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165 Court Street
Rochester, NY 14647

ExcellusBCBS.com

November 4, 2022

Carissa Parloto, Town Clerk
Town of Ulysses
10 Elm Street
Trumansburg, New York 14886

RE: Town of Ulysses
Group Number (s) –
00501491 Medicare BluePPO
00058636 Dental All Actives; COBRA

Dear Carissa Parloto,

Thank you for choosing Excellus BlueCross BlueShield as your health partner.

In Process

Enclosed are your group agreements that we require in order to finalize your group's enrollment for coverage. Please review the agreements, ***sign and date in all places indicated***, and return within 10 days.

Upon receipt of your signed agreements, we will countersign the agreements and return the executed versions to you for your records.

We value your business and as always, I encourage you to contact me at (315) 798-4281 if you have any questions.

Sincerely,

Lauren Bauer
Account Sales Consultant

Enclosures

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MASTER GROUP AGREEMENT

BETWEEN

EXCELLUS HEALTH PLAN, INC., DOING BUSINESS AS EXCELLUS BLUECROSS BLUESHIELD (the "Plan")

AND

TOWN OF ULYSSES ("Group")

This is the record of a group contract ("Master Group Agreement" or "Agreement") made effective January 1, 2022, between the Plan, with offices located at 165 Court Street, Rochester, New York 14647 and Group, with offices located at 10 Elm Street, Trumansburg, New York 14886. The Plan is a nonprofit independent licensee of the BlueCross BlueShield Association.

1. **Purpose.** This Agreement sets forth the terms and conditions on which the Plan will issue to Group certain health benefits certificates and/or riders for the benefit of Group's employees, and/or members and/or (if applicable) retirees; and/or (if applicable) employees or members and/or (if applicable) retirees of Group's member firms or participants (collectively, as applicable, "Group Members").

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2. **Term of Agreement; Renewal.** This Agreement and the coverage to be provided pursuant to it will be effective on the date set forth above, provided that the Group meets all underwriting criteria, and the first premium has been paid to the Plan by the effective date. The Agreement and coverage will continue for the period specified in the attached Premium Rate Schedule (the "Initial Term"), unless earlier terminated as provided below. The Agreement will automatically be renewed for successive one year renewal terms (each a "Renewal Term") on each subsequent anniversary of the effective date, unless earlier terminated as provided below.

3. **Benefits.**

   a. Certificate. The Plan will provide group health care benefits (the "Benefits") to Group Members and their eligible dependents in the classification(s) specified in the association, trust fund, or employer agreement between the Plan and Group. The Benefits that the Plan will provide under this Agreement, including limitations and exclusions, are described in the Certificate of Coverage(s), including the Schedule of Benefit(s), and Riders(s), if any (collectively, the "Certificate") that are identified on the attached List of Products and Forms and made a part of this Agreement. If any provision of this Agreement conflicts with any provision of the Certificate, this Agreement controls.

   b. Changes in the Certificate. The Plan may unilaterally change the Certificate upon renewal, if the Plan gives Group 45 days' prior written notice. Upon receipt of notice of a change in the Certificate, Group will be deemed to have accepted the change unless Group provides written notice to the Plan, as set forth in the "Termination" section of this Agreement and in the Certificate, of its intention to terminate this Agreement.

4. **Premiums.** Group will pay premiums to the Plan to secure the Benefits for Group Members and their enrolled dependents.

   a. Initial Premium Rates; Changes in Premium Rates. The initial premium rates are set out in the attached Premium Rate Schedule. The Plan's rating methodology includes factors for sales, general, and administrative expenses, one of which is a factor for broker commissions. The broker commission factor is mandatory; it shall apply to the calculation of rates without regard to whether a broker is used in the sale or renewal of an individual account's group health coverage. Changes in premium rates will be made as set forth on the attached Schedule of Changes in Premium Rates.

   b. Payment of Premiums. All premium payments are due in advance. Group will be required to remit payment when the first bill is received. All subsequent premium payments must be paid on or before the due date; except that the Plan will allow Group a 30-day grace period after the due date for payment. Notwithstanding the preceding sentence, the grace period shall not apply if an authorization for payment (e.g., check or ACH authorization) has been returned or refused by Group's bank due to insufficient funds in the account on which the payment was drawn with respect to a billing period occurring (in whole or in part) during the 12 months preceding the failure to make timely payment.

   c. Effect of Nonpayment.

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      i. If Group fails to pay the first premium payment due for the Benefits prior to the effective date, no coverage will be provided.

      ii. If Group fails to pay any subsequent premium payment by the end of the grace period, the Plan may terminate the Agreement as set forth in the provision of the "Termination" section pertaining to default in the payment of premiums. In the event that the Plan terminates the Agreement for nonpayment of premiums:
         - the Plan will notify Group of its intention to terminate the Agreement for nonpayment of premiums, as set forth in the Agreement;
         - the Plan will include, with its notice of termination, a written notice to Group regarding Group's obligations under Section 217 of the New York Labor Law, as required by Section 4235 of the New York Insurance Law; and
         - Group will be responsible for the payment of all premiums owed to the Plan as of the date of termination, which will be the first day following the end of the period for which premiums were paid.

   d. Cure of Default by Group. If, prior to the end of the grace period, Group pays all of the premiums owed to the Plan, this Agreement will not be terminated by the Plan for nonpayment of premiums.

5. **Delivery of Notices and Materials.** When notices or other materials (e.g., applications, identification cards, certificates and riders) are to be provided by the Plan to Group Members, the Plan may deliver them to Group, and Group will, in a timely manner, distribute them to the Group Members.

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6. **Termination.**

   a. By Group. This Agreement may be terminated by Group upon the provision of 30 days' advance written notice to the Plan.

   b. By the Plan. At the option of the Plan, this Agreement may be terminated by the Plan as follows:

      i. This Agreement may be terminated if Group has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid.

      ii. This Agreement may be terminated if Group has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

      iii. This Agreement may be terminated if Group has failed to comply with a material plan provision relating to employer contribution or group participation rules.

      iv. This Agreement may be terminated if Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

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      v. This Agreement may be terminated 180 days from the date on which the Plan provides notice to Group, if the Plan withdraws from the applicable market through which Group obtained coverage under this Agreement;

      vi. This Agreement may be terminated as of the date there is no longer any enrollee who lives, resides, or works in the Plan's Service Area.

      vii. This Agreement may be terminated for any reason approved by the Superintendent of Financial Services and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

   c. By the Superintendent. This Agreement will automatically terminate if the Superintendent of Financial Services of the State of New York informs the Plan that it may not participate in this Agreement.

   d. Termination of Specific Certificates, Schedule of Benefits, and Riders. The Plan may terminate specific group certificates, include the schedule of benefits, and riders forming part of the Certificate, without regard to claims experience or health related status, 90 days from the date on which the Plan provides notice to Group, if the Plan terminates the entire class of contract to which such certificates, schedule of benefits, and riders belong.

7. **Relationship of Parties.** The parties to this Agreement are independent contractors and are not to be construed as having any other relationship, either with respect to this transaction or any other transaction between the parties. No party will have, or hold itself out as having, the power or authority to bind or create liability for the other by its intentional or negligent act or omission.

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8. **Notices.** All notices and other communications given under this Agreement must be in writing and delivered personally, by established overnight courier or by first class mail, postage prepaid, to the addresses set forth at the beginning or to such other address as one party may provide to the other in writing. Notices and communications will be deemed received at the time of personal delivery (except that, if personal delivery occurs on a day other than a business day, the next business day will be deemed the date of receipt), one business day after shipping via overnight courier, and three business days after mailing.

9. **Jurisdiction; Venue.** Jurisdiction of any litigation with respect to this Agreement will be in New York, with venue in a court of competent jurisdiction in Monroe County, Onondaga County, or Erie County.

10. **Choice of Law.** This Agreement will be governed by, and construed in accordance with, the laws of the State of New York.

11. **Entire Agreement.** This Agreement, including attached schedules (as they may be replaced or added from time to time) constitutes the entire agreement between the parties and supersedes any prior understandings or agreements with respect to the subject matter. No changes, additions or modifications to the terms of this Agreement will be made or binding, unless in writing and signed by both parties.

12. **Drug Utilization, Cost Management, and Rebates.** We conduct various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, members benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for coverage. The Plan may, from time to time, also enter into agreements that result in the Plan's receipt of rebates or other funds ("rebates") directly or indirectly from prescription drug manufacturers, prescription drug distributors, or others. Any rebates are based upon utilization of prescription drugs across all of our business and not solely on any one member's utilization of prescription drugs. Any rebates received by the Plan may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of the Plan's prescription drug premiums. Instead, any such rebates may be retained by the Plan, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities, and increasing reserves for the protection of members. Rebates will not change or reduce the amount of any cost-sharing (deductible, copayment, and/or coinsurance) applicable under the Plan's prescription drug coverage.

13. **Right to Audit.** The Plan will have the right to conduct random audits of Group, to verify that Group is in compliance with the underwriting rules of the Plan, any rules imposed upon the Plan by external agencies/entities with authority over the Plan, and/or applicable law and regulation. Group will be required to provide the Plan with any and all documentation needed to facilitate the audit.

14. **Out-of-Area Services.** The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." Whenever Group Members and their enrolled dependents (collectively, "Members") access health care services outside of the Plan's Service Area, the claims for those services may be processed through one of these Inter-Plan Arrangements and presented to the Plan for payment according to the Inter-Plan Programs

policies then in effect. The Inter-Plan Arrangements available to Members under this Agreement are described generally below.

Typically, Members, when accessing care outside the Plan's Service Area, will obtain care from health care providers that have a contractual agreement (i.e., are "Participating Providers" or "In-Network 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 Non-Participating (or Out-of-Network) Providers with the Host Blue. The Plan remains responsible for fulfilling its contractual obligation to the Group. The Plan's payment practices in both instances are described below.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Plan to provide the specific service or services.

a. **BlueCard® Program.** The BlueCard® Program is an Inter-Plan Arrangement. Under the BlueCard Program, when Members access covered healthcare services within the geographic area served by a Host Blue, the Plan will remain responsible to Group for fulfilling the Plan's contractual obligations. However, in accordance with the applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its Participating/In-Network Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, the Plan's action will be consistent with the spirit of this description.

i. **Liability Calculation Method per Claim**. The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar Copayment, will be based on the lower of: the Participating/In-Network Provider's billed covered charges for covered services; or the negotiated price made available to the Plan by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending upon the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to the Plan by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

- an actual price. An actual price is a negotiated payment without any other increases or decreases; or
- 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 nonclaim-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
- an average price. An average price is a percentage of billed covered charges 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

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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.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Arrangements policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to providers or refunds received or anticipated to be received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to the Plan is a final price irrespective of any future adjustments based on the use of estimated or average pricing. The method of claims payment by Host Blue is taken into account by the Plan in determining the Group's premiums.

A small number of states require a Host Blue either: to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Plan would then calculate Member liability in accordance with applicable law.

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b. **Return of Overpayments.** Under the BlueCard Program, recoveries from a Host Blue or its Participating/In-Network Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Arrangements policies, which generally require correction on a claim-by-claim or prospective basis.

c. **Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees**
In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include any such surcharge, tax or other fee in determining the Group's premium.

d. **Calculation of Member Liability for Services of Non-Participating/Out-of-Network Providers outside the Plan's Service Area.** The Allowed Amount definition in the Member's Contract or Certificate, as amended from time-to-time, describes how the Plan's payment (the "Allowed Amount") for covered services of Non-Participating/Out-of-Network Providers outside the Plan's Service Area is calculated. For HMO Members, based upon that Allowed Amount definition, the HMO Member's liability for covered services is limited to the Copayment, if any, required by the Member's Contract or Certificate. For other (non-HMO) Members, the Allowed Amount may be based upon the amount provided to the Plan by the Host Blue

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or the payment the Plan would make to Non-Participating/Out-of-Network Providers inside the Plan's Service Area. Regardless of how the Allowable Expense is calculated, the Member will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowed Amount, which amount is in addition to any other cost sharing (Deductible, Copayment or Coinsurance) required by the Member's Contract or Certificate.

e. **Blue Cross Blue Shield Global Core.** 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 BCBS Global Core when accessing covered healthcare services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS 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 member will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- Inpatient Services. In most cases, if members contact the BCBS Global Core Service Center for assistance, hospitals will not require the member to pay for covered inpatient services, except for their cost-sharing amounts. In such cases, the hospital will submit the member claims to the service center to begin claims processing. However, if the member paid in full at the time of service, the member must submit a claim to receive reimbursement for covered healthcare services.
- Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require the member to pay in full at the time of service. The member must submit a claim to obtain reimbursement for covered healthcare services.
- Submitting a BCBS Global Core Claim. When members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a BCBS 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 the Plan, the service center or online at www.bcbsglobalcore.com. If members need assistance with their claim submission, 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.

15. The Plan Is Independent. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the BlueCross BlueShield Association, an Association of independent Blue Cross and Blue Shield Plans, which licenses Excellus BlueCross BlueShield to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the BlueCross BlueShield Association. Excellus BlueCross BlueShield is solely responsible for the obligations created under this Agreement.

16. From time to time, the Plan enters into agreements with third party vendors to provide enhanced services in support of the administration of Group's Benefits, including but not limited to the prescription drug program or care management programs. The amount the Plan charges Group for the services will include the third party vendor's and the Plan's service fees, as well as any applicable commission payments.

17. <u>Required Disclosure</u>. The Plan is required to notify Group of the following:

> **Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and will also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.**

The parties' assent to the terms of this Agreement as of the date set forth at the beginning is established by their signatures below.

Dated: _________________________

Excellus Health Plan, Inc., d/b/a Excellus BlueCross BlueShield

In Process

By: ________________________________

Title: ________________________________

Dated: _________________________

Town of Ulysses

By: ________________________________

Title: ________________________________

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SCHEDULE OF CHANGES IN PREMIUM RATES
Community-Rated, Rolling Rate

1. Changes in Premium upon Renewal.

   The premium rates for each Renewal Term of the Agreement will be provided to Group in a renewal rate notice, which will specify the effective date of the new rates.

2. Notice of Changes in Premium Rates. The Plan will not make any changes to the premium rates without giving Group at least 30 days' prior written notice. Upon receipt of notice of a change in the premium rates, Group will be deemed to have accepted the new rates, unless Group provides timely written notice to the Plan of its intention to terminate this Agreement or modify the Benefits.

3. Affected Products. The foregoing provisions apply to all contracts, certificates, riders, and/or endorsements forming part of the Certificate.

In Process

Excellus

Medicare Blue PPO Copay Plan
Small Group Plan 1
Effective: 01/01/2022

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Annual deductible	None	$250
Annual out-of-pocket maximum (medical services only, does not include prescription drugs)	$1,250 in network	$8,000 combined in network and out-of-network annual out-of-pocket maximum
Out-of-network benefits	N/A	Benefits are available, but additional costs may apply
Lifetime maximum	None	
Physician office services		
Office visit copay (PCP)	$15 copay	$25 copay
Office visit copay (Specialist)	$15 copay	$25 copay
Chiropractor office visit (manual manipulation to correct subluxation)	$15 copay	$25 copay
Podiatrist office visit (for medically necessary foot care)	$15 copay	$25 copay
Allergy tests/injections	$15 copay if performed in PCP office, $15 copay if performed in a specialist office	$25 copay if performed in PCP office, $25 copay if performed in specialist office
Lifestyle and wellness benefits		
Ways to help you and your family live healthier every day	Silver&Fit® is an Exercise Program that gives you the choice of: - Membership in a fitness club/exercise center ($25 annual fee) - Home Fitness Program ($10 annual fee) - $150 annual reimbursement toward paid membership at non-participating fitness clubs/exercise centers - Silver&Fit® copays will not be included in the Annual Out-Of-Pocket Maximum. Blue365: Exclusive discounts on health-related products and services	
Preventive health care services (office visit copay may apply)		
Annual wellness exam	Covered in full, limited to one per year	$25 copay, limited to one per year
Immunizations (flu, pneumonia, Hepatitis B, and other vaccines if patient is at risk)	Covered in full flu, pneumonia and Hepatitis B. All other vaccines 20% coinsurance	Covered in full for Flu and pneumonia. Hepatitis B and other vaccines 20% coinsurance subject to the deductible

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This is not a contract. It is intended to highlight the coverage of this plan. Benefits are determined by the terms of the Evidence of Coverage (contract). All benefits are subject to medical necessity.

A nonprofit independent licensee of the BlueCross BlueShield Association

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Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Preventive mammography	Covered in full for preventive mammography, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Pap smear/pelvic exam	Covered in full, limited to one every 24 months	20% coinsurance, subject to the deductible, limited to one per year
Routine GYN exam	Covered in full, limited to one every 24 months	$25 copay, limited to one per year
Prostate cancer screening	Covered in full, limited to one per year	20% coinsurance, subject to the deductible, limited to one per year
Bone density screening	Covered in full, limited to one every 24 months	20% coinsurance, subject to the deductible, limited to one per year
Colorectal screening	Covered in full for preventive colonoscopies, limited to one every 24 months	20% coinsurance, subject to the deductible, limited to one per year
Smoking cessation	Covered in full	$25 copay
Routine hearing exam	$0 copay, limited to one exam per year. Must use a TruHearing Provider.	$0 copay, limited to one exam per year. Must use a TruHearing Provider.
Hearing Aid(s)	$699 Copay for Advanced Hearing Aids or $999 Copay for Premium Hearing Aids. Limit of 2 per year. Must use a TruHearing Provider. TruHearing Copays are not included in the Out of Pocket Maximum.	
Routine vision exam	$15 copay per visit, limited to one exam per year	$25 copay, limited to one exam per year
Eyewear allowance	$100 allowance available once every calendar year.	
Inpatient hospital benefits		
Hospital benefits	$250 copay per admission for unlimited days (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission, unlimited days
In-Hospital Physician Visits	Covered in full	20% coinsurance, subject to the deductible
Anesthesia	Covered in full	20% coinsurance, subject to the deductible
Inpatient chemical dependence	$250 copay per admission (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission
Inpatient mental health care	$250 copay per admission (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission
Skilled nursing facility		

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Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Skilled nursing facility (3 day inpatient stay is not required)	$0 copay per day, days 1-20. $188 copay per day, days 21-100. Not covered, days 101 and beyond	50% coinsurance, subject to the deductible, days 1-100. Not covered, days 101 and beyond
Emergency care		
Emergency room care (covered worldwide)	$65 copay per visit; unless admitted within 23 hours	$65 copay per visit; unless admitted within 23 hours
Urgent care (covered worldwide)	$15 copay	$15 copay
Ambulance	$65 copay	$65 copay
Outpatient benefits		
Surgical care	$50 copay	20% coinsurance, subject to the deductible
Ambulatory surgical center	$50 copay	20% coinsurance, subject to the deductible
Hospital Observation Stay	$50 copay	20% coinsurance, subject to deductible
Office surgery	$15 copay if performed in PCP office, $15 copay if performed in specialist office	$25 copay if performed in PCP office, $25 copay if performed in specialist office
Diagnostic tests and laboratory services	Covered in full	20% coinsurance, subject to the deductible
X-rays (film) and radiation therapy	$15 copay	20% coinsurance, subject to the deductible
Advanced Diagnostic Imaging (MRI, MRA, CT, PET, etc)	$15 copay	20% coinsurance, subject to the deductible
Chemotherapy	$15 copay	20% coinsurance, subject to the deductible
Outpatient mental health care	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Partial hospitalization	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Outpatient chemical dependence care	20% coinsurance, unlimited visits	20% coinsurance, subject to the deductible
Other services		
Rehabilitative therapy (physical, occupational and speech)	$15 copay	$25 copay
Cardiac rehabilitation	$15 copay	$25 copay

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Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Telehealth	MDLive Provider: $15 copay Behavioral Health Provider:$15 copay Additional Telehealth Services: follows in-person copay	Not Covered
Acupuncture	50% coinsurance, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis	50% coinsurance, up to 20 visits per year for chronic lower back pain and 10 additional visits for any other diagnosis
Medicare Part B drugs including chemotherapy drugs	20% coinsurance	20% coinsurance, subject to the deductible
Diabetic education	Covered in full	$25 copay
Diabetic supplies	Meters and test strips: $5 copay per 30 day supply, from a preferred manufacturer	20% coinsurance, subject to the deductible
Durable medical equipment	20% coinsurance	20% coinsurance, subject to the deductible
Prosthetic devices	20% coinsurance	20% coinsurance, subject to the deductible
Home care	Covered in full	20% coinsurance, subject to the deductible
Hospice	Covered by Original Medicare	Covered by Original Medicare
Kidney dialysis	Covered in full	Covered in full

In Process

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Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Prescription drugs		
Prescription drug coverage	Prior Authorization and Step Therapy apply. Quantity Limits Apply. Deductible: $0 Initial Coverage: up to $4,430 in covered drugs 30 day supply: $10/$25/$40 90 day supply: Subject to 3 times the copay Coverage Gap: up to $7,050 out-of-pocket 30 day supply: $10/$25/$40 90 day supply: Subject to 3 times the copay Coverage for generic drugs is provided by the Part D plan. Coverage for brand name drugs is provided by a wraparound group health plan. Catastrophic Coverage: The member pays the greater of $3.95 copay for generic and a $9.85 copay for all other drugs, or 5% coinsurance.	Covered at in-network cost sharing in emergency situations only.

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. Medicare Blue PPO Copay Plan

Quote Effective: 01/01/2022	Rating Region: CNY/Utica
Plan Cycle: Calendar Year	Rate Type: Small Group

Plan Feature Highlights	Medicare Blue PPO Copay Plan	
Type of Care/Plan Benefits	**In-Network**	**Out-of-Network**
Office visit copay (PCP)	$15 copay	$25 copay
Office visit copay (Specialist)	$15 copay	$25 copay
Hospital benefits	$250 copay per admission for unlimited days (maximum 3 copays per year)	20% coinsurance, subject to the deductible per admission, unlimited days
Emergency room care	$65 copay per visit unless admitted within 23 hours. Covered worldwide.	
Urgent care	$15 copay In-Network. Covered worldwide.	
Out-of-network benefits	Benefits are available, but additional costs may apply	
Prescription drugs	$10/$25/$40 Subject to 3 times the copay for a 90 day supply	Covered at in-network cost sharing in emergency situations only.
Eyewear allowance	$100 eyewear allowance available once every calendar year	
Annual deductible	None	$250
Annual out-of-pocket maximum (medical services only)	$1,250 in network	$8,000 combined in-network and out-of-network annual out-of-pocket maximum
Lifestyle and wellness benefits	Silver&Fit® fitness program, Blue365: Exclusive discounts on health-related products and services	

In Process

Proposed Rate	
1 Tier	$408.01

NOTE: Rate is subject to New York State Department of Financial Services approval of employer group prescription drug plans.

By signing this rate quote, the employer group agrees to the following:

Compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for Uniform Premium waivers in relation to premiums charged to our group plan participants. The employer group plan sponsor cannot charge participants covered under this plan an amount greater than the standard Medicare Part D beneficiary premium plus up to 100% of the value of any supplement prescription drug coverage.

Administration of any Low Income Subsidy (LIS) premium payments received for plan participants in accordance with CMS regulations (any LIS premium payments we receive from CMS for plan participants will be passed through to the employer group).

Compliance with alternative disclosure requirements under ERISA, including Summary Plan descriptions of benefit offerings to participants covered under this plan.

Qualification as an employer group under standard underwriting guidelines. The employer group plan sponsor must operate in the plan service area, offer active employees a benefit offering (no retiree only groups), have 2 or more employees, contribute to the premium and not be a Chamber, Trust or Association.

This is not a contract. It is intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. All benefits are subject to medical necessity.

Quoted premium rates contain a factor for broker commissions included in the overall retention load. The Sales Representative providing this quote is a New York State licensed insurance producer. The individual will be compensated in part based on this sale. The amount of compensation is based on a number of factors, including the contract selected and the volume of sales. You may request information about the expected compensation from your Sales Representative.

Signature: __________________________ Title: _______________________ Date: ___________
(Group Representative)

Quote Effective Date: 01/01/2022

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List of Products and Forms

The **Medicare Blue PPO** Certificates consists of the following subscriber contracts, certificates, riders, and/or endorsements (form numbers and/or descriptions, including variables):

MBP PPO Small Group Plan 1	
MCC-131AY22	Evidence of Coverage: Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Medicare Blue PPO (PPO)
MBPS1S22Y22	Annual Notice of Changes for 2022
XX4	Privacy Notice: How Medical Information May Be Used And Disclosed And How To Get Access To This Information
B-5606	Notice of Nondiscrimination

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ADDENDUM TO
MASTER GROUP AGREEMENT

BETWEEN

EXCELLUS HEALTH PLAN, INC., DOING BUSINESS AS
EXCELLUS BLUECROSS BLUESHIELD
("Health Plan")

AND

TOWN OF ULYSSES
("Plan Sponsor")

This is the record of an addendum (the "Addendum") made effective January 1, 2022, ("the Effective Date") between Health Plan , with offices located at 165 Court Street, Rochester, NY 14647, and Plan Sponsor, with offices located at 10 Elm Street, Trumansburg, New York 14886.

Section 1 - Recitals

In Process

1.1 Health Plan and Plan Sponsor have entered into an agreement (the "Contract") to provide certain

☒ health care benefits to Plan Sponsor's employees or members or

☐ health care claims processing and other services to Sponsor.

1.2 This Addendum amends the Contract to set forth the terms and conditions on which Health Plan will provide a Medicare Part D prescription drug plan ("MA-PD" or "PDP") to certain of Plan Sponsor's Medicare-eligible members and their Medicare-eligible dependents (each a "Member", collectively, "Members").

1.3 All of the terms and conditions of the Contract to which this Addendum is attached also apply to this Addendum, except where they are specifically changed by this Addendum.

Section 2 - Definitions

2.1 **"Benefits"** means the Part D and non-Part D drugs available under the MA-PD or PDP.

2.2 **"CMS"** means the Centers for Medicare and Medicaid Services.

2.3 "**CMS Enrollment and Disenrollment Guidance**" means Chapter 2 of the Medicare Managed Care Manual (CMS Pub.# 100-16) and Chapter 3 of the Medicare Prescription Drug Benefit Manual (CMS Pub. #100-18).

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

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2.5 **"Late Enrollment Penalty"** Under Section §1860D-13(b) of the Social Security Act, and 42 CFR §423.46 423.56(g), Medicare beneficiaries may incur a late enrollment penalty (LEP) if there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage.

2.6 **"Low Income Subsidy"** provides assistance to certain low-income individuals to supplement the premiums and cost-sharing (including deductibles and cost-sharing during the coverage gap) associated with the Part D benefit.

2.7 **"Part D drug"** has the same meaning as in 42 C.F.R. Section 423.882.

2.8 **"Part D Eligible Individual"** means a Member who is entitled to Medicare benefits under Part A and/or enrolled in Medicare Part B, who lives in a region served by Health Plan's PDP and who is a retiree, or a Medicare-eligible dependent of a retiree.

2.9 **"Rebates"** means any manufacturer discounts, charge-backs, rebates, and similar price concessions attributable to drugs covered under the PDP.

In Process

Section 3 – Benefits

3.1 **Provision of Benefits.** Health Plan will provide the Benefits to Members designated by Plan Sponsor as set forth in Section 5.

3.2 **Evidence of Coverage.** The Benefits that Health Plan will provide under this Addendum, including limitations and exclusions, are described in the Evidence of Coverage ("EOC") provided to the Member. If any provision of this Addendum conflicts with any provision of the EOC, this Addendum controls.

Section 4 – Fees

4.1 **Payments to Health Plan.** Plan Sponsor will make payment to Health Plan in accordance with one of the following options:

☒ Plan Sponsor will pay premiums to Health Plan as set forth in the Contract in order to secure the Benefits for Members; or

☐ Health Plan will process claims for Benefits and provide other administrative services and Sponsor will reimburse Health Plan for such services as set forth in the Contract.

4.2 **Plan Sponsor Contributions to Member Premium.**

Plan Sponsor may determine how much of a Member's Medicare Part C and/or Part D monthly beneficiary premium it will subsidize, subject to certain restrictions as set forth below:

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a. Plan Sponsor may subsidize different amounts for different classes of members in the employer sponsored MA-PD or Part D plan; provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

b. Plan Sponsor may not vary the premium subsidy for individuals within a given class of members.

c. Plan Sponsor may not charge a Member for prescription drug coverage provided under the MA-PD or Part D plan more than the sum of his/her monthly beneficiary premium attributable to basic prescription drug coverage plus 100% of the monthly beneficiary premium attributable to his/her non-Medicare Part D benefits (if any). Plan Sponsor must pass through direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or, in those instances where the enrollee pays premiums on behalf of an eligible spouse or dependent, the amount paid by the enrollee on behalf of the spouse or dependent).

d. Plan Sponsor cannot charge an enrollee for Part C coverage provided under the MA-PD more than the sum of his or her monthly beneficiary premium attributable to basic benefits provided under the plan as defined in 42 CFR 422.2 (i.e., all Medicare-covered benefits, except hospice services) and 100% of the monthly beneficiary premium attributed to his or her non-Medicare Part C benefits (if any). Health Plan must pass through the monthly payments described under 42 CFR 422.304(a) received from CMS to reduce the amount that the Member pays.

In Process

4.3 <u>Low-Income Subsidy Pass Through</u>.

a. To the extent required by federal law and regulation, Health Plan will pass through low income premium subsidies it receives from CMS to offset the payments described above. Plan Sponsor agrees that Low Income premium subsidy payments for an eligible Member that are passed through to Plan Sponsor will be used first to reduce the portion of any monthly premium payable by the Member, with any remainder then used to reduce Plan Sponsor's payments. Plan Sponsor further agrees that the amount of the LIS refund may not exceed the amount of the monthly premium contribution by the Member and/or the Plan Sponsor. Any amount in excess must be returned to CMS. Plan Sponsor may reduce up-front the MA-PD or PDP premium contribution required for the Member eligible for the low income subsidy. In those instances where Plan Sponsor is not able to reduce up-front the MA-PD or PDP premiums paid by the Member, Plan Sponsor shall directly refund to the Member the amount of the low-income premium subsidy, up to the MA-PD or PDP monthly premium contribution previously collected from the Member. Plan Sponsor must complete the refund within forty-five (45) days of the date that Health Plan receives from CMS the low-income premium subsidy amount paid for the low-income subsidy Member. Plan Sponsor shall retain and provide on request to Health Plan

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documents evidencing that low-income premium subsidy amounts were properly passed through or refunded by Plan Sponsor.

☒ Insured Financial Arrangements – Health Plan will pass through to Plan Sponsor, in the form of reduced monthly premiums, low income premium subsidy payments received from CMS on behalf of any Member.

☐ ASC or ASO Billing Arrangements – Health Plan will issue a check to Plan Sponsor by the last day of the month for the prior month's actual low income premium subsidy payments received from CMS on behalf of any Member.

b. Health Plan will provide the information necessary for Plan Sponsor to satisfy its obligation to refund its low-income subsidy beneficiaries within the required period. By the last day of the month, depending upon the structure of Plan Sponsor's funding arrangement with Heath Plan, Health Plan will either (i) communicate the necessary information via the Plan Sponsor's monthly invoice; or (ii) provide through a secure transmission method, the following data elements for each low-income subsidy beneficiary, for the prior month's payments:

- Subscriber Identification Number
- Medicare Beneficiary Identifier (MBI)
- Last Name of LIS beneficiary
- First Name of LIS beneficiary
- Date of Birth of LIS beneficiary
- LIS start date
- LIS end date
- LIS beneficiary cost sharing
- LIS beneficiary premium subsidy amount (This data element is not provided to claims based billing plan sponsors)

In Process

c. Health Plan will use its best efforts to meet the timelines set forth above, subject to variability based on actions by CMS, quality of data, and other related factors; except, however, that under no circumstances will actual timelines exceed those required by applicable federal law and regulation.

d. Plan Sponsor agrees that if the low income premium subsidy amount for which a Member is eligible is less than the portion of the Part D monthly beneficiary premium paid by the Member, then the Plan Sponsor shall communicate to the Member the financial consequences of the low-income subsidy eligible individual enrolling in the Plan Sponsor's group MA-PD or PDP as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low income premium subsidy amount.

4.4 Late Enrollment Penalty. Health Plan will bill Plan Sponsor for any applicable late enrollment penalty ("LEP") incurred by Members, and Plan Sponsor is responsible for paying the LEP incurred by its Members. Plan Sponsor may only bill to Members the actual LEP that Health Plan bills to Plan Sponsor.

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Section 5 – Responsibilities of Employer

5.1 **Responsibility for Determining Eligibility.** Plan Sponsor, in consultation with Health Plan if appropriate and requested by Plan Sponsor, shall be solely responsible for determining whether a Member is a Part D eligible individual.

5.2 **Member Data.** Plan Sponsor will submit complete and accurate member enrollment and disenrollment elections in accordance with the CMS Enrollment and Disenrollment Guidance and Section 6 of this Agreement.

5.3 **Compliance with Laws and Regulations.** Plan Sponsor shall be responsible for complying with all applicable CMS laws and regulations pertaining to its involvement in a MA-PD or PDP.

Section 6 Enrollment and Disenrollment

6.1 **Enrollment Requirements.** Plan Sponsor and Health Plan agree to work cooperatively to ensure that Group MA-PD or PDP enrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance, as amended. If Plan Sponsor elects to use the group enrollment process, Health Plan and Plan Sponsor will mutually determine and document which party is responsible for providing CMS-required notices to Members.

In Process

6.2 **Enrollment**. Plan Sponsor agrees that eligible individuals can enroll directly with Health Plan by using the enrollment mechanisms available to individuals or may be enrolled using a Group enrollment process as allowed by CMS. In order to use the Group enrollment process, Plan Sponsor must:

a. Provide Health Plan with any information Plan Sponsor has on a Member's other insurance coverage for the purposes of coordination of benefits.

b. Provide Health Plan with information on a Member's creditable coverage history for purposes of CMS assessing any late enrollment penalty.

c. Notify each Member as follows:

1) Each Member must be notified in advance that Plan Sponsor intends to enroll them in a MA-PD or PDP that Plan Sponsor is offering; and that the Member may affirmatively opt out of such enrollment, explaining the process to opt out, and any consequences to employer or union benefits opting out would bring.

2) This notice must be provided by Plan Sponsor not less than 21 calendar days prior to the effective date of the Member's enrollment in the Plan Sponsor's MA-PD or PDP.

3) Additionally, the information provided must include a Summary of Benefits offered under the MA-PD or PDP, an explanation of how to get more

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information about the MA-PD or PDP, and an explanation on how to contact Medicare for information on other Medicare or Part D options that might be available to the Member.

4) For PDPs, each Member must also receive the information on Page 3 of Exhibit 1 of Chapter 3 of the Medicare Prescription Drug Benefit Manual (CMS Pub. #100-18) (as amended). For MA-PDs each Member must receive the information currently contained in Exhibit 2 of Chapter 2 of the Medicare Managed Care Manual (CMS Pub.# 100-16) (as amended) under the heading "Please Read & Sign Below."

5) Plan Sponsor agrees to ensure all of the notice requirements set forth in this section 5.2(c) are met prior to submission of the enrollment transactions to CMS.

d. Provide Health Plan with all the information required for Health Plan to submit a complete enrollment request transaction to CMS.

e. Plan Sponsor must maintain a copy of the advance notice provided to Members, the list of Members that received the advance notice, and any opt-out requests for the current contract period and for a ten (10) year period thereafter.

In Process

6.3 **Data Provided to Health Plan to Facilitate Enrollment**. Plan Sponsor recognizes that particular data elements must be provided to Health Plan in order to facilitate enrollment in the Group MA-PD or PDP. Plan Sponsor will be responsible for providing this data prior to the effective date of the Member's enrollment. These elements will be set forth in the Group OEC template, which Health Plan shall provide to Plan Sponsor, along with guidance for Plan Sponsor to follow. Failure to provide required data in a timely manner may result in a delay of a Member's effective date in the Group MAPD or PDP.

6.4 **Disenrollment**. In certain circumstances, a Member may be disenrolled on either a voluntary or involuntary basis. Plan Sponsor and Health Plan will work cooperatively to ensure that Member disenrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance. At a minimum, disenrollments will be conducted in accordance with one of the following procedures:

a. For voluntary disenrollments and for involuntary disenrollments other than those described in b. below, Health Plan will process the disenrollment under the individual disenrollment requirements specified in the CMS Enrollment and Disenrollment Guidance. If eligible, the Member may elect to become a member of an Individual MA-PD or PDP offered by Health Plan.

b. For involuntary disenrollments that occur when Plan Sponsor determines that a Member is no longer eligible to participate in the Group MA-PD or PDP, or when Health Plan or Plan Sponsor terminates this Contract, Plan Sponsor and Health Plan agree that the Member will be disenrolled from Health Plan. Plan Sponsor must submit

documentation to Health Plan that Plan Sponsor provided members with prospective notices no later than 21 calendar days prior to the effective date of the disenrollment. Alternately, Plan Sponsor may request that Health Plan provide members with such notice. Any such, notice, whether provided by Plan Sponsor or Health Plan, shall include information for the Member to contact Medicare regarding other plan options that may be available to the Member.

1) Plan Sponsor agrees that, prior to the effective date of disenrollment, it will provide a prospective notice of the termination event to Health Plan. This notice must be sent no later than 30 days prior to the effective date of disenrollment.

2) Health Plan agrees that it shall provide to the affected Member(s), no later than 21 calendar days prior to the effective date of enrollment in the individual plan, notice alerting the Member that his/her plan is changing, including information about how to contact Medicare regarding other plan options that may be available to the Member.

Section 7 – Prescription Drug Rebates

7.1 Health Plan conducts various utilization management activities designed to ensure appropriate prescription drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, Plan Sponsor and Members benefit by obtaining appropriate prescription drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the premiums for coverage.

In Process

7.2 From time to time, Health Plan enters into agreements with pharmacy benefit managers, manufacturers of prescription drugs, prescription drug distributors or other entities (collectively, "Vendor"), which result in Health Plan receiving rebates for prescription drugs.

7.3 Rebates are based upon utilization of prescription drugs across all of the Health Plan's business and not solely on a covered person's or group's utilization of prescription drugs. Any rebates received by Health Plan may or may not be applied, in whole or in part, to reduce premiums or administrative expenses. Rebates may be retained by Health Plan at its discretion, in whole or in part, in order to fund such activities as negotiating and administering rebate arrangements, retail pharmacy audits, new utilization management activities, community benefit activities, and increasing reserves for the protection of covered persons.

7.4 Plan Sponsor will obtain the benefit of the prescription drug rebates as set forth in the Contract, but only to the extent consistent with Health Plan's agreement with CMS and as otherwise permitted by federal law and regulation in connection with a MA-PD or PDP.

Section 8 – Audits

8.1 **Audit Procedure.** At any time during the term of this Addendum, for ten years after termination of the Addendum, and as otherwise permitted by federal law or regulation,

the Department of Health and Human Services, the Office of the Inspector General, CMS, or their designees may conduct audits of Health Plan's provision of services and performance under this Addendum. Plan Sponsor shall cooperate with Health Plan, at no cost to Health Plan, in its response to any audits by providing reasonable and timely access to its premises and such data and other information as may be requested by Health Plan or the party conducting the audit.

Section 9 – Term, Termination, and Services Following Termination

9.1 **Term.** The term of this Addendum will commence on the Effective Date and will continue for a period of one year, unless earlier terminated in accordance with the terms of the Contract or Section 9.4 below.

9. 2 **Termination Based on Termination of Health Plan's Agreement with CMS.** Health Plan may terminate this Addendum upon 30 days' prior written notice to Plan Sponsor following the termination of Health Plan's agreement with CMS to provide a PDP.

9.3 **Termination Based on Termination of the Contract.** This Addendum will terminate automatically upon termination of the Contract.

In Progess

9.4 **Termination of the Addendum.** Either party may terminate this Addendum in its entirety, without terminating the Contract, upon 60 days' prior written notice to the other party.

9.5 **Termination for Breach.** In the event of a material breach by either party, this Addendum may be terminated in accordance with the termination provisions of the Contract.

9.4 **Transition requirements.**

a. If this Addendum is terminated by either party for any reason other than as the result of a material breach of this Addendum by a party, the parties agree to take the following actions to minimize disruption to both parties and Members:

i. Transition plan. The parties will develop and implement a detailed plan for transitioning the services described in this Addendum and both parties will cooperate fully to arrange for the transfer of services to Plan Sponsor's designee.

ii. Transition period. Health Plan will continue to provide services in accordance with this Addendum for a reasonable transition period (the "Transition Period"). The transition period will not exceed 60 days from the date of notice of termination. Except as otherwise provided in this Addendum, the terms and conditions of this Addendum will apply during the transition period.

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iii. Prompt payment. The parties will take reasonable steps to ensure that any payments due under this Addendum will be made promptly following termination of this Addendum, including, without limitation, any amounts due to Health Plan for services performed during the Transition Period which will be paid at the rates set forth in the Contract. Termination of this Addendum will not terminate the rights or liabilities of either party arising out of the period prior to the effective date of the termination.

iv. Post-transition reporting. Health Plan will provide Plan Sponsor with such information as is reasonably necessary to facilitate the provision of prescription drug benefits to the successor designated by Plan Sponsor.

Section 10 - Indemnification

10.1 Indemnification by Plan Sponsor. Plan Sponsor agrees to indemnify, defend (at Health Plan's request) and hold harmless Health Plan and its agents, officers, employees, directors and subcontractors, against any loss, cost, suit, claim, damage, liability or expense, including reasonable attorneys' fees, arising from any inaccurate or incomplete data provided to Health Plan, arising out of the negligence, intentional act or omission, or willful misconduct of Plan Sponsor, its directors, officers, employees, agents, or assigns, including without limitation any unlawful or unauthorized use or disclosure of information pertaining to a Member.

In Process

10.2 Indemnification by Health Plan. Health Plan agrees to indemnify, defend (at Sponsor's request) and hold harmless Plan Sponsor and its agents, officers, employees, directors and subcontractors, against any loss, cost, suit, claim, damage, liability or expense, including reasonable attorneys' fees, arising out of the negligence, intentional act or omission, or willful misconduct of Health Plan, its directors, officers, employees, agents, or assigns, including without limitation any unlawful or unauthorized use or disclosure of information pertaining to a Member.

Section 11 - Standard of Care, Cooperation and Regulatory Changes

11.1 Standard of Care. The parties recognize that because the Medicare Part D program continues to evolve, CMS requirements and procedures may not be fully defined and developed, and that subsequent administrative guidance or requirements from CMS may materially alter the scope of services or manner in which the services contemplated by this Addendum are to be provided. In light of these factors, Health Plan will make a good faith effort to compile and provide complete and accurate information in accordance with its best understanding and interpretation of Medicare Part D requirements.

11.2 Third Party Data. In satisfying its obligations under this Addendum, Health Plan may utilize and/or obtain and/or provide data that is developed and maintained by third parties with which it contracts. By obtaining this data from a third party source, Health Plan

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does not warrant and/or assume responsibility for the accuracy of such data. In addition, Health Plan may obtain or use data or information provided by Sponsor or third parties not contracted by Plan Sponsor. Health Plan does not warrant and/or assume responsibility for the accuracy of any data provided by Plan Sponsor or any third party not contracted by Health Plan.

11.3 **Cooperation.** The parties recognize that they must mutually cooperate to perform the services required under this Addendum, and that Health Plan is not responsible for any failure to complete any tasks or obligations described in this Addendum because Plan Sponsor, or any third party contracted by Plan Sponsor, failed to meet its obligations, including providing required data.

11.4 **Regulatory changes.** If either party believes that subsequent guidance or requirements from CMS has materially altered the scope of services or manner in which the services contemplated by this Addendum are to be provided, or that any provision of this Addendum is inconsistent with Medicare Part D requirements, that party shall promptly notify the other party in writing, and the parties shall negotiate to amend this Addendum.

Section 12 – Retention of Records

In Process

12.1 Health Plan and Plan Sponsor shall maintain all records required by 42 C.F.R §423.505(d) for a period not less than ten (10) years after the expiration of the MA-PD or PDP year in which Part D drug costs were incurred or an audit was conducted, or as otherwise required by law.

Section 13 – HIPAA Compliance

13.1 The parties acknowledge and agree that this Addendum involves the use and disclosure of Protected Health Information, as that term is defined in the HIPAA Privacy Regulations. The parties therefore agree that all uses and disclosures of Protected Health Information pursuant to this Addendum will be undertaken in compliance with all applicable HIPAA requirements.

Section 14 – General Provisions

14.1 **Assignment.** This Addendum may not be assigned by either party to an unrelated third party without the prior written consent of the other party.

14.2 **Subcontracting.** The parties acknowledge and agree that Health Plan may use subcontractors to perform some or all of the services described in this Addendum.

14.3 **No Third Party Beneficiary.** Nothing in this Addendum is intended to create, or will be deemed or construed to create, any rights or remedies in any third party including, without limitation, any Members.

14.4 **Severability.** If any provision of this Addendum is rendered invalid or unenforceable by any local, State, or federal law, rule or regulation, or declared null and void by any court

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of competent jurisdiction, the remainder of this Addendum will remain in full force and effect.

14.5 **Force Majeure.** Neither Health Plan nor Plan Sponsor will be liable for its failure to perform any obligation under this Addendum because of contingencies beyond its reasonable control, including but not limited to strikes (other than strikes within such party's own labor force), riots, war, fire, acts of God, disruption or failure of electronic or mechanical equipment or communication lines, telephone or other interconnections, unauthorized access, theft, or acts in compliance with any law or government regulation. If a party's failure to perform continues for more than twenty (20) business days, the other party will have the right to terminate this Addendum immediately.

14.6 **Headings.** The headings in this Addendum have been included solely for reference and are to have no force or effect in interpreting its provisions.

14.7 **Counterparts.** This Addendum may be executed in counterparts, any of which need not contain the signature of more than one party, but all of which taken together, will be one and the same agreement.

14.8 **Survival.** The provisions of Sections 7, 8, 9, 10, and 11 will survive the expiration or termination of this Addendum for any reason.

In Process

14.9 **Conflicts with Contract.** If any provision of this Addendum conflicts with the Contract, the terms of this Addendum shall control

IN WITNESS WHEREOF, the parties have executed this Addendum.

Excellus Health Plan, Inc. d/b/a Excellus BlueCross BlueShield	**Town of Ulysses**
BY: ______________________________	BY: ______________________________
TITLE: ____________________________	TITLE: ____________________________
DATE: ____________________________	DATE: ____________________________

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MASTER GROUP AGREEMENT

BETWEEN

EXCELLUS HEALTH PLAN, INC., DOING BUSINESS AS EXCELLUS BLUECROSS BLUESHIELD (the "Plan")

AND

TOWN OF ULYSSES ("Group")

This is the record of a group contract ("Master Group Agreement" or "Agreement") made effective January 1, 2022. between the Plan, with offices located at 165 Court Street, Rochester, New York 14647 and Group, with offices located at 10 Elm Street, Trumansburg, New York 14886. The Plan is a nonprofit independent licensee of the BlueCross BlueShield Association.

In Process

1. **<u>Purpose</u>.** This Agreement sets forth the terms and conditions on which the Plan will issue to Group certain health benefits certificates and/or riders for the benefit of Group's employees, and/or members and/or (if applicable) retirees; and/or (if applicable) employees or members and/or (if applicable) retirees of Group's member firms or participants (collectively, as applicable, "Group Members").

2. **<u>Term of Agreement; Renewal</u>.** This Agreement and the coverage to be provided pursuant to it will be effective on the date set forth above, provided that the Group meets all underwriting criteria, and the first premium has been paid to the Plan by the effective date. The Agreement and coverage will continue for the period specified in the attached Premium Rate Schedule (the "Initial Term"), unless earlier terminated as provided below. The Agreement will automatically be renewed for successive one year renewal terms (each a "Renewal Term") on each subsequent anniversary of the effective date, unless earlier terminated as provided below.

3. **<u>Benefits</u>.**

   a. Certificate. The Plan will provide group health care benefits (the "Benefits") to Group Members and their eligible dependents in the classification(s) specified in the association, trust fund, or employer agreement between the Plan and Group. The Benefits that the Plan will provide under this Agreement, including limitations and exclusions, are described in the Certificate of Coverage(s), including the Schedule of Benefit(s), and Riders(s), if any (collectively, the "Certificate") that are identified on the attached List of Products and Forms and made a part of this Agreement. If any provision of this Agreement conflicts with any provision of the Certificate, this Agreement controls.

   b. Changes in the Certificate. The Plan may unilaterally change the Certificate upon renewal, if the Plan gives Group 45 days' prior written notice. Upon receipt of notice of a change in the Certificate, Group will be deemed to have accepted the change unless Group provides written notice to the Plan, as set forth in the "Termination" section of this Agreement and in the Certificate, of its intention to terminate this Agreement.

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4. **COBRA Administration.** If not already provided by another administrator, the Plan will provide services related to the continuation of coverage provisions applicable to the Certificate pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), applicable state group health continuation coverage laws ("State Continuation Coverage") and the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), as applicable. As used in this Agreement: the general term "Continuation Coverage" refers to COBRA, State Continuation Coverage, and USERRA; the term "qualified beneficiary" refers to any person entitled to elect continued group health coverage under any such law; and the term "qualifying event" refers to an event which entitles such person to elect continued group health coverage under any such law; unless the context indicates otherwise.

   a. Reports. Upon request from Group and pursuant to reasonable instructions provided by Group, the Plan shall make available to Group any reports necessary for Group to calculate and pay all taxes and fees applicable to Comparative Effectiveness Research (CER), the Patient-Centered Outcomes Research Institute, or similar initiatives that require counts of covered persons. Group will also be granted access to the reporting information on the Plan's employer portal and described herein.

   b. Notification and Election Procedures. The Plan will adhere to the following procedures to facilitate the proper administration of Continuation Coverage on behalf of Group.

      i. Upon the occurrence of each qualifying event as determined by Group consisting of the divorce or legal separation of an employee, or a child's loss of dependent status under the Plan, Group will notify the Plan of the qualifying event in writing at the address designated by the Plan by completing and submitting to the Plan a qualifying event fact sheet supplied to Group by the Plan or information entered into the Plan system via the employer portal. The qualifying event fact sheet/file/information must be submitted to the Plan within thirty (30) days after the earlier of receipt by Group of notification of the event or the date Group becomes aware (or should have become aware) of the event. Group will also provide to the Plan all information and data needed for the Plan to notify the qualified beneficiary of his or her rights and obligations under Continuation Coverage.

      ii. Upon the occurrence of each qualifying event consisting of the termination or reduction in hours of an employee's employment, or an employee's entitlement to Medicare benefits, the death of an employee, or military service that is subject to USERRA Group will timely notify the Plan of each qualifying event, and the Plan will notify each qualified beneficiary of his or her right to elect Continuation Coverage.

      iii. The Plan will program into its computer system all pertinent information and data supplied by Group for purposes of Continuation Coverage notification and will provide, within fourteen (14) days of receipt of the data a Continuation Coverage notification and election form to each qualified beneficiary either by first-class mail or by certified mail, return receipt requested, at the option of Group.

      iv. If the Plan does not receive a qualified beneficiary's completed notification and election form in a timely manner, or if a qualified beneficiary notes upon the form an intention to decline Continuation Coverage, the Plan shall, on the date of expiration of the sixty (60) day election period, close the file maintained by the Plan with respect to the qualified beneficiary.

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v. If a qualified beneficiary properly elects Continuation Coverage by submitting an appropriate notification and election form to the Plan within the sixty (60) day election period, the Plan will provide to the qualified beneficiary confirmation of the election to continue coverage, along with an invoice for Continuation Coverage premium(s) due from the date of termination of benefits under the Plan. The confirmation form utilized by the Plan will indicate the expiration date of the forty-five (45) day period for payment of the first premium(s), including any retroactive payments owed.

vi. Open Enrollment. The Plan will provide to Group, approximately ten (10) business days prior to the commencement of the open enrollment period, a list of names and addresses of all qualified beneficiaries covered under a Certificate. Group will then send annual election forms to each qualified beneficiary on the list. At the close of the open enrollment period, Group will notify the Plan of any changes in the coverage selected by the qualified beneficiaries.

vii. Group Obligations. Group will be responsible for complying with all federal or state law requirements, as applicable, that have not been specifically delegated to the Plan under this Agreement, and for determining whether an individual whose group health coverage under a Certificate would otherwise terminate is entitled to Continuation Coverage.

In Process

viii. Other Legal Requirements. Group will be solely responsible for complying with all applicable state law and federal law requirements relating to the timely notification of the exact dates of employment termination and termination of coverage in connection with any qualifying event. The Plan assumes no liability for such compliance or for compliance with any other legal requirements imposed upon Group now or in the future, except as specifically set forth in this Agreement.

ix. Conversion. At, or shortly before the end of the applicable maximum period for Continuation Coverage, the Plan will send to each qualified beneficiary a notice of the right to convert to a direct payment contract, if and as prescribed by applicable law, rule, or regulation.

x. Collection and Provision of Historical Data.

a) The Plan will monitor the status of all Continuation Coverage qualified beneficiaries covered under a Certificate, and will provide to each such qualified beneficiary, as prescribed by law, rule, or regulation, a notification and election form in the event of notification of any subsequent qualifying event by Group that may affect the qualified beneficiary's coverage under a Certificate.

b) Group will be granted access to the following monthly Continuation Coverage reporting information on the Plan's employer portal:

(i) the names of all Continuation Coverage enrollees with respect to whom any Continuation Coverage premium payments were received by the Plan in the preceding calendar month, and the amounts received;

(ii) the names of all qualified beneficiaries who elected to continue Continuation Coverage in the preceding calendar month, and the type of coverage selected; and

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(iii) the names of all qualified beneficiaries whose Continuation Coverage was terminated in the preceding calendar month, the reason for each termination of coverage, and a brief coverage history on each such qualified beneficiary (including all dates of events, notifications, and Continuation Coverage premium payments).

c) With respect to state continuation coverage and USERRA qualified beneficiaries, the Plan will monitor the status of the each such qualified beneficiary's coverage under the Certificate and will provide the services and information described in Subsections (a) and (b) above as agreed upon by Group and the Plan.

d) The Plan shall provide access to its employer portal without representation or warranty of any kind, and further, access to the Plan's employer portal is not represented or guaranteed to be error free or uninterrupted.

e) Group must provide written notification to the Plan of Group's employees that are to be granted access to the Plan's employer portal. In the event that there is a change to the list of employees granted access to the Plan's employer portal, Group must provide written notification to the Plan within 2 business days after the effective date of such change.

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5. **Premiums.** Group will pay premiums to the Plan to secure the Benefits for Group Members and their enrolled dependents.

a. Initial Premium Rates; Changes in Premium Rates. The initial premium rates are set out in the attached Premium Rate Schedule. The Plan's rating methodology includes factors for sales, general, and administrative expenses, one of which is a factor for broker commissions. The broker commission factor is mandatory; it shall apply to the calculation of rates without regard to whether a broker is used in the sale or renewal of an individual account's group health coverage. Changes in premium rates will be made as set forth on the attached Schedule of Changes in Premium Rates.

b. Payment of Premiums. All premium payments are due in advance. Group will be required to remit payment when the first bill is received. All subsequent premium payments must be paid on or before the due date; except that the Plan will allow Group a 30-day grace period after the due date for payment. Notwithstanding the preceding sentence, the grace period shall not apply if an authorization for payment (e.g., check or ACH authorization) has been returned or refused by Group's bank due to insufficient funds in the account on which the payment was drawn with respect to a billing period occurring (in whole or in part) during the 12 months preceding the failure to make timely payment.

c. Effect of Nonpayment.

i. If Group fails to pay the first premium payment due for the Benefits prior to the effective date, no coverage will be provided.

ii. If Group fails to pay any subsequent premium payment by the end of the grace period, the Plan may terminate the Agreement as set forth in the provision of the "Termination" section pertaining to default in the payment of premiums. In the event that the Plan terminates the Agreement for nonpayment of premiums:

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- the Plan will notify Group of its intention to terminate the Agreement for nonpayment of premiums, as set forth in the Agreement;
- the Plan will include, with its notice of termination, a written notice to Group regarding Group's obligations under Section 217 of the New York Labor Law, as required by Section 4235 of the New York Insurance Law; and
- Group will be responsible for the payment of all premiums owed to the Plan as of the date of termination, which will be the first day following the end of the period for which premiums were paid.

d. Cure of Default by Group. If, prior to the end of the grace period, Group pays all of the premiums owed to the Plan, this Agreement will not be terminated by the Plan for nonpayment of premiums.

6. <u>Delivery of Notices and Materials</u>. When notices or other materials (e.g., applications, identification cards, certificates and riders) are to be provided by the Plan to Group Members, the Plan may deliver them to Group, and Group will, in a timely manner, distribute them to the Group Members.

7. <u>Termination</u>.

a. By Group. This Agreement may be terminated by Group upon the provision of 30 days' advance written notice to the Plan.

In Process

b. By the Plan. At the option of the Plan, this Agreement may be terminated by the Plan as follows:

i. This Agreement may be terminated if Group has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid.

ii. This Agreement may be terminated if Group has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

iii. This Agreement may be terminated if Group has failed to comply with a material plan provision relating to employer contribution or group participation rules.

iv. This Agreement may be terminated if Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage.

v. This Agreement may be terminated 180 days from the date on which the Plan provides notice to Group, if the Plan withdraws from the applicable market through which Group obtained coverage under this Agreement;

vi. This Agreement may be terminated as of the date there is no longer any enrollee who lives, resides, or works in the Plan's Service Area.

vii. This Agreement may be terminated for any reason approved by the Superintendent of Financial Services and authorized by the Health Insurance Portability and Accountability Act of 1996, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

c. By the Superintendent. This Agreement will automatically terminate if the Superintendent of Financial Services of the State of New York informs the Plan that it may not participate in this Agreement.

d. Termination of Specific Certificates, Schedule of Benefits, and Riders. The Plan may terminate specific group certificates, include the schedule of benefits, and riders forming part of the Certificate, without regard to claims experience or health related status, 90 days from the date on which the Plan provides notice to Group, if the Plan terminates the entire class of contract to which such certificates, schedule of benefits, and riders belong.

8. Relationship of Parties. The parties to this Agreement are independent contractors and are not to be construed as having any other relationship, either with respect to this transaction or any other transaction between the parties. No party will have, or hold itself out as having, the power or authority to bind or create liability for the other by its intentional or negligent act or omission.

9. Notices. All notices and other communications given under this Agreement must be in writing and delivered personally, by established overnight courier or by first class mail, postage prepaid, to the addresses set forth at the beginning or to such other address as one party may provide to the other in writing. Notices and communications will be deemed received at the time of personal delivery (except that, if personal delivery occurs on a day other than a business day, the next business day will be deemed the date of receipt), one business day after shipping via overnight courier, and three business days after mailing.

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10. Jurisdiction; Venue. Jurisdiction of any litigation with respect to this Agreement will be in New York, with venue in a court of competent jurisdiction in Monroe County, Onondaga County, or Erie County.

11. Choice of Law. This Agreement will be governed by, and construed in accordance with, the laws of the State of New York.

12. Entire Agreement. This Agreement, including attached schedules (as they may be replaced or added from time to time) constitutes the entire agreement between the parties and supersedes any prior understandings or agreements with respect to the subject matter. No changes, additions or modifications to the terms of this Agreement will be made or binding, unless in writing and signed by both parties.

13. Right to Audit. The Plan will have the right to conduct random audits of Group, to verify that Group is in compliance with the underwriting rules of the Plan, any rules imposed upon the Plan by external agencies/entities with authority over the Plan, and/or applicable law and regulation. Group will be required to provide the Plan with any and all documentation needed to facilitate the audit.

14. The Plan Is Independent. Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the BlueCross BlueShield Association, an Association of independent Blue Cross and Blue Shield Plans, which licenses Excellus BlueCross BlueShield to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the BlueCross

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BlueShield Association. Excellus BlueCross BlueShield is solely responsible for the obligations created under this Agreement.

15. From time to time, the Plan enters into agreements with third party vendors to provide enhanced services in support of the administration of Group's Benefits, including but not limited to the prescription drug program or care management programs. The amount the Plan charges Group for the services will include the third party vendor's and the Plan's service fees, as well as any applicable commission payments.

16. Required Disclosure. The Plan is required to notify Group of the following:

> **Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and will also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.**

The parties' assent to the terms of this Agreement as of the date set forth at the beginning is established by their signatures below.

In Process

Dated: ________________________

Excellus Health Plan, Inc., d/b/a
Excellus BlueCross BlueShield

By: ______________________________

Title: ______________________________

Dated: ________________________

Town of Ulysses

By: ______________________________

Title: ______________________________

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SCHEDULE OF CHANGES IN PREMIUM RATES
Community-Rated, Rolling Rate

1. Changes in Premium upon Renewal.

   The premium rates for each Renewal Term of the Agreement will be provided to Group in a renewal rate notice, which will specify the effective date of the new rates.

2. Notice of Changes in Premium Rates. The Plan will not make any changes to the premium rates without giving Group at least 30 days' prior written notice. Upon receipt of notice of a change in the premium rates, Group will be deemed to have accepted the new rates, unless Group provides timely written notice to the Plan of its intention to terminate this Agreement or modify the Benefits.

3. Affected Products. The foregoing provisions apply to all contracts, certificates, riders, and/or endorsements forming part of the Certificate.

In Process

Rating Region: Syracuse

Version Updated: 09/30/2022

Package ID	DBOE-48-26/26	
Plan Name	**Dental Blue Options**	
Plan Type	PPO EmpSponsored	
Effective Date	1/1/2022 - 3/31/2022	
Rate ($)		
Single	$46.55	
Subscriber & Spouse	$93.09	
Subscriber & Child	$86.65	
Subscriber & Child(ren)	$86.65	
Family	$140.97	
Dental Plan Features		
Dependents and students	Qualified dependents and students are covered to age 26.	
Annual Deductible	$25 Single/$75 Family: applies to classes II, IIA and III	
Annual Maximum	$1,500 applies to classes II, IIA and III	
Annual Maximum Rollover	N/A	
Orthodontia Lifetime Maximum includes dependents to age 19	Not Covered	
Domestic partner	Covered	
Waiting periods & other limitations	Does not apply	
Network Benefits		
	In-Network	**Out Of Network**
In Area	Coverage provided through Excellus BlueShield dental provider network	Covered at fee schedule, subject to balance billing
Out of area	Coverage provided through National Dental Grid+ DenteMax provider network	Covered at fee schedule, subject to balance billing
Class I - Preventive		
Class I - Preventive	**In-Network**	**Out Of Network**
Class I - Coinsurance	Covered at 100%	Covered at 100%, subject to balance billing
Cleanings & exams	Covered at 100%	Covered at 100%, subject to balance billing
Fluoride treatments covered to age 16	Covered at 100%	Covered at 100%, subject to balance billing
Sealants	Covered at 100%	Covered at 100%, subject to balance billing
Bitewing x-rays	Covered at 100%	Covered at 100%, subject to balance billing
Full mouth and panorex x-rays	Covered at 100%	Covered at 100%, subject to balance billing

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Package ID	DBOE-48-26/26	
Plan Name	**Dental Blue Options**	
Space maintainers	Covered at 100%	Covered at 100%, subject to balance billing
Emergency palliative treatment	Covered at 100%	Covered at 100%, subject to balance billing
Dental Prophylaxis	Covered at 100%	Covered at 100%, subject to balance billing
Class II - Basic Restorative		
Class II - Basic Restorative	**In-Network**	**Out Of Network**
Class II - Coinsurance	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and balance billing
Fillings	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and balance billing
Simple Extraction Oral Surgery	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and balance billing
Class II A - Basic Restorative		
Class II A - Basic Restorative	**In-Network**	**Out Of Network**
Class II A - Coinsurance	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Oral surgery	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Endodontics	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Periodontal surgery	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Periodontal scaling and root planing	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Periodontal maintenance following surgery	Covered at 100%, subject to deductible	Covered at 100%, subject to deductible and subject to balance billing
Class III - Major Restorative		
Class III - Major Restorative	**In-Network**	**Out Of Network**
Class III - Coinsurance	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Fixed prosthetics	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Removable prosthetics	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Inlays / Onlays / Crowns	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Relines / rebases	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Implants	Covered at 80%, subject to deductible	Covered at 80%, subject to deductible and balance billing
Class IV - Orthodontia Group must have 5 contracts enrolled		
Class IV - Orthodontia Group must have 5 contracts enrolled	**In-Network**	**Out Of Network**
Class IV - Coinsurance	Not Covered	Not Covered
Braces	Not Covered	Not Covered

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This is not a contract or binding agreement, but a summary of benefits and services. You should rely on the subscriber contract as the complete description of member rights, responsibilities, benefits available under the benefit plan, and the definition of contract year as it applies to any benefit limitations. In the event of a dispute between this summary and your member contract, the member contract will prevail.

Certain services require pre-certification. Please refer to your contract for additional information regarding applicable services and penalties charged if pre-certification is not obtained.

For technical web issues please contact our Web Help Desk at 1-800-278-1247

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List of Products and Forms

The Certificates consists of the following subscriber contracts, certificates, riders, and/or endorsements (form numbers and/or descriptions, including variables):

Dental Blue Options	
EXDC-3 (Rev. 1)	Dental Blue Options Certificate of Coverage
EXDS-3 (Rev. 1)	Schedule of Benefits
EXHP-205	Domestic Partner Rider For California Residents
XX2	The New York Consumer Guide To Health Insurers
XX4	Privacy Notice: How Medical Information May Be Used And Disclosed And How To Get Access To This Information
B-5495	Notice of Nondiscrimination

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AGREEMENT

Between

Excellus Health Plan, Inc., Doing Business As
Excellus BlueCross BlueShield
(The "Plan")

And

Town of Ulysses
("Employer")

This is the record of an Agreement (the "Agreement") made effective January 1, 2022 between the Plan, with offices located at 165 Court Street, Rochester, New York 14647 and Employer, with offices located at 10 Elm Street, Trumansburg, New York 14886. The Plan is a nonprofit independent licensee of the BlueCross BlueShield Association.

1. **Purpose.** This Agreement establishes certain mutual obligations in connection with the Plan's issuance of one or more group and/or group remittance contracts to or through Employer for purposes of providing coverage to Employer's employees and their eligible dependents. All the terms and conditions of the group and/or group remittance contracts to which this Agreement attach also apply to this Agreement, except where they are specifically changed by this Agreement.

2. **Representations and Warranties of Employer.** Employer represents and warrants to the Plan at the time of execution of this Agreement and throughout the term of this Agreement as follows:

   a. If an organization, Employer is duly organized, validly existing and in good standing under the laws of the jurisdiction of its organization.

   b. Employer's documents required to be delivered to the Plan pursuant to paragraph 6 of this Agreement are accurate and complete;

   c. If Employer does not have 20 or more individuals in current employment status for each working day in each of 20 or more calendar weeks in the current and preceding calendar years, the group health plan maintained by Employer has taken the steps required to elect to have Medicare as primary payer for Medicare-eligible employees/members and their covered dependents;

   d. Employer has not denied and will not deny either individual participation or the Plan's coverage, directly or indirectly, based upon age, sex, health status, or occupation of any employee or any covered dependent;

   e. All employees of Employer, or all of any class or classes thereof determined by conditions pertaining to their employment or a combination of such conditions and

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conditions pertaining to family status, are eligible for coverage through Employer; and

f. The premiums for the coverage are paid by Employer, either from Employer's funds, or from amounts contributed by Employer's employees, or jointly from amounts contributed by Employer and the employees. If no amounts are contributed by the employees, then all employees (or all of any class or classes thereof determined by conditions pertaining to their employment or a combination of such conditions and conditions pertaining to family status) are covered at all times. If all or part of the premium is derived from amounts contributed by the employees, then at least the percentage of employees required by the Plan's minimum participation rules, which shall be at least 50% (or, if less, 50 of the employees) are covered at all times.

3. **Breach of Representations and Warranties.** Employer will defend with competent counsel, indemnify, and hold harmless the Plan and its directors, officers, employees, agents, successors, and assigns from and against any and all claims, demands, actions, suits and proceedings (whether civil, criminal or administrative), and all liability, loss, expense (including reasonable attorneys' fees), costs or damages, that result, directly or indirectly, from a breach of Employer's representations and warranties under this Agreement. Without limitation, Employer will reimburse the Plan for any expense or loss resulting from inaccurate eligibility information that is provided to the Plan by Employer.

In Progress

4. **Coverage and Termination of Individuals**.

a. Employer will be responsible for notifying the Plan when its employees and their eligible dependents are to become covered or are no longer to be covered by a Plan contract or certificate, in accordance with the requirements of the contract or certificate. The Plan will not be responsible for providing or terminating benefits, unless it receives notification from Employer within 30 days of the occurrence of the event causing a person's eligibility or ineligibility for coverage. Employer will obtain completed applications from its employees and shall submit the applications in hard copy format, or an accurate reproduction of the information contained in the applications in a mutually agreeable electronic format, on a timely basis sufficient to permit the Plan to provide coverage within the time frames specified in the Plan's contracts and certificates. In the event that Employer submits electronic enrollment information pursuant to the preceding sentence, (i) each such submission shall constitute a representation by Employer that it has received a signed application from the employee, and that the information submitted to the Plan accurately reflects the information set forth in the application; (ii) Employer shall maintain each underlying application form in a secure location for a period of six years after coverage has terminated for all persons listed on the application; and (iii) Employer shall make the underlying application forms available to the Plan upon reasonable advance notice at any time during the period referenced in clause (ii).

b. Within 30 days of receipt of each invoice from the Plan, Employer will review and reconcile the invoice and provide the Plan with written notice of any errors in the invoice.

c. When coverage changes occur, Employer is solely responsible for administering continuation coverage under the federal law and regulations commonly known as "COBRA," including the provision of all notices required under COBRA, if applicable. In addition, Employer will notify each employee and spouse, if any, enrolled for coverage of the continuation coverage right available under New York State law, as described in the contract(s) and/or certificate(s).

5. **Enrollment Process and Requirements.**

a. During the term of this Agreement, Employer must meet or exceed the Plan's minimum participation levels, as established from time to time by the Plan.

b. Without the Plan's prior written approval, Employer's open enrollment periods will be limited to one per year.

c. During each open enrollment period, Employer will permit the Plan's personnel to have access to its eligible employees, to recruit eligible persons to enroll for benefits. Persons who become eligible for coverage as set out in the contract(s) and/or certificate(s) other than during Employer's open enrollment periods will be offered the opportunity to enroll for benefits at the time they meet the eligibility requirements set out in the contract(s) and/or certificate(s).

6. **Additional Duties of Employer.** In addition to Employer's duties that may be described elsewhere in this Agreement:

a. Employer will verify to the Plan, upon request, the employment status of any covered individuals.

b. Employer will deliver to the Plan information regarding its covered individuals who are covered by or eligible for Medicare, indicating whether Medicare is the primary or secondary payer.

c. Prior to the effective date of coverage, Employer will deliver to the Plan the following documentation:

i. a completed group information form or enrollment questionnaire; or other information requested by the Plan for purposes of validating Employer for group coverage.

ii. a copy of Employer's most recent NYS-45-ATT form with notations indicating eligible and ineligible employees; and

iii. if applicable, a copy of the documentation authorizing the Administrator to act on behalf of Employer.

7. **Termination.** This Agreement will automatically terminate upon the termination of all master group and/or group remittance agreements between Employer and the Plan.

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8. **Relationship of Parties.** The parties to this Agreement are independent contractors and are not to be construed as having any other relationship, either with respect to this transaction or any other transaction between the parties. No party will have, or hold itself out as having, the power or authority to bind or create liability for the others by its intentional or negligent act or omission.

9. **Jurisdiction; Venue.** Jurisdiction of any litigation with respect to this Agreement will be in New York, with venue in a court of competent jurisdiction in Onondaga County.

10. **Governing Law.** This Agreement will be governed by, and construed in accordance with, the laws of the State of New York.

11. **Entire Agreement.** This Agreement, together with the group agreement and/or group remittance agreement entered into between the parties as of the date of this Agreement and any other agreements contemplated thereby, constitutes the entire agreement among the parties and supersedes any prior understandings or agreements with respect to the subject matter. No changes, additions or modifications to the terms of this Agreement will be made or binding, unless in writing and signed by all parties to the Agreement.

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12. **Notices.** All notices and other communications given under this Agreement must be in writing and delivered personally, by established overnight courier or by first class mail, postage prepaid, to the addresses set forth at the beginning or to such other address as one party may provide to the other in writing. Notices and communications will be deemed received at the time of personal delivery (except that, if personal delivery occurs on a day other than a business day, the next business day will be deemed the date of receipt), one business day after shipping via overnight courier, and three business days after mailing.

13. **The Plan Is Independent.** Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield, is an independent corporation organized under the Insurance Law of New York State. Excellus BlueCross BlueShield also operates under licenses with the BlueCross BlueShield Association, an Association of independent Blue Cross and Blue Shield Plans, which licenses Excellus BlueCross BlueShield to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus BlueCross BlueShield does not act as an agent of the BlueCross BlueShield Association. Excellus BlueCross BlueShield is solely responsible for the obligations created under this Agreement.

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The parties' assent to the terms of this Agreement as of the date set forth at the beginning is established by their signatures below.

Dated:______________________________

Excellus Health Plan, Inc., d/b/a
Excellus BlueCross BlueShield

By: _________________________________

Title: _______________________________

Dated:______________________________

Town of Ulysses

By: _________________________________

Title: _______________________________

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