ADMINISTRATIVE SERVICES AGREEMENT

FOR

CITY OF LA CROSSE

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ADMINISTRATIVE SERVICES AGREEMENT

THIS Service Agreement ("Agreement") is made and entered into this 15th day of August, 2017 by and between City of La Crosse, a municipal corporation duly organized and existing under the laws of the state of Wisconsin with its principal place of business at 400 La Crosse Street, La Crosse, WI 54601 (hereinafter referred to as the "Plan Sponsor") and Quartz Health Solutions, Inc., a corporation duly organized and existing under the laws of the state of Wisconsin with its principal place of business at 840 Carolina Street, Sauk City, Wisconsin 53583-1374 (hereinafter referred to as the "Claims Administrator") (each entity is individually a "Party", collectively "Parties").

WHEREAS, the Plan Sponsor is a municipal corporation that sponsors a self-funded employee welfare benefit plan (the "Plan") within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA), as amended; and

WHEREAS, the Plan Sponsor desires to make available a program of health care benefits under the Plan; and

WHEREAS, the Plan Sponsor wishes to contract with an independent third party to perform certain services with respect to the Plan as enumerated below; and

WHEREAS, the Claims Administrator desires to contract with the Plan Sponsor to perform certain services with respect to the Plan as enumerated below; and

THEREFORE, in consideration of the promises and mutual covenants contained herein, the Plan Sponsor and the Claims Administrator enter into this Agreement for administrative services for the Plan.

ARTICLE I. DEFINITIONS

For the purposes of this Agreement, the following words and phrases have the meanings set forth below, unless the context clearly indicates otherwise and wherever appropriate, the singular shall include the plural and the plural shall include the singular.

1.1 **Actuarial Services** means services for incurred but not reported (IBNR), liability estimates, stop loss solicitation and administration and ad hoc reporting.

1.2 **Add-On Service** means any service that is not included in the Basic Monthly Maintenance Fee.

1.3 **Basic Monthly Maintenance Fee** means the monthly fee charged to Plan Sponsor per covered employee that includes services outlined in Article III of this Agreement but does not include Add-On Services.

1.4 **Calendar Year** means January 1st through December 31st of the same year.

1.5 **Claim** means the definition of Claim under 29 CFR s. 2560.503-1.

1.6 **Claimant** means any person or entity submitting expenses for payment or reimbursement from the Plan.

1.7 **Claims Payment Account** means an account established by and owned by the Plan Sponsor for payment or reimbursement for Covered Services, which Account shall be an asset of the Plan Sponsor and not the Plan.

1.8 **Clean Claim** means a complete and accurate 837I as directed by the current version or its successor, of the National Electronic Data Interchange Transaction Set Implementation Guide (IG); or UB04 Claim form, or its successor, meeting all the requirements set forth by the National Uniform Billing Committee (NUBC); or a complete

and accurate 837P or 837D as directed by the current version of the IG or its successor; or Center for Medicare and Medicaid Services ("CMS") 1500 Claim form or its successor; or ADA Dental Claim form or its successor, meeting the requirements of the National Uniform Claim Committee (NUCC). A Clean Claim also includes all Health Care Provider and Participant information, as well as records, additional information, or documents needed from the Participant or Health Care Provider to enable Claim Administrator to process the Claim.

1.9 **Cost Management** means evaluation of the appropriateness and medical need of health care services based on policies and procedures for the purpose of controlling costs and monitoring the utilization and quality of care.

1.10 **Covered Services** means the care, treatments, services, or supplies described in the Plan Document and Summary Plan Description as eligible for payment or reimbursement from the Plan.

1.11 **Employer** means City of La Crosse and any successor organization or affiliate of such Employer which assumes the obligations of the Plan and this Agreement.

1.12 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

1.13 **Fee Schedule** means the listing of fees or charges for services provided under this Agreement. This Fee Schedule may be modified from time to time in writing by the mutual agreement of the Parties. It is contained in Appendix A and is a part of this Agreement.

1.14 **Health Care Provider** means any person, institution or other entity licensed by the state in which he/she or it is located to provide health care services covered by the Plan within the lawful scope of his/her or its license.

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

1.16 **In-Network Provider** means a Health Care Provider that has a contract with the Claims Administrator to offer services to Plan Sponsors and Participants upon a contractual fee schedule and typically at a reduced cost-sharing amount.

1.17 **Medical Benefit** means a Covered Services administered by Claims Administrator and not Pharmacy Benefit Manager.

1.18 **Network** means a group of Health Care Providers that have contracted to provide medical services to Plan Participants based upon a contractual Fee Schedule.

1.19 **Out-of-Network Provider** means a Health Care Provider that is not an In-Network Provider and may require additional cost sharing from Participants.

1.20 **PEPM** means per employee per month.

1.21 **Plan** means the self-funded employee welfare benefit Plan, which is the subject of this Agreement and which the Plan Sponsor has established pursuant to the Plan Document.

1.22 **Plan Document** means the instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of Covered Services.

1.23 **Plan Participant** is any person who is properly enrolled and entitled to benefits from the Plan.

1.24 **Plan Year** means the period of time specified as such in the Plan Document.

1.25 **Preferred Vendor** means Plan Sponsor utilization of a vendor with whom Claims Administrator has a contractual relationship.

1.26 **Summary of Benefits and Coverage** means the written Summary of Benefits and Coverage required to be provided Plan Participants under the Public Health Service Act, section 2715.

1.27 **Summary Plan Description or SPD** means the document required to be provided under Sec. 102 of ERISA that describes the terms and conditions under which the Plan operates.

ARTICLE II. RELATIONSHIP OF PARTIES

2.1 **Delegation.** The Plan Sponsor delegates to the Claims Administrator only those powers and responsibilities with respect to development, maintenance, and administration of the Plan which are specifically enumerated in this Agreement. Any function not specifically delegated to and assumed by the Claims Administrator pursuant to this Agreement shall remain the sole responsibility of the Plan Sponsor.

2.2 **Independent Contractor.** The Parties enter into this Agreement as independent contractors and not as agents of each other. Neither Party shall have any authority to act in any way as the representative of the other, or to bind the other to any third party, except as specifically set forth herein.

2.3 **General Acknowledgements.** The Parties acknowledge that:

(a) this is a contract for administrative services only as specifically set forth herein; and
(b) the Claims Administrator shall not be obligated to disburse more in payment for Claims or other obligations arising under the Plan than the Plan Sponsor shall have made available in the Claims Payment Account; and
(c) this Agreement shall not be deemed a contract of insurance under any laws or regulations. The Claims Administrator does not insure, guarantee, or underwrite the liability of the Plan Sponsor under the Plan. The Plan Sponsor has total responsibility for payment of Claims under the Plan and all expenses incidental to the Plan.

2.4 **Assignment.** Except as specifically set forth herein, this Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives and successors; provided, however, neither Party may assign this Agreement nor any or all of its rights or obligations hereunder (except by operation of law) without the prior written consent of the other Party, which consent may not be unreasonably withheld.

2.5 **Disputes.** The Parties will attempt in good faith to resolve any dispute or claim arising out of or in relation to this Agreement through negotiations. If a dispute cannot be settled amicably within sixty (60) calendar days from the date on which either Party has served written notice on the dispute then the Parties may, if they wish, agree to mediation or other voluntary form of dispute resolution in accordance with procedures to be agreed to by the Parties. Unless otherwise agreed, the Parties do not waive their right to pursue remedies in the court of law.

To the extent permitted by applicable law, all negotiations pursuant to this clause are confidential and shall be treated as compromise and settlement negotiations for purposes of the Federal Rules of Evidence and state rules of evidence.

2.6 **Compliance with Applicable Laws.** Each Party shall take all practicable steps to ensure that each Party will comply with applicable law.

Plan Sponsor acknowledges that it should consult with legal counsel regarding the aspects of the Plan and its appropriateness for Plan Sponsor. Claims Administrator assumes no liability for provisions contained in the Plan Document or Summary Plan Description. Periodically, Claims Administrator may provide Plan Sponsor with correspondence concerning the Plan. Such correspondence is only informational and should not be considered legal advice for the maintenance of the Plan. Plan Sponsor should consult legal counsel with respect to any revisions, changes or amendments to the Plan Document and/or SPD.

2.7 **Subcontractors**. The work to be performed by the Claims Administrator under this Agreement may be performed directly by it or wholly or in part through a vendor or affiliate of the Claims

Administrator or under an agreement with an organization, agent, advisor, or other person of its choosing.

2.8 **License, Bond and Insurance.** The Claims Administrator agrees to be duly licensed as Third Party Administrator to the extent required under applicable law and agrees to maintain such licensure throughout the term of this Agreement. The Claims Administrator will possess throughout the term of this Agreement, an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its clients. Additionally, the Claims Administrator agrees to comply with any state or federal statutes or regulations regarding its operations and to obtain any additional licenses or registrations which may apply in the future.

Plan Sponsor will maintain excess loss insurance with a Best's-rated A- or better carrier as referenced in its Binder of Coverage and provide a copy of the Certificate of Insurance at Agreement signing and upon request thereafter. Plan sponsor shall promptly notify the Claims Administrator of any termination, expiration, lapse, or modification of this insurance.

2.9 **Reliance on Information.** The Claims Administrator shall be entitled to rely, without investigation or inquiry, upon any written or oral information or communication of the Plan Sponsor or agents of the Plan Sponsor.

2.10 **Indemnification**. The Claims Administrator will indemnify, defend, save, and hold the Plan Sponsor harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, including violations of any applicable statutes or regulations, damages, and expenses of any kind including, but not limited to, direct, indirect, consequential, or punitive damages, expenses or fees, including court costs and attorney's fees, with respect to the Plan to the extent that such Claims, losses, liabilities, damages, and expenses arise out of or are based upon the fraudulent, negligent, or criminal acts of the Claims Administrator or its employees, except for acts taken at the specific direction of the Plan Sponsor.

The Plan Sponsor will indemnify, defend, save, and hold the Claims Administrator harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, including violations of any applicable statutes or regulations, damages, taxes under applicable local, state or federal law, and expenses of any kind including, but not limited to, direct, indirect, consequential, or punitive damages, expenses or fees, including court costs and attorney's fees, to the extent that such claims, losses, liabilities, damages, taxes and expenses arise out of or are based upon (a)the Plan Sponsor's negligence in the performance of its duties under this Agreement, (b) a release of Claims data by the Claims Administrator to (1) the Plan Sponsor, or (2) if such release is at the request of the Plan Sponsor, to any other entity or person, (c)an interpretation of the Plan, or (d) any other written or oral communication by the Plan Sponsor or any of its authorized representatives upon which the Claims Administrator relies, including but not limited to, failure to provide accurate or timely data to Claims Administrator or any breach of this Agreement by the Plan Sponsor, including, but not limited to, failure to fund the Claims Payment Account.

The Plan Sponsor will indemnify, defend, save, and hold the Claims Administrator harmless from any taxes imposed on the Plan or Claims Administrator under section 4980I of the Internal Revenue Code (IRC) for the Plan's excess benefit as defined under IRC §4980I(b).

2.11 **Limitation of Liability.** Each Party agrees that, to the fullest extent permitted by law, that the Party, its affiliates, its directors, trustees, officers, agents and employees acting in the course of their employment shall not be liable to the other Party or its employees or their spouses or dependents who participate in the Plan for any and all injuries, Claims, losses, expenses or damages whatsoever ("Claim") arising out of or in any way related to this Agreement in excess of twelve (12) months Basic Monthly Administrative Fees paid to Claims Administrator, as a result of any act, negligence, error, omission or breach of this Agreement by that Party, its directors, officers, agents and employees acting in the course of their employment not

amounting to a willful or intentional wrong. Section 2.11 shall not apply to any Claim against any other person providing services to the Plan, including, but not limited to, any person providing such services as a subcontractor of Claims Administrator, arising out of or related to any act, negligence, error, omission or breach of contract, willful, or intentional wrong by such other person.

Health Care Providers and Participating Pharmacies ("Provider(s)") are independent contractors and not subcontractors or agents of Claims Administrator, and Claims Administrator does not exercise any control over the professional judgment of any Providers providing medical services, dispensing prescriptions or otherwise providing pharmaceutical or medical care and related services. As a result, Claims Administrator shall have no liability to Plan Sponsor or any Eligible Participant for a Claim resulting from any act or omission of any Provider or its agents or employees, absent Claims Administrator's negligence or willful misconduct.

2.12 **Warranties**. Claims Administrator and its Preferred Vendors may rely on Medi-Span, First Databank, or other industry comparable databases in providing Plan Sponsor and eligible Participants with Claims adjudication and drug utilization review services. Claims Administrator has utilized due diligence in collecting and reporting the information contained in its databases and has obtained such information from sources believed to be reliable. Claims Administrator does not warrant the accuracy of reports, alerts, codes, prices or other data contained in such databases. The clinical information contained in these databases is not intended as a supplement to, or a substitute for, the knowledge, expertise, skill, and judgment of physicians, pharmacists, or other healthcare professionals involved in Eligible Participants' care. The absence of a warning for a given drug or drug combination shall not be construed to indicate that the drug or drug combination is safe, appropriate or effective for any Eligible Participant. EXCEPT AS EXPRESSLY WARRANTED IN THIS AGREEMENT, CLAIMS ADMINSTRATOR DISCLAIMS ALL EXPRESS AND IMPLIED WARRANTIES OF ANY KIND, INCLUDING THE SUITABILITY FOR ANY PARTICULAR PURPOSE OF THE DATA GENERATED THROUGH ITS OR ITS PREFERRED VENDORS' SOFTWARE SYSTEM.

ARTICLE III. THE CLAIMS ADMINISTRATOR'S RESPONSIBILITIES

The Claims Administrator will provide the following Plan administrative services for the Plan Sponsor under the Basic Monthly Maintenance Fee, unless otherwise stated:

3.1 **Initial Configuration**. Perform initial configuration to establish Plan administrative services, including:

(a) Administering up to ten (10) group records and up to two (2) benefit Plans requiring no system configuration;
(b) Establish file feeds with Pharmacy Benefit Manager ("PBM");
(c) Establishing file feeds for administrative service to Preferred Vendors; and
(d) Enrollment processing and ongoing maintenance.

Not included in the Basic Monthly Maintenance Fee for initial configuration is any file feed from any other Vendor not included in this Section and customization for any vendor, including Preferred Vendors. Additional fees may also apply if Plan Sponsor switches vendors during this Agreement.

3.2 **Identification Cards.** Set up and initial printing of identification cards based on Claims Administrator's standard template, subject to Plan Sponsor's approval of final design.

3.3 **Maintenance of Records and Audit.** Maintain:

(a) Plan records of Plan coverage applicable to each Plan Participant based on information submitted by the Plan Sponsor;

(b) Plan records regarding payments of Claims, denials of Claims and subrogation; and
(c) Claim file on every Claim reported to it pursuant to this Agreement.

Such files and all Plan-related information with the exception of medical records shall be made available to the Plan Sponsor for consultation, review, and audit upon reasonable notice and request, during the business day and at the office of the Claims Administrator. Any such audit will be at the sole expense of the Plan Sponsor. The Claims Administrator will charge a separate fee for its time spent in cooperation with such consultation, review, and audit.

An audit at the request of the Plan Sponsor (and not a regulatory agency) shall be conducted by an auditor mutually acceptable to the Plan Sponsor and the Claims Administrator and will include, but not necessarily be limited to, a review of procedural controls, a review of system controls, a review of Plan provisions, a review of the sampled Claims, and comparison of results to performance standards and statistical models previously agreed to by the Plan Sponsor and the Claims Administrator.

3.4 **Document Retention.** Upon termination of this Agreement and upon written request, a file with Claim information, filings with governmental entities filed by the Claims Administrator on the Plan's behalf, Plan documentation and other documentation required by ERISA §107, as amended, in the Claims Administrator's possession, will be remitted to the Plan Sponsor as feasible. Until that time, these records will be maintained at the Claims Administrator's principal administrative office or secure storage facilities for at least seven (7) years following the termination of a Plan Year. At the end of the seven (7) year period following the Plan Year or termination of this Agreement, whichever is earlier, the Claims Administrator shall notify the Plan Sponsor that these records will be destroyed in accordance with the Claims Administrator's data destruction policy in existence at that time unless the Plan Sponsor requests, in writing, that all of the records be forwarded to the Plan Sponsor.

3.5 **Regulatory Notices.** Prepare and distribute annually regulatory notices as requested by the Plan Sponsor. A statement of work will be created and the Plan Sponsor will be invoiced per a statement of work.

3.6 **Medical Benefit Claims**. Respond to Claims in accordance with the Plan, Claims procedures, and applicable ERISA Claims regulations, subject to the following provisions:

(a) The Claims Administrator shall be responsible for the initial determination of Claims only if the Plan Sponsor submits eligibility information on a timely basis under Section 4.1.

(b) Unless Plan Claims procedures clearly provide to the contrary, a Claim will be denied if the Claimant fails to respond with requested information within the applicable deadline to a request for additional information.

(c) Adjudicate Claims incurred by Plan Participants according to the terms of the Plan Document and Summary Plan Description as construed by the Plan Sponsor. These Claims will be adjudicated for In-Network Providers based on contractual rates in place with providers, and for Out-of-Network Providers in accordance with industry practices. The Claims Administrator will use an industry-recognized method of determining usual, customary, and reasonable charges.

(d) Process with due diligence and according to the terms of the Plan Document and Summary Plan Description as construed by the Plan Sponsor, subrogation per Section 3.7, and coordination of benefits situations per Section 3.8.

(e) If a Claim cannot be determined by the Claims Administrator without an interpretation of the Plan terms by the Plan Sponsor, such Claim shall be promptly referred to the Plan Sponsor. Upon receipt of the Plan Sponsor's response, the Claims Administrator shall

process payment of the Claim or prepare a notice of adverse benefit determination, as applicable.

(f) Decide as to the validity of a Claim or the need for additional information. If additional information is needed, the request will be sent to the appropriate person (with a copy to the Plan Participant) within the time required for similar types of Claims under applicable federal regulations. The request will generally be sent by U.S. Mail, but in the case of Urgent Care Claims (as defined under ERISA regulations) the request may be oral or sent by fax or electronic means.

When all necessary documents and Claim form information have been received and the Claim has been approved, a Claim check or draft will be remitted in a timely fashion.

(g) Perform Claim management functions. This consists of submitting Claims through Claims Administrator's standard claim editing software procedures and if applicable, performing contract negotiations on the Plan Sponsor's behalf on out of area Claims or utilizing a wrap network.

(h) Refer any doubtful or disputed Claims to Plan Sponsor for a final decision in accordance with Section 4.3.

3.7 **Subrogation**. Administer and enforce any and all rights to subrogation provided under the Plan in accordance with the terms of the Plan and to the extent permitted by federal law.

If Plan Sponsor becomes a party to litigation as a result of the Plan's subrogation rights, Plan Sponsor delegates to Claims Administrator's Preferred Vendor for subrogation, Discovery Health Partners, to defend Plan Sponsor's third party liability subrogation lawsuit.

Additionally, Discovery Health Partners shall have authority to redeem, compromise or settle subrogation claims per Discovery Health Partner's standard procedures, except that Discovery Health through the Claims Administrator shall seek Plan Sponsor approve in the following situations ("Exception(s)"):

(a) Cases where the Plan Sponsor's subrogation and/or reimbursement interest is in excess of $50,000; and Discovery Health Partners proposes a recovery amount less than 80% of the case value; or

(b) Cases where Plan Sponsor's subrogation and/or reimbursement interest is in excess of $50,000 and Discovery Health Partner proposes to waive Plan Sponsor's interest.

If an Exception does arise, Claims Administrator shall in writing contact the Plan Sponsor for Plan Sponsor's approval to settle Exceptions within the time frame set by Claims Administrator. Plan Sponsor shall designate individual(s) in writing who have authority to make decisions on Exceptions. Claims Administrator shall not be responsible for any loss in recoveries due to Plan Sponsor's failure to timely respond to Claims Administrator.

3.8 **Coordination of Benefits.** Claims Administrator shall process Plan Sponsor's rights under the Plan to coordination of benefits, and recovery of overpayments, including coordination with Medicare.

Coordinate an annual mailing to Participants to identify other coverage and process Claims accordingly. Additionally, Claims Administrator will investigate other coverage if such coverage is indicated on a Claim.

3.9 **Pharmacy Benefit Claims.** Claims Administrator agrees to establish an interface with Plan Sponsor's PBM to exchange information for eligibility and Claims administration services.

3.10 **Medical Benefit Claim Adverse Benefit Determinations and Appeals.** Notify Plan Participants in writing through the U. S. Mail or through a secure portal of a Medical Claim resulting in an initial Adverse Benefit Determination, pursuant to the written Claims review and appeal procedure in the Plan. This notification will be made within accordance with 29 CFR § 2560.503-1.

In accordance with ERISA regulations, prepare documentation of Participants' internal appeal of any adverse benefit determination as defined under 29 CFR §2560.503-1(m)(4) for appeals that involve medical judgment and rescission of coverage for the Plan Sponsor fiduciary responsible for deciding the appeal. Provide medical review of the Adverse Benefit Determination and make available an independent medical expert to provide medical judgment to Plan Sponsor fiduciary regarding the appeal.

A separate fee will be charged for the following outlined in Appendix A Add-On Services. If a Participant requests external review, and the Medical Claim is eligible for external review, Claim Administrator will contract, and prepare and send documentation to accredited Independent Review Organization (IRO) on behalf of Plan Sponsor.

3.11 **Preparation of Medical Benefit Claims Payments.** For electronic funds transfer (EFT), Claims Administrator shall prepare the Check Register and CCD+file and identify any discrepancies. Once approved by the Claims Administrator, Claims Administrator will place the check register on the Plan Sponsor's secure portal and upload the CCD+file to the Plan Sponsor's bank for the release of funds from the Claims Payment Account. After the release of EFT claim payment funds, Claims Administrator will provide Plan Sponsor with a receipt that verifies the payment matches the check register.

Every month, the Claims Administrator will reconcile the Claims Payment Account and will notify the Plan Sponsor of the existing balance. If an additional deposit is required for higher than usual claims as determined by the Claims Administrator, the Claims Administrator will request a push of additional funds (as needed).

While this Agreement is in effect, the Claims Administrator shall make the following good faith attempts to recover any overpayments, or unrecovered monies. The Claims Administrator shall follow contract terms between Claims Administrator and In-Network Providers to determine whether Claims Administrator will: 1) send a refund request letter once every 30 calendar days, for a period of 90 calendar days ("Refund Process"); or 2) allow for a Claim offset within 90 calendar days ("Offset Process"). If there is no Claim under which to offset within 90 calendar days, then Claims Administrator will follow the Refund Process after the Offset Process. For all other parties, including but not limited to Plan Participants and non-Network providers, Claims Administrator shall implement the Offset Process. In the event Claims Administrator is unable to recover overpayments or unrecovered monies of amounts greater than five hundred dollars ($500.00), Claims Administrator will provide Plan Sponsor with a report at least quarterly of such unrecovered monies. If the unrecoverable amount is less than five hundred dollars ($500.00), the Claims Administrator will discontinue the recovery process after exhausting the processes outlined above.

Plan Sponsor is ultimately responsible for recovery of any overpayments, or unrecovered monies including Claims indicated on the CCD+file or on paper check, and paid in good faith but in error. In the event Plan Sponsor terminates this Agreement with Claims Administrator, Claims Administrator will have no obligations to recover overpayments or unrecovered monies after the date of contract termination; notwithstanding, Claims Administrator will send Plan Sponsor a report of all overpayments and/or unrecovered monies within ninety (90) days of the date of termination.

3.12 **HIPAA Compliance.** Subject to HIPAA, Claims Administrator will respond to Claims inquiries

by a Plan Participant, the authorized representative of a Plan Participant, the authorized representative of the estate of a Plan Participant, an authorized Health Care Provider, or as otherwise required by law.

Maintain information that identifies a Plan Participant in a confidential manner. The Claims Administrator agrees to take all reasonable precautions to prevent disclosure or the use of Claims information for a purpose unrelated to the administration of the Plan.

The Claims Administrator will only release this information for treatment, payment, and health care operations as required or permitted under HIPAA to perform the duties under this Agreement. This includes, but is not limited to, releasing information for medical necessity determinations; to set uniform data standards; to update relative values scales; to use in Claims analysis; to further cost containment programs; to verify eligibility; to comply with federal, state or local laws; for coordination of benefits; for subrogation; in response to a civil or criminal action upon issuance of a subpoena; or with the written consent of the Plan Participant or his or her legal representative.

Claims Administrator may only release information to other vendors of the Plan Sponsor, if that the Plan Sponsor provides written permission to Claims Administrator on Claims Administers data release template document and such release of information is necessary for Claims Administrator to carry out its duties under this Agreement. Annually, the Claims Administrator may verify with the Plan Sponsor the vendors to whom Claims Administrator may release information.

Other duties under HIPAA are outlined in the business associate agreement between Claims Administrator and Plan Sponsor.

3.13 **Regulatory Filings.** Will assist with the following:

(a) Capture data for IRS form filings and provide entry for the Affordable Care Act reinsurance accrual.
(b) Perform Section 111 Medicare, Medicaid, and SCHIP Extension Act of 2007 monitoring and provide data to the Centers for Medicare and Medicaid Services, as applicable.
(c) Any other reports as required by state or federal laws or regulations. This is considered an Add-On Service and subject to the fees outlined in Appendix A.

3.14 **Reporting.** Provide the following reports through a secure portal which are included in the Basic Monthly Maintenance Fee, subject to any limitations under HIPAA:
(a) monthly paid Claims;
(b) weekly check register;
(c) monthly administrative fee invoices;
(d) Plan data maintained by Claims Administrator including:
    (i) Total Participants by month
    (ii) Aggregate Plan Data- all Plans by month
    (iii) Benefit Plan data – per employee per month
    (iv) Benefit Plan data – per participant per month
    (v) Stop loss paid Claims per month
    (vi) Stop loss premium calculation per month; and
(e) Other reports requested the Plan Sponsor may be subject to an additional fee.

3.15 **Stop Loss**. Claims Administrator agrees to the following:
(a) Establish an interface with Plan Sponsor's stop loss carrier;
(b) Notify the stop loss carrier of any potential large Claims which may become a claim under the excess loss policy;
(c) On behalf of the Plan, file in a timely manner any claims for benefits under the excess

loss policies; and

(d) Promptly forward to the Plan Sponsor any premium and other notices received from the excess loss insurance company concerning the policy. In the event the stop loss carrier sends the excess loss claim reimbursement to Claims Administrator, Claims Administrator shall promptly deposit such funds with the Plan Sponsor.

3.16 **Network.** To the extent, Plan Sponsor purchases Claims Administrator's Network, establish and maintain a Network of Health Care Providers who will deliver, as independent contractors, the Covered Services of the Plan. The Claims Administrator shall be responsible for obtaining, verifying, and monitoring In-Network Health Care Provider qualifications. This clause does not apply to additional providers requested to be included in the Network at the request of Plan Sponsor or Out-of-Network Providers.

Claims Administrator shall also offer wrap networks, including EOS/Multiplan and Zelis Healthcare for additional savings on Out-of-Network Claims subject to the Fees outlined in Appendix A. Claims Administrator shall first submit Out-of-Network Claims through EOS/Multiplan. If EOS/Multiplan cannot apply a discount through its Network the Claim shall be sent back to Claims Administrator. Claims Administrator may then submit Out-of-Network Claim through Zelis Healthcare for a determination of whether Zelis Healthcare can apply a discount through its Network. A fee is only charged to Plan Sponsor if Plan Sponsor receives a discount pursuant to the applicable wrap network. If a discount is applied by EOS/Multiplan and Zelis Healthcare, the Out-of-Network Provider may not balance bill a Participant.

If the Claim receives no discount with EOS/Multiplan or Zelis Healthcare, Claims Administrator shall process Claim per the Plan by applying the Usual, Customary and Reasonable amount ("UCR"). If the Claim does not receive a discount through EOS/Multiplan or Zelis Healthcare and its paid per UCR, the Out-of-Network Provider may balance bill a Participant for amounts above and beyond UCR.

An exception to the wrap Network process may apply to high dollar claims when stop loss carrier is involved. In such cases, Claims Administrator shall provide written notice to Plan Sponsor.

The Claims Administrator will not be responsible for any services provided (or any failure to provide services) by any Health Care Providers.

3.17 **Customer Service.** Claims Administrator's customer service will provide live customer service representative assistance via secure email, written correspondence, or phone calls between the hours of 8:00 a.m. and 5:00 p.m. Central Standard Time to Plan Participants, an authorized representative of a Plan Participant, an authorized representative of the estate of a Plan Participant, or an authorized Health Care Provider; assign dedicated representatives to perform enrollment services and answer customer service questions for Participant and Plan Sponsor; and translation of telephone calls to a foreign language.

3.18 **Medical Benefit Cost Management and Health Services.** Provide Cost Management program for Medical Benefits. Claims Administrator will:

(a) Administer a utilization management program:
  (i) Administer the standard Quartz prior authorization program for inpatient medical, behavioral health and substance abuse, skilled nursing facility, hospice and home health care and medications administered in a healthcare facility by healthcare professionals.
  (ii) Perform concurrent review and discharge Planning for select inpatient care as determined by the Claims Administrator.
  (iii) Administer prior authorizations based on criteria developed by Claims Administrator's Cost Management Preferred Vendor(s)).

(b) Provide large case management to Participants with high-cost medical conditions or

diagnosis as defined by Claims Administrator's Cost Management Preferred Vendor with the goal of improved continuity of care and lower Claims costs.

(c) Provide complex case management, including coordination of care and services to Participants who have experienced a critical event that requires the extensive use of resources and who may need assistance in facilitating appropriate delivery of care and services.

(d) Administer disease management programs which includes disease management of diabetes and asthma, both of which focus on emotional wellness.

3.19 **Eligibility**. Perform Plan eligibility determinations utilizing the Plan Sponsor's criteria outlined in the Summary Plan Description for extension of dependent child coverage for children who are incapable of self-support due to a physical or mental impairment. Claims Administrator shall refer any unclear or ambiguous evidence of Plan eligibility to Plan Sponsor for final determination per Section 4.3.

3.20 **Run-Out Period.**

(a) In the event of termination of this Agreement, Claims Administrator shall continue to provide all services described herein until the close of business of the day the termination of this Agreement becomes effective. Upon notification of termination, Plan Sponsor shall inform Claims Administrator in writing whether it desires Claims Administrator to continue post-termination to process claims for Covered Services provided to Beneficiaries while this Agreement was in effect. Pricing for post-termination services shall be in accordance with the terms specified for "Post Termination Services" found within Appendix A. On the first day following the end of the time period specified by Plan Sponsor for post termination services, Claims Administrator shall forward any applicable claims not yet fully processed, if at all, to Plan Sponsor, if permitted by law, or to the Plan or a person or entity to whom. Plan Sponsor directs Claims Administrator to send such claims.

(b) During the Run-Out Period, Plan Sponsor shall continue to fund the Claims Payment Account, for any claims for Covered Services provided to Beneficiaries while this Agreement was in effect and processed by Claims Administrator while the Agreement was in effect or during the Run-Out Period. Notwithstanding the foregoing, if Claims Administrator has terminated this Agreement due to the breach of Plan Sponsor, including but not limited to, failure to fund the Claims Payment Account, Claims Administrator shall have no obligation to continue to render any services beyond the date this Agreement terminates, except for those services or obligations that survive the termination of this Agreement as described herein.

3.21 **Services Not Provided Under This Agreement**. The following services and items are not provided by Claims Administrator under this Agreement:

(a) Consulting services, nor payment of consulting fees;
(b) Legal services, nor payment of legal fees;
(c) Audit services, nor payment of audit fees;
(d) Actuarial Services, nor payment of actuarial fees
(e) Investment services, nor payment of investment fees
(f) Plan Sponsor expenses
(g) Determining the cost of any coverage under the Plan
(h) The cost of supplies, postage and printing for Plan Sponsor approved special mass mailings to Participants. This does not include costs for Participant newsletters, or similar wellness or preventive care mailings;
(i) The cost of postage and reprinting of erroneous standard issue ID cards that were approved for print by Plan Sponsor; and
(j) The cost of postage and reprinting of revised standard issue ID cards whereby changes to the ID card are requested by the Plan Sponsor.

The above is not an exhaustive list of the services that are excluded from this Agreement.

3.22 **Network Performance Guarantee.** The Claims Administrator agrees to develop a network performance guarantee and penalties to be paid to Plan Sponsor for failure to meet the network performance guarantee.

ARTICLE IV. THE PLAN SPONSOR'S RESPONSIBILITIES

The Plan Sponsor will:

4.1 **Plan Eligibility.** Maintain current and accurate Plan eligibility and coverage records, verify Plan Participant eligibility, and submit this information regularly to the Claims Administrator.

This information shall be provided either via the 834 electronic data interchange format or in a format reasonably acceptable to the Claims Administrator and include the following for each Plan Participant: name and address, Social Security number or Tax ID number (or an opt-out affidavit per Section 111 (42 U.S.C. §1395y(b)(7)) reporting requirements, if applicable), date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan.

The Plan Sponsor assumes the responsibility for the erroneous disbursement of benefits by the Claims Administrator in the event of error or neglect on the Plan Sponsor's part of providing eligibility and coverage information to the Claims Administrator, including but not limited to, failure to give timely notification of ineligibility of a former Plan Participant.

4.2 **Coordination of Benefits.** Provide Claims Administrator with any and all Coordination of Benefits (COB) information requested by Claims Administrator or Preferred Vendor, including without limitation all other payer status and order of payment information which will be stated in the Plan Document and Summary Plan Description and processing guidelines in accordance with any applicable Law, to enable Claims Administrator to perform COB on Plan Participants' Claims. The Plan Sponsor agrees to provide this information in a format acceptable to Claims Administrator and at a frequency to allow Claims Administrator to process COB Claims timely and accurately. In the event Claims Administrator does not receive the required information in an acceptable format and frequency, Plan Sponsor will be responsible for over or under payments on Claims requiring reprocessing or re-adjudication for COB purposes. Claims Administrator shall be entitled to rely on such information. Notwithstanding the above, Claims Administrator will perform duties related to other coverage outlined in Section 3.6(f).

4.3 **Plan Ambiguities and Disputes.** Resolve all Plan ambiguities and disputes relating to the Plan eligibility of a Plan Participant, Plan coverage, denial of Claims or decisions regarding appeal or denial of Claims, or any other Plan interpretation questions, within ten (10) business days or by the specific time frame indicated by Claims Administrator, whichever is sooner. Claims Administrator agrees to notify Plan Sponsor as soon as reasonably possible of Plan ambiguities and disputes. The time frame shall be decided on a case-by-case basis between the Parties, with the understanding that the Claims Administrator must receive a prompt response in order to provide a timely response under the Plan's Claims procedures and the ERISA Claims regulations.

The Claims Administrator will administer and adjudicate Claims in accordance with Article III if the Plan Document and Summary Plan Description are clear and unambiguous as to the validity of the Claims and the Plan Participants' eligibility for coverage under the Plan, but will have no discretionary authority to interpret the Plan or adjudicate Claims. If adjudication of a Claim

requires interpretation of ambiguous Plan language, and the Plan Sponsor has not previously indicated to the Claims Administrator the proper interpretation of the language, then the Plan Sponsor will be responsible for resolving the ambiguity or any other dispute.

In any event, the Plan Sponsor's decision as to any Claim (whether or not it involves a Plan ambiguity or other dispute) shall be final and binding.

4.4 **Enrollment**. Conduct and control all enrollment meetings, maintenance of enrollment records, and distribution of enrollment materials. Pertinent enrollment information will be sent to the Claims Administrator regularly either in a 834 Fill File format or in a format reasonably acceptable to the Claims Administrator.

4.5 **Plan Design and Documents.** Claim Administrator shall assist Plan Sponsor in the design and content of the plan, including any amendments to the Plan, subject to Section 4.11. Plan Sponsor shall have sole responsibility for drafting documents stipulating the benefits provided under the Plan unless otherwise agreed to by the Parties.

Notwithstanding above, if Plan Sponsor purchases Claims Administrator's Network, Plan Sponsor must have a minimum ten percent (10%) coinsurance differential between in Network and out of Network benefits.

4.6 **Claims Payment Account**. Claims Administrator will set up an agented account with Plan Sponsor's W9. Plan Sponsor authorizes Claims Administrator sole access to the Claims Payment Account so as to prepare the CCD+file and release funds. Claims Administrator shall pay banking fees associated with Claims Payment Account and invoice Plan Sponsor in arrears for such banking fees on its monthly invoice as indicated in Appendix A.

The Plan Sponsor shall prospectively fund the Claims Payment Account for medical Claims every time a check register is presented for payment. Failure to prospectively fund the Claims Payment Account is considered a material breach of this Agreement and subject to Section 5.4. Additionally, Plan Sponsor acknowledges in the event that the Claims Payment Account is not prospectively funded or Plan Sponsor fails to respond timely to Claims Administrator on questions related to claims payment that University Health Care, Inc. may assess, at its discretion, a 10% penalty on claims owed if such claims are not paid within 45 days of a Clean Claim. No penalties may be assessed on Plan Sponsor if the delay in payment of Clean Claims is due solely to the Claim Administrator's action or inaction.

Upon notification from Claims Administrator that additional funds are needed to pay the Claims liability, Plan Sponsor shall deposit additional funds in the Claims Payment Account to be received no later than forty-eight (48) hours from request.

4.7 **Claim Appeals**. Plan Sponsor shall appoint a person or committee responsible to review any claim appeals and to make final determinations with respect to Plan or Summary Plan Description interpretations. Claims Administrator requires such determination in a written format. Plan Sponsor shall advise Claims Administrator, in writing, if a successor is appointed in this capacity.

4.8 **Identification Cards.** If Plan Sponsor utilizes its own identification card template, the card must include the Claims Administrator's logo if the Plan Sponsor purchased the Network from the Claims Administrator and instructions for providers or Plan Participants to verify eligibility and benefits, and filing Claims.

4.9 **Provider Compensation Appeals**. If a Health Care Provider appeals a Claim related solely to provider compensation, Plan Sponsor must complete its review so that Claims Administrator can respond to the appeal within thirty (30) days of a Health Care Provider's filing appeal.

4.10 **Payment Authorization.** Not require the Claims Administrator, under any circumstances, to issue payment(s) for Claims, excess loss premiums, or any other costs arising out of the subject matter of this Agreement, unless the Plan Sponsor has so authorized and has previously deposited sufficient funds to cover such payment(s).

4.11 **Plan Amendments**. Any Plan changes shall be provided to the Claims Administrator at least ninety (90) calendar days prior to the effective date of the changes. The Claims Administrator must have the ability to implement the change and will use good faith effort to implement the changes by the effective date.

4.12 **Regulatory Notices.** Provide and timely distribute all notices and information required to be given to Plan Participants, maintain and operate the Plan in accordance with applicable law, maintain all recordkeeping, and file all forms relative thereto pursuant to any federal, state, or local law, unless this Agreement specifically assigns such duties to the Claims Administrator.

4.13 **Fiduciary Status**. Acknowledge that it is the Plan Sponsor, Plan Administrator, and Named Fiduciary, as these terms are defined in ERISA. As such, Plan Sponsor retains full discretionary control and authority and discretionary responsibility in the operation and administration of the Plan.

4.14 **Taxes**. Pay any and all taxes, surcharges, licenses, and fees levied, if any, by any local, state, or federal authority in connection with the Plan, including but not limited to those imposed pursuant to the Patient Protection and Affordable Care Action of 2010, as amended.

4.15 **Confidentiality**. Hold confidential information obtained that is proprietary to the Claims Administrator or information or material not generally known by personnel other than management employees of the Claims Administrator. Such information includes, but is not limited to, provider contracting arrangements, reasonable and customary Claims levels, and Claims administration guidelines.

4.16 **Control Group**. Warrant and represent that the only entities that participate, or will participate, in the Plan are in the Plan Sponsor's "controlled group of corporations" as that term is used in ERISA.

4.17 **Fee Schedule.** Pay, in accordance with the Fee Schedule, attached hereto as Appendix A and incorporated herein by reference, the Claims Administrator's fees for services rendered under this Agreement. To determine fees that are invoiced per Appendix A, Claims Administrator will determine the number of enrolled employees effective on the first business day of the month being invoiced (a list of Quartz holidays can be provided upon request). Claims Administrator will send Plan Sponsor an invoice within five (5) business days of the first business day of the month. Fees due will be invoiced to Plan Sponsor on a monthly basis and are due upon invoice. No adjustments shall be made to fees by Claims Administrator for retroactive adjustments, with the exception of any stop loss premium amount, which shall be adjusted per the contractual terms between the stop loss carrier and Plan Sponsor. Failure to pay fees timely may result in termination of this Agreement under Section 5.4.

Claims Administrator may adjust fees in the event of (i) any changes in federal, state or other applicable law or rules; (ii) changes in Plan design required by the applicable regulatory authority (e.g. mandated benefits) or by the customer; (iii) any taxes, surcharges, assessments, or similar charges being imposed by a governmental entity on Claims Administrator; (iv) if a division, subsidiary or affiliated company is added or deleted from the Plan, or if the number of the Participants changed by more than fifteen percent (15%) or more from the proposal; or (v) additional interfaces with external vendors with whom Claims Administrator is required to interface in order to comply with federal and/or state statutes and regulations.

4.18 **Sales Intake Form**. Annually sign the sales intake form developed by Claims Administrator which outlines the Plan Sponsor's decisions on items relating to the administration of its Plan ("Sales Intake Form"). When signing the Sales Take Form, the Plan Sponsor warrants that the information listed in the Sales Intake Form is accurate.

ARTICLE V. DURATION OF AGREEMENT

5.1 **Term of Agreement.** This Agreement shall commence on 01/01/2018 and end on 12/31/2018.

5.2 **Amendments.** At any time during the term of this Agreement, either the Plan Sponsor or the Claims Administrator may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the Plan Sponsor and the Claims Administrator. If any such amendment increases the anticipated Claims experience under the Plan or the Claims Administrator's cost of administering the Plan, the Plan Sponsor agrees to pay any increase in Claims expenses, as well as increases in administrative fees or other costs which the Claims Administrator reasonably expects to incur as a result of such modification.

5.3 **Termination for Convenience.** This Agreement may be terminated by either the Plan Sponsor or the Claims Administrator at any time, either upon giving sixty (60) days advance written notice to the other Party unless both Parties agree to waive such advance notice in writing.

5.4 **Termination for Cause**:

(a) If either Party (a) commits a material breach or material default in the performance or observance of any of its obligations under this Agreement, and (b) such breach or default continues for a period of thirty (30) days after delivery by the other Party of written notice reasonably detailing such breach or default, then (c) the non-breaching or non-defaulting Party shall have the right to terminate this Agreement, with immediate effect, by giving written notice to the breaching or defaulting Party.

(b) Notwithstanding the above, the Claims Administrator may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to the Plan Sponsor:

(i) The Plan Sponsor fails to prospectively fund the Claims Payment Account per Section 4.6.;

(ii) The Plan Sponsor is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all of the Plan Sponsor's assets, the Plan Sponsor makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Plan Sponsor and it is not dismissed within forty-five (45) days of such filing;

(iii) The Plan Sponsor fails to pay administration fees or other fees for the Claims Administrator's services upon presentation for payment and in accordance with the Fee Schedule within twenty (20) days of presentation for payment;

(iv) The Plan Sponsor engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the Claims Administrator is in violation of any federal, state, or other government statute, rule, or regulation;

(v) The Plan Sponsor, through its acts, practices, or operations, exposes the Claims Administrator to any existing or potential investigation or litigation; or

(vi) The Plan Sponsor permits its excess loss insurance to lapse, whether by failure to pay premiums or otherwise.

(c) The Plan Sponsor may, at its option, terminate this Agreement effective immediately upon the occurrence of any one or more of the following events on written notice to the Claims Administrator:

(i) The Claims Administrator is adjudicated as bankrupt, becomes insolvent, a temporary or permanent receiver is appointed by any court for all or substantially all of the Claims Administrator's assets, the Claims Administrator makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Claims Administrator and it is not dismissed within forty-five (45) days of such filing;

(ii) The Claims Administrator engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the Plan Sponsor is in violation of any federal, state, or other government statute, rule, or regulation; or

(iii) The Claims Administrator, through its acts, practices, or operations, exposes the Plan Sponsor to any existing or potential investigation or litigation.

5.5 **Duties After Termination.** Claims Administrator shall process Claims after the termination of Agreement in accordance with this Agreement and subject to the run-out claims processing fee indicated in Appendix A.

ARTICLE VI. MISCELLANEOUS

6.1 **Entire Agreement.** This Agreement, together with the aforesaid addenda, exhibits, and appendices constitutes the entire agreement between the Parties with respect to its subject matter. It supersedes all previous agreements, representations, conditions, warranties, proposals and understandings between the Parties and each Party acknowledges that, in entering into this agreement, it does not do so on the basis of or in reliance upon any representations, promises, undertakings, warranties or other statements (whether written or oral) of any nature whatsoever except as expressly provided in this agreement.

6.2 **Notification of Lawsuit**. Each Party hereto agrees to notify the other Party at the time a lawsuit is initiated concerning any dispute with any third person or entity that is relevant to any rights, obligations, or other responsibilities or dues provided for under this Agreement.

6.3 **Warranties**. The Parties hereto, having read and understood this entire Agreement, acknowledge and agree that there are no other representations, conditions, promises, agreements, understandings, or warranties that exist outside this Agreement which have been made by either of the Parties hereto, which have induced either Party or has led to the execution of this Agreement by either Party. Any statements, proposals, representations, conditions, warranties, understandings, or agreements which may have been heretofore made by either of the Parties hereto, and which are not expressly contained or incorporated by reference herein, are void and of no effect.

6.4 **Counterparts.** This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument.

6.5 **Amendments.** Except as provided in Article V, (regarding termination without advance notice), no changes in or additions to this Agreement shall be recognized unless and until made in writing and signed by all Parties hereto.

6.6 **Addendum**. The "Standard Terms and Conditions", attached hereto as Addendum 1 is incorporated into this Agreement.

6.7 **Severability.** In the event, any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms.

6.8 **Force Majeure**. In the event that either Party is unable to perform any of its obligations under this Agreement because of natural disaster, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies (any one of these events which is referred to as a "Force Majeure Event"), the Party who has been so affected shall immediately notify the other Party and shall do everything possible to resume performance.

Upon receipt of such notice, all obligations under this Agreement shall be immediately suspended. If the period of non-performance exceeds ten (10) working days from the receipt of notice of the Force Majeure Event, the Party whose ability to perform has not been so affected may, by giving written notice, terminate this Agreement.

6.9 **Notice**. All notices required to be given to either Party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three (3) days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested as follows:

To Claims Administrator:
Quartz Health Solutions, Inc.
Attention: President
840 Carolina Street
Sauk City, Wisconsin 53583
Fax: 608-643-1450

Copy to:
Quartz Health Solutions, Inc.
Attention: General Counsel
840 Carolina Street
Sauk City, Wisconsin 53583

To Plan Sponsor:
City of La Crosse
400 La Crosse Street
La Crosse, WI 54601

6.9 **Choice of Law**. This Agreement shall be interpreted and construed in accordance with the laws of the state of Wisconsin except to the extent superseded by federal law.

6.10 **Waiver**. No forbearance or neglect on the part of either Party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.

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

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective this 15th day of August, 2017.

PLAN SPONSOR

SIGNATURE: Timothy Karbst

PRINTED NAME: TIMOTHY KARBST

TITLE: MAYOR

DATE: 08/17/2017

CLAIMS ADMINISTRATOR

SIGNATURE: DocuSigned by: Terry Bolz AE22B7218A5548F...

PRINTED NAME: Terry Bolz

TITLE: President and CEO

DATE: 8/31/2017

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APPENDIX A

FEE SCHEDULE AND FINANCIAL ARRANGEMENT

The Plan Sponsor and the Claims Administrator hereby agree to the compensation schedules set forth below as being the sole compensation to the Claims Administrator for any of its services which relate to the Plan. Fees shall be invoiced monthly and shall be payable upon receipt. Failure to pay fees timely may result in termination of this Agreement under Section 5.4.

Fees assume services will be handled according to Claims Administrator's standard format and procedures, unless otherwise specifically addressed in this Agreement. Check customization, special statistical reports other than those enumerated in this contract, medical underwriting, new taxes assessed against the Plan, or other services mutually agreed upon will be billed separately at the actual costs of such services.

Basic Monthly Maintenance Fee

1. Monthly administration fee of $28.42 PEPM

Add On Fees

1. Per Claim fee of $25.00 for Claims reprocessing on retroactive enrollment transactions within the last sixty (60) days or plan design changes

2. Pass through fee for Independent Review Organization Filings

3. Pass through fee for Medical Records invoices

4. Pass through savings for subrogation, estimated to be approximately 25% except Claims Administrator will retain a one percent (1%) of savings plus vendor fee(s)

5. Wrapped Networks percentage of savings for Out-of-Network Claims (16% for Health EOS/Multiplan; 26% Zelis Healthcare; Claims Administrator will retain one percent (1%) savings)

6. Pass through fee for bank service charges related to Claims Payment Account

7. Per hour fee of $70.00 for ad hoc reporting requests including state fees and surcharges quarterly report

8. For any other services not explicitly stated in this Agreement, including but not limited to services for regulatory audits, Actuarial Services, the creation of additional reports, translation of written letters/materials into non-English text or sending regulatory notifications (including postage and printing, etc.), a statement of work will be made available upon request, listing the services included in creating and providing the requested services and the scope of the request and amount charged.

Post-Termination Services Fee

In the event of the termination of this Agreement, the Run-Out Service Fee for providing post-termination administration services during the Run-Out Period as defined in the Agreement shall be equal to the amount set forth below.

1. Monthly administration fee of Basic Monthly Maintenance Fee for three (3) months following date of termination, then $20.00 per claim for run-out Claims processing

2. The administrative Run-Out Fee cover the following services:
    a. Adjudicating and paying claims according to the Schedule of Benefits effective as of the date of termination.
    b. Adjudicating and paying claims involving Medicare Secondary Payor requests.
    c. Providing standard reports as were provided during the contract period.
    d. Providing copies of explanations of benefits to plan members.
    e. Applying Maximum Allowable Charge schedules to billed charges on claims being processed for payment to out-of-network providers.
    f. Refund claim overpayments.

3. The administrative Run-Out fees do not cover:
    a. Disease Management, Large Case Management or Complex Case Management
    b. Utilization Management for medical, behavioral health and medical pharmacy services.
    c. ID card issuance for retroactively added Participants
    d. The following vendor file feeds:
        i. PBM vendor
        ii. Eligibility vendor
        iii. Wrapped network vendor(s)

4. All claims processing, adjudication and payments, recovery efforts, Medicare Secondary Payor investigations, refund processing and subrogation efforts will cease on the date that the run-out agreement ends.

5. Plan Sponsor responsibilities during the Run-Out Period:
    a. The Plan Sponsor will be responsible for processing, adjudicating and paying all claims incurred after the expiration of the Administrative Services Agreement.
    b. The Plan Sponsor will be responsible for processing and adjudicating all claims incurred prior to expiration of the Administrative Services Agreement and received after the termination of this Run-Out Agreement.
    c. The Plan Sponsor will assist the Claims Administrator in obtaining names, addresses and phone numbers of Employees or former Employees as necessary.
    d. The Plan Sponsor agrees to pay to Claims Administrator an hourly consulting fee (the amount of which to be determined by the parties when applicable) if retrospective review or audit of claims paid is requested.

ADDENDUM 1
STANDARD TERMS AND CONDITIONS

This Standard Term and Conditions Addendum ("Addendum") is made part of the Agreement. To the extent that there are any conflicts between the provisions of the Agreement and the provisions of this Addendum, the provisions of this Addendum shall supersede the conflicting provisions of the Agreement.

1. DEFINITIONS: In this section "Contracting Party" shall mean any party that is entering into this Agreement with the City of La Crosse. "La Crosse" shall mean the City of La Crosse. These definitions shall apply only to this section titled "Standard Terms and Conditions" and shall not replace modify or supersede any definitions used in other sections of this agreement.
2. STANDARD OF PERFORMANCE: Contracting Party agrees that the performance of the services, pursuant to the terms & conditions of this Agreement shall be performed in a manner consistent with the degree of care and skill ordinarily exercised by members of the same professions currently practicing under similar circumstances providing like services. Contracting party agrees to abide by all applicable federal, state and local laws, regulations and ordinances and all provisions of this Agreement.
3. FULLY QUALIFIED: Contracting Party represents that personnel engaged in the performance of the services set forth in this Agreement shall be fully qualified and shall be authorized or permitted under state and local laws to perform the services.
4. SCOPE OF SERVICES: Contracting Party is required to perform, do and carryout in a satisfactory, timely and professional manner the services set forth in this Agreement. The Contracting Party is required to furnish all services and labor necessary as indicated in this Agreement, including without limitation materials, equipment, supplies and incidentals. The scope of services to be performed shall include without limitation, those services set forth in this Agreement. La Crosse may from time to time request the Contracting Party to perform additional services which are not set forth in this Agreement. In the even that such a request is made, the performance of such services shall be subject to the terms conditions and contingencies set forth in this Agreement.
5. CHANGE OF SCOPE: The scope of services set forth in this agreement is based on the facts known at the time of the execution of this Agreement, including, if applicable, information supplied by Contracting Party. Scope may not be fully definable during initial phases. As projects progress facts discovered may indicate that the scope must be redefined. Parties shall provide a written amendment to this Agreement to recognize such change.
6. COMPENSATION: Contracting Party will be compensated by La Crosse for the services provided under this Agreement and subject to the terms, conditions and contingencies set forth in the Agreement.
7. TAXES, SOCIAL SECURITY, INSURANCE AND GOVERNMENT REPORTING: Personal income tax payments, social security contributions, insurance and all other government reporting and contributions required as a consequence of the contracting party receiving payment under this Agreement shall be the sole responsibility of the Contracting Party.
8. TERMINATION FOR CAUSE: Termination by either party shall be consistent with terms set for in Section 5.4 of the Agreement.
9. SAFETY: Unless specifically included as a service to be provided under this Agreement, La Crosse specifically disclaims any authority or responsibility for general job site safety, or the safety of persons or property.
10. DELAYS: If performance of La Crosse's obligations is delayed through no fault of La Crosse, La Crosse shall be entitled to an extension of time equal to the delay.

11. OPINIONS OF COST: Any opinion of cost prepared by La Crosse is supplied for general guidance of Contracting Party only. La Crosse cannot guarantee the accuracy of such opinions as compared to actual costs to contracting party.
12. USE OF LA CROSSE PROPERTY: Any property belonging to La Crosse being provided for use by Contracting Party shall be used in a responsible manner and only for the purposes provided in this Agreement.
13. INSURANCE: The insurance obligations of each party are set forth in Section 2.8 of the Agreement.
14. INDEMNIFICATION. The indemnification obligations of the Parties are set forth in Section 14 of the Agreement.
15. NO PERSONAL LIABILITY. Under no circumstances shall any trustee, officer, official, commissioner, directory, member, partner or employee of La Crosse, have any personal liability arising out of this Agreement, and Contracting Party shall not seek or claims any such personal liability.
16. INDEPENDENT CONTRACTORS. The parties, their employees, agents, volunteers, and representatives shall be deemed independent contractors of each other and shall in no way be deemed as a result of this Agreement to be employees of the other. The parties, their employees, agents, counters, and representatives are not entitles to any of the benefits that the other providers for its employees. The parties shall not be considered joint agents, joint venturers, or partners.
17. GOVERNING LAW. This agreement and all questions and issues arising in connection herewith shall be governed by and construed in accordance with the law of the State of Wisconsin. Venue for any action arising out of or in any way related to this Agreement shall be exclusively in La Crosse County, Wisconsin. Each party waives the right to change venue.
18. NOTIFICATION. Contracting Party shall:
    1) As soon as possible and in any event within a reasonable period of time after the occurrence of any default, notify La Crosse in writing of such default and set forth the details thereof and the action which is being taken or proposed to be taken by Contracting Party with respect thereto.
    2) Promptly notify La Crosse of the commencement of any litigation or administrative proceeding that would cause any representation and warranty of Contracting Party contained in this Agreement to be untrue.
    3) Notify La Crosse, and provide copies, immediately, upon receipt , of any notice, pleading, citation, indictment, complaint, order or decree from any federal, state or local government agency or regulatory body, asserting or alleging a circumstance or condition that requires or may require a financial action or other response by or on the part of Contracting Party or any guarantor under any environmental laws, rules, regulations, ordinances or which seeks damages or civil, criminal or punitive penalties from or against Contracting Party or any guarantor for an alleged violation or any environmental laws, rules regulations or ordinances.
19. SEVERABILITY. The provisions of this Agreement are severable if any provision or part of this Agreement or the application thereof to any person or circumstance shall be held by a court of competent jurisdiction to be invalid or unconstitutional for any reason, the remainder of this Agreement and the application of such provision or part thereof to other persons or circumstances shall not be affected thereby.
20. ASSIGNMENT, SUBLET, AND TRANSFER, Contracting Party shall not assign, sublet, or transfer its interests or obligations under the provisions of this Agreement without the prior written consent of La Crosse. This Agreement shall be binding on the heirs, successors, and assignees of each

party hereto. Contracting Party shall provide not less than forty-five (45) days advance written notice of any intended assignment, sublet, or transfer.

21. NO WAIVER. The failure of any party to insist, in any one or more instance, upon performance of any of the terms, comments, or conditions of this Agreement shall not be constituted as a waiver, or relinquishment of the future performance of any such term, comment, or condition by any other party hereto but the obligations of such other party with respect to such future performance shall continue in full force and affect.
22. SUBCONTRACTING. None of the services to be performed under this Agreement shall be subcontracted without the prior written approval of La Crosse. If any of the services are subcontracted, the performance of such services shall be specified by written contract and shall be subject to each provision of this Agreement. Coordinating Party shall be fully responsible to La Crosse for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by them, as it is for acts and omissions of persons directly employed by it.
23. CONFLICTS OF INTEREST. Contracting Party covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contracting Party further covenants that in the performance of this Agreement no person having any conflicting interest shall be employed. Any interest on the part of Contracting Party or its employee must be disclosed to La Crosse.
24. NON-DISCRIMINATION. Pursuant to law, it is unlawful and Contracting Party agrees not to willfully refuse to employ, to discharge, or to discriminate against any person otherwise qualified because of race, color, religion, sex, sexual orientation, age, disability, national origin, or ancestry, lawful source of income, marital status, creed, or familial status; not to discriminate for the same reason in regard to tenure, terms, or conditions of employment, not to deny promotion or increase in compensation solely for the reasons: not to adopt or enforce any employment policy which discrimination between employees on account of race, color, religion, sex, creed, age, disability, national origin or ancestry, lawful source of income, marital status or familial status; not to seek such information as to any employee as a condition of employment; not to penalize any employee or discriminate is the selection of personnel for training, activity on the basis of race, color, religion, sex, sexual orientation, age, disability, nation origin or ancestry, lawful source of Income, marital status, creed or familial status. Contracting Party shall include or cease to be included in each subcontract covering any of the services to be performed under this Agreement a provision similar to the above paragraph, together with a clause requiring such insertion in further subcontracts that may in turn be made.
25. POLITICAL ACTIVITIES. Contracting Party recognizes that certain health system owners of Coordinating Party may be registered lobbyists in the state of Wisconsin. If Contracting Party determines that an affiliate of Coordinating Party's political activities directly impact La Crosse in a negative manner, La Crosse shall have the right to terminate this agreement pursuant to Section 5.3 of the Agreement.
26. GOVERNMENTAL APPROVALS. Contracting Party acknowledges that various of the specific undertakings of La Crosse described in this Agreement may require approval form the City of La Crosse Council, City of La Crosse bodies, and or other public bodies, some of which may require public hearings and other legal proceedings as conditions precedent thereto. Contracting Party further acknowledges that this Agreement is subject to appropriation by the La Crosse Common Council; La Crosse's obligation to perform under this Agreement is conditioned upon obtaining all such approvals in the manner required by law. La Crosse cannot assume that all such approvals will be obtained; however, it agrees to use good faith efforts to obtain such approvals on a timely basis.
27. ENTIRE AND SUPERSEDING AGREEMENT. This writing. All Exhibits herein, and the other documents and agreements reference herein, constitute the entire Agreement between the

parties with respect to the subject matter hereof, and all prior agreements, correspondences, discussions and understandings of the parties (whether written or oral) are merged herein and made a part hereof. This Agreement, however shall be deemed and read to include and incorporate such minutes, approvals, plans, and specifications, as referenced in this Agreement, and in the event of a conflict between this Agreement and any action of La Crosse, granting approvals or conditions attendant with such approval, the specific action of La Crosse shall be deemed controlling. To the extent that any terms and conditions contained in this Agreement, all Exhibits hereto, and the other documents and agreement referenced herein conflict with these Standard Terms and Conditions, the Standard Terms and Conditions shall take precedence.

28. AMENDMENT. This Agreement shall be amended only by formal written supplementary amendment. No oral amendment of this Agreement shall be given any effect. All amendments to this Agreement shall be in writing executed by both parties.
29. IMPLEMENTATION SCHEDULE AND TIME OF THE ESSENCE. Any and all phases and schedules which are the subject of approvals, or an act forth herein, shall be governed by the principle that time is of the essence, and modification or deviation from such schedule shall occur only upon approval of La Crosse. The Mayor, or in the Mayor's absence, the Council President, shall have the ability to postpone any deadline listed herein, up to a maximum of ninety (90) days.
30. TIME COMPUTATION. Any period of time described in this Agreement by reference to a number of days includes Saturdays, Sundays, and any state or national holidays. Any period of time described in this Agreement by reference to a number of business days does not include Saturdays, Sundays, or any state or national holidays. If the date or last date to perform any act or to give any notices is a Saturday, Sunday or state or national holiday, that act or notice may be timely performed or given on the next succeeding day which is not a Saturday, Sunday, or state or national holiday.
31. NOTICES. Any notice, demand, certificate or other communication under this Agreement shall be given in writing and deemed effective: a) when personally delivered, b) three (3) days after deposit with the United States Postal Service, postage prepaid, certified, return receipt required: or c) one (1) business day after deposit with a nationally recognized overnight courier service, addressed by name and to the party or person intended as follows:

To the City:	Attn: City Clerk City of La Crosse 400 La Crosse Street La Crosse, WI 54601	Copy to:	Attn: City Attorney City of La Crosse 400 La Crosse Street La Crosse, WI 54601

Contracting party shall identify in writing and provide to La Crosse the contact person and address for notices under this Agreement.

32. INCORPORATION OF PROCEEDINGS AND EXHIBITS. All motions adopted, approvals granted, minutes documenting such motions and approvals, and plans and specifications submitted in conjunction with any and all approvals as granted by La Crosse, including but not limited to adopted or approved plans or specifications on file with La Crosse, and further including but not limited to all exhibits are referenced herein, are incorporated by reference herein and are deemed to be the contractual obligation of Contracting Party whether or not herein enumerated.
33. ACCESS TO RECORDS. Contracting Party, as its sole exposure, shall maintain books, records, documents, and other evidence pertinent to this Agreement in accordance with accepted applicable professional practices. La Crosse, or any of its duly authorized representatives, shall have access, at no cost to La Crosse, to such books, records, documents, papers or any records, including electronic, of Contracting Party which are pertinent to the Agreement, for the purpose of making audits, examinations, excerpts and transcription.
34. PUBLIC RECORDS LAW. Contracting Party understands and acknowledges that La Crosse is subject to the Public Records Law of the State of Wisconsin. As such, Contracting Party agrees

to retain all records as defined by Wisconsin Statue §19.32(2) applicable to this Agreement for a period of not less than seven (7) years after the termination or expiration of this Agreement. Contracting Party agrees to assist La Crosse in complying with any public records requires that La Crosse receives pertaining to this agreement. Additionally, Contracting Party agrees to indemnify and hold harmless La Crosse, its elected and appointed officials, officers, employment, and authorized representatives for any liability, including without limitation, attorney fees related to or in any way arising from Contracting Party's actions or omissions which contribute to La Crosse's inability to comply with the Public Records Law. In the event that Contracting Party decides not to retain its records for a period of seven (7) years, then it shall provide written notice to La Crosse whereupon La Crosse shall take custody of said records assuming such records are not already maintained by La Crosse. This provision shall survive the termination of this Agreement.

35. CONSTRUCTION. This Agreement shall be construed without regard to any resumptions or rule requiring construction against the party causing such instrument to be drafted. This Agreement shall be deemed to have been drafted by the parties of equal bargaining strength. The captions appearing at he the first of each numbered section of this Agreement are inserted and included solely for convenience but shall never be considered or given any effect in constructing this Agreement with the duties, obligations, or liabilities of the respective parties herein or in ascertaining intent. If any questions of intent should arise, all terms and words used in this Agreement, whether singular or plural and regardless of the gender thereof, shall be deemed to include any other number and any other gender as the content may require.
36. NO THIRD-PARTY BENEFICIARY. Nothing contained in this Agreement, nor the performances of the parties hereunder, is intended to benefit, nor shall inure to the benefit, of any third party.
37. COMPLIANCE WITH LAW. The parties shall comply in all material respects with any and all applicable federal, state and local laws, regulations and ordinances.
38. FORCE MAJEURE. La Crosse shall not be responsible to Contracting Party for any resulting losses and it shall not be a default hereunder if the fulfillment of any of the terms of this Agreement is delayed or prevented by revolutions or other civil disorders, wars, acts of enemies, strikes, fires, floods, acts of God, adverse weather conditions, legally required environmental remedial actions, industry-wide shortage of materials, or by say other cause not within the control of the party whose performance was interfered with, and which exercise of reasonable diligence such party is unable to prevent, whether of the class of causes hereinabove enumerated or not, and the time for performance shall be extended by the period of delay occasioned by any such cause.
39. GOOD STANDING. Contracting Party confirms that it is a company duly formed and validly updating and in good standing under the laws of the State of Wisconsin and has the power and all necessary licenses, penalties, and franchises to own its assets and properties and to carry on its business. Contracting Party is duly licensed or qualified to do business and is in good standing in the State of Wisconsin and in all other jurisdictions in which failure to do so would have a material adverse effect on its business or financial condition.
40. AUTHORITY. The persons signing this Agreement warrant that they have the authority to sign as, or on behalf of the party for whom they are signing.
41. EXECUTION OF AGREEMENT. Contracting Party shall sign and execute this Agreement on or before sixty (60) days of the approval by the La Crosse Common Council, and Contracting Party's failure to do so will render the approval of the Agreement by the La Crosse Common Council null and void unless otherwise authorized.
42. COUNTERPARTS. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same agreements and shall become effective when one or more counterparts have been signed by each of the parties and delivered to the other party.

43. SURVIVAL. All express representatives, indemnifications and limitation of liability included in this Agreement will survive its completion or termination for any reason.