agreement may not be assigned by either party hereto without the express written consent of the other party, which may not be unreasonably withheld. Envision may assign this Agreement to a commonly controlled subsidiary or affiliate company, or a controlling parent company.

10.5 Binding Effect: This Agreement and the exhibits and schedules attached hereto shall be binding upon and inure to the benefit of the respective parties hereto, and their respective successors and assigns.

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10.6 Intellectual Property: Each party hereto reserves the right to and control of the use of their names, symbols, trademarks or service marks presently existing or hereafter established, and no party may use any names, symbols, trademarks or service marks of any other party without the owner's written consent.

10.7 Waiver: Neither the failure nor any delay on the part of either party hereto to exercise any right, power or privilege hereunder will operate as a waiver thereof, nor will any single or partial exercise of any such right, power or privilege preclude any other or further exercise thereof, or the exercise of any other right, power or privilege. In the event any party hereto should waive any breach of any provision of this Agreement, it will not be deemed or construed as a waiver of any other breach of the same or different provision.

10.8 Severability: The invalidity or unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision.

10.9 Change in Law or Market Conditions: If any law, regulation, or market condition (e.g. an applicable industry standard reference on which pricing hereunder is based, changes the methodology for determining drug price in a way that materially changes the pricing or economics of this Agreement), either now existing or subsequently occurring, affects the ability of either party hereto to carry out any obligation or causes the economic benefits derived by Envision from this Agreement to materially decrease hereunder (a "Material Change"), Envision and Plan Sponsor shall renegotiate the affected terms of this Agreement, in good faith, to preserve, to the extent possible, the relative positions of the parties that existed prior to such Material Change. Either party may notify the other party of a Material Change. If a successful renegotiation is not achieved within thirty (30) days after notification of a Material Change, any failure of the affected party to meet its obligations hereunder due to the effect of such Material Change shall not be deemed to be a breach of this Agreement; however, if continuation of this Agreement without modification is in violation of any law or regulation, or makes it impracticable for the affected party to meet its obligations hereunder, either party may terminate this Agreement with sixty (60) days prior written notice.

10.10 Taxes, Assessment or Fees: Any applicable sales, use, excise, gross receipts or other similarly assessed and administered tax, surcharge, or fee imposed on items dispensed, or services provided hereunder, or the fees or revenues generated by the items dispensed or services provided hereunder, or any other amounts Envision or one or more of its subsidiaries or affiliates may incur or be required to pay arising from or relating to Envision's or its subsidiaries' or affiliates' performance of services as a pharmacy benefit manager, third party administrator, or otherwise in any jurisdiction, will be the sole responsibility of Plan Sponsor or the Member. If Envision is legally obligated to collect and remit, or to incur or pay, any such sales, use, excise, gross receipts or other similarly assessed and administered tax, surcharge, or fee in a particular jurisdiction, such amount will be reflected on the applicable invoice or subsequently invoiced at such time as Envision becomes aware of such obligation or as such obligation becomes due. Envision reserves the right to charge a reasonable administrative fee for collection and remittance services provided on behalf of Plan Sponsor.

PROVIDED AS SAMPLE

10.11 Headings: The section or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

10.12 Entire Agreement: This Agreement shall constitute the entire agreement between Envision and Plan Sponsor with respect to the subject matter herein and supersede any prior understanding or agreements of any kind preceding this Agreement with respect to such subject matter. Any modification or amendment to this Agreement, or additional obligation assumed by Envision or Plan Sponsor in connection with this Agreement, shall be binding only if evidenced in a writing signed by both parties hereto. No term or provision of this Agreement shall establish a precedent for any term or provision in any other agreement.

10.13 Acceptance of Offer: Notwithstanding anything herein to the contrary, this Agreement shall not be binding upon the parties hereto unless and until this Agreement is signed and executed by a duly authorized officer of each of the parties. The signing of this Agreement by Plan Sponsor constitutes an offer only until the same has been accepted by Envision.

10.14 Choice of Law: This Agreement shall be construed, interpreted, and governed according to the laws of the State of Ohio, without regard to its conflict of laws rules, except to the extent such laws are preempted by applicable Federal law.

10.15 Force Majeure: Neither Envision nor Plan Sponsor will be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control. Without limiting the generality of the foregoing, such causes include acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, acts of terrorism, acts of war, war-operations, restraints of government, power or communications line failure or other circumstances beyond such party's control, or by reason of the judgment, ruling or order of any court or agency of competent jurisdiction, or change of law or regulation (or change in the interpretation thereof) subsequent to the execution of this Agreement. The party claiming force majeure must provide the other party with reasonable written notice. However, as soon as the cause preventing performance ceases, the party affected thereby shall fulfill its obligations as set forth under this Agreement. This Section 10.15 shall not be considered to be a waiver of any continuing obligations under this Agreement, including, without limitation, the obligation to make payments.

10.16 Fax Communications: Plan Sponsor agrees that Envision may communicate with Plan Sponsor via fax, and by doing so, such fax is not a violation of the Telephone Consumer Protection Act, 47 U.S.C. §227.

10.17 Notices: All notices required under this Agreement shall be in writing, signed by the party giving notice and shall be deemed sufficiently given immediately after being delivered by hand, or by traceable overnight delivery service, or by registered or certified mail (return receipt requested), to the other party at the address set forth below or at such address as has been given by proper notice.

10.18 Representations: Plan Sponsor represents and warrants that (i) it is self-insured single employer; (ii) the entering into this Agreement for PBM Services is not in violation of any other agreement; (iii) has no undisclosed conflicts of interest; and (iv) it maintains, and shall continue to maintain throughout the term of this Agreement, any and all licenses, governmental authority, or other authorization required to operate an entity of its type. Envision represents that there are no organizational arrangements that could potentially create a conflict of interest that affects clinical or financial decisions. In addition, each signatory named below represents and warrants that he or she (i) has read this Agreement, Exhibits, and other attachments, and fully understands and agrees to the content therein; (ii) has entered into this Agreement voluntarily; (iii) has not transferred or assigned or otherwise conveyed in any manner or form any of the rights, obligations or claims which are the subject matter of this Agreement; and (iv) has the full power and authority to execute this Agreement.

10.19 Third Party Administrator/Consultants/Brokers: Unless specified in Exhibit 2 hereunder, no payments shall be made by Envision to any of Plan Sponsor's Third Party Administrators (TPA), consultants, brokers, or other third party to carry out any of Plan Sponsor's obligations under this Agreement or for any other reason.

[SIGNATURE PAGE FOLLOWS]

CONFIDENTIAL SAMPLE

PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT
SIGNATURE PAGE

IN WITNESS WHEREOF, Envision and Plan Sponsor have executed this Agreement as of the Effective Date above.

For ENVISION:

By:_____

_____
Print Name and Title

Address:
Envision Pharmaceutical Services, LLC
2181 East Aurora Road
Twinsburg, OH 44087
PH: 330-405-8080
FX: 330-405-8081

For PLAN SPONSOR:

By:_____

_____
Print Name and Title

Address:

PH:
FX:
E-MAIL:
FEIN:

CONFIDENTIAL SAMPLE

TBD based on proposal and Envision standard pricing, terms, conditions, and assumptions.

EXHIBIT 1
FEES AND PRICING

CONFIDENTIAL SAMPLE

EXHIBIT 2

AUTHORIZED THIRD PARTIES

Plan Sponsor has engaged the services of a Third Party Administrator (TPA), set forth below, to provide certain financial and administrative services on behalf of Plan Sponsor. Plan Sponsor has authorized TPA to submit eligibility data to Envision, make changes to eligibility, and make payments due from Plan Sponsor hereunder to Envision. Plan Sponsor hereby authorizes Envision to provide Claims and related data to TPA as necessary for the TPA to carry out its obligations to Plan Sponsor. Plan Sponsor represents that it has entered into and maintains a Business Associate Agreement with TPA and acknowledges that Envision may request a confidentiality agreement of the TPA as an additional condition of providing Plan Sponsor's data to the TPA. Plan Sponsor shall notify Envision, in writing, at least ten (10) days prior to any change to Plan Sponsor's TPA.

Envision further understands that Plan Sponsor has negotiated with TPA to pay a fee to TPA (the "TPA Fee") and has requested Envision to invoice Plan Sponsor for this fee and remit same to TPA. Plan Sponsor hereby confirms that the TPA Fee is fair and reasonable, commensurate with other TPA fees in the industry and not in violation of any law or regulation. Envision agrees to invoice the TPA Fee to Plan Sponsor on a monthly basis and, upon payment by Plan Sponsor, remit the TPA Fee to TPA so long as (i) Plan Sponsor has executed this Agreement; and (ii) Plan Sponsor is current in its payment obligations to Envision. Plan Sponsor acknowledges and agrees that the TPA Fee is not included in the Administrative Fee due to Envision under this Agreement and no portion of the TPA Fee will be retained by Envision.

TPA Fee: _____
Legal Name of TPA: _____
Address: _____

Plan Sponsor has engaged the services of a broker or consultant ("Consultant"), set forth below, to provide consultative services for Plan Sponsor. Envision understands that Plan Sponsor has negotiated with Consultant to pay a fee to Consultant (the "Consultant Fee") and has requested Envision to invoice Plan Sponsor for this fee and remit same to Consultant. Plan Sponsor hereby confirms that the Consultant Fee is fair and reasonable, commensurate with other consultant fees in the industry and not in violation of any law or regulation. Envision agrees to invoice the Consultant Fee to Plan Sponsor on a monthly basis and, upon payment by Plan Sponsor, remit the Consultant Fee to Consultant so long as (i) Plan Sponsor has executed this Agreement; and (ii) Plan Sponsor is current in its payment obligations to Envision. Plan Sponsor acknowledges and agrees that the Consultant Fee is not included in the Administrative Fee due to Envision under this Agreement and no portion of the Consultant Fee will be retained by Envision.

Consultant Fee: _____
Legal Name of Consultant: _____
Address: _____

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CLINICAL PROGRAMS EXHIBIT

Envision shall provide the following Clinical Programs to Plan Sponsor:

Standard Cost Reduction Services (included in Administrative Fee)

Concurrent Drug Utilization Review ("DUR") Program – point of sale system checks to identify contraindicated drugs and drug strengths not recommended

Envision's Concurrent DUR Program provides electronic clinical monitoring of prescription drugs at the point-of-sale claims system edits. It is designed to encourage cost-effective, high quality drug therapies by notifying pharmacists of potential drug therapy complications at the point-of-sale before prescriptions are dispensed. The DUR Program is intended to be used by the pharmacist as a screening tool to detect outlying prescription drug utilization patterns, but not substitute for professional judgment.

All claims submitted through the Envision Concurrent DUR Program are entered into the patient's active drug profile, thus allowing the system to evaluate prescription claims prior to the initiation of drug therapy. The patient's profile is accessed regardless of the participating pharmacy the patient may choose.

Drug Utilization Review

Listed below are the eleven major Concurrent DUR modules that Envision utilizes during the processing of prescription drug claims. All of the clinical modules use National Council of Prescription Drug Plans ("NCPDP") standard conflict codes:

- Duplicate Therapy (drugs from the same therapeutic class)
- Drug-Drug Interaction (combinations of drugs with potential for severe adverse effects)
- Low Dose Alert (drug doses that fail to meet the suggested minimum daily dose)
- High Dose Alert (drug doses that exceed the suggested maximum daily dose)
- Excessive Utilization ("Too Soon Refill" Monitoring which monitors refill claims sent before a defined percentage of the previous fill is used)
- Geriatric Precautions (drugs inappropriate for patients over the age of 60)
- Pediatric Precautions (drugs inappropriate for pediatrics based on the patient's tender age)
- Drug Duplication (drugs containing the same ingredients)
- Drug-Gender Precaution (drugs not indicated for a specific gender)
- Drug-Disease Precaution (drugs inappropriate)
- Under-Utilization (Late Refill Monitoring which is a refill for a chronic maintenance drug requested at an interval longer than directed by the prescriber)

Each DUR warning is accompanied by the appropriate NCPDP DUR conflict code and message. The message received will be in a format designed by the pharmacy software vendor. Additionally, most pharmacy software may also have editing capability, but may be limited to prescriptions filled at that store or chain.

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Additional Clinical Program Services (priced separately)

Medication Therapy Management/Drug Therapy Management

Envision's Medication Therapy Management/Drug Therapy Management ("MTM/DTM") Program is designed to achieve appropriate therapeutic outcomes for targeted patients through improved medication use. This includes the involvement of patients, caregivers, care providers, pharmacists, physicians, educators, and care coordinators. The Program is consistent with evidence based-guidelines, including guidance from the Centers for Medicare and Medicaid Services ("CMS"). Prospective candidates for the DTM/MTM Program are those patients who have multiple chronic conditions, are taking multiple medications, and will most likely incur high annual drug costs. In addition, specific patients that fall outside of the previously mentioned identification criteria may be identified as eligible for DTM/MTM intervention due to significant therapy care gaps.

The MTM/DTM Program consists of 2 basic elements: Therapy Care Gap interventions and Adherence and Persistence (A&P) interventions.

A) Therapy Care Gap Management

Therapy Care Gaps are interventions designed to identify patients who have a gap between their current therapy and the ideal therapy needed to achieve optimal clinical outcomes. Therapy Care Gap recommendations are developed based on current clinical guidelines and clinical evidence. Patients with therapy gaps are identified using full prescription drug claims history as well as patient demographics, concurrent disease states and concurrent medications. Therapy Care Gaps are then reviewed for clinical relevance by clinical pharmacists, and the prescribing physician and patient are notified as appropriate. Patients will also receive educational materials on a quarterly basis. Outcomes reporting at 6 months and annually will quantify the number of Therapy Care Gaps identified, changes in physician prescribing post-identification and communication, and the change in actual patient medication history post-identification.

B) Medication Adherence and Persistency (three disease states)

Medication Adherence and Persistency ("A&P") interventions identify members who are not properly following the prescriber's instruction regarding medications ("adherence") or are not remaining on the prescribed therapy for the recommended time period ("persistence"). The Program targets medication for chronic diseases such as hypertension, diabetes, and high cholesterol. Additional (greater than 3) disease states can be selected for an additional fee. Potential medication non-adherence is identified in a target patient population using four major parameters: Medication Possession Ratio ("MPR"), Median Gap, Persistence, and Days of Therapy. This service seeks to identify and resolve issues related to compliance and/or persistency by offering patients quarterly progress reports on their adherence and notifications to providers and/or disease management firms for further interventions that foster compliant and persistent behavior. In addition to the individualized quarterly member progress reports, annual outcomes reports documenting the change in adherence parameters for the year as

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compared to the baseline period.

C) Included Reports:

- Outcomes reports at 6 months and annually on all Therapy Care Gaps;
- Disease state specific reports and 6 months and annually regarding chronic medication adherence for those drugs within those disease states; and
- Quarterly and annual individual personalized member medication adherence reports.

Fees for Additional Clinical Program Services

- Drug Therapy Care Gap Management: $0.55 PMPM
- Medication Adherence and Persistency (up to three disease states): $0.55 PMPM

CONFIDENTIAL SAMPLE

COVERAGE DETERMINATION AND APPEALS PROCESS ADDENDUM

This Coverage Determination and Appeals Process Addendum (hereinafter "Addendum") is entered into by and between Envision Pharmaceutical Services, LLC (hereinafter "Envision") and _____ (hereinafter "Plan Sponsor") as follows. This Addendum is effective _____ (hereinafter the "Effective Date").

BACKGROUND

Envision and Plan Sponsor are parties to a Pharmacy Benefit Management Services Agreement dated _____ (hereinafter "Agreement") under which Envision provides PBM Services to Plan Sponsor. Plan Sponsor wishes for Envision to provide additional services under the Agreement as set forth below.

NOW THEREFORE, Envision and Plan Sponsor agree as follows:

1. Initial Coverage Determinations and Appeals: Envision shall administer a Coverage Determination and Appeals Process under Plan Sponsor's direction as described in Exhibit 1-A. The Coverage Determination and Appeals Process will include: (i) Real-time adjudication to determine coverage/non-coverage status of a Claim; (ii) Initial Determinations (including Clinical Prior Authorizations); and (iii) Redeterminations ("Internal Appeals"). [(iii) Redeterminations ("Internal Appeals"); and (iv) External Appeals utilizing an Independent Review Organization (IRO).] The Coverage Determination and Appeals Process will meet the requirements of the Department of Labor's Internal Claims and Appeals and External Review Processes under 29 CFR §2590.715-2719.

2. Compensation: Plan Sponsor shall pay Envision the following fees:

Provided Internally by Envision	
Coverage Determinations (including Clinical Prior Authorizations)	$35.00 per request
Redeterminations (Internal Appeals)	$125 per request
External Reviews Performed by IRO	
Standard Turnaround Time (2 days or greater)	100% pass-through of costs incurred
Standard Turnaround Time for Complex Independent Review*	
Expedited Turnaround Time (within 72 hours)	
Expedited Turnaround Time for Complex Independent Review*	
*Complex Independent Review is defined as requiring greater than one hundred pages of clinical documentation	

3. All other terms and conditions of the Agreement not modified by this Addendum or any prior amendment or addenda shall remain unchanged.

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IN WITNESS WHEREOF, Envision and Plan Sponsor have executed this Addendum as of the Effective Date above.

For ENVISION:

By:_____

_____

Print Name and Title

For PLAN SPONSOR:

By:_____

_____

Print Name and Title

CONFIDENTIAL SAMPLE

EXHIBIT 1-A

EnvisionRxOptions
Coverage Determination and Redetermination (Internal Appeal) Program Description [, Redetermination (Internal Appeal) and Independent Review (External Appeal) Program Description]
(Revision date 5/23/2019)

Envision maintains a process for Coverage Determinations (including Clinical Prior Authorizations), and Redeterminations. [Redeterminations, and External Reviews (Independent Review Organization submissions).] Envision utilizes a claim adjudication platform to determine real-time coverage/non-coverage status for Claims submitted electronically at the Point-of-Sale. Claims failing one or more Benefit Plan coverage rules are rejected at the Point-of-Sale and information regarding the reject reason(s) is conveyed to the dispensing pharmacy at the Point-of-Sale. Pharmacy personnel may contact Envision's Customer Service Department to begin the Coverage Determination process or they may inform the Member of the reason(s) for the rejection and provide the Member with instructions to contact the Customer Service Department in the event the Member would like to initiate a Coverage Determination.

Coverage Determinations (or Clinical Prior Authorizations)

When a Coverage Determination request is initiated, the information connected with the rejected prescription is conveyed by Envision to the Prescriber via fax with a request for specific information regarding the Member's medication history and disease diagnosis. The Prescriber completes the form and returns it to Envision where the information provided by the Prescriber is evaluated by an Envision clinical pharmacist. Expedited Coverage Determinations occur as soon as possible, taking into account medical exigencies, but no later than 24 hours of receipt of the request and standard determinations occur within 72 hours of receipt of the request.

If the information provided meets the criteria to allow an override of the initial rejection, an override will be configured in the adjudication system that will allow the Claim to process. If the clinical review determines the prescription fails to meet the coverage criteria, the prescription will remain in rejected status.

The result of the Coverage Determination is communicated to the Member by written letter, the Prescriber by fax, and the dispensing pharmacy by fax. In the event the Coverage Determination results in an Adverse Benefit Determination, as defined below, the notice to the Member and Prescriber includes information identifying the Claim involved, the specific reason for the Adverse Benefit Determination, instructions about the right to initiate a Redetermination (Internal Appeal), a link providing the availability and contact information of an agency offering assistance to the Member with the appeals and external review processes, if one is available, and may contain additional information as directed by Plan Sponsor.

An Adverse Benefit Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a

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participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. 29 CFR 2560.503-1(m). An Adverse Benefit Determination also includes any rescission of coverage as defined in the regulations restricting rescissions (26 CFR 54.9815–2712T(a)(2), 29 CFR 2590.715–2712(a)(2), and 45 CFR 147.128(a)(2)), whether or not there is an adverse effect on any particular benefit at that time.

The availability and contact information of an agency offering assistance to the Member with the appeals and external review processes can be found at: www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

Redetermination (Internal Appeal)

Upon initiation of a Redetermination by the Prescriber or Member (or the Member's appointed representative), additional supporting documentation may be requested by Envision from the Prescriber. Expedited Redetermination request evaluations occur as soon as possible, taking into account medical exigencies, but no later than 72 hours of receipt of the request to allow the Member to submit additional information for consideration, and standard evaluations occur within 72 hours of receipt of the request. The evaluation is performed by a clinical pharmacist or pharmacists other than the pharmacist or pharmacists that reviewed the original Coverage Determination request, to maintain impartiality within the review process.

Envision will allow a Member to review the claim file and to present evidence and testimony as part of the Internal Appeals process. Envision will provide the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Redetermination as soon as possible and sufficiently in advance of the date on which the notice of an Adverse Benefit Determination is required to be provided, to give the Member a reasonable opportunity to respond prior to that date.

If the Redetermination information supports an override of an Adverse Benefit Determination, an override will be configured in the adjudication system which will allow the Claim to process. If evaluation determines the Redetermination request fails to meet the coverage criteria, the Claim will remain in rejected status.

The result of the Redetermination is communicated to the Member by written letter and the Prescriber by fax. In the event the Redetermination results in an Adverse Benefit Determination, the notice to the Member and Prescriber will include information identifying the Claim, the specific reason for the Adverse Benefit Determination including a discussion of the decision including the plan provision relied upon, instructions about their right to initiate an External Review, if applicable, a statement that the Member has a right to bring a civil action under ERISA Section 502(a) following a denial upon appeal, a link providing the availability and contact information of an agency offering assistance to the Member with the external review process, if one is available, and may contain additional information as directed by Plan Sponsor. The

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Member may, upon request and free of charge, receive reasonable access to and copies of all documents, records, and other information used in the Coverage Determination

The availability and contact information of an agency offering assistance to the Member with the appeals and external review processes can be found at: www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

External Appeal (Independent Review Organization)

A Member may file a request for an External Review with the plan within four months after the date of receipt of notice of a final Adverse Benefit Determination. The Redetermination (Internal Appeal) process must be exhausted before an External Appeal is requested; however a simultaneous request for a Redetermination and an External Appeal may be made in an urgent care situation. When a Member (or the Member's duly appointed representative) initiates an External Appeal request, Envision will complete a preliminary review of the request within five business days of receipt for a standard request and immediately if expedited. This preliminary review will determine (i) if the Member was covered under the Benefit Plan on the date of service, (ii) if the rejection does not relate to the Member's failure to meet the requirements for eligibility, (iii) if the Member has exhausted the Plan Sponsor's internal appeal process, and (iv) if the Member has provided all information required to process an External Review.

After the preliminary review is complete, Envision will issue a notification in writing to the Member. Notice will be sent immediately for expedited requests and within one business day after the completed preliminary review for standard requests. If the request is complete, but determined to be ineligible for External Review, the Member notification will include the reason the Claim has been determined to be ineligible and contact information for the Employee Benefits Security Administration. If the request is incomplete, the Member notification will specify the information needed to make the request complete. The Member will have an opportunity to provide the needed information within the four month filing period, or within 48 hours of receiving the notification, whichever is later.

Once the preliminary review has been determined to be complete for an External Review, Envision will provide the Claim information, Benefit Plan exclusion and coverage criteria documentation, and clinical review criteria to an Independent Review Organization (IRO). Envision has contracted with three IROs. External Appeal requests are assigned to the IROs by rotation to avoid selection bias. Each contracted IRO holds URAC accreditation status to conduct External Reviews. The IRO is not bound by the previous Redetermination decision and reviews each case in accordance with the terms of the Benefit Plan and coverage documentation.

The IRO will notify the Member once it receives the Member's claim information and the Member will have ten business days to submit any additional information for the IRO to consider in its External Appeal.

The IRO will convey a final decision to Envision and the Member within 45 days for standard reviews and within 72 hours for expedited reviews. Expedited reviews are permitted when standard review timeframes would seriously jeopardize the life or health of the Member.

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If the IRO reverses Envision's adverse Redetermination decision, then Envision will provide coverage and/or payment of the Claim within twenty-four hours of notification of the IRO decision. If the IRO upholds Envision's Adverse Benefit Redetermination decision, the IRO will communicate the decision to Envision and the Member. If the Prescriber files the request on behalf of the Member, then the Prescriber will be notified as well. The Member and Prescriber (if applicable) are provided letters with the specific reasons including the plan provision relied upon for the Adverse Benefit Determination, a statement that the Member may, upon request and free of charge, receive reasonable access to and copies of all documents, records, and other information used in the Coverage Determination, if applicable, a statement that the Member has a right to bring a civil action under ERISA Section 502(a) following a denial upon appeal, and may contain additional information as directed by Plan Sponsor.

The IRO's decision is binding, except to the extent that other remedies (including judicial review of the decision) may be available under applicable law to either the Plan or the Member.

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COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: FY21 Budget Amendment Ordinance and Resolutions

Department: Budget

Presented by: Erin Tucker

Requested Council Action:

Ordinance	☒
Resolution	☒
Motion	☐
Direction	☐
Information	☐

Summary

Amendment to the FY21 Budget for the City's General Fund, Airport Fund, Water Resources and Stormwater Funds.

Staff Recommendation

Approve Appropriations Ordinance 20-O-31 and Resolutions 20-R-22 and 20-R-23.

Background Information

On June 10, 2020, Council approved the FY21 Budget. That Budget anticipated the economic effects of measures implemented to address the pandemic. Because of these measures, state and national economic projections showed a significant decline in local government revenues. Fortunately, actual revenues during this period was stronger than projected, which permits the City to return to normal service levels and to enhance critical service areas. An amendment to the FY21 Budget is necessary to appropriate the required funds.

Expenses will be carefully monitored as state and local leaders continue to address the public health situation. Council will also be informed of the economic conditions and potential deviations from the revised budget expectations.

Council Priorities Served

Responsible budgeting

The City adopted a restricted FY21 Budget to responsibly accommodate the state and national projections of significant decreases in local government revenues resulting from the measures necessary to handle the pandemic. With stronger than anticipated revenues during this period, a conservative amendment to the adopted Budget permits a careful return to normal service levels.

Fiscal Impact

The amendment to FY21 Budget will reflect an addition to the unassigned fund balance of $354,172 and use of Airport Fund Balance of $40,800. Water Resources

and Stormwater budget Resolutions are also included to account for additional payroll expenditures.

Attachments

1. Budget Amendment Summary
2. Budget Supplementals List
3. FY21 Budget Ordinance 20-O-31
4. FY21 Water Resources Budget Resolution 20-R-22
5. FY 21 Stormwater Fund Budget Resolution 20-R-23

Budget Amendment Summary

Revenues

Revenues were adjusted to reflect current economic conditions.

Sales Tax

Sales Tax was originally budgeted to reflect a 55% decrease in the first quarter of the year. Instead, the City has recognized an 8% increase to Local Option and a 5% increase to State Shared Sales Tax revenues as compared to FY20 collections. Rather than budget a decrease to sales tax, the amendment is adjusted to match FY20 actual collections. This reflects an increase to these revenues while remaining conservative and allowing for possible economic dips or slow downs later in the fiscal year.

One-Time Revenues

Grant revenues were also adjusted to include Federal CARES Act Funding in response to the COVID-19 pandemic. The City has been allocated $2.1 million as part of this legislation. This funding will support already budgeted expenditures. Other State Grants of $3.1 million were presented to Council in August. Of this, $511,500 has been allocated for capital purchases for Police and Rover. The remaining $2.6 million should also be recognized along with related expenditures.

The City sold a parcel of property on Medical Center Parkway for a one-time revenue adjustment of $1.27 million in FY21.

Other Revenue Increases

Other revenue adjustments include increases to Business License Taxes ($864,500), Cable Franchise Tax ($100,000), and miscellaneous Fire, Street and Civic Plaza revenues ($120,600).

Revenue Decreases

Revenue decreases are also reflected in the amendment. These decreases are in response to unanticipated COVID-19 closures. Parks and Recreation revenues are decreasing by $466,900 and Mixed Drink Tax revenues are decreasing by $113,000. City Court revenues are also anticipating a $92,000 drop in revenues in FY21 due to the pandemic.

Summary

Revenue adjustments total $15.7 million with one-time revenue adjustments making up $6 million. Recurring revenue adjustments total $10.2 million.

Expenditures

Expenditures were prioritized based on continued or improvement to service delivery, impact to public safety, technological priority and recurring or non-recurring impact to the operating budget.

$5.9 million in items of a non-recurring nature were prioritized and considered to off-set one-time revenue sources. These include:

1. $2.78 million in Fire Rescue Equipment. Of this, $2.75 million is for Fire Rescue Pumper Apparatus Replacements. (2) Fire Pumper Apparatus replacements are budgeted at a cost of $1.425 million and (1) Quint Apparatus Replacement is budgeted at a cost of $1.325 million. These replacements would otherwise be funded through CIP. $26,420 in hazardous materials and water rescue equipment is included along with $26,000 in COVID response grant funded expenditures.
2. $1.5 million for Siegel Soccer Park Building. This facility is expected to be used for Recreation purposes but may also be rented to private businesses. All revenues will flow back through General Fund.
3. $964,300 for Police technology and equipment. Includes $725,000 for a camera system to be utilized as part of crime prevention and investigations. An additional $239,300 for public safety software and equipment is included (including gas masks, night vision binoculars, radar units, mobile surveillance trailer).
4. $116,360 for Community Development Grant Administrator and Administrative Assistant. These positions will be funded by the Community Development annual grants.
5. $247,300 in Information Technology – including firewall, network switches, back-up servers and training facility computers.
6. $77,000 for Golf equipment and parking lot resurfacing.
7. $25,000 in Parks and Recreation projects – replacing pavilion roof at Rogers Park.
8. $38,100 for Planning Commission equipment and Room 218 Conference Room furniture replacement.
9. $36,000 for (2) full-time bus driver positions at Rover. These positions were previously classified as part-time. Both positions will be grant funded.
10. $35,000 for Legal Case Management software.
11. $28,000 for Transportation Department vehicle.
12. $13,500 for bathroom partition replacement at Senior Center.

Recurring Expenditures were budgeted at $5 million and were prioritized between 1-3, with 1 showing the highest priority.

Priority 1 Expenditures reflect $3 million in additional expenditures.

1. $1.5 million for Police salaries and benefits - including (16) police officer positions and (3) lieutenant positions.
2. $640,000 in funding vacancies with the hiring freeze lifted.
3. $424,500 in Police equipment - $259,500 for shot spotter system which will include $210,000 in recurring expenditures. This system will help pinpoint location of gunshots. $165,000 in annual expenditures for Automated License Plate Recognition System.
4. $214,100 for Information Technology requests – including Land Management software, Street software and licenses and license and support for server backups.
5. $61,200 for Fire Rescue salaries and benefits – including a data analyst position and partial year allowance for vacancy funding.
6. $45,100 for Street laborer position that will be funded by Stormwater revenues.
7. $25,000 for Civic Plaza dome repairs. This will have partial County participation in the costs.
8. $35,600 in position requests for Traffic, Communications and Planning.

Priority 2 Expenditures reflect $1.9 million in additional expenditures.

1. $1.48 million in salary increases, factored over 7 months. This includes a 1.5% COLA plus step increases for those in step system and 1.5% for open range positions.
2. $180,000 in Solid Waste positions – including (2) drivers and (1) crew leader.
3. $140,000 in training across all General Fund departments.
4. $28,000 in Fire for Administrative Support Specialist which will replace (2) existing part-time positions.
5. $15,000 for Human Resources part-time administrative support position.
6. $15,000 for outside Legal Services for economic development.
7. $13,000 in positions adjustments for Street and Golf.

Priority 3 Expenditures reflect $161,540 in additional expenditures.

1. $47,500 in Parks and Recreation Patterson Pool area painting and door replacements.
2. $60,000 for a downtown parking study.
3. $40,000 for a Sign Ordinance consultant.
4. $14,040 for (2) Golf facility attendant positions.

2021 Requested Budget Supplements

Supplement	Dept	Amount	Position	Position Priority	Priority	Notes	On-going
Fire apparatus	Fire	2,750,000			0	State Grant	
Siegel Soccer Park Building	Parks & Rec	1,500,000			0		
Public Safety Camera System	Police	725,000			0		x
Community Development Grant Administrator	Comm. Dev.	82,180	P	0	0	Grant funded	x
New equipment to replace old network firewall	IT	80,300			0		x
Replacement Network Switches 5 years or older	IT	65,000			0		
Server to backup and restore full servers	IT	62,000			0		x
Mobile Surveillance Trailer	Police	47,000			0		x
Public Safety software	Police	45,000			0		
Rover Drivers (2 positions - part-time to full-time)	Transportation	36,000	P	0	0	Grant funded	x
Legal Case/Project Management Software	Legal	35,000			0		x
Community Development Admin Assistant	Comm. Dev.	34,180	P	0	0	Grant funded	
Office Furniture for 3 Communications Offices	Police	29,600			0		
43 Gas Masks	Police	28,600			0		
Ford Explorer	Transportation	28,000			0		
10 Radar Units	Police	25,700			0		
Replace carpet for Old Fort clubhouse	Golf	25,000			0		
Replace Pavilion Roof and Trusses at Rogers Park	Parks & Rec	25,000			0		
3 Copiers	Police	24,000			0		
Room 218 Planning Commission equipment	Planning	23,100			0		
Parking lot reseal, restripe, and crack fill for Old Fort	Golf	22,000			0		
Pallet Jack	Police	21,000			0		
Zero-turn mowers (2)	Golf	20,000			0		
VM Host Server	IT	20,000			0		
Training room virtual PC's	IT	20,000			0		
Hazardous Materials Equipment	Fire	19,220			0		
Covid PPE/Supplies FEMA Grant	Fire	26,600			0		
2 Night Vision Binocular - SOU	Police	18,400			0		
Room 218/Planning conference room furniture	Planning	15,000			0		
New bathroom partitions for Sr. Center	Facilities	13,500			0		
Fairway dethatching unit attachment for Old Fort mower	Golf	10,000			0		
Water Rescue Equipment	Fire	7,200			0		
Shot Spotter	Police	259,500			1	$210,000 in recurring expenditures	
Automated License Plate Recognition System	Police	165,000			1		x
Police Officer (16)	Police	1,170,000	P	1	1	Includes other costs ($145,000)	x
Lieutenant (3)	Police	379,121	P	1	1	Includes other costs ($27,000)	x
Expired Hiring Freeze	Police	368,825			1	6 months - various positions	
Land Management Software	IT	131,700			1		
Expired Hiring Freeze	Fire	123,750			1	3 months - various positions	
Fire Rescue Data Analyst	Fire	61,156	P	1	1		x
Support and Licenses to backup & restore full servers	IT	57,400			1		x
Expired Hiring Freeze	Parks & Rec	55,850			1	9 months - various positions	
Laborer	Street	45,100	P	1	1	stormwater funded	x
Expired Hiring Freeze	IT	35,000			1	6 months - GIS	
Expired Hiring Freeze	Street	30,000			1	3 months - various positions	
Expired Hiring Freeze	Planning	26,250			1	3 months - Administrative Assistant	
Civic Plaza Dome Repair	Facilities	25,000			1		
Laborer	Transportation	18,839	P	1	1		x
Part-Time Administrative Support	Communications	15,000	P	1	1	8 months of new position	x
Software Annual License Fee	Street	15,000			1		x
Software Design Fee	Street	10,000			1		x
TAC and ALT-TAC Stipend	Police	3,653	P	1	1		x
Sergeant	Police	2,013	P	1	1	Equity	x
Planner	Planning	1,761	P	1	1	Transfer	x
Raises (1.5% COLA, 2.5% Step, 1.5% open range)	City	1,478,750			2	12 month impact - $2.2 million	x
Training & Travel	City	140,000			2		
Solid Waste Drivers (2)	Solid Waste	105,000	P	2	2		x
Solid Waste Crew Leader	Solid Waste	75,000	P	2	2		x
Admin Support Specialist I	Fire	28,000	P	2	2		x
Part-Time Administrative Support	HR	15,071	P	2	2	Part-time to assist with internal communications/MED retirees	
Outside Legal Services - Economic Development	Legal	15,000			2		
Superintendent - Athletic/Recreation	Golf	3,832	P	2	2	Transfer	x
Budget Analyst	Street	3,370	P	2	2	Promotion	x
Landscaper/Greenskeeper Specialist	Golf	2,725	P	2	2	Transfer	x
Landscaper/Greenskeeper Foreman	Golf	3,000	P	2	2	Promotion	x
Downtown Parking Study	Econ Dev	60,000			3		
Sign Ordinance Consultant	Building & Codes	40,000			3		
Replace Doors to Pool Area at Patterson Community Center	Parks & Rec	27,500			3		
Paint Pool Area at Patterson Community Center	Parks & Rec	20,000			3		
Facility Attendant (2)	Golf	14,040	P	3	3		x

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ORDINANCE 20-O-31 amending the 2020-2021 Budget (2nd Amendment).

WHEREAS, the City Council adopted the 2020-2021 Budget by motion; and,

WHEREAS, the City Council adopted an appropriations ordinance, Ordinance 20-O-18, on June 10, 2020 to implement the 2020-2021 Budget; and,

WHEREAS, it is now desirable and appropriate to adjust and modify the 2020-2021 Budget by this Ordinance to incorporate expenditure decisions made during the 2020-2021 fiscal year.

NOW THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF MURFREESBORO, TENNESSEE, AS FOLLOWS:

SECTION 1. The 2020-2021 Budget adopted by the City Council is hereby revised and amended as shown on Exhibit A, attached hereto.

SECTION 2. That this Ordinance take effect immediately upon and after its passage upon second and final reading, as an emergency Ordinance, an emergency existing, and it being imperative to provide for the necessary expenses, general and special, of said City of Murfreesboro for the Fiscal Year 2020-2021 at the earliest practicable time, the welfare of the City requiring it.

Passed:

1st reading _____

2nd reading _____

_____
Shane McFarland, Mayor

ATTEST:

_____
Melissa B. Wright
City Recorder

APPROVED AS TO FORM:

DocuSigned by:
Adam F. Tucker
43A2B35551F9D1...

Adam F. Tucker
City Attorney

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Exhibit A
Page 1

Department	Account	BUDGET AS PASSED OR PREV AMENDED	AMENDED BUDGET	AMENDMENT INCREASE (DECREASE)
General Fund				
Revenues	Revenues			
City Court	City Court Fines and Costs	$ 1,300,000.00	$ 1,077,120.00	$ (222,880.00)
Fire Department	Federal Grants	$ 659,100.00	$ 685,700.00	$ 26,600.00
General Fund Revenues	Other State Revenue	$ 511,500.00	$ 3,149,244.00	$ 2,637,744.00
General Fund Revenues	Sales of Fixed Assets	$ -	$ 1,270,500.00	$ 1,270,500.00
General Fund Revenues	Other Federal Revenue	$ -	$ 2,120,160.00	$ 2,120,160.00
General Fund Revenues	Local Sales Tax	$ 41,990,000.00	$ 49,500,000.00	$ 7,510,000.00
General Fund Revenues	State Sales Tax	$ 9,534,000.00	$ 11,200,000.00	$ 1,666,000.00
General Fund Revenues	Business License	$ 3,135,500.00	$ 4,000,000.00	$ 864,500.00
General Fund Revenues	Mixed Drink Tax	$ 1,363,000.00	$ 1,250,000.00	$ (113,000.00)
General Fund Revenues	Cable Franchise	$ 1,400,000.00	$ 1,500,000.00	$ 100,000.00
Parks & Recreation Dept	Recreation Revenues	$ 2,088,900.00	$ 1,632,376.00	$ (456,524.00)
Police Department	Safe Street Revenues	$ 950,000.00	$ 1,080,970.00	$ 130,970.00
Street Department	Street Maintenance Contract	$ 302,689.00	$ 341,259.00	$ 38,570.00
Street Department	Charges to Stormwater	$ 750,000.00	$ 795,100.00	$ 45,100.00
Transportation Department	Federal Grants	$ 1,058,400.00	$ 1,094,400.00	$ 36,000.00
				$ 15,653,740.00
Expenditures	Expenditures			
Building & Codes Dept	Contractual Services	$ 1,000.00	$ 41,000.00	$ 40,000.00
General Fund	Salaries & Benfits (to be allocated to departments)	$ -	$ 1,478,750.00	$ 1,478,750.00
General Fund	Training & Travel (to be allocated to departments)	$ 680,800.00	$ 820,800.00	$ 140,000.00
Communications	Part-Time Salaries & Benefits (new position)	$ -	$ 15,000.00	$ 15,000.00
Economic Development	Professional Services	$ -	$ 60,000.00	$ 60,000.00
Facilities Maintenance	Furniture & Fixtures	$ -	$ 13,500.00	$ 13,500.00
Facilities Maintenance	Repair & Maintenance - Buildings	$ 81,300.00	$ 106,300.00	$ 25,000.00
Fire Department	Grant Expense	$ 17,984.00	$ 44,584.00	$ 26,600.00
Fire Department	Machinery & Equipment	$ 30,300.00	$ 56,720.00	$ 26,420.00
Fire Department	Transportation Equipment - Fire apparatus	$ -	$ 2,750,000.00	$ 2,750,000.00
Fire Department	Salaries & Benfits	$ 19,168,734.00	$ 19,381,640.00	$ 212,906.00
Golf Department	Machinery & Equipment	$ 7,000.00	$ 37,000.00	$ 30,000.00
Golf Department	Building Expense	$ -	$ 25,000.00	$ 25,000.00
Golf Department	Repair & Maintenance - Grounds & Improvements	$ 8,000.00	$ 30,000.00	$ 22,000.00
Golf Department	Salaries & Benfits	$ 1,046,708.00	$ 1,070,306.00	$ 23,598.00
Human Resources Department	Part-Time Salaries & Benefits (new position)	$ -	$ 15,071.00	$ 15,071.00
IT Department	Salaries & Benfits	$ 1,677,079.00	$ 1,712,079.00	$ 35,000.00
IT Department	Machinery & Equipment	$ 40,000.00	$ 287,300.00	$ 247,300.00
IT Department	Computer Software Expense	$ 50,000.00	$ 239,100.00	$ 189,100.00
Legal Department	Computer Software Expense	$ -	$ 35,000.00	$ 35,000.00
Legal Department	Legal Services - Economic Development	$ -	$ 15,000.00	$ 15,000.00
Parks & Recreation Dept	Building Expense	$ 4,600.00	$ 1,557,100.00	$ 1,552,500.00
Parks & Recreation Dept	Parks & Recreation Facilities	$ 24,680.00	$ 44,680.00	$ 20,000.00
Parks & Recreation Dept	Salaries & Benefits	$ 7,995,597.00	$ 8,051,447.00	$ 55,850.00
Parks & Recreation Dept	Operating Expenses	$ 3,593,005.00	$ 3,359,105.00	$ (233,900.00)
Planning Department	Salaries & Benefits	$ 1,144,323.00	$ 1,172,334.00	$ 28,011.00

Department	Account	BUDGET AS PASSED OR PREV AMENDED	AMENDED BUDGET	AMENDMENT INCREASE (DECREASE)
Planning Department	Computer Equipment Expense	$ -	$ 23,100.00	$ 23,100.00
Planning Department	Furniture & Fixtures	$ 2,000.00	$ 17,000.00	$ 15,000.00
Police Department	Salaries & Benefits	$ 29,139,985.00	$ 31,063,596.00	$ 1,923,611.00
Police Department	Machinery & Equipment	$ -	$ 1,290,200.00	$ 1,290,200.00
Police Department	Computer Software Expense	$ 5,000.00	$ 50,000.00	$ 45,000.00
Police Department	Office Machinery & Equipment	$ -	$ 24,000.00	$ 24,000.00
Police Department	Furniture & Fixtures	$ 7,000.00	$ 36,600.00	$ 29,600.00
Solid Waste Department	Salaries & Benefits	$ 2,890,487.00	$ 3,070,487.00	$ 180,000.00
Street Department	Salaries & Benefits	$ 3,357,429.00	$ 3,435,899.00	$ 78,470.00
Street Department	Computer Software Expense	$ -	$ 10,000.00	$ 10,000.00
Street Department	Software Subscriptions	$ 1,200.00	$ 16,200.00	$ 15,000.00
Transportation Department	Salaries & Benefits	$ 1,220,527.00	$ 1,275,366.00	$ 54,839.00
Transportation Department	Transportation Equipment	$ -	$ 28,000.00	$ 28,000.00
				$ 10,564,526.00
CHANGE IN FUND BALANCE (CASH)	CHANGE IN FUND BALANCE (CASH)	$ (5,490,942.00)	$ (401,728.00)	5,089,214.00
Airport Fund				
Revenues	Revenues			
	Plant and Facility Rentals	$ 38,000.00	$ 58,000.00	$ 20,000.00
				$ 20,000.00
Expenditures	Expenditures			
	Salaries & Benefits	$ 521,337.00	$ 546,337.00	$ 25,000.00
	Building & Office Rental	$ -	$ 20,000.00	$ 20,000.00
	Machinery & Equipment	$ 15,000.00	$ 30,800.00	$ 15,800.00
				$ 60,800.00
CHANGE IN FUND BALANCE (CASH)	CHANGE IN FUND BALANCE (CASH)	$ 577,980.00	$ 537,180.00	(40,800.00)

Exhibit B

City of Murfreesboro

Authorized Full Time Position Counts FY 2018 to FY 2021

	Actual	Actual	Estimated	Adopted	Budget Amendment
Department	FY 2018	FY 2019	FY 2020	FY 2021	FY 2021
Mayor and Council	7	7	7	7	7
City Manager's Office	7	11	13	13	13
Finance and Tax	18	18	18	18	18
Legal	7	7	9	9	9
City Court	6	6	6	6	6
Purchasing	2	2	2	2	2
Information Technology	16	17	20	20	20
Communications	5	5	6	6	6
Human Resources	8	7	10	10	10
Facilities Maintenance	9	11	11	11	11
Fleet Services	15	16	16	17	17
Police	319	326	350	350	369
Fire & Rescue	206	235	236	236	238
Building & Codes	26	26	26	26	26
Planning	13	14	14	14	14
Community Development	2	1	1	1	3
Transportation	23	24	25	25	27
Engineering	16	14	14	14	14
Street	48	51	51	51	52
Civic Plaza	1	1	1	1	1
Parks and Recreation	88	84	90	90	90
Golf Course	16	15	15	15	15
Solid Waste	41	42	43	43	46
Airport	2	3	3	3	4
Risk Management	3	3	0	0	0
	904	946	987	988	1018

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RESOLUTION 20-R-22 amending the 2020-2021 Murfreesboro Water Resources Department Budget (1st amendment).

WHEREAS, the City Council adopted the 2020-2021 Murfreesboro Water Resources Department Budget by motion; and,

WHEREAS, the City Council adopted Resolution 20-R-13 on June 4, 2020 to implement the 2020-2021 Murfreesboro Water Resources Department Budget; and

WHEREAS, it is now desirable and appropriate to adjust and modify the 2020-2021 Murfreesboro Water Resources Department Budget by this Resolution to incorporate expenditure decisions made by the Murfreesboro Water Resources Department.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY
OF MURFREESBORO, TENNESSEE, AS FOLLOWS:

SECTION 1. The 2020-2021 Murfreesboro Water Resources Department Budget as adopted by the City Council is hereby revised as shown on Attachment A.

SECTION 2. This Resolution shall be effective immediately upon its passage and adoption, the public welfare and the welfare of the City requiring it.

Passed: _____

_____
Shane McFarland, Mayor

ATTEST:

_____
Melissa B. Wright
City Recorder

APPROVED AS TO FORM:

DocuSigned by:
Adam F. Tucker
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Adam F. Tucker
City Attorney

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Exhibit A

Department	Account	BUDGET AS PASSED OR PREV AMENDED	AMENDED BUDGET	AMENDMENT INCREASE (DECREASE)
General Fund				
Revenues	Revenues			
Water Resources Dept	Combined Revenues	$ 47,816,000.00	$ 47,816,000.00	$ -
				$ -
				$ -
				$ -
Expenditures	Expenditures			
Water Resources	Salaries & Benefits (All Departments)	$ 10,318,100.00	$ 10,773,100.00	$ 455,000.00
Transfers to Reserves	Future Capital Expeneditures	$ 1,132,300.00	$ 677,300.00	$ (455,000.00)
				$ -
				$ -
				$ -
CHANGE IN FUND BALANCE (CASH)	CHANGE IN FUND BALANCE (CASH)	$ -	$ -	-

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RESOLUTION 20-R-23 amending the 2020-2021 Stormwater Utility Management Fund (1st amendment).

WHEREAS, the City Council adopted the 2020-2021 Stormwater Utility Management Fund by motion; and,

WHEREAS, the City Council adopted Resolution 20-R-14 on June 4, 2020 to implement the 2020-2021 Stormwater Utility Management Fund; and

WHEREAS, it is now desirable and appropriate to adjust and modify the 2020-2021 Stormwater Utility Management Fund by this Resolution to incorporate expenditure decisions made by the Murfreesboro Water Resources Department.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY
OF MURFREESBORO, TENNESSEE, AS FOLLOWS:

SECTION 1. The 2020-2021 Stormwater Utility Management Fund as adopted by the City Council is hereby revised as shown on Attachment A.

SECTION 2. This Resolution shall be effective immediately upon its passage and adoption, the public welfare and the welfare of the City requiring it.

Passed: _____

_____
Shane McFarland, Mayor

ATTEST:

_____
Melissa B. Wright
City Recorder

APPROVED AS TO FORM:

DocuSigned by:
Adam F. Tucker
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Adam F. Tucker
City Attorney

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Exhibit A

Department	Account	BUDGET AS PASSED OR PREV AMENDED	AMENDED BUDGET	AMENDMENT INCREASE (DECREASE)
General Fund				
Revenues	Revenues			
Stormwater	Fee Revenues	$ 3,150,000.00	$ 3,150,000.00	$ -
				$ -
				$ -
				$ -
Expenditures	Expenditures			
Stormwater	Salaries & Benefits	$ 620,406.00	$ 647,706.00	$ 27,300.00
Transfers to Reserves	Future CIP	$ 901,838.00	$ 874,538.00	$ (27,300.00)
				$ -
				$ -
				$ -
CHANGE IN FUND BALANCE (CASH)	CHANGE IN FUND BALANCE (CASH)	$ -	$ -	-

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title:	Community Investment Program FY21 Budget
Department:	Administration
Presented by:	Erin Tucker, Budget Director

Summary

Set Community Investment Program (CIP) budget for the FY21.

Staff Recommendation

Approve the FY21 CIP Budget.

Background Information

In February 2020, Council reviewed and established a CIP Budget for FY21 that incorporated projects totaling approximately $24m. Shortly thereafter, the national public health crisis was declared. State and national projections reflected a significant negative economic impact on local revenues resulting from measures implemented to address this crisis. The City, therefore, restricted expenditures, including major CIP purchases and initiation of CIP projects.

Actual revenue information has now been received and dictate a return to normal operations while carefully monitoring the public health situation. Projects slated for the FY21 CIP Budget were reviewed, including contractual commitments that arose during the crisis. Restructuring of projects previously reviewed by Council and the completion of projects on-going during this period permitted the accumulation of CIP funding that permits purchases on projects in the FY21 CIP Budget to be handled without additional debt. These projects, totaling approximately $20m, are presented in the attached Summary.

Additionally, a preliminary review of FY22 CIP projects has been conducted. While this review is on-going, Council input of the FY22 CIP Budget is helpful. It is anticipated that a more detailed discussion will be held in November. Approval of the FY22 CIP Budget by the end of 2020 would allow for potential debt issuance in early 2021 with debt service due in FY22.

Council Priorities Served

Responsible budgeting

Funding the CIP has a direct impact on the City's operating budget through the maintenance of debt service. The City conservative financial policies assist in the management of the City's debt and reduces that impact on the City operating budget. With this guidance, diligent management of this debt is a critical part of responsible budgeting.

Improve economic development

The CIP provides a funding for capital projects that support economic development opportunities.

Expand infrastructure

The CIP provides a roadmap for capital projects that will improve the City's infrastructure

Maintain public safety

Maintaining a high standard of public safety requires consistent, responsible CIP funding.

Fiscal Impacts

FY21 CIP Budget totals approximately $20 million. These funds are in-hand, which avoids the requirement for additional debt.

Attachments

FY21 CIP Summary

FY21 CIP Summary

Department	Service Class	Project	Eco Dev	Total Project Cost Estimate	Previous Funding	Other Funding	FY21 Funding	FY22 Funding	FY23 Funding	FY24 Funding	FY25 Funding	Future Funding
Administration	5	City Hall renovations & security		725,000	326,300	-	-	398,700	-	-	-	-
Administration	5	Land Acquisition/Contingency costs/Preliminary Design	EcD	2,272,550	-	-	300,000	372,550	400,000	400,000	400,000	400,000
Administration	5	Linebaugh Library relocation		2,500,000	-	-	-	-	-	-	-	2,500,000
		Department Total		**5,497,550**	**326,300**	**-**	**300,000**	**771,250**	**400,000**	**400,000**	**400,000**	**2,900,000**
Airport	5	Airport Taxiway Echo	EcD	1,850,000	-	1,000,000	850,000	-	-	-	-	-
Airport	5	Hangar 3 Renovations	EcD	400,000	-	-	-	-	-	-	-	400,000
Airport	5	Fuel Truck Purchase		150,000	-	150,000	-	-	-	-	-	-
Airport	5	Pavement Maintenance		1,000,000	-	900,000	-	100,000	-	-	-	-
Airport	5	Fuel Farm Relocation and Upgrade	EcD	900,000	-	900,000	-	-	-	-	-	-
Airport	5	Apron Expansion		2,000,000	-	-	-	-	-	2,000,000	-	-
Airport	5	Taxiway F Development and T-hangar Construction	EcD	2,000,000	-	-	-	2,000,000	-	-	-	-
Airport	5	MTSU Aircraft Maintenance Hangar and Apron		4,000,000	-	4,000,000	-	-	-	-	-	-
		Department Total		**12,300,000**	**-**	**6,950,000**	**850,000**	**2,100,000**	**-**	**2,000,000**	**-**	**400,000**
Building & Codes	4	Work Vehicles	0	340,000	-	-	-	110,000	80,000	75,000	75,000	-
		Department Total		**340,000**	**-**	**-**	**-**	**110,000**	**80,000**	**75,000**	**75,000**	**-**
Economic Development	5	Broad Street Property	EcD	1,500,000	-	-	-	-	-	-	-	1,500,000
Economic Development	5	Downtown Parking Garage construction	EcD	3,000,000	-	-	-	-	-	-	-	3,000,000
Economic Development	5	Historic Bottoms/Highland Avenue Redevelopment	EcD	2,700,000	-	-	-	-	-	-	-	2,700,000
Economic Development	5	West Main St. Property	EcD	750,000	-	-	-	-	-	-	-	750,000
Economic Development	5	Church Street Property	EcD	2,000,000	-	-	-	-	-	-	-	2,000,000
Economic Development	5	Church Street Property Demolition	EcD	1,500,000	-	-	-	-	-	-	-	1,500,000
		Department Total		**11,450,000**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**11,450,000**
Facilities	5	ADA Renovations		4,550,000	295,065	-	475,000	425,000	425,000	425,000	425,000	2,079,935
Facilities	5	City Court Build-Out		2,000,000	-	-	-	-	-	-	-	2,000,000
		Department Total		**6,550,000**	**295,065**	**-**	**475,000**	**425,000**	**425,000**	**425,000**	**425,000**	**4,079,935**

FY21 CIP Summary

Department	Service Class	Project	Eco Dev	Total Project Cost Estimate	Previous Funding	Other Funding	FY21 Funding	FY22 Funding	FY23 Funding	FY24 Funding	FY25 Funding	Future Funding
Fire Rescue	4	Administrative Offices		7,440,920	15,920	-	-	-	-	-	-	7,425,000
Fire Rescue	4	Pumper Apparatus Replacement 20-01		700,000	-	700,000	-	-	-	-	-	-
Fire Rescue	4	Pumper Apparatus Replacement 20-02		725,000	-	725,000	-	-	-	-	-	-
Fire Rescue	4	Quint Apparatus Replacement 22-01		1,375,000	-	-	-	1,375,000	-	-	-	-
Fire Rescue	4	Fire Station 12 Construction		6,000,000	-	-	-	-	6,000,000	-	-	-
Fire Rescue	4	Fire Station 3 Replacement		6,000,000	-	-	-	-	6,000,000	-	-	-
Fire Rescue	4	Fire Station 6 Replacement		7,000,000	-	-	-	-	-	-	7,000,000	-
Fire Rescue	4	Fire Station 13 Construction		7,000,000	-	-	-	-	-	-	7,000,000	-
Fire Rescue	4	Quint Apparatus Replacement 21-01		1,325,000	-	1,325,000	-	-	-	-	-	-
Fire Rescue	4	New Pumper Apparatus 20-01		775,000	-	-	-	-	775,000	-	-	-
Fire Rescue	4	Special Operations Equipment 22-01		250,000	-	-	-	250,000	-	-	-	-
Fire Rescue	4	Pumper Apparatus Replacement 21-01		750,000	-	-	-	750,000	-	-	-	-
Fire Rescue	4	New Quint Apparatus 24-01		1,600,000	-	-	-	-	-	-	1,600,000	-
Fire Rescue	4	Fire Station 14 Construction		7,538,400	-	-	-	-	-	-	-	7,538,400
Fire Rescue	4	Special Operations Equipment 24-01		250,000	-	-	-	-	250,000	-	-	-
		Department Total		**48,729,320**	**15,920**	**2,750,000**	**-**	**2,375,000**	**13,025,000**	**-**	**15,600,000**	**14,963,400**
Golf	3	Maintenance Equipment Replacement - Finishing Mower		20,000	-	-	-	20,000	-	-	-	-
Golf	3	Equipment Replacement - Tee & Greens Mowers		65,000	-	-	-	65,000	-	-	-	-
Golf	3	Maintenance Equipment Replacement - Fairways Mowers		128,000	-	-	-	63,000	65,000	-	-	-
Golf	3	Maintenance Equipment Replacement - Turf Sprayer		70,000	-	-	-	-	-	-	70,000	-
Golf	3	Equipment Replacement - Rough Mower		65,000	-	-	-	-	-	-	65,000	-
Golf	3	Driving Range Netting Installation		350,000	-	-	-	-	-	350,000	-	-
		Department Total		**698,000**	**-**	**-**	**-**	**148,000**	**65,000**	**350,000**	**135,000**	**-**

FY21 CIP Summary

Department	Service Class	Project	Eco Dev	Total Project Cost Estimate	Previous Funding	Other Funding	FY21 Funding	FY22 Funding	FY23 Funding	FY24 Funding	FY25 Funding	Future Funding
Parks	3	Adams Tennis Complex Improvements		240,000	-	-	-	40,000	40,000	160,000	-	-
Parks	3	Administrative Office		2,500,000	-	-	-	-	-	-	-	2,500,000
Parks	3	Barfield Crescent Park Back Country Improvements	EcD	382,000	-	-	-	150,000	-	232,000	-	-
Parks	3	Barfield Crescent Park Expansion		3,000,000	-	-	-	3,000,000	-	-	-	-
Parks	3	Barfield Crescent Park Playground / Ballfield Improvements	EcD	1,080,000	-	-	-	180,000	750,000	150,000	-	-
Parks	3	Barfield Crescent Park Trail Improvements	EcD	626,435	276,435	-	-	350,000	-	-	-	-
Parks	3	Bradley Academy		300,000	-	-	-	300,000	-	-	-	-
Parks	3	Cannonsburgh	EcD	776,781	91,781	-	-	150,000	150,000	385,000	-	-
Parks	3	Equipment Lift		18,200	-	-	-	-	-	-	-	18,200
Parks	3	Greenway - North Connector	EcD	2,920,000	19,000	-	-	-	-	2,620,000	281,000	-
Parks	3	Greenway Reconstruction	EcD	733,200	276,000	-	-	140,000	40,000	20,000	20,000	237,200
Parks	3	McFadden Community Center Improvements		250,000	-	-	-	-	100,000	150,000	-	-
Parks	3	McKnight Park Renovations		190,575	-	-	-	-	-	-	-	190,575
Parks	3	McKnight Park Parking Addition		830,000	-	-	-	430,000	400,000	-	-	-
Parks	3	McKnight Park Volleyball Improvements		100,000	-	-	-	-	-	100,000	-	-
Parks	3	Murfree Springs Wetland Trail Improvements		268,075	-	-	-	-	-	-	-	268,075
Parks	3	Oaklands		80,000	-	-	-	-	-	-	-	80,000
Parks	3	Old Fort Park Ballfield Improvement	EcD	1,200,000	-	-	-	200,000	400,000	600,000	-	-
Parks	3	Old Fort Park Improvements		56,000	-	-	-	-	-	-	-	56,000
Parks	3	Old Fort Park Parking Improvement	EcD	430,000	-	-	-	430,000	-	-	-	-
Parks	3	Patterson Improvements		649,849	169,849	-	80,000	400,000	-	-	-	-
Parks	3	Paving Improvements		150,000	-	-		50,000	-	50,000	-	50,000
Parks	3	Playground Deferred Maintenance		150,000	-	-	-	50,000	50,000	-	50,000	-
Parks	3	Siegel Park Enhancements		14,000,000	4,835,000	1,500,000	4,000,000	3,665,000	-	-	-	-
Parks	3	Siegel Park Playground Replacement	EcD	400,000	-	-	-	-	-	400,000	-	-
Parks	3	Star Plex Improvements		95,000	-	-	-	95,000	-	-	-	-
Parks	3	Vehicle Replacement		225,000	-	-	-	75,000	-	75,000	-	75,000
Parks	3	Walter Hill Park Renovation		812,293	12,293	-	-	200,000	600,000	-	-	-
Parks	3	West Murfreesboro Park Developments		57,730,877	9,220,877	-	-	-	-	880,000	2,100,000	45,530,000
		Department Total		**90,194,285**	**14,901,235**	**1,500,000**	**4,080,000**	**9,905,000**	**2,530,000**	**5,822,000**	**2,451,000**	**49,005,050**
Police	4	Blackman Precinct		8,000,000	-	-	-	-	500,000	7,500,000	-	-
Police	4	Police Information Technology Replacements		2,092,432	589,032	-	-	320,000	200,000	200,000	200,000	583,400
Police	4	Police Mobile Data Terminal Replacements		1,354,462	380,797	-	-	240,000	150,000	200,000	75,000	308,665
Police	4	Mobile Video Equipment (Video Replacements)		959,595	233,695	-	-	175,000	175,000	175,000	175,000	25,900
Police	4	Public Safety Radio		2,750,000	-	-	-	550,000	550,000	550,000	550,000	550,000
Police	4	Police Public Safety Software		895,000	520,000	-	100,000	50,000	100,000	50,000	75,000	-
Police	4	Police Vehicles - Marked		16,173,000	6,988,000	-	-	1,820,000	1,820,000	1,820,000	1,820,000	1,905,000
Police	4	Police Vehicles - Unmarked		1,996,667	1,133,167	-	-	-	294,000	294,000	275,500	-
		Department Total		**34,221,156**	**9,844,691**	**-**	**100,000**	**3,155,000**	**3,789,000**	**10,789,000**	**3,170,500**	**3,372,965**

FY21 CIP Summary

Department	Service Class	Project	Eco Dev	Total Project Cost Estimate	Previous Funding	Other Funding	FY21 Funding	FY22 Funding	FY23 Funding	FY24 Funding	FY25 Funding	Future Funding
Schools	2	Access Point Update		920,815	184,163	736,652	-	-	-	-	-	-
Schools	2	Bleachers		260,000	-	260,000	-	-	-	-	-	-
Schools	2	Carpet Replacement with Vinyl		900,000	-	900,000	-	-	-	-	-	-
Schools	2	Data Cabling Upgrade		150,525	30,105	120,420	-	-	-	-	-	-
Schools	2	Full Size buses		1,060,000	-	1,060,000	-	-	-	-	-	-
Schools	2	New Schools		36,960,000	-	-	-	-	-	-	-	36,960,000
Schools	2	Parking Lot Seal Coat and Striping		225,000	-	225,000	-	-	-	-	-	-
Schools	2	Playground Equipment & Surface		1,100,000	-	1,100,000	-	-	-	-	-	-
Schools	2	Roofs		700,000	-	700,000	-	-	-	-	-	-
Schools	2	Special Education Buses		560,000	-	560,000	-	-	-	-	-	-
Schools	2	Student Computers/Chromebooks		2,625,000	280,932	2,344,068	-	-	-	-	-	-
Schools	2	Teacher & Staff Computers		1,875,000	-	1,875,000	-	-	-	-	-	-
Schools	2	Vehicle Replacement - Used vans		275,000	-	275,000	-	-	-	-	-	-
		Department Total		**47,611,340**	**495,200**	**10,156,140**	**-**	**-**	**-**	**-**	**-**	**36,960,000**
Solid Waste	5	Automated Side Loader Replacements		5,210,000	-	-	-	710,000	750,000	1,250,000	1,250,000	1,250,000
Solid Waste	5	Solid Waste Transfer Stations		10,500,000	-	-	3,500,000	-	7,000,000	-	-	-
Solid Waste	5	Rear Loader Replacements		190,000	-	-	-	-	-	-	190,000	-
Solid Waste	5	Recycling Center Improvements		275,000	-	-	-	275,000	-	-	-	-
Solid Waste	5	Front end loader		345,000	-	-	-	345,000	-	-	-	-
Solid Waste	5	Engine Replacement		120,000	-	-	-	80,000	40,000	-	-	-
Solid Waste	5	Boom trucks		1,000,000	-	-	-	200,000	400,000	400,000	-	-
Solid Waste	5	Routing tracking software		200,000	-	-	200,000	-	-	-	-	-
Solid Waste	5	Trommel Screen		400,000	-	-	-	400,000	-	-	-	-
Solid Waste	5	Pick-up - 4 wheel drive		60,000	-	-	-	-	-	60,000	-	-
		Department Total		**18,300,000**	**-**	**-**	**3,700,000**	**2,010,000**	**8,190,000**	**1,710,000**	**1,440,000**	**1,250,000**
Streets	1	Street 3/4 Ton Trucks		500,000	-	-	-	100,000	100,000	100,000	100,000	100,000
Streets	1	Street Dual Axle Dump Trucks		1,180,000	-	-	-	380,000	200,000	200,000	200,000	200,000
Streets	1	Chipper (from the UED 2020 CIP)		88,000	-	-	-	88,000	-	-	-	-
Streets	1	Guardrail install - Sevier, S. Spring, S. Academy	0	86,000	-	-	-	-	-	-	86,000	-
Streets	1	Mini Skid Steer with log grapple		36,000	-	-	-	36,000	-	-	-	-
Streets	1	Street One Ton Dump Truck		200,000	-	-	-	90,000	-	-	110,000	-
Streets	1	Street Paving Machine		375,000	-	-	-	375,000	-	-	-	-
Streets	1	Salt Bin (located with new Solid Waste Transfer Station)		500,000	-	-	-	500,000	-	-	-	-
Streets	1	Salt Bin Roof Replacement		110,000	35,000	-	75,000	-	-	-	-	-
Streets	1	Street Tractors		600,000	-	-	-	150,000	150,000	150,000	150,000	-
Streets	1	Street Vacuum Leaf Truck		425,000	-	-	-	200,000	-	-	225,000	-
Streets	1	Paving - former UED lot		35,000	-	-	-	-	-	-	-	35,000
Streets	1	Public Works South Annex		1,400,000	-	-	-	-	-	-	-	1,400,000
		Department Total		**5,535,000**	**35,000**	**-**	**75,000**	**1,919,000**	**450,000**	**450,000**	**871,000**	**1,735,000**
Transit	1	Bus Replacement		1,534,000	-	1,534,000	-	-	-	-	-	-
Transit	1	Transit Facility		14,503,492	1,124,840	10,190,652	1,700,000	1,488,000	-	-	-	-
		Department Total		**16,037,492**	**1,124,840**	**11,724,652**	**1,700,000**	**1,488,000**	**-**	**-**	**-**	**-**

FY21 CIP Summary

Department	Service Class	Project	Eco Dev	Total Project Cost Estimate	Previous Funding	Other Funding	FY21 Funding	FY22 Funding	FY23 Funding	FY24 Funding	FY25 Funding	Future Funding
Transportation	1	Battleground Dr Phase 2		8,100,000	-	-	-	-	-	-	600,000	7,500,000
Transportation	1	Bradyville Pike Improvements		13,992,582	369,412	13,623,170	-	-	-	-	-	-
Transportation	1	Bridge Ave and Kings Hwy Improvements		5,700,000	-	-	-	-	440,000	5,260,000	-	-
Transportation	1	Brinkley Rd reconstruction		13,600,000	419,078	-	-	3,000,000	2,000,000	5,746,522	2,434,400	-
Transportation	1	Broad & Thompson Separated Grade		58,180,020	-	56,180,020	-	-	1,000,000	-	1,000,000	-
Transportation	1	Burnt Knob Road		5,250,000	12,000	-	-	-	-	-	-	5,238,000
Transportation	1	Butler Dr. Improvements	EcD	15,000,000	-	6,500,000	-	8,500,000	-	-	-	-
Transportation	1	Caroline Farms		3,545,886	263,800	45,886	-	-	-	3,236,200	-	-
Transportation	1	Cherry Lane Extension (Sazerac)	EcD	8,900,000	-	3,806,250	-	3,093,750	2,000,000	-	-	-
Transportation	1	Cherry Lane Extension - Phase 2	EcD	16,800,000	1,045,000	-	-	7,000,000	8,755,000	-	-	-
Transportation	1	Cherry Lane Extension and 840 Interchange - Phase 3	EcD	53,750,000	1,174,400	7,001,600	2,000,000	10,000,000	16,000,000	9,574,000	8,000,000	-
Transportation	1	Clark Blvd Sidewalks		4,050,000	-	-	-	-	300,000	750,000	3,000,000	-
Transportation	1	Front-Vine Street Realignment	EcD	2,500,000	-	-	-	2,500,000	-	-	-	-
Transportation	1	Gresham La/John Rice Blvd	EcD	8,750,000	65,200	400,000	-	-	-	5,000,000	3,284,800	-
Transportation	1	Gateway Extension to Robert Rose Drive	EcD	2,450,000	60,000	-	-	750,000	1,640,000	-	-	-
Transportation	1	Haynes Dr Widening		11,394,770	94,770	-	-	-	-	450,000	3,750,000	7,100,000
Transportation	1	Jones Blvd Improvements		9,100,000	3,850,000	-	-	-	-	-	-	5,250,000
Transportation	1	Lytle St Reconstruction Ph 3 (First United Methodist)		3,500,000	-	-	-	3,500,000	-	-	-	-
Transportation	1	Memorial Blvd	EcD	14,800,000	-	12,800,000	-	-	1,000,000	-	1,000,000	-
Transportation	1	Mercury Boulevard Sidewalks		3,337,178	610,000	2,027,178	700,000	-	-	-	-	-
Transportation	1	New Salem Highway Phase 1		13,556,378	81,000	13,475,378	-	-	-	-	-	-
Transportation	1	New Salem Highway Phase 2		32,905,222	189,000	32,716,222	-	-	-	-	-	-
Transportation	1	New Salem Highway Phase 3		23,270,000	90,000	23,180,000	-	-	-	-	-	-
Transportation	1	North Maney Avenue		4,185,000	45,000	-	-	-	-	-	395,000	3,745,000
Transportation	1	River Rock - Beasie Rd		8,550,000	-	-	2,550,000	6,000,000	-	-	-	-
Transportation	1	Racquet Club Drive Improvements	EcD	1,800,000	-	-	-	-	100,000	200,000	1,500,000	-
Transportation	1	Rucker Lane Reconstruction		15,531,000	8,432,000	109,000	-	-	6,990,000	-	-	-
Transportation	1	Rutherford Blvd ASCT Project		3,481,010	-	3,356,010	125,000	-	-	-	-	-
Transportation	1	Rutherford Blvd Extension	EcD	25,000,000	21,000	-	-	500,000	1,000,000	979,000	10,000,000	12,500,000
Transportation	1	Spence Creek		750,000	-	-	-	750,000	-	-	-	-
Transportation	1	St. Clair Street		1,500,000	-	150,000	-	-	-	1,350,000	-	-
Transportation	1	Sulphur Springs Rd - Phase 3		4,530,000	-	-	-	-	-	780,000	-	3,750,000
Transportation	1	Sulphur Springs Rd -Phase 2		6,280,000	-	-	-	-	-	600,000	400,000	5,280,000
Transportation	1	Sulphur Springs Rd -Phase 1		9,200,000	-	-	-	-	-	600,000	600,000	8,000,000
Transportation	1	Thomspon Lane Widening		58,500,000	1,700,000	56,800,000	-	-	-	-	-	-
Transportation	1	Warrior Drive Extension	EcD	5,000,000	-	2,000,000	3,000,000	-	-	-	-	-
Transportation	1	Wilkinson Pike Widening		9,215,035	375,600	158,085	-	-	-	1,500,000	3,125,950	4,055,400
		Department Total		**485,954,081**	**18,897,260**	**234,328,799**	**8,375,000**	**45,593,750**	**41,225,000**	**36,025,722**	**39,090,150**	**62,418,400**
		Totals		**783,418,224**	**45,935,511**	**267,409,591**	**19,655,000**	**70,000,000**	**70,179,000**	**58,046,722**	**63,657,650**	**188,534,750**

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title:	August 2020 Dashboard
Department:	Administration
Presented by:	Erin Tucker, Budget Director

Summary

August 2020 Dashboard packet

Background Information

August's dashboard information includes relevant Financial, Building & Codes, Risk Management and Construction data.

Council Priorities Served

Responsible budgeting

Providing Council with assessible financial information on a regular basis assists in critical decision-making about the fiscal affairs of the City.

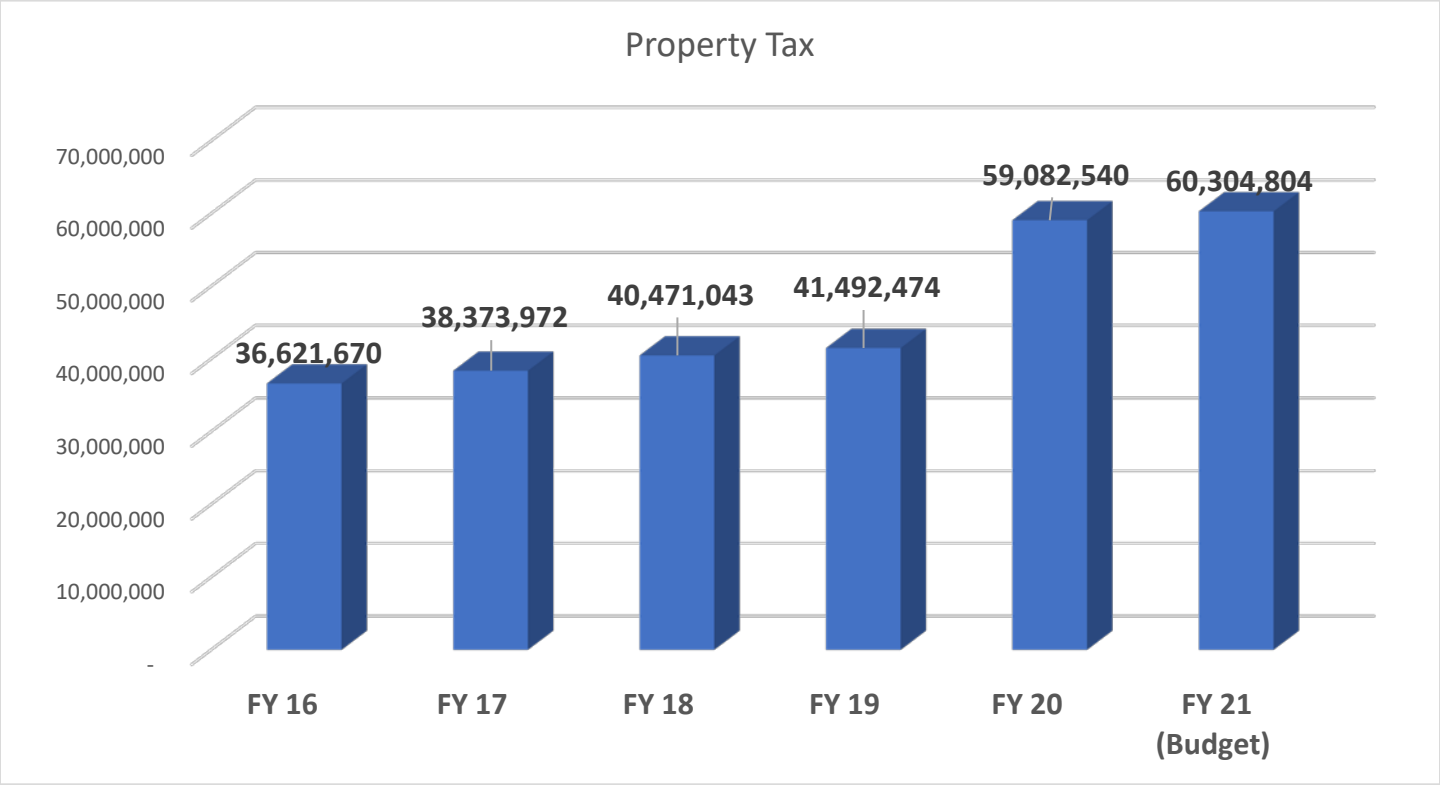
Fiscal Impacts

None

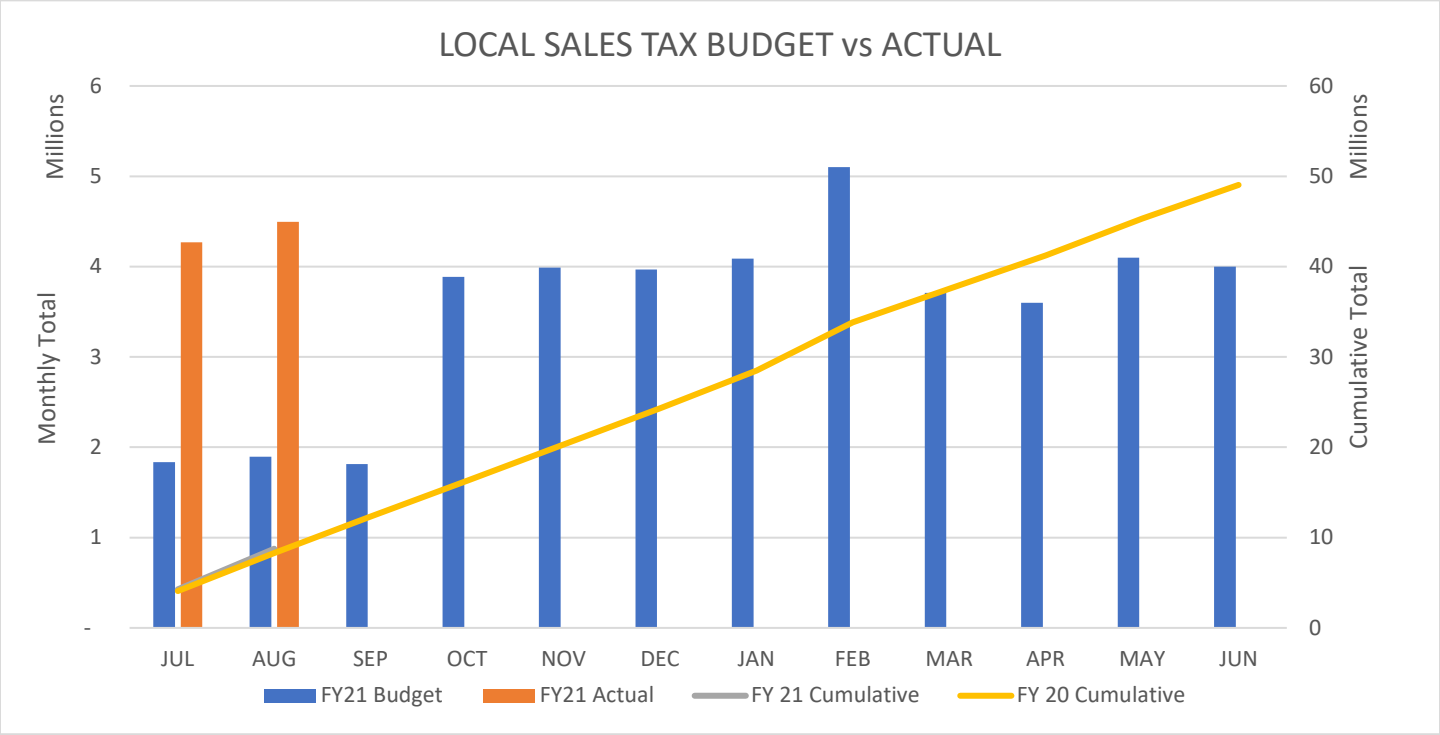
Attachments:

1. August 2020 Dashboard
2. City Schools August Dashboard

August DASHBOARD

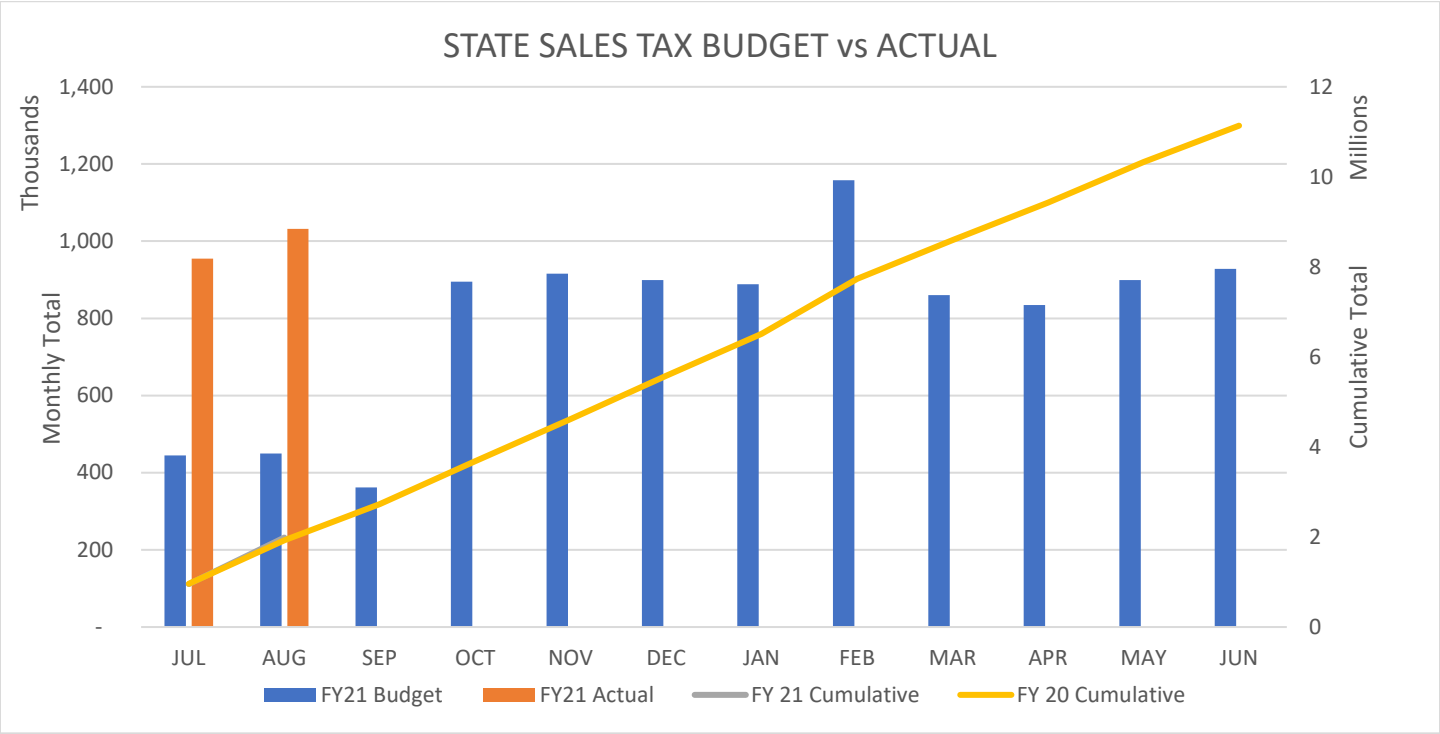


Property Tax notices will be mailed in early October. The FY21 Budget assumes a 2% increase. Final assessment information is not yet available.

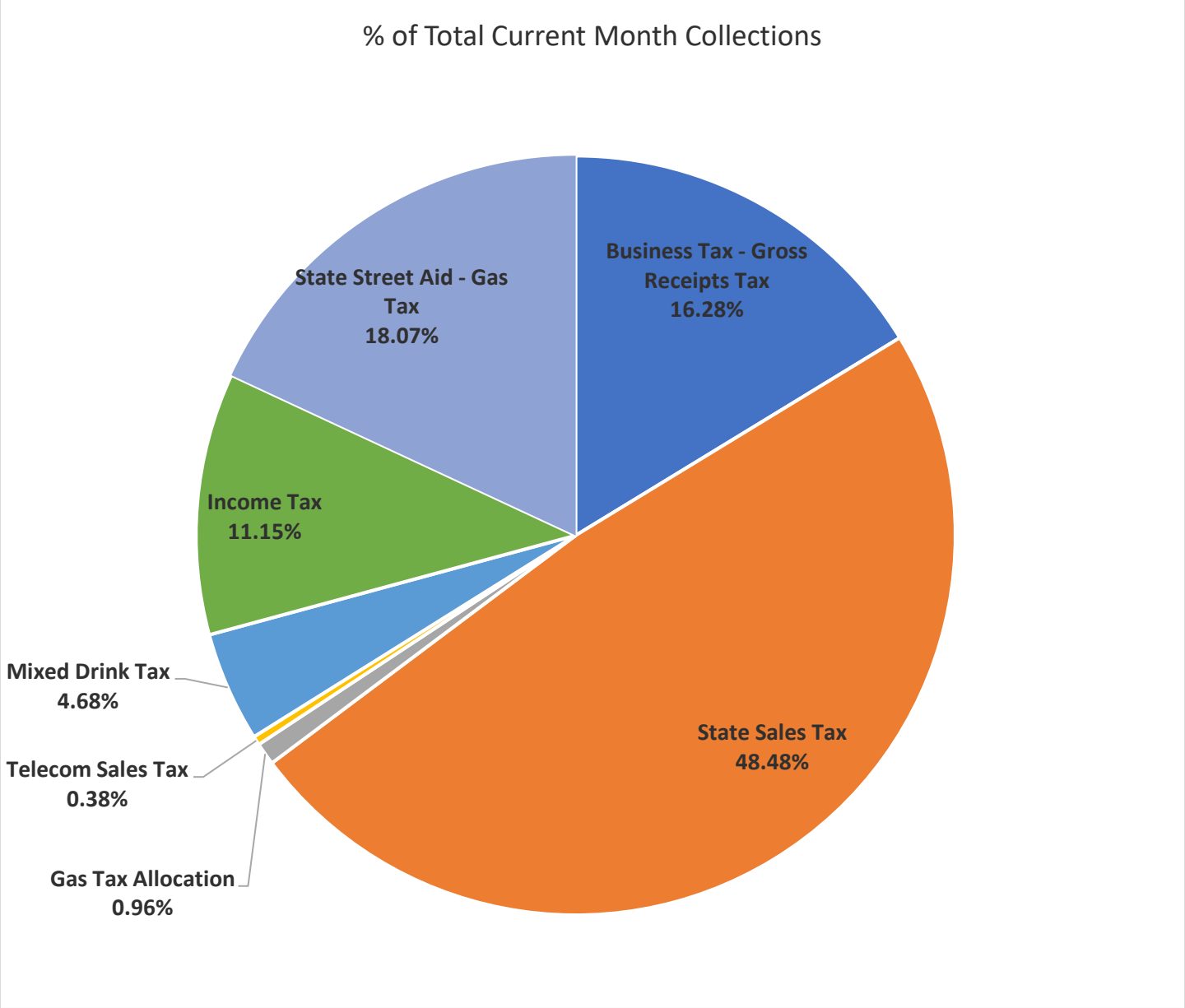


Initial estimates for the COVID-19 impact on Local Sales Tax indicated a 55% decrease as compared to FY20 through the first quarter of FY21. Instead, collections for July were exceeded, rather than lagged, FY20. This trend continued through August with collections 6.8% over August 2020 and 137% over budget. FY21 cumulative collections show 5.7% increase

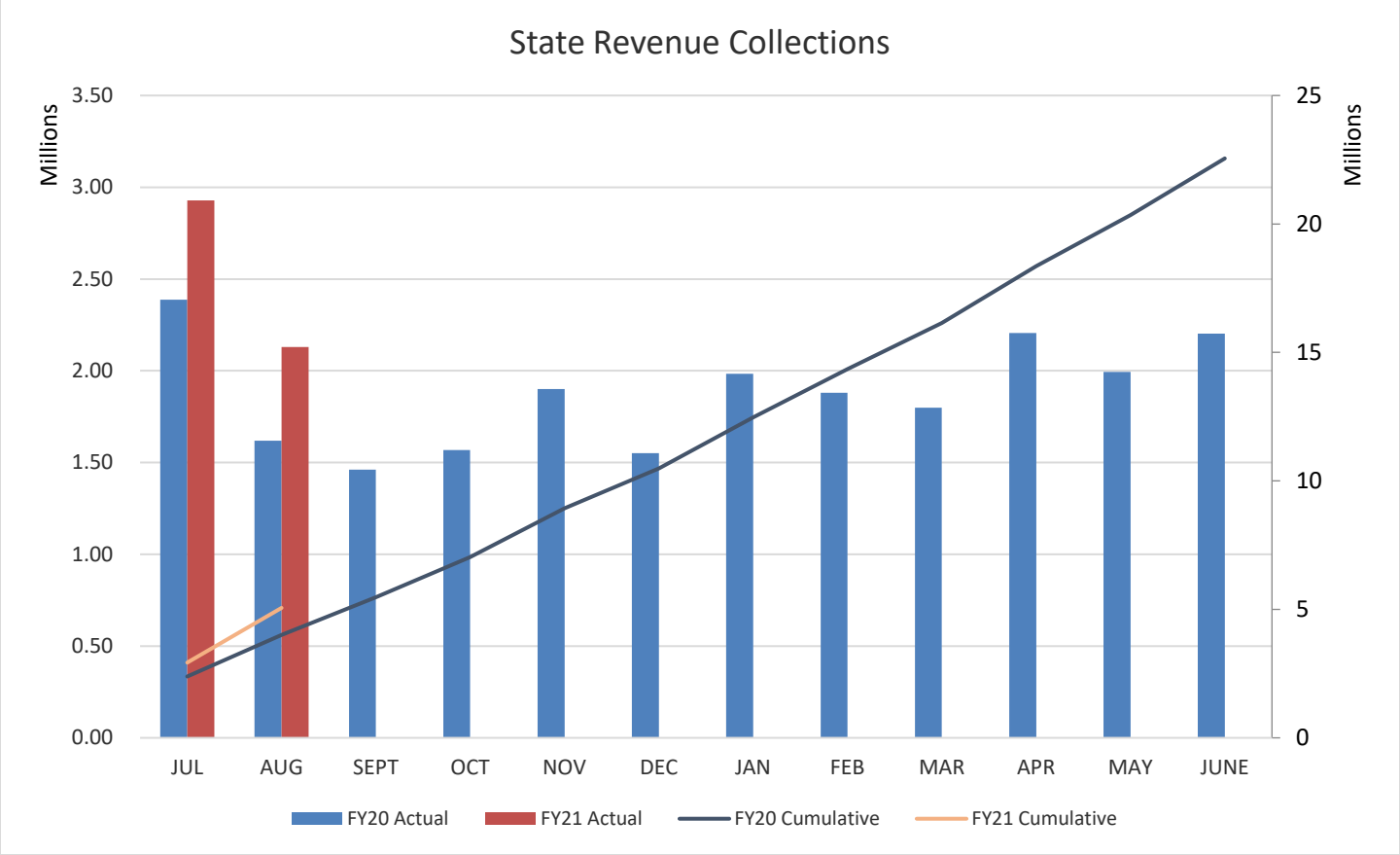
over FY20 and 134.9% over this year's budget. This information reflects a 2-month lag – the collections are for June 2020 taxes. Barring any future shut-downs or significant economic downturns, this trend is expected to continue.



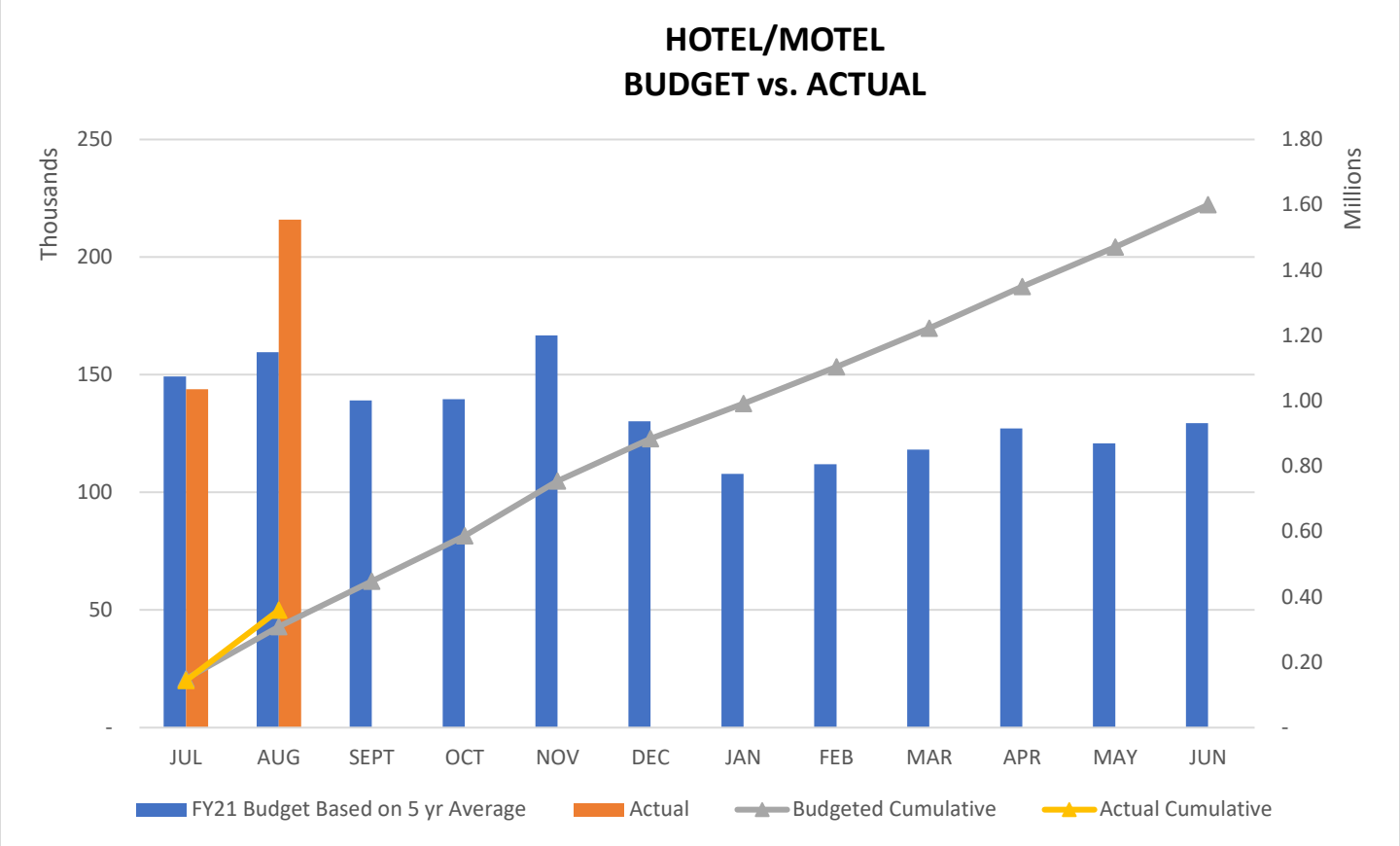
State Sales Tax was also budgeted at a 55% loss as compared to the first quarter of FY20. Actual results show a nearly flat effect for July and a 6.8% increase for August as compared to FY20. Cumulatively, State Sales Tax is up 3.125% over FY20 and 122% over budget. This information reflects a 2-month lag – the collections are for June 2020 taxes. Again, barring any future shut-downs or significant economic downturns, this trend is expected to continue.



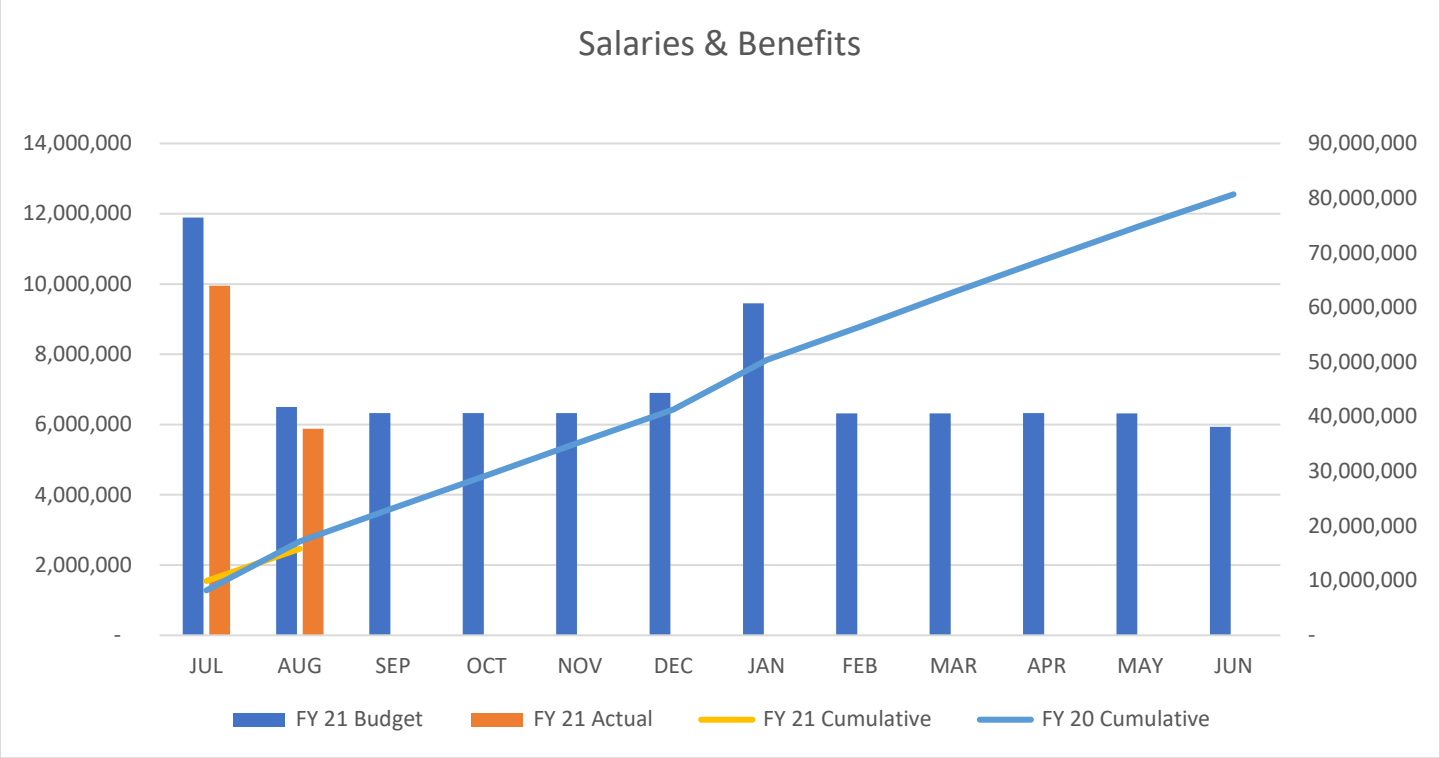
Sales Tax made up over 48% of the State Shared collections for August, while the State Street Aid Gas Tax (restricted to road improvements) made up an additional 18%. Business License Taxes were down significantly in previous months due to filing extensions as a result of COVID-19. The July & August receipts for May & June remittances leveled the revenue source with FY20 collections and resulted in an overall 4% increase as compared to FY20.



Overall, State Shared Revenue collections showed a 26% increase over last year's State Shared revenues thru August.

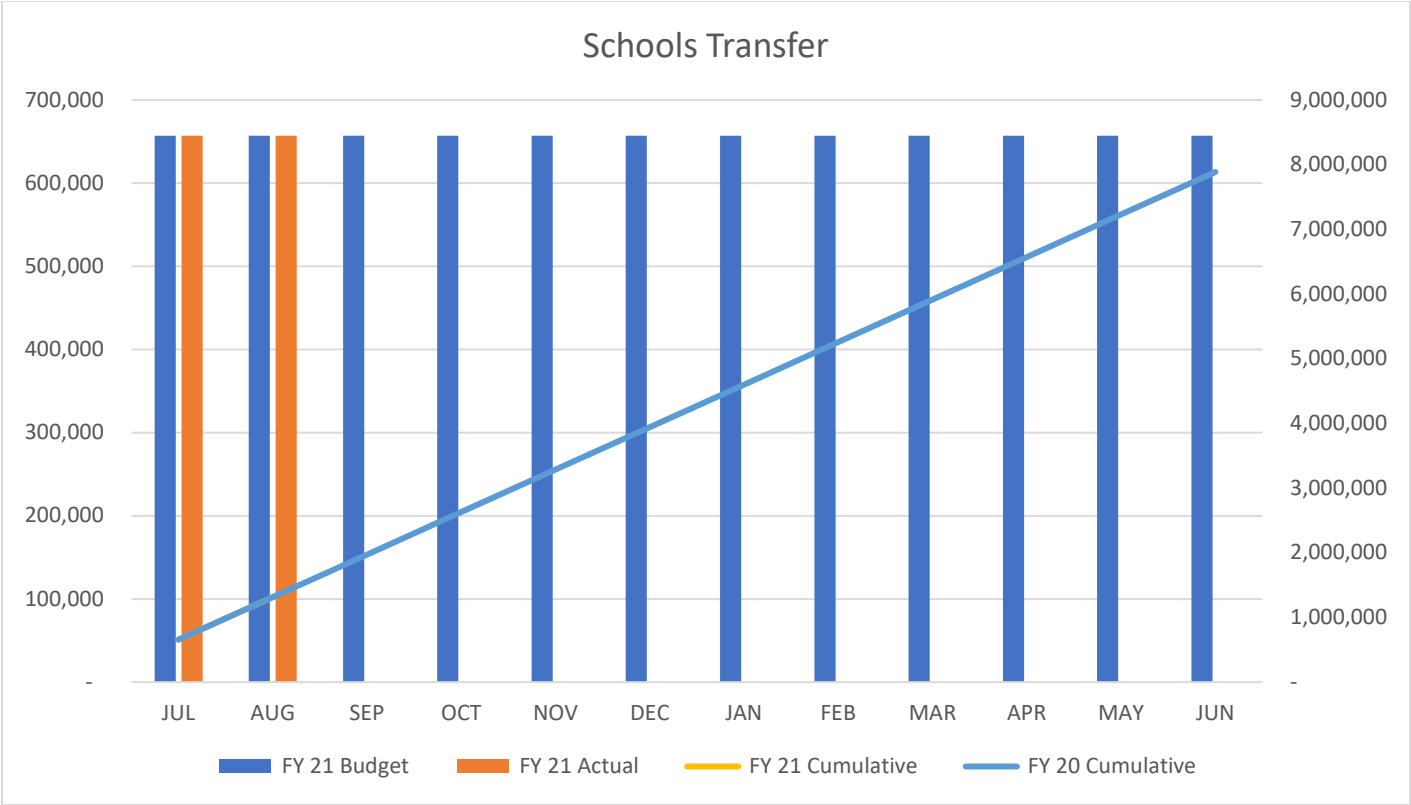


The Hotel/Motel Tax rate doubled in FY20 from 2.5% to 5%. The August remittance, for July taxes, shows a 27% decrease over last year's reported occupancy and a 35% increase from this year's budget. This trend is expected to continue due to the COVID-19 impact on tourism.

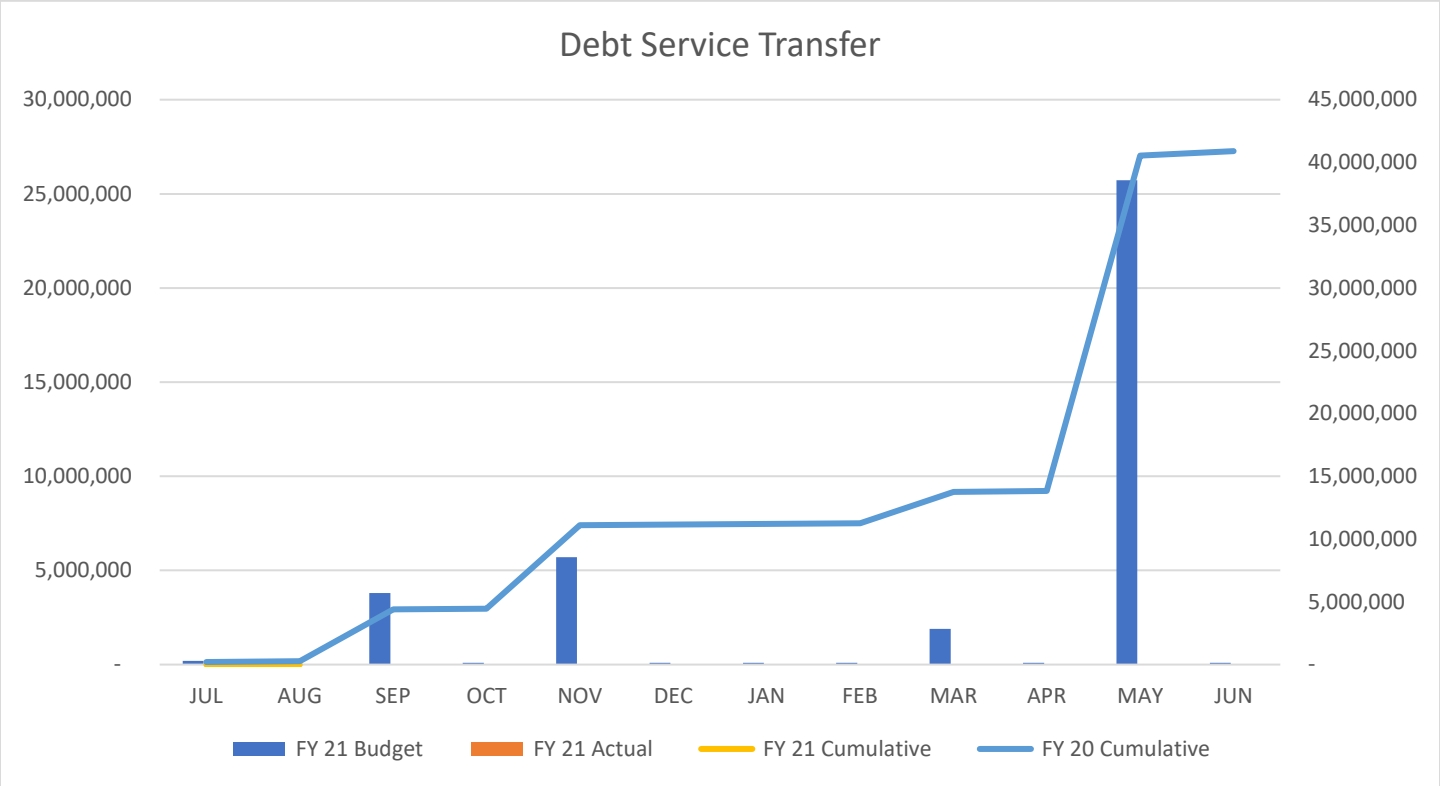


Effective 3/19/20, a hiring freeze was implemented with only critical vacancies being filled. As a result, Salaries & Benefits were trending a little under budget due to unfilled vacancies within the City through July. As of 7/31/20, there were 930 filled full-time positions and 58 vacancies – which is up from 51 vacancies in July. Police had 27 open positions at the end of August, including 12 sworn officer positions and 11 emergency communications staff. Fire had 10 open positions.

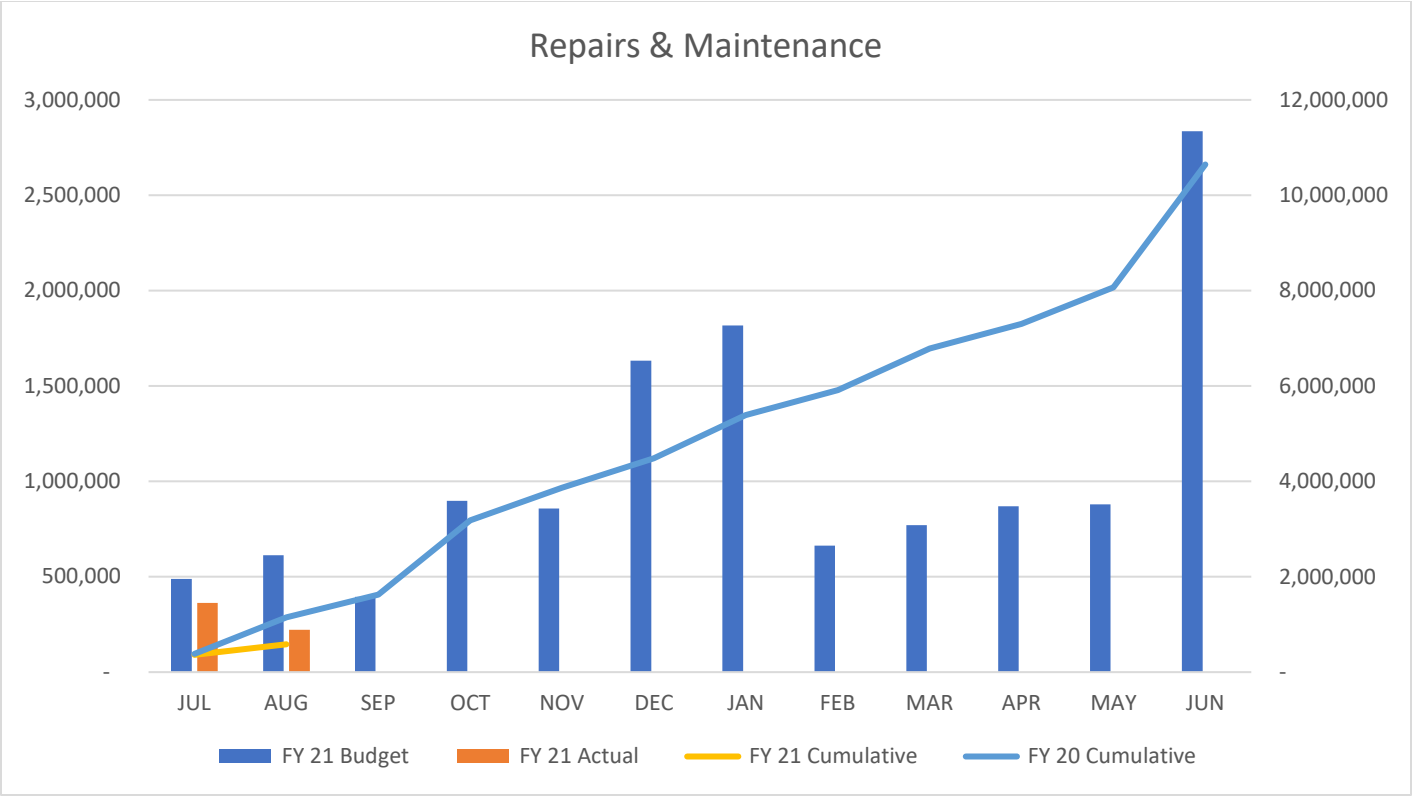
Department	Position	# of Vacancies
City Manager's Office	Communication Outreach Spec.	1
City Manager's Office	Director of Project Development	1
Facilities Maintenance Department	Custodian	1
Police Department	Sergeant	6
Police Department	Police Officer	6
Police Department	Communications Shift Supervisor	1
Police Department	Dispatcher	10
Police Department	Parking Enforcement Aide	1
Police Department	Administrative Support Specialist II	2
Police Department	Custodian	1
Fire Department	Fire Captain	3
Fire Department	Firefighter	7
Building and Codes Department	Plan Examiner	1
Planning Department	Principal Planner	1
Planning Department	Project Engineer*	1
Planning Department	Administrative Support Specialist I	1
Street Department	Director - Street	1
Street Department	Equipment Operator	-1
Street Department	Laborer (Full time)	1
Street Department	W/WW Maintenance Worker	-3
Street Department	Lead Landscaper/Greenskeeper	1
Street Department	Landscaper/Greenskeeper	3
Information Technology Department	GIS Analyst	1
Fleet Services Department	Administrative Support Specialist II	1
Fleet Services Department	Heavy Equipment Mechanic	1
Parks and Recreation	Recreation Facility Coordinator	1
Parks and Recreation	Assistant Recreation Facility Coordinator	1
Parks and Recreation	Facility Maintenance Foreman	1
Parks and Recreation	Groundskeeper/Maintenance	1
Golf Course	Irrigation Technician	1
Solid Waste Department	Director - Solid Waste	1
Solid Waste Department	Driver	1
Solid Waste Department	Laborer	1
Airport	Airport Manager	1
		58



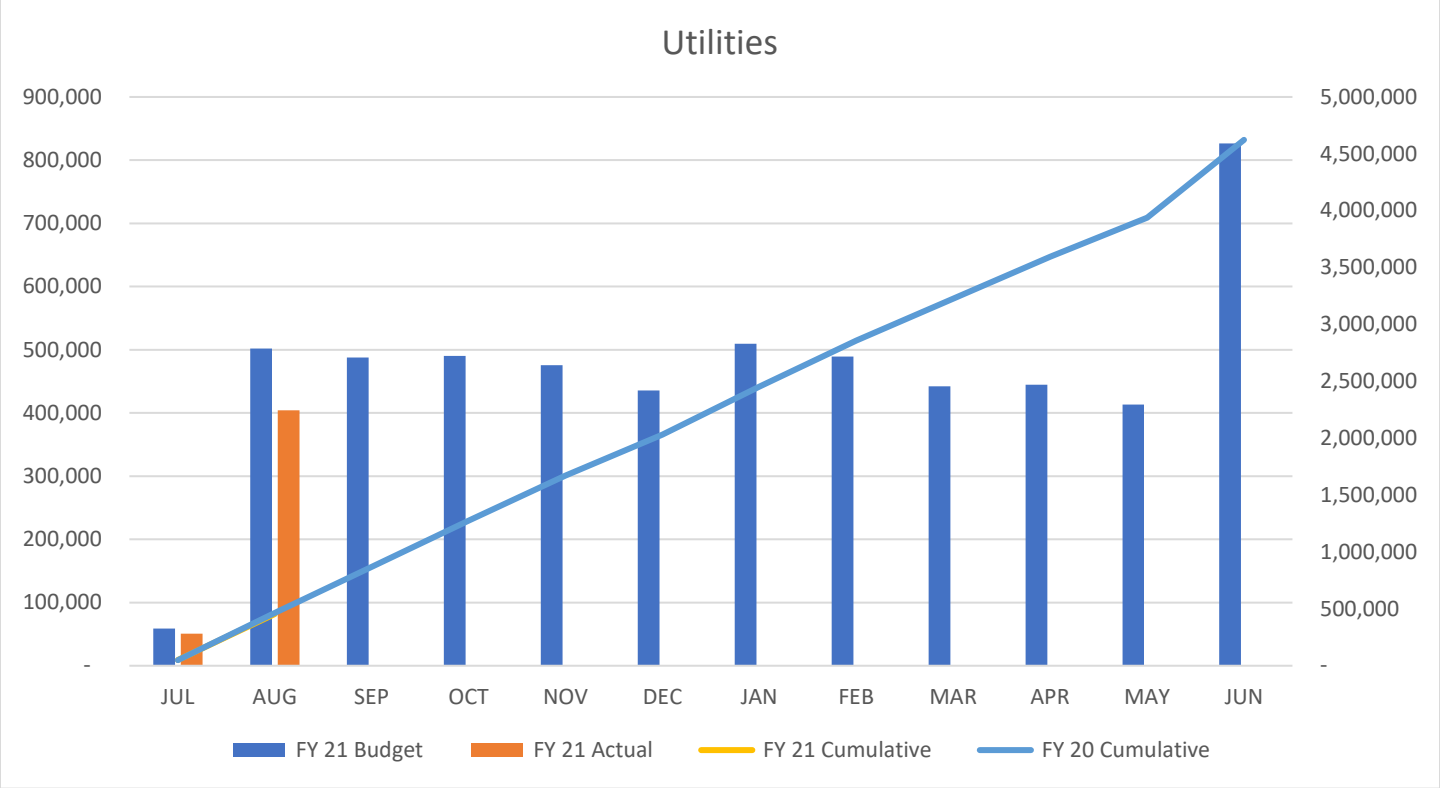
Budgeted Transfers to City Schools is budgeted at $7.885M. This transfer is made in monthly increments evenly distributed throughout the year.



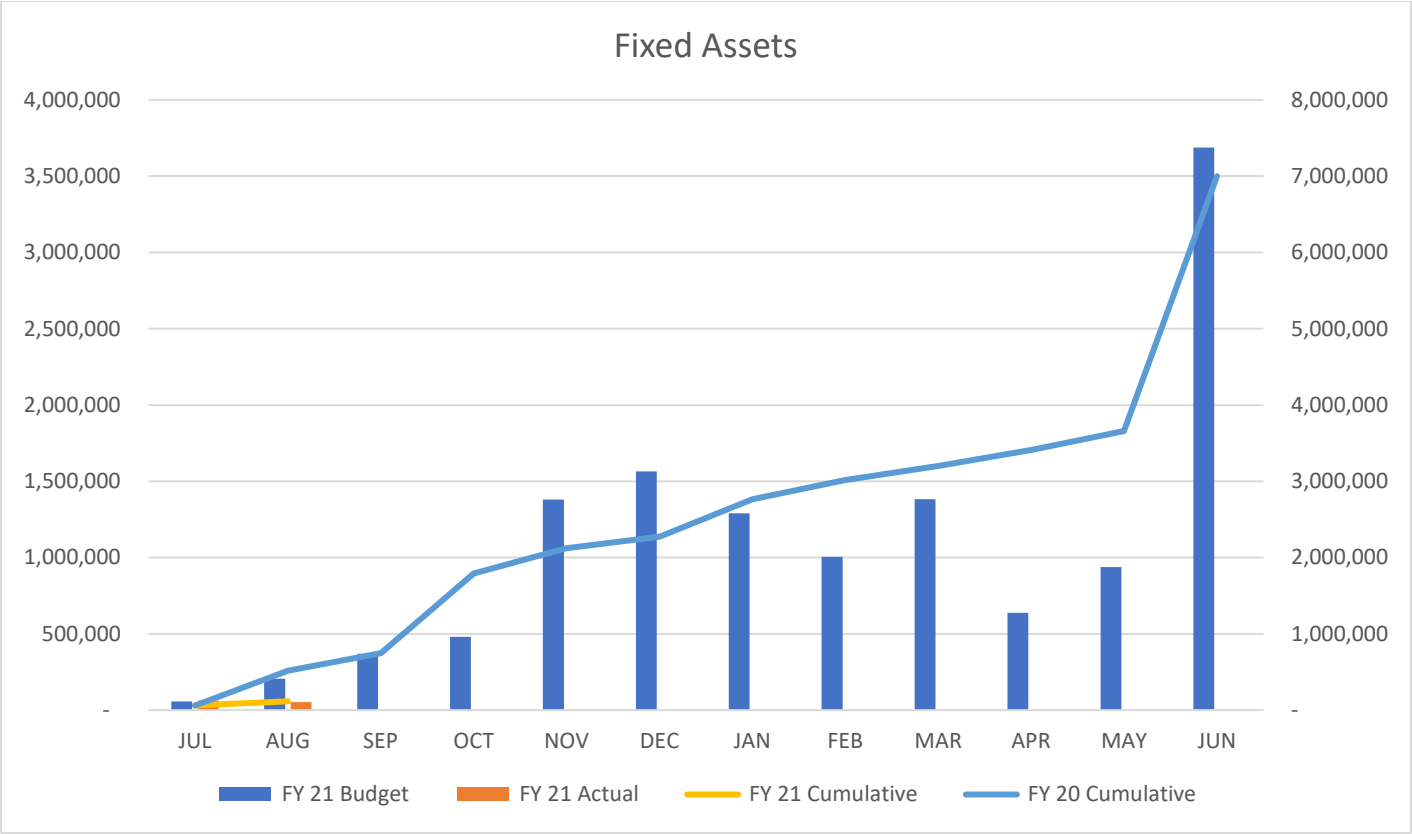
The budgeted Debt Service Transfer decreased by $3.3M in FY21. This is due to debt payoff ($2.8M), refinanced debt (with budgeted savings of $236,600) and no new debt service for FY21.



Repairs & Maintenance make up 7% of General Fund budgeted expenses. This includes maintenance of software ($1.2M), fleet services ($2.7M), and Police R&M for radios, mobile data terminals, etc. ($1.4M). State Street Aid R&M of streets, markings and right of way totals $4.4M. These expenses are seasonal and fluctuate depending on contract timing and timing of repairs. This was trending 47% under budget and 49% less than FY20 through August.



Utilities were budgeted to stay relatively flat in FY20 as compared to FY19 and were running 19% under budget for the year through August.

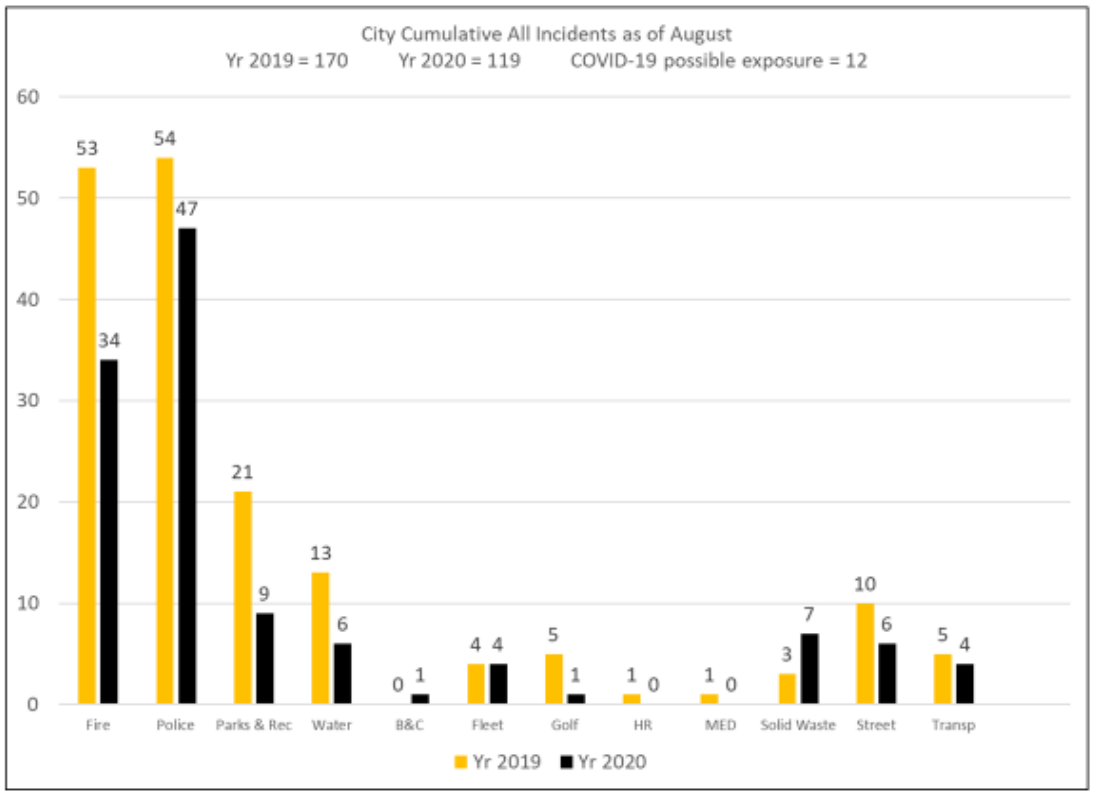


$13M budgeted for Fixed Assets in FY 21 includes:

- $9.25M in Infrastructure for grant funded road construction
- $1.4M – Transit Facility
- $1.1M – Rover bus replacement (grant funded portion)
- $111k software & computer hardware
- $98k Recreation equipment
- $436k public safety;

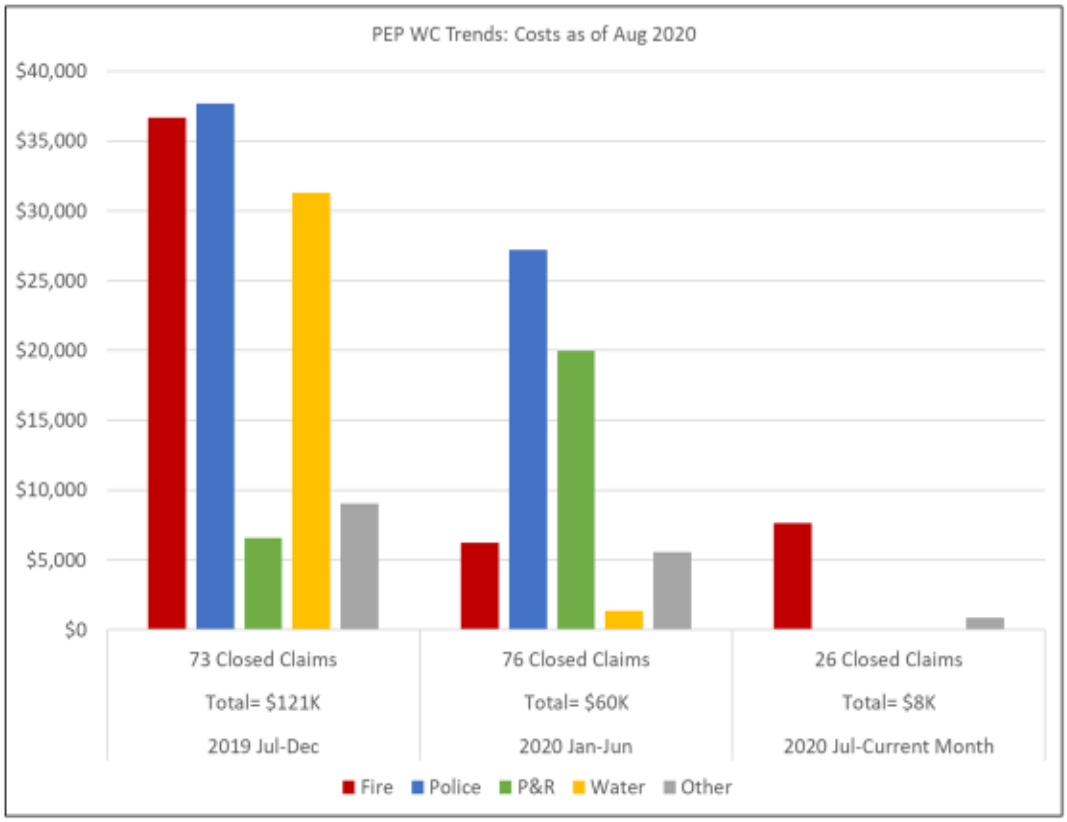
Timing on spending in Fixed Assets is also seasonal and can fluctuate based on the construction schedules and delivery of equipment. Through August, fixed asset spending was down 78% as compared to last year due to the City-wide non-essential spending freeze and timing of road construction projects funded through the Infrastructure Department.

AUGUST SAFETY REPORT

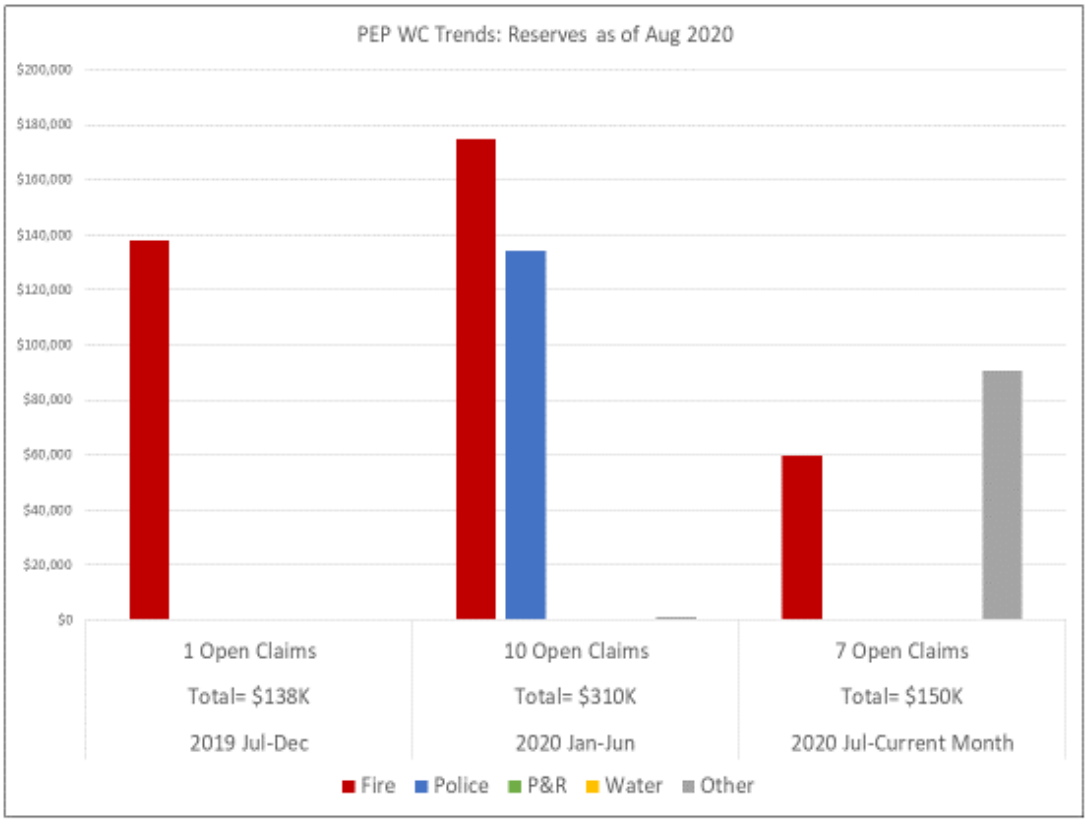


Overall for the City, total incidents showed a 30% decrease over the same time period last year. The City is showing 12 possible COVID-19 related Workers Compensation claims. A claim is filed when an employee states that they may have been exposed to COVID-19 as part of their job duties. This is not a measure of COVID-19 testing. COVID-19 testing results will not be a part of this report.

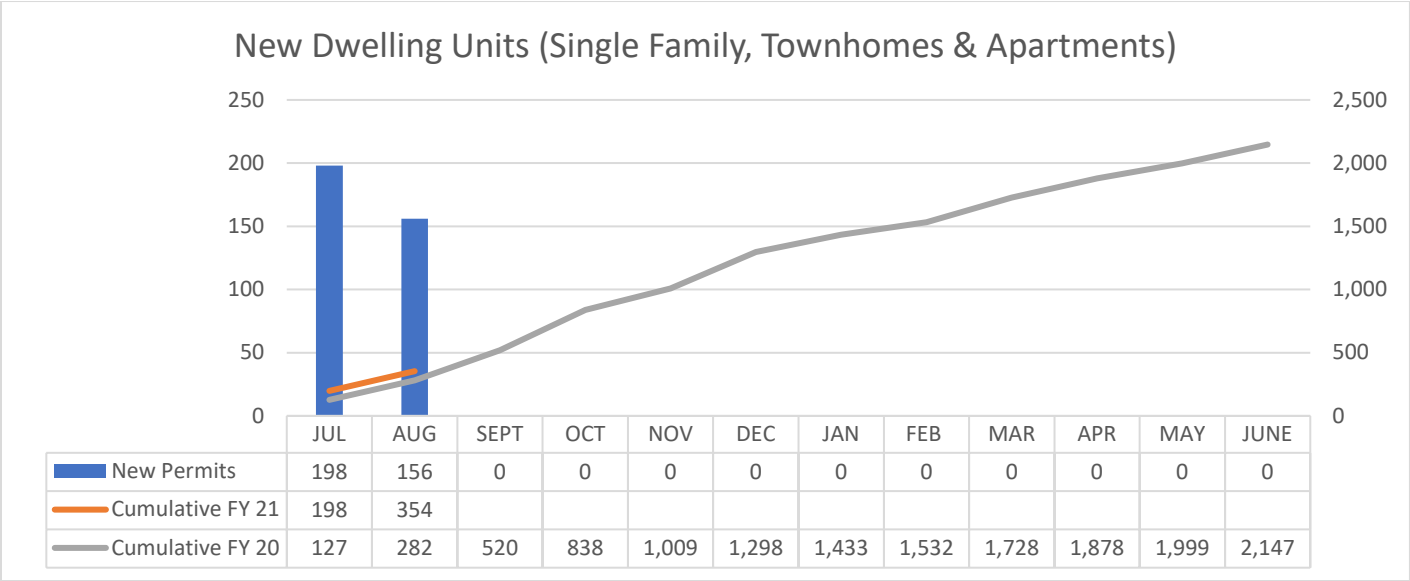
Workers' Compensation



Workers' Compensation

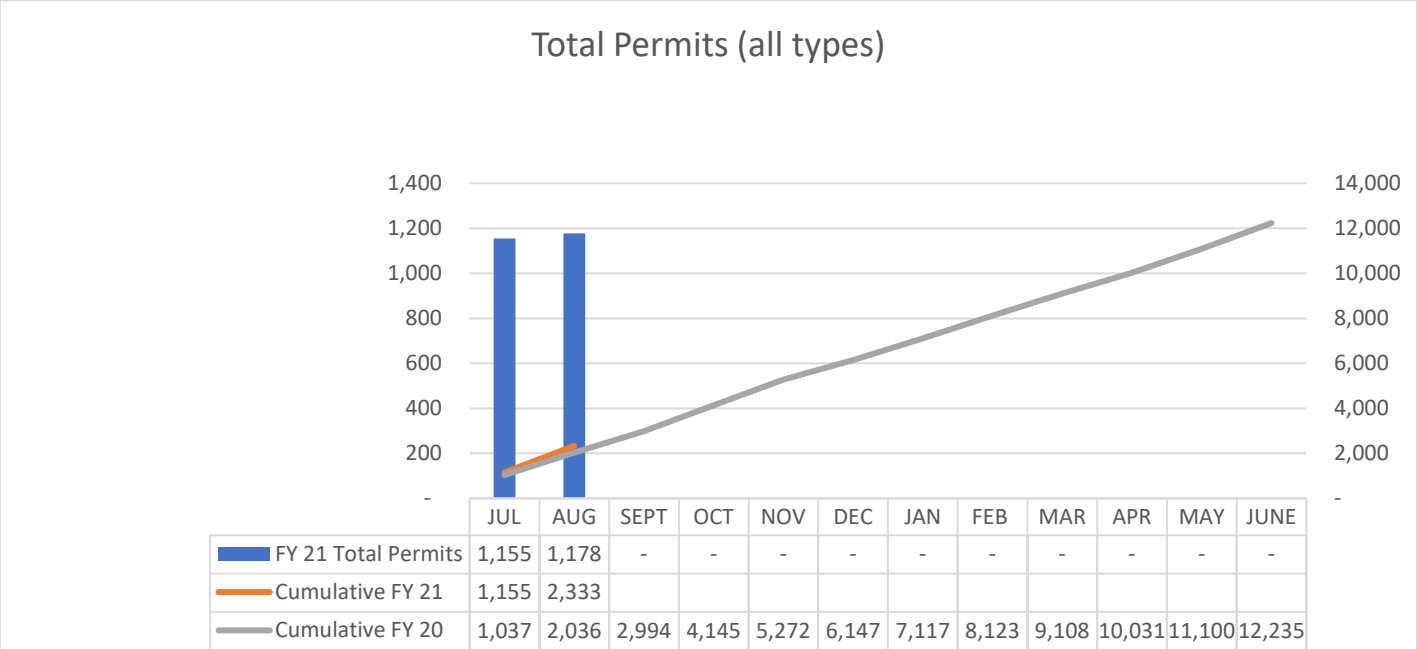


BUILDING & CODES



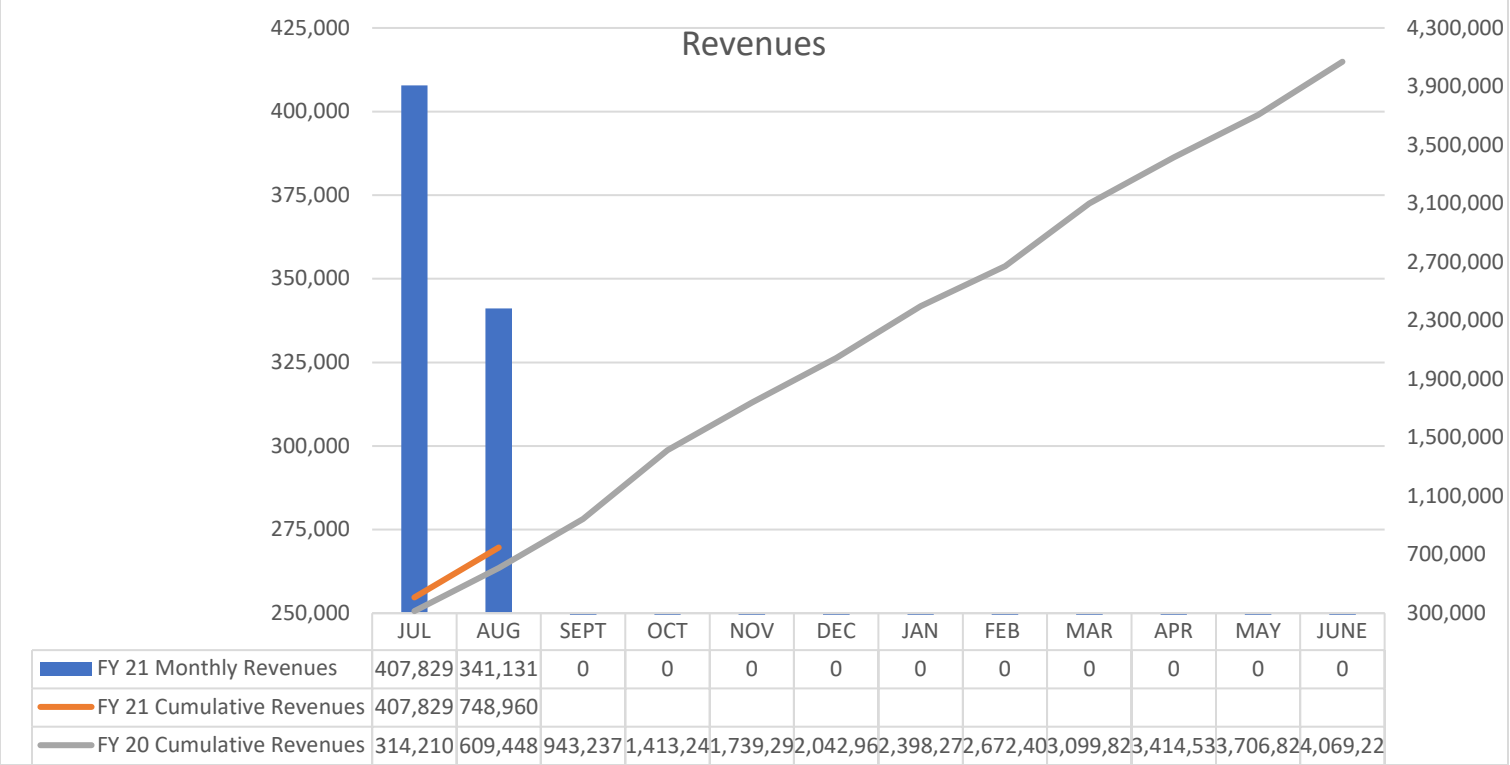
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
New Permits	198	156	0	0	0	0	0	0	0	0	0	0
Cumulative FY 21	198	354										
Cumulative FY 20	127	282	520	838	1,009	1,298	1,433	1,532	1,728	1,878	1,999	2,147

Dwelling permits were up 26% as compared to FY20.



	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
FY 21 Total Permits	1,155	1,178	-	-	-	-	-	-	-	-	-	-
Cumulative FY 21	1,155	2,333										
Cumulative FY 20	1,037	2,036	2,994	4,145	5,272	6,147	7,117	8,123	9,108	10,031	11,100	12,235

Total permits were trending up over last year by 14.6% through August.

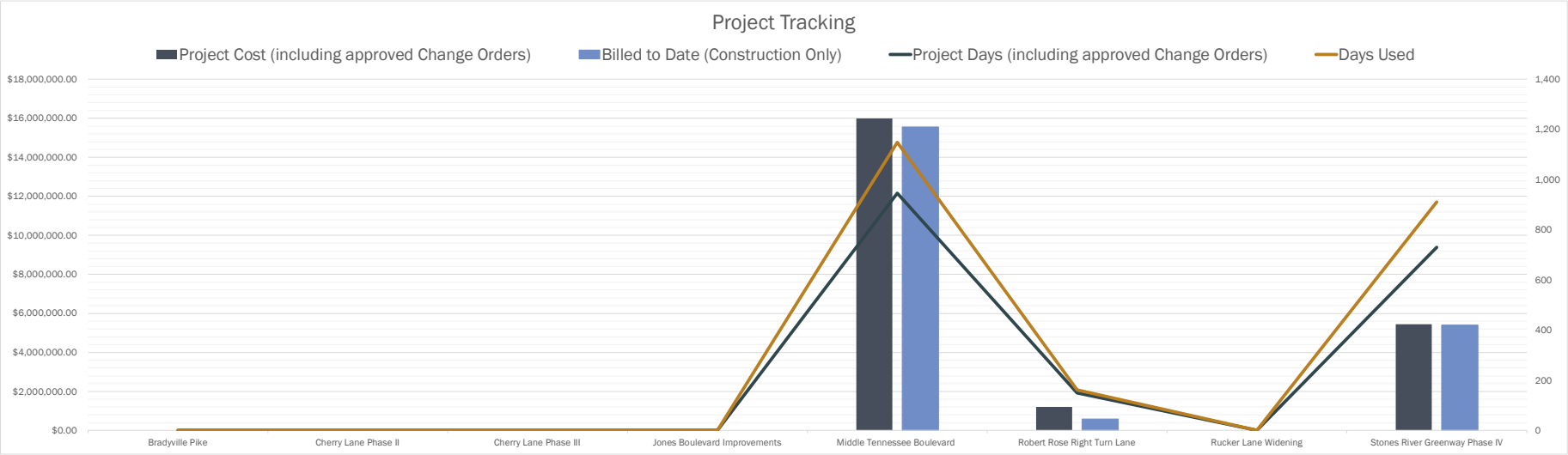


	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
FY 21 Monthly Revenues	407,829	341,131	0	0	0	0	0	0	0	0	0	0
FY 21 Cumulative Revenues	407,829	748,960										
FY 20 Cumulative Revenues	314,210	609,448	943,237	1,413,241	1,739,292	2,042,962	2,398,272	2,672,403	3,099,823	3,414,533	3,706,824	4,069,22

August Building & Code revenues increased by 22.89% as compared to last year.

ENGINEERING CONSTRUCTION UPDATE

SEPTEMBER 10, 2020



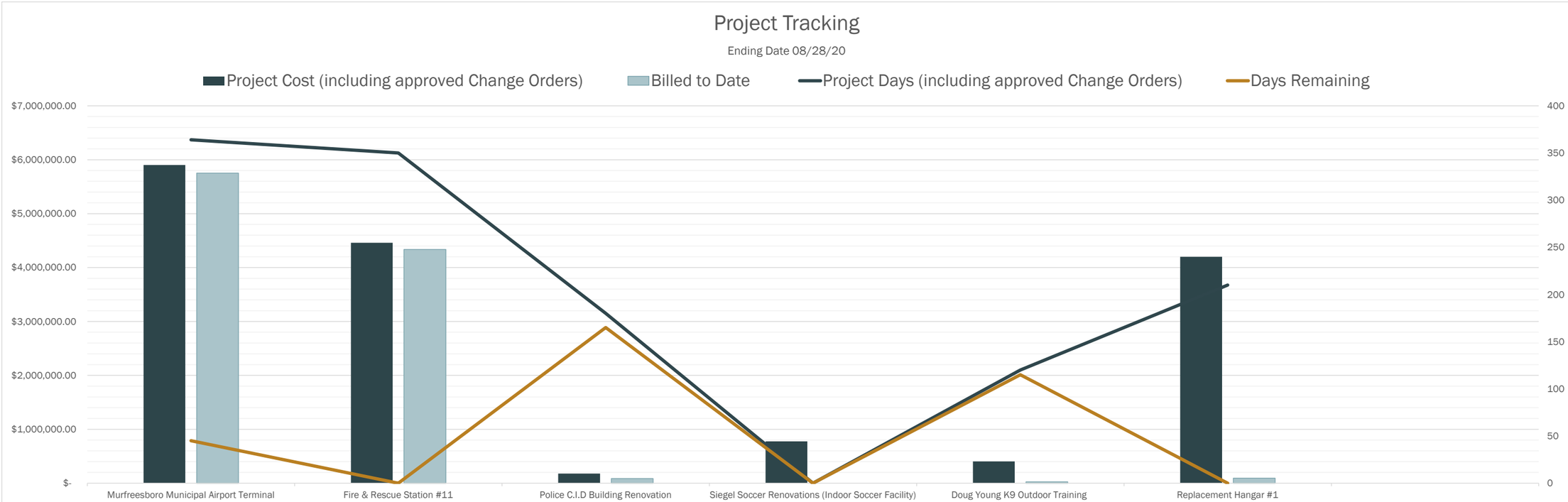
	Project Limits									
Project Name	**From**	**To**	**Distance**	**Project Cost (including approved Change Orders)**	**Billed to Date (Construction Only)**	**Project Days (including approved Change Orders)**	**Days Used**	**Percent Days**	**Today / Substantial Completion**	**N.T.P.**
Bradyville Pike	SE Broad St	S Rutherford Blvd	**2.10 Miles**	$10,570,000 (Est Cost)	$0.00	0	0	0%		
Cherry Lane Phase II	Siegel Soccer Park	Sulphur Springs Road	**1.73 Miles**	$13,800,000 (Est Cost)	$0.00	0	0	0%		
Cherry Lane Phase III	Broad Street	Memorial Blvd (231)	**1.10 Miles**	$46,000,000 (Est Cost)	$0.00	0	0	0%		
Jones Boulevard Improvements	Medical Center Parkway	Clark Boulevard	**0.54 Mile**	$3,419,212 (Est Cost)	$0.00	0	0	0%		
Middle Tennessee Boulevard	East Main Street	Greenland Drive	**0.8 Mile**	$15,986,859	$15,550,141	945	1148	121%	3/4/2019	1/11/2016
Robert Rose Right Turn Lane	Robert Rose	Thompson Lane	**0.14 Mile**	$1,208,196	$593,225.04	150	162	108%	9/8/2020	3/30/2020
Rucker Lane Widening	Highway 96 (Franklin Road)	Veterans Parkway	**2.5 Miles**	$13,200,000 (Est Cost)	$0.00	0	0	0%		
Stones River Greenway Phase IV	Barfield Road	Barfield Crescent Park	**2.65 Miles**	$5,445,977	$5,400,021	730	911	125%	3/10/2020	9/11/2017
			Total	**$109,630,244**	**$21,543,387**					

ENGINEERING CONSTRUCTION UPDATE

SEPTEMBER 10, 2020

Project	Project Status / Comments
Cherry Lane Phase II	Alignment study for final enviromental review ongoing. ROW legal documents being drafted by consultant. Meeting onsite with Consultants and TDEC September 14.
Cherry Lane Phase III	Utility coordination meetings held regarding bridge design. 840 Bridge plans being reviewed by City before submission, Stones River Bridge to be delivered for City review by end of month.
Mercury Blvd Sidewalk	Selection of CEI and Material Testing Vendor completed. Awaiting NTP from TDOT.
Middle Tennessee Boulevard	Working on close out documentation.
Robert Rose Drive	Contractor poured wall for box culvert. Comcast cable to be completed by end of week 9/8/20. Street Lights being installed.
Rucker Lane Widening	Bid 3/10/20, with Rogers Group being the apparent low bidder. Project on hold till further notice.
Stones River Greenway Phase IV	Punchlist completed. Working on closeout. Final change order to be received by the end of the month.

Project	ROW Updates
Bradyville Pike	12% of ROW Acquisition completed
Cherry Lane Phase II	On hold; under envrionmental review
Cherry Lane Phase III	Vendor selection pending
Jones Blvd	87% ROW Acquisition completed



Project Name	Project Limits: Start Date	Project Limits: Delivery Method	Project Limits: Completion	Project Cost (including approved Change Orders)	Billed to Date	Project Days (including approved Change Orders)	Days Remaining	Percent Days	Today / Substantial Completion	Construction Opportunities
Murfreesboro Municipal Airport Terminal	4/17/2019	Design Build	**4/17/2020**	$ 5,901,969.76	5,752,544.94	364	45	12%	Working on Punch List	Directional Signage
Fire & Rescue Station #11	7/2/2019	Hard Bid	**6/16/2020**	$ 4,460,869.16	$ 4,336,003.67	350	0	0%	Closing out financials	N/A
Police C.I.D Building Renovation	4/15/2020	Hard Bid	**6 months**	177,785.00	$ 85,492.50	180	165		Continued Framing	None
Siegel Soccer Renovations (Indoor Soccer Facility)	4/23/2020	Hard Bid	**7 months**	$ 776,800.00	$0.00	N/A	N/A	N/A	On Hold	Funding
Doug Young K9 Outdoor Training	4/1/2020	Hard Bid	**3 months**	$ 403,868.00	$ 24,566.40	120	115	0%	Masonry Block and concrete complete	None
Replacement Hangar #1	In Design	Design Build	**6 months**	$ 4,200,000.00	$ 93,553.99	210	0	0%	Reviewing Contract	Construction Cost
								#DIV/0!		
			Total	**$15,921,291.92**	**$10,292,161.50**					

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: August 2020 MCS Cash Flow Statement and Revenue and Expenditure Budget Comparison Reports

Department: Murfreesboro City Schools

Presented by: Ralph Ringstaff

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☐
Direction	☐
Information	☒

Summary

FY21 Cash Flow Statement (August 2020)

FY21 Revenue and Expenditure Budget Comparison Reports (August 2020)

Background Information

The State has recommended the Schools provide a Cash Flow Statement to the City Council on a monthly basis to indicate enough cash reserves are forecasted to be available to pay monthly expenses. We also will be including Revenue and Expenditure Budget Comparison Reports, that is provided to the Murfreesboro City School Board each month. This information will be included in the Wednesday agenda each month. A formal presentation will not be made each month, however there will be an opportunity for questions and comments.

Council Priorities Served

Strong and Sustainable Financial and Economic Health

Fiscal Impact

None

Attachments

August 2020 MCS Cash Flow Statement

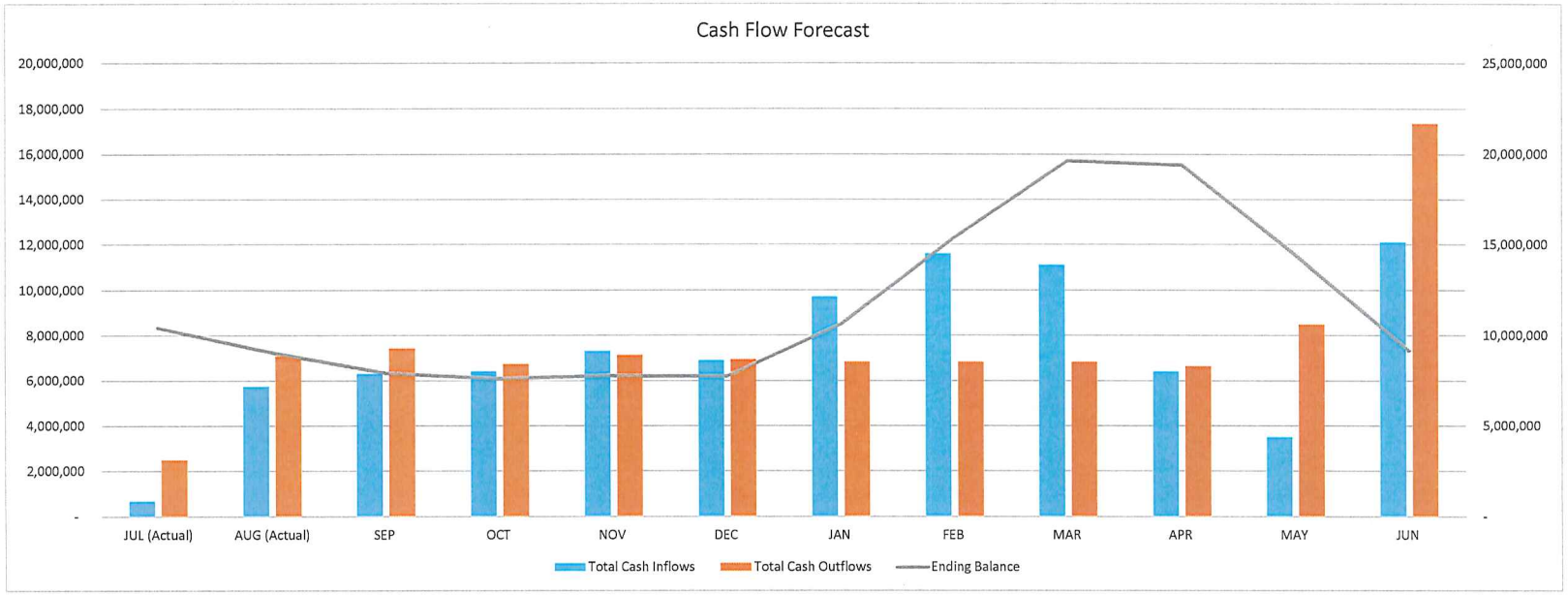
August 2020 MCS Revenue and Expenditure Budget Comparison Reports

FY21 GENERAL PURPOSE CITY SCHOOL FUND

Cash Flow Forecast Schedule **
FY 2021

General Purpose School Fund	JUL (Actual)	AUG (Actual)	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL
Cash Receipts	$ 678,493	$ 5,727,714	$ 6,300,000	$ 6,400,000	$ 7,300,000	$ 6,900,000	$ 9,700,000	$ 11,600,000	$ 11,100,000	$ 6,400,000	$ 3,500,000	$ 12,095,821	$ 87,702,028
Loan Proceeds	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Cash Inflows	678,493	5,727,714	6,300,000	6,400,000	7,300,000	6,900,000	9,700,000	11,600,000	11,100,000	6,400,000	3,500,000	12,095,821	87,702,028
Beg Cash Bal	12,229,127	10,433,658	9,076,355	7,944,375	7,612,395	7,780,415	7,748,435	10,616,455	15,384,475	19,652,495	19,420,515	14,441,572	
Available Cash	12,907,620	16,161,372	15,376,355	14,344,375	14,912,395	14,680,415	17,448,435	22,216,455	26,484,475	26,052,495	22,920,515	26,537,393	
Cash Payments	$ 2,441,982	$ 7,053,037	$ 7,400,000	$ 6,700,000	$ 7,100,000	$ 6,900,000	$ 6,800,000	$ 6,800,000	$ 6,800,000	$ 6,600,000	$ 8,446,963	$ 17,303,391	90,345,373
Debt Service	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	31,980	57,420	409,200
Transfers Out	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Cash Outflows	2,473,962	7,085,017	7,431,980	6,731,980	7,131,980	6,931,980	6,831,980	6,831,980	6,831,980	6,631,980	8,478,943	17,360,811	90,754,573
Ending Balance	10,433,658	9,076,355	7,944,375	7,612,395	7,780,415	7,748,435	10,616,455	15,384,475	19,652,495	19,420,515	14,441,572	9,176,582	
Cash Inflows - Outflows	$ (1,795,469)	$ (1,357,303)	$ (1,131,980)	$ (331,980)	$ 168,020	$ (31,980)	$ 2,868,020	$ 4,768,020	$ 4,268,020	$ (231,980)	$ (4,978,943)	$ (5,264,990)	$ (3,052,545)

**Amounts are estimated unless otherwise indicated.



COMPARISON OF BUDGET TOTALS
July 1, 2020 Through August 31, 2020

TOTAL INCOME	7/1/20 - 8/31/20	$	6,406,204
TOTAL EXPENSES	7/1/20 - 8/31/20		9,558,979
NET INCOME	8/31/20	$	(3,152,775)

YEAR-TO-DATE REVENUE COMPARISON

AUGUST 2020

	BUDGET CLASS.	2019-20 BUDGET	2019-20 YTD REV.	2019-20 OVR/(UNDR) BUDGET	2019-20 %	2020-21 BUDGET	2020-21 YTD REV.	2020-21 OVR/(UNDR) BUDGET	2020-21 %
1	**40110-Current Prop. Tax**	14,308,810	2,247	(14,306,563)	0.0%	15,312,150	9,617	(15,302,533)	0.1%
2	**40210-Local Option Sales Tax**	11,843,830	-	(11,843,830)	0.0%	12,330,550	-	(12,330,550)	0.0%
3	**40000-41110-Other County Rev**	1,830,000	193,670	(1,636,330)	10.6%	1,850,000	297,772	(1,552,228)	16.1%
4	**44000-Other Local Revenue**	594,500	51,855	(542,645)	8.7%	634,500	82,028	(552,472)	12.9%
5	**46511-Basic Educ. Program**	46,301,465	4,509,800	(41,791,665)	9.7%	48,350,000	4,679,500	(43,670,500)	9.7%
6	**46512-BEP ARRA**	-	-	-	N/A	-	-	-	N/A
7	**46530-Energy Efficient Sch**	-	-	-	N/A	-	-	-	N/A
8	**46615-Ext. Contract-ARRA**	-	-	-	N/A	-	-	-	N/A
9	**46990-Other State Funds**	370,600	-	(370,600)	0.0%	217,600	23,103	(194,497)	10.6%
10	**46592-CONNECT TEN ARRA**	-	-	-	N/A	-	-	-	N/A
11	**46595-Family Resource ARRA**	-	-	-	N/A	-	-	-	N/A
12	**46595-SSMS ARRA**	-	-	-	N/A	-	-	-	N/A
13	**47000- Federal Funds**	1,109,977	-	(1,109,977)	0.0%	1,122,125	-	(1,122,125)	0.0%
14	**49100-49800 Bond & City Transfers**	-	-	-	N/A	-	-	-	N/A
15	**49810-Approp./City Gen. Fund**	7,885,103	1,314,184	(6,570,919)	16.7%	7,885,103	1,314,184	(6,570,919)	16.7%
16	**49820-Operating Transfers**	1,300,000	-	(1,300,000)	N/A	-	-	-	N/A
	TOTALS	***$ 85,544,285***	***$6,071,756***	***$ (79,472,529)***	***7.1%***	***$87,702,028.00***	***$ 6,406,204***	***$ (81,295,824)***	***7.3%***

YEAR-TO-DATE EXPENDITURE COMPARISON

AUGUST 2020

	BUDGET CLASS.	2019-20 BUDGET	2019-20 YTD EXP.	2019-20 OVR/(UNDR) BUDGET	2019-20 %	2020-21 BUDGET	2020-21 YTD EXP.	2020-21 OVR/(UNDR) BUDGET	2020-21 %
1	**71100-Reg. Instruction**	46,539,548	4,220,537	(42,319,011)	9.1%	48,863,591	4,337,370	(44,526,221)	8.9%
2	**71200-Sp. Ed. Instruction**	9,147,978	742,278	(8,405,700)	8.1%	9,646,900	756,849	(8,890,051)	7.8%
3	**71400-Student Body Ed.**	-	-	-	N/A	-	-	-	N/A
4	**72110-Attendance**	167,489	31,797	(135,692)	19.0%	157,489	24,833	(132,656)	15.8%
5	**72120-Health Services**	951,390	103,403	(847,987)	10.9%	948,039	112,651	(835,388)	11.9%
6	**72130-Guidance**	2,667,036	362,987	(2,304,049)	13.6%	2,601,101	242,734	(2,358,367)	9.3%
7	**72210-Reg. Instr. Support**	2,130,181	270,028	(1,860,153)	12.7%	2,225,349	347,611	(1,877,738)	15.6%
8	**72220-Sp. Ed. Support**	1,793,880	192,642	(1,601,238)	10.7%	1,841,650	188,124	(1,653,526)	10.2%
9	**72250-Technology**	1,793,131	434,073	(1,359,058)	24.2%	1,938,863	488,596	(1,450,267)	25.2%
10	**72310-Bd. Of Education**	1,525,937	616,171	(909,766)	40.4%	1,492,877	620,667	(872,210)	41.6%
11	**72320-Office of Supt.**	381,240	75,902	(305,338)	19.9%	388,039	38,339	(349,700)	9.9%
12	**72410-Office of Principal**	4,663,756	581,682	(4,082,074)	12.5%	4,717,965	582,826	(4,135,139)	12.4%
13	**72510-Fiscal Services**	579,593	130,397	(449,196)	22.5%	470,480	119,464	(351,016)	25.4%
14	**72520-Personnel Services**	428,543	95,939	(332,604)	22.4%	587,033	128,350	(458,683)	21.9%
15	**72610-Oper. Of Plant**	6,051,082	664,391	(5,386,691)	11.0%	6,304,017	657,042	(5,646,975)	10.4%
16	**72620-Maint. Of Plant**	2,724,053	288,512	(2,435,541)	10.6%	2,732,833	278,210	(2,454,623)	10.2%
17	**72710-Pupil Transp.**	3,230,544	549,860	(2,680,684)	17.0%	3,578,755	379,158	(3,199,597)	10.6%
18	**73300-Community Service**	540,533	74,540	(465,993)	13.8%	557,708	73,995	(483,713)	13.3%
19	**73400-Early Childhood Educ.**	1,251,966	97,470	(1,154,496)	7.8%	1,162,684	93,635	(1,069,049)	8.1%
20	**76100-Reg. Cap. Outlay**	1,505,500	18,899	(1,486,601)	1.3%	130,000	24,565	(105,435)	18.9%
21	**82130-Education Debt Serv.**		-	-	N/A	-	-	-	N/A
22	**99100-Operating Transfers**	413,105	63,960	(349,145)	15.5%	409,200	63,960	(345,240)	15.6%
	TOTALS	***88,486,485***	***9,615,468***	***$ (78,871,017)***	***10.9%***	***90,754,573***	***9,558,979***	***$ (81,195,594)***	***10.5%***

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: Report of New Debt Obligation

Department: Finance

Presented by: Melissa Wright

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☐
Direction	☐
Information	☒

Summary

Report of new debt obligation as required by state statute, which requires a summary of the new debt issuance be presented at a public meeting.

Staff Recommendation

Acknowledge receipt of CT-0253 form pertaining to refunding of the City's 2012 Tennessee Municipal Bond Pool debt.

Background Information

The bond issuance to refund City debt closed on September 30th. State statute (T.C.A. § 9-21-151) requires the reporting of the new debt obligation in a specified format (State Form No. CT-0253), which summarizes new debt issuance and presentation of this form at a public meeting.

Council Priorities Served

Responsible budgeting

Management of debt in compliance with state law is an important part of maintaining fiscal control and oversight of City resources.

Fiscal Impact

None

Attachments

State Form CT-0253 2020C Refunding

Tennessee Comptroller of the Treasury
Division of Local Government Finance
Original Receipt Date: Sep 30, 2020

State Form No. CT-0253
Revised Effective 2/6/2020

REPORT ON DEBT OBLIGATION

(Pursuant to Tennessee Code Annotated Section 9-21-151)

1. Public Entity:

Name: Murfreesboro, Tennessee

Address: 111 West Vine Street (37130)
Murfreesboro, Tennessee 37133

Debt Issue Name: General Obligation Refunding Bonds, Series 2020C

If disclosing initially for a program, attach the form specified for updates, indicating the frequency required

2. Face Amount: $ 18,760,000.00

Premium/Discount: $ 2,048,875.45

3. Interest Cost: 0.5447932 %

[X] Tax-exempt [ ] Taxable

[X] TIC [ ] NIC

[ ] Variable: Index _____ plus _____ basis points; or

[ ] Variable: Remarketing Agent _____

[ ] Other: _____

4. Debt Obligation:

[ ] TRAN [ ] RAN [ ] CON

[ ] BAN [ ] CRAN [ ] GAN

[X] BOND [ ] Loan Agreement [ ] Capital Lease

If any of the notes listed above are issued pursuant to Title 9, Chapter 21, enclose a copy of the executed note with the filing with the Official State and Local Finance ("OSFL")

5. Ratings:

[ ] Unrated

Moody's Aa1 Standard & Poor's _____ Fitch _____

6. Purpose:

			BRIEF DESCRIPTION
[ ]	General Government	%	
[ ]	Education	%	
[ ]	Utilities	%	
[ ]	Other	%	
[x]	Refunding/Renewal	100%	Refunding all of the 2012B Loan Agreement

7. Security:

[X] General Obligation [ ] General Obligation + Revenue/Tax

[ ] Revenue [ ] Tax Increment Financing (TIF)

[ ] Annual Appropriation (Capital Lease Only) Other (Describe): _____

8. Type of Sale:

[X] Competitive Public Sale [ ] Interfund Loan _____

[ ] Negotiated Sale [ ] Loan Program _____

[ ] Informal Bid

9. Date:

Dated Date: 9/30/2020 Issue/Closing Date: 9/30/2020

State Form No. CT-0253
Revised Effective 2/6/2020

REPORT ON DEBT OBLIGATION

(Pursuant to Tennessee Code Annotated Section 9-21-151)

10. Maturity Dates, Amounts and Interest Rates*:

Year	Amount	Interest Rate	Year	Amount	Interest Rate
2022	$ 2,450,000	3.00%			
2023	$ 2,525,000	3.00%			
2024	$ 2,600,000	3.00%			
2025	$ 2,675,000	3.00%			
2026	$ 2,755,000	3.00%			
2027	$ 2,835,000	3.00%			
2028	$ 2,920,000	3.00%			

If additional space is needed, attach additional sheet

If (1) the debt has a final maturity of 31 or more years from the date of issuance, (2) principal repayment is delayed for two or more years, or (3) if debt service payments are not level throughout the retirement period, then a cumulative repayment schedule (grouped in 5 year increments out to 30 years) including this and all other entity debt secured by the same source **MUST BE PREPARED AND ATTACHED.** For purposes of this form, debt secured by an ad valorem tax pledge and debt secured by a dual ad valorem tax revenue pledge are secured by the same source. Also, debt secured by the same revenue stream, no matter what lien level, is considered secured by the same source.

*This section is not applicable to the Initial Report for Borrowing Program.

11. Cost of Issuance and Professionals:

☐ No costs or professionals

		AMOUNT (round to nearest $)	FIRM NAME
Financial Advisor Fees		$ 50,000	Cumberland Securities Company, Inc.
Legal Fees			
Bond Counsel		$ 27,500	Bass, Berry & Sims PLC
Issuer's Counsel			
Trustee's Counsel			
Bank Counsel			
Disclosure Counsel			
Paying Agent Fees		$ 700	U.S. Bank
Registrar Fees			
Trustee Fees			
Remarketing Agent Fees			
Liquidity Fees			
Rating Agency Fees		$ 18,000	Moody's Rating Agency
Credit Enhancement Fees			
Bank Closing Costs			
Underwriter's Discount	0.161%	$ 30,217	Citigroup Global Markets
Take Down			
Management Fee			
Risk Premium			
Underwriter's Counsel			
Other Expenses			
Printing & Advertising Fees		$ 6,595	Print Shop, I-Deal, CUSIP,MuniHub
Issuer/Administrator Program Fees			
Real Estate Fees		$	
Sponsorship/Referral Fee			
Other Costs: Misc		$ 4,863	structuring, postage, doc product, travel, etc.
TOTAL COSTS		$ 137,875	

State Form No. CT-0253
Revised Effective 2/6/2020

REPORT ON DEBT OBLIGATION

(Pursuant to Tennessee Code Annotated Section 9-21-151)

12. Recurring Costs:

[ ] No Recurring Costs

	AMOUNT (Basis points/$)	FIRM NAME (if different from #11)
Remarketing Agent		
Paying Agent/Registrar	$ 450.00	U.S. Bank
Trustee		
Liquidity/Credit Enhancement		
Escrow Agent		
Sponsorship/Program/Admin		
Other		

13. Disclosure Document/Official Statement:

[ ] None Prepared
[X] EMMA Link https://emma.msrb.org/P11408958-P11094881-P11503704.pdf
[ ] Copy Attached

14. Continuing Disclosure Obligations:

Is there an existing continuing disclosure obligation related to the security for this debt? [X] Yes [ ] No
Is there a continuing disclosure obligation agreement related to this debt? [X] Yes [ ] No
If yes to either question, date that disclosure is due 6/30/2020
Name and title of person responsible for compliance Melissa Wright, City Recorder-Finance Director

15. Written Debt Management Policy:

Governing Body's approval date of the current version of the written debt management policy 11/3/2011
Is the Debt obligation in compliance with and clearly authorized under the policy? [X] Yes [ ] No

16. Written Derivative Management Policy:

[X] No Derivative
Governing Body's approval date of the current version of the written derivative management policy
Date of Letter of Compliance for derivative
Is the derivative in compliance with and clearly authorized under the policy? [ ] Yes [ ] No

17. Submission of Report:

To the Governing Body: on 9/30/2020 and presented at the public meeting held on 10/1/2020
Copy to Director of OSLF: on 9/30/2020 either by:
[ ] Mail to: 425 Fifth Avenue North, Cordell Hull Building, Nashville, TN 37243-3400
[X] Email to: SLF.PublicDebtForm@cot.tn.gov

18. Signatures:

	AUTHORIZED REPRESENTATIVE	PREPARER
Name		Chris Bessler
Title	Mayor	Senior Vice President
Firm	Murfreesboro, Tennessee	Cumberland Securities Company, Inc.
Email	smcfarland@murfreesboro.gov	chris.bessler@cumberlandsecurities.com
Date	9/30/2020	9/30/2020

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: Wine Sales Certificate of Compliance – RaceTrac #2527

Department: Finance

Presented by: Melissa Wright

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☐
Direction	☐
Information	☒

Summary

Information pertaining to the issuance of a certificate of compliance for wine sales in a grocery store.

Background Information

State law requires that an applicant for wine sales in a retail food store obtain a certificate of compliance from the local jurisdiction to be submitted to the Tennessee Alcoholic Beverage Commission as part of the Commission's licensing process. Compliance for the certificate is based only on the applicant's criminal background information and that the location complies with local zoning ordinances.

A certificate of compliance is requested by Nick Webb for the RaceTrac #2527 at 1596 New Salem Highway, which is a new location for wine in a retail food store. This request complies with statutory requirements.

Council Priorities Served

Maintain public safety

The City's role in issuing a Certificate of Good Moral Character allows the City to be aware of locations that would like to include wine, to review zoning restrictions, review applicant background issues, and check for past problems with following City Code.

Attachments

Summary of Request for Certificate of Compliance for Sale of Wine in Grocery Store

City of Murfreesboro
Request for Certificate of Compliance for Wine in Retail Stores

Summary of information from the application:

Name of Business Entity RaceTrac Petroleum, Inc.

Type of Application:

New - wine sale in retail store

Corporation	X
LLC	
Partnership	
Sole Proprietor	

Owner

Name	Nick Webb
Age	30
Home Address	1018 Lennox Avenue
Residency City/State	Greenbriar, TN 37073
Race/Sex	White/M
10 Year Background Check Findings:	
City of Murfreesboro:	None
Rutherford County:	None
Nashville/Davidson County:	None
TBI/FBI	No indication of any record that may preclude the applicant for consideration.

Name of Business	RaceTrac #2527
Business Location	1596 New Salem Highway

Application Completed Properly? Yes

Location meets zoning requirement? Yes

The actual application is available in the office of the City Recorder.

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: Wine Sales Certificate of Compliance – RaceTrac #2554

Department: Finance

Presented by: Melissa Wright

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☐
Direction	☐
Information	☒

Summary

Information pertaining to the issuance of a certificate of compliance for wine sales in a grocery store.

Background Information

State law requires that an applicant for wine sales in a retail food store obtain a certificate of compliance from the local jurisdiction to be submitted to the Tennessee Alcoholic Beverage Commission as part of the Commission's licensing process. Compliance for the certificate is based only on the applicant's criminal background information and that the location complies with local zoning ordinances.

A certificate of compliance is requested by Nick Webb for the RaceTrac #2554 at 2121 Medical Center Parkway, which is a new location for wine in a retail food store. This request complies with statutory requirements.

Council Priorities Served

Maintain public safety

The City's role in issuing a Certificate of Good Moral Character allows the City to be aware of locations that would like to include wine, to review zoning restrictions, review applicant background issues, and check for past problems with following City Code.

Attachments

Summary of Request for Certificate of Compliance for Sale of Wine in Grocery Store

City of Murfreesboro
Request for Certificate of Compliance for Wine in Retail Stores

Summary of information from the application:

Name of Business Entity RaceTrac Petroleum, Inc.

Type of Application:

New - wine sale in retail store

Corporation	X
LLC	
Partnership	
Sole Proprietor	

Owner

Name	Nick Webb
Age	30
Home Address	1018 Lennox Avenue
Residency City/State	Greenbriar, TN 37073
Race/Sex	White/M
10 Year Background Check Findings:	
City of Murfreesboro:	None
Rutherford County:	None
Nashville/Davidson County:	None
TBI/FBI	No indication of any record that may preclude the applicant for consideration.

Name of Business	RaceTrac #2554
Business Location	2121 Medical Center Parkway

Application Completed Properly? Yes

Location meets zoning requirement? Yes

The actual application is available in the office of the City Recorder.

COUNCIL COMMUNICATION

Meeting Date: 10/14/2020

Item Title: Wine Sales Certificate of Compliance – RaceTrac #2559

Department: Finance

Presented by: Melissa Wright

Requested Council Action:

Ordinance	☐
Resolution	☐
Motion	☐
Direction	☐
Information	☒

Summary

Information pertaining to the issuance of a certificate of compliance for wine sales in a grocery store.

Background Information

State law requires that an applicant for wine sales in a retail food store obtain a certificate of compliance from the local jurisdiction to be submitted to the Tennessee Alcoholic Beverage Commission as part of the Commission's licensing process. Compliance for the certificate is based only on the applicant's criminal background information and that the location complies with local zoning ordinances.

A certificate of compliance is requested by Nick Webb for the RaceTrac #2559 at 2927 Old Fort Parkway, which is a new location for wine in a retail food store. This request complies with statutory requirements.

Council Priorities Served

Maintain public safety

The City's role in issuing a Certificate of Good Moral Character allows the City to be aware of locations that would like to include wine, to review zoning restrictions, review applicant background issues, and check for past problems with following City Code.

Attachments

Summary of Request for Certificate of Compliance for Sale of Wine in Grocery Store

City of Murfreesboro
Request for Certificate of Compliance for Wine in Retail Stores

Summary of information from the application:

Name of Business Entity RaceTrac Petroleum, Inc.

Type of Application:

New - wine sale in retail store

Corporation	X
LLC	
Partnership	
Sole Proprietor	

Owner

Name	Nick Webb
Age	30
Home Address	1018 Lennox Avenue
Residency City/State	Greenbriar, TN 37073
Race/Sex	White/M
10 Year Background Check Findings:	
City of Murfreesboro:	None
Rutherford County:	None
Nashville/Davidson County:	None
TBI/FBI	No indication of any record that may preclude the applicant for consideration.

Name of Business	RaceTrac #2559
Business Location	2927 Old Fort Parkway

Application Completed Properly? Yes

Location meets zoning requirement? Yes

The actual application is available in the office of the City Recorder.