The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard; and PATRICIA PRITCHARD, Plaintiffs, v. BLUE CROSS BLUE SHIELD OF ILLINOIS, Defendant.	NO. 3:20-cv-06145-RJB DECLARATION OF ELEANOR HAMBURGER IN SUPPORT OF PLAINTIFF CLASS'S OPPOSITION TO DEFENDANT'S MOTION TO DECERTIFY **Note on Motion Calendar: March 3, 2023**

I, Eleanor Hamburger, declare under penalty of perjury and in accordance with the laws of the State of Washington and the United States that:

1. I am a partner at Sirianni Youtz Spoonemore Hamburger and am one of the attorneys for plaintiff class in this action.

2. Attached as ***Exhibit 1*** is a true and correct copy of the Administrative Services Agreement between Catholic Health Initiatives ("CHI") and Blue Cross Blue Shield of Illinois ("BCBSIL") produced in discovery in this matter.

3. Attached as ***Exhibit 2*** is a true and correct copy of the 2019 Benefit Program Application ("BPA") between CHI and BCBSIL.

SIRIANNI YOUTZ
SPOONEMORE HAMBURGER PLLC
3101 WESTERN AVENUE, SUITE 350
SEATTLE, WASHINGTON 98121
TEL. (206) 223-0303 FAX (206) 223-0246

4. Attached as ***Exhibit 3*** is a true and correct excerpt of the Rule 30(b)(6) Deposition of Telisa Drake.

DATED this 27th day of February, 2023 at Seattle, Washington.

/s/Eleanor Hamburger

Eleanor Hamburger (WSBA #26478)
SIRIANNI YOUTZ SPOONEMORE HAMBURGER
3101 Western Avenue, Suite 350
Seattle, WA 98121
Tel. (206) 223-0303; Fax (206) 223-0303
Email: ehamburger@sylaw.com

Attorneys for Plaintiffs

Exhibit 1

BlueCross BlueShield of Illinois

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is January 1, 2014.

For Employer Group Number(s): As shown on the Account Structure

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

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

By: Peter Hellstrom

Title: Vice President, Underwriting - IL

Date: 8/27/2015

CATHOLIC HEALTH INITIATIVES

ACCOUNT #008591

By: Linda Vance

Title: Vice Pres, Employee Benefits / Wellness

Date: 8/24/15

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

RECITALS

WHEREAS, the Client is an employer and is also related to various other affiliates, subsidiaries, divisions or similar which have employees (collectively the "Employer"); and

WHEREAS, the Client on behalf of the Group Health Plan has executed an ASO Benefit Program Application ("ASO BPA") and the Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4, with such ASO BPA and this Agreement collectively referred to hereinafter as the "Agreement", unless specified otherwise; and

WHEREAS, the Client has established and adopted an employee welfare benefit plan ("Plan") as defined below and as described in its plan document, which shall be provided by the Client to the Claim Administrator along with such other Plan documents; and

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

WHEREAS, it is desirable to set forth more fully the obligations, duties, rights and liabilities of the Claim Administrator and the Client (on behalf of itself and the Employers), as representative of the Group Health Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree as follows:

SECTION 1: APPOINTMENT

The Client hereby retains and appoints the Claim Administrator to provide services as hereinafter described in connection with the administration of the Plan.

SECTION 2: AGREEMENT DEFINITIONS

2.1 "Administrative Charge" means the monthly service charge that is required by the Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement.

2.2 "Alternative Compensation Arrangement Payments" means additional payments made to Network Providers for Covered Services for which no formal Claim form may be submitted, including, but not limited to, capitation payments, performance based reimbursement payments, care coordination payments, and other alternative funding arrangements as set forth in Claim Administrator's arrangement with the Network Provider.

2.3 "Average Discount Percentage ("ADP")" means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to Covered Persons by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out–of–pocket maximums and/or any benefit maximums. The ADP will often vary from Claim to Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount, not to exceed fi[redacted] of such estimate, to reflect related costs. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into

Redacted

account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when the Covered Person's benefits under the Plan are secondary to Medicare and/or coverage under any other group program.

2.4 "Certificate of Creditable Coverage" means a document which is generated for Covered Persons terminating coverage under the Plan. The certificate is provided to Covered Persons as evidence for credit of health coverage held under the Plan during the term of this Agreement.

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

2.6 "Claim Charge" means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.)

2.7 "Claim Payment" means the benefit calculated by the Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge, Maximum Allowance and/or Dental Maximum Allowance, in accordance with the benefit coverage(s) elected on the most current Exhibit 4 - ASO BPA, for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.) Claim payment also includes Client's pro rata share of Alternative Compensation Arrangement Payments.

2.7A "Client" means Catholic Health Initiatives, or its successor or assigns permitted pursuant to Section 14.4.

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

2.9 "Coordinated Home Care Program" means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. A Covered Person must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and must require Skilled Nursing Service on an intermittent basis under the direction of a Physician, physician assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. A Coordinated Home Care Program includes occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

2.11 "Covered Employee" shall (i) have the same meaning as defined in the Plan or (ii) such other individuals reported by the Client to Claim Administrator as eligible for and included under the Plan.

2.12 "Covered Person" shall (i) have the same meaning as defined in the Plan or (ii) such other individuals reported by the Client to Claim Administrator as eligible for and included under the Plan.

2.13 "Covered Service" means a service or supply specified in the Plan for which benefits will be provided.

2.14 "Custodial Care Service" means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of a Covered Person's condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable

non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by the Covered Person.

2.15 **"Dental Maximum Allowance"** means one of the following amounts in accordance with the type of dental benefits coverage elected, if dental benefits coverage is elected on the most current Exhibit 4 - ASO BPA:

a. For a Provider who has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Participating Dentist"), the amount such Participating Dentist has agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Dentists will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full.

b. For a Provider who does not have a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer a participating provider option dental benefits program at the time Covered Services for dental benefits are rendered ("Non-Participating Dentist"), the amount described in i. or ii. below, in accordance with the type of dental benefits coverage elected by the Client:

i. The lesser of the Non-Participating Dentist's Claim Charge or an amount that is equal to the standard contracted fee for Participating Dentists in the same geographic area. In the event such lesser amount does not equate to the Non-Participating Dentist's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

ii. The lesser of the Non-Participating Dentist's Claim Charge or the Claim Administrator's "Dental Usual and Customary Charge" amount which is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Dental Usual and Customary Charge will be 50% of the Non-Participating Dentist's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing all Participating Dentist Claims for processing Claims submitted by Non-Participating Dentists which may also alter the Dental Usual and Customary Charge for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The Dental Usual and Customary Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the Dental Usual and Customary Charge amount does not equate to the Non-Participating Dentist's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

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

2.16 **"Eligible Charge"** means **(a)** in the case of a Provider other than a professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Participating Provider"), such Participating Provider's Claim Charge for Covered Services; and **(b)** in the case of a Provider other than a professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the lesser of:

i. the Non-Participating Provider's Claim Charge; or

ii. the Claim Administrator's non-contracting Eligible Charge. Except as otherwise provided in this definition, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately [Redacted] of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be [Redacted] of the Non-Participating Provider's standard Claim Charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for the Non-Participating Provider will be [Redacted] of the Non-Participating Provider's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

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

2.16A "Employer" means the Client, along with various other affiliates, subsidiaries, divisions or similar which have employees, and which entity is either (i) designated by the Client to the Claim Administrator either for services under this Agreement or (ii) is a participating employer under the Plan with respect to a Covered Employee as determined by the Client.

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

2.18"Fee Schedule" means the specifications setting out certain particulars of this Agreement as set forth in Exhibit 4 - ASO BPA of this Agreement including, but not limited to, the Administrative Charge and other service charges; or any such other subsequent set of specifications supplied by the Claim Administrator as set forth in a subsequent ASO BPA as replacement to the initial Exhibit 4 - ASO BPA. The specifications or items of the Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 2's "COMPENSATION TO CLAIM ADMINISTRATOR" provisions.

2.19"Fee Schedule Period" means the period of time indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement.

2.20"Group Health Plan" or "Plan" means, the Catholic Health Initiatives ERISA Welfare Benefit Plan a self-insured employee welfare benefit plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996 established by the Client, in effect as of the Effective Date, for the benefit of the Covered Employees as determined by the Plan documents; provided, however, that the Client may report to the Claim Administrator as covered under this Agreement other welfare benefit plans, programs or arrangements sponsored by one or more Employers, which in such event such plans, programs or arrangements shall be deemed and treated as a Group Health Plan or Plan covered by this Agreement, effective as of the dates provided by the Client, until removed by the Client from the scope of this Agreement upon notice to the Claim Administrator.

2.21"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

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

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

2.24"Maximum Allowance" means in the case of a professional Provider one of the following amounts in accordance with the type of medical benefits coverage elected on the most current Exhibit 4 - ASO BPA:

a. For a professional Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Participating Professional Provider"), the amount such Participating Professional Provider has agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by a Participating Professional Provider will be based on the Schedule(s) of Maximum Allowances which such Provider has agreed to accept as payment in full.

b. For a professional Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Participating Professional Provider"), the lesser of the Non-Participating Professional Provider's Claim Charge or the Claim Administrator's non-contracting Maximum Allowance amount which is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard Claim Charge for such Covered Services.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the non-contracting Maximum Allowance will be 50% of the Non-Participating Professional Provider's standard Claim Charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, a Covered Person will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance and deductible amount(s).

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

2.25"Net Claim Payment" means the net benefit payment calculated by the Claim Administrator, upon submission of a Claim, in accordance with the benefits specified in the Plan, plus any related Surcharges. All Net Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, less the ADP if applicable, irrespective of any separate financial arrangement between the Claim Administrator and the particular Provider. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.)

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

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

2.28 "Outpatient Prescription Drug Program Eligible Charge" means (a) in the case of a Provider which has a written agreement with the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program at the time Covered Services are rendered ("Participating Prescription Drug Provider"), such Provider's Claim Charge for Covered Services; and **(b)** in the case of a Provider which does not have a written agreement with the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to provide prescription drug services to a Covered Person at the time Covered Services are rendered ("Non-Participating Prescription Drug Provider"), the lesser of the following charges for Covered Services:

i. the charge which the particular Non-Participating Prescription Drug Provider usually charges for Covered Services, or

ii. the agreed upon cost between Participating Prescription Drug Providers and the Claim Administrator, a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program.

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

2.29A "Plan Administrator" means the Client, which is responsible for the operation and administration of the Plan. The Client is deemed to be and is treated as the Plan Administrator.

2.30"Primary Care Physician" means a physician who is a Network Provider at the time Covered Services are rendered under the Claim Administrator's point–of–service managed care health benefits coverage program, if applicable to the Plan under this Agreement, and who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who approves and makes medically appropriate referrals for any non–Primary Care Physician services and who provides medical care within the scope of a license permitting him/her to legally practice medicine in the recognized areas of pediatrics, obstetrics and gynecology, internal medicine and family practice.

2.31"Private Duty Nursing Service" means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of eight (8) hours or greater per day and does not include nursing care of less than eight (8) hours per day. Private Duty Nursing Service does not include Custodial Care Service.

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

2.33"Skilled Nursing Service" means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

2.34"Supplemental Charge" means a charge for costs due and payable to the Claim Administrator by the Client that is separate and apart from the service charges detailed in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of this Agreement. A Supplemental Charge may be applied for any customized reports, forms or other materials or for any additional services or supplies not documented in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in writing prior to the Claim Administrator's performance and/or provision of such.

2.35"Surcharges" means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to World Access Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by the Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Client shall furnish to Claim Administrator in a timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges

may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

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

- **a.** With respect to all payments due the Claim Administrator by the Client under this Agreement, within ten (10) calendar days of notification of the Client by the Claim Administrator; or
- **b.** With respect to all information due the Claim Administrator by the Client concerning Covered Persons, within thirty–one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or
- **c.** With respect to all Plan information due the Claim Administrator by the Client, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

2.37 **"World Access Fee"** means the Surcharge imposed upon the Claim Administrator under the BlueCard® Worldwide program for the administration of an international Claim.

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR

3.1 ***Subcontractors.*** During the continuance of this Agreement, the Claim Administrator will perform such services as set forth in Exhibit 1 of this Agreement, attached hereto and made a part hereof. The Claim Administrator, at its sole discretion, may contract with other entities for performance of any of the services to be performed by the Claim Administrator hereunder; provided, however, the Claim Administrator shall remain fully responsible for integrating and ensuring delivery of all services contracted for it under this Agreement, regardless of which entity delivers the services and liable for performance of any such services to be performed by the Claim Administrator but delegated to other entities.

3.2 ***Subsidiaries.*** Further, any of the services to be performed by the Claim Administrator under this Agreement may be performed by the Claim Administrator, or any of its subsidiaries (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written approval by the Client. Any reference in this Agreement to the Claim Administrator shall include its directors, officers and employees as well as the directors, officers and employees of any of its subsidiaries and the Claim Administrator shall be responsible and liable for all performance or failure to perform by such subsidiaries in connection with this Agreement.

SECTION 4: CERTAIN RESPONSIBILITIES OF THE CLIENT AND THE CLAIM ADMINISTRATOR

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

4.2 ***Claim Administrator Responsibility.*** The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non–compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Client shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by Client or by or through Claim Administrator; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.

4.3 ***Litigation.*** Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. The Client shall undertake the defense of such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys

selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement.

4.4 ***Claim overpayments.*** The Client acknowledges that unintentional administrative errors may occur. When the Claim Administrator becomes aware of a Claim overpayment, the Claim Administrator will make a diligent attempt to recover any such payment. The Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will the Claim Administrator be required to reimburse the Plan, except for gross negligence or intentional acts by the Claim Administrator.

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

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

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

It is the Client's obligation to Timely notify the Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by the Client to the Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by the Claim Administrator to effect such changes.

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

4.7 ***Claim information disclosure.*** The Claim Administrator will disclose Claim information in accordance with HIPAA privacy regulations and the Business Associate Agreement entered into by the parties.

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

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

SECTION 5: THIRD PARTY DATA RELEASE

5.1 ***Types of data.*** In the event the Client directs the Claim Administrator to provide data directly to its third party consultant and/or vendor and the Claim Administrator accepts, the Client acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

a. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 5, "Confidential Information").

b. Release of the Confidential Information may also reveal the Claim Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 5, "Proprietary Information").

c. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 5, collectively, "Information").

5.2 ***Third party obligations.*** The third party consultant and/or vendor shall:

a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Client.

b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Client.

c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.

d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.

e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.

f. Not use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.

g. Execute the Claim Administrator's then–current confidentiality agreement.

5.3 ***Client obligations.*** The Client shall:

a. Designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

b. Provide the Claim Administrator with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

c. Indemnify, defend (at the Claim Administrator's request) and hold harmless the Claim Administrator and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Claim Administrator in connection with any claim based upon the Claim Administrator's disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Covered Person at the direction of the Client or breach by the third party consultant and/or vendor of any obligation described in this Agreement.

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

As provided in this Agreement, the Claim Administrator will receive eligibility information, review and process Claims, and respond to customer inquiries; however, the Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan. Therefore, in certain instances, the Claim Administrator may refer certain Claims to the Client for review and final decision. Such referral shall be at the sole discretion of the Claim Administrator.

SECTION 7: CLAIM DISPUTE RESOLUTION

7.1 ***Claim appeals.*** After exhaustion of all remedies offered by the Claim Administrator, a Covered Person may appeal all adverse determinations with the Client. The Claim Administrator will cooperate in providing Claim information pursuant to Section 4 above.

7.2 ***Claim reviews.*** On occasion the Claim Administrator may deny all or part of submitted Claims. The Claim Administrator will provide a full and fair review of any determination of a Claim, any determination of a request for pre–notification, and any other determination made in accordance with the benefits and procedures detailed in the Plan.

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES

8.1 ***Client authority and responsibility.*** The Client retains the final authority and responsibility to establish and construe the terms and conditions of the Plan and to determine Covered Persons' eligibility.

8.2 ***Referrals to Client.*** Certain claims and/or inquiries will be referred to the Client for final review and determination in the following instances:

a. When Claims for services do not appear to qualify for payment under the Plan, claims or inquiries where there is a question of eligibility, claims where there is a question as to the amount of payment due, and claims involving litigation or the threat of litigation; and

b. When a Covered Person chooses to appeal adverse determinations with the Client after exhaustion of all remedies offered by the Claim Administrator.

SECTION 9: COOPERATION OF THE PARTIES

The parties shall use their best efforts to cooperate with and assist each other, as applicable, in the performance of their duties under this Agreement.

SECTION 10: HIPAA/CERTIFICATE OF CREDITABLE COVERAGE

10.1 ***HIPAA requirement.*** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the preparation and distribution of a Certificate of Creditable Coverage to individuals who terminate coverage under the Plan.

10.2 ***Responsible party.*** In accordance with the Client's election indicated on the most current Exhibit 4 - ASO BPA of this Agreement:

a. ***If the Client elects the Claim Administrator to issue certificates,*** the Claim Administrator shall issue a Certificate of Creditable Coverage consistent with the requirements under HIPAA. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of this Agreement and information provided to the Claim Administrator by the Client.

b. ***If the Client does not elect the Claim Administrator to issue certificates,*** the Client acknowledges that the Claim Administrator is not the Group Health Plan issuer offering group coverage under the Group Health Plan nor the plan administrator and, therefore, the Claim Administrator has no obligation to prepare or distribute a Certificate of Creditable Coverage. The Client further acknowledges that the obligation to provide a Certificate of Creditable Coverage is the obligation of the Client.

SECTION 11: INDEMNIFICATION

11.1 ***Claim Administrator indemnifies Client.*** The Claim Administrator hereby agrees to indemnify and hold harmless the Client and its directors, officers, employees, agents, affiliates, and Plan fiduciaries, against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to the Plan or this Agreement resulting from or arising out of any acts or omissions of the Claim Administrator or its directors, officers or employees which have been adjudged to be (i) negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment and/or Net Claim Payment errors by the Claim Administrator.

11.2 ***Client indemnifies Claim Administrator.*** The Claim Administrator does not insure or underwrite the liability of the Client under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Client retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. The Client agrees to indemnify and hold harmless the Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands,

settlements or judgments brought against the Claim Administrator in connection with the design or administration of the Plan, unless the liability therefor was the direct consequence of the acts or omissions of the Claim Administrator or its directors, officers or employees and is adjudged to be (i) negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment and/or Net Claim Payment errors by the Claim Administrator.

11.3 ***Examples of actions brought against Claim Administrator.*** The following list is intended to exemplify types of actions related to design and administration of the Plan(s), but not to allocate indemnification responsibility with respect to such examples, which shall be determined in accordance with Section 11.1 or 11.2, as applicable.

a. Any claim in connection with a claim for benefits under the Plan.

b. Any claim based upon the disclosure of any information regarding a Covered Person by the Claim Administrator to the Client.

c. Any claim in connection with un–Timely and/or inaccurate eligibility data or Claim information data provided by the Client to the Claim Administrator, or any such data provided by the Client in a format not approved by the Claim Administrator.

d. Any claim arising from the Client's use or posting of electronic files on the intranet and/or internet pursuant to Section 17 below.

e. Any claim that may arise from or in connection with the Claim Administrator's suspension of Claim Payments due to the Client's failure to pay when due any amounts owed the Claim Administrator under this Agreement and/or the termination of this Agreement in accordance with Section 13.2 below.

f. Any claim arising from the Client's directive to the Claim Administrator to print Client–assigned unique identification numbers on membership identification cards or to otherwise use such assigned numbers in violation of any applicable federal, state and local rules, laws and regulations.

g. Any claim arising from the Client's directive to the Claim Administrator to include mutually agreed upon Client ERISA Summary Plan Description information in Claim Administrator prepared benefit booklets for distribution to Covered Persons.

h. Any claim arising from Plan documentation and compliance with reporting and disclosure requirements of ERISA applicable to the Plan Document and Summary Plan Description.

i. Any claim that may arise from or in connection with the Claim Administrator's issuance of Certificate(s) of Creditable Coverage, if elected on the most current Exhibit 4 - ASO BPA, based upon un–Timely and/or inaccurate data provided by the Client to the Claim Administrator with respect to individuals whose coverage under this Agreement terminates.

j. Any claim based upon Medicare Secondary Payer ("MSP) laws or regulations including, but not limited to, the untimely and/or inaccurate provision by the Client to the Claim Administrator of Client Acknowledgement Forms ("EAFs") as and when requested by the Claim Administrator.

k. Any claim that may rise from or in connection with the Claim Administrator's issuance of written statements of creditable coverage and/or the filing of electronic reports to the Massachusetts Department of Revenue, if elected on the most current Exhibit 4 - ASO BPA, based upon untimely and/or inaccurate data or certification provided by the Client to the Claim Administrator with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS

12.1 ***Client audits Claim Administrator.*** During the term of this Agreement and within one (1) year after its termination (or such later date as needed for the Plan to comply with ERISA), the Client or an authorized agent of the Client (subject to Claim Administrator's reasonable approval) may, upon at least sixty (60) days prior written notice to the Claim Administrator, conduct reasonable audits of records related to this Agreement to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement and the benefits specified in the Plan(s). The audit must be free of bias, influence or conflict of interest. Contingency fee based audits are deemed to have an

inherent conflict of interest and will not be supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. The Client will be responsible for all costs associated with the audit. Claim Administrator reserves the right to charge Client for any reasonable personnel time in excess of one hundred sixty (160) person-hours required to support audits conducted during the term of this Agreement. Client will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. All such audits shall be subject to the Claim Administrator's current external audit policy and procedures, a copy of which shall be furnished to the Client upon request to the Claim Administrator. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. The audit period will be limited to the most recent twenty-four (24) or for such other period required by any governmental agency or as maybe required for the Client to comply with ERISA or applicable law. A report by the Claim Administrator's independent accountant on the controls over claims adjudication (known as a SOC 1 report) is provided at no cost upon request. The Client and such agent that have access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary information, and to hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information by executing an Audit Agreement with the Claim Administrator that sets forth the terms and conditions of the audit.

12.2 ***Errors identified.*** The Claim Administrator shall be responsible for the correction of errors identified in during the Audit subject to the terms and conditions of the Agreement.

SECTION 13: TERM AND TERMINATION OF AGREEMENT

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

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

- **a.** By either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA upon ninety (90) days prior written notice to the other party.
- **b.** By both parties on any date mutually agreed to in writing.
- **c.** By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Agreement, upon written notice as provided under Section 22 below.
- **d.** By the Claim Administrator, upon the Client's failure to pay all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current Exhibit 4 - ASO BPA.
- **e.** By either party immediately upon written notice in the event of: the bankruptcy, insolvency or liquidation of the other party.

13.3 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 13, the Client agrees to notify all Covered Employees. The parties agree that the Client will give such notice because the Client maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 14: RELATIONSHIP OF PARTIES

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

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

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

14.3 ***Exclusivity.*** The Client agrees not to engage any other party to perform the same services that the Claim Administrator performs hereunder while this Agreement is in effect, unless the Client gives notice of termination pursuant to the terms of this Agreement.

14.4 ***Assignment.*** Except as otherwise permitted by Section 3 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Claim Administrator's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment under this Agreement.

SECTION 15: ERISA

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

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

15.3 ***In Relation to Claim Administrator's Responsibilities.*** The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Client's Plan. As such, the Claim Administrator is intended to be a fiduciary with respect to the Client's ERISA employee welfare benefit plan. The Client represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Client's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Client's ERISA employee welfare benefit plan.

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SECTION 16: PROPRIETARY MATERIALS

16.1 ***Types of materials as may be used by the parties.*** The parties acknowledge that each party has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). Neither party shall use or disclose to any third party Business Proprietary Information without prior written consent of the other party. Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Claim Administrator may include the Client in its list of clients.

16.2 ***Claim Administrator/Association ownership.*** The Client acknowledges that the Claim Administrator's Proprietary Marks and Business Proprietary Information are the sole property of the Blue Cross and Blue Shield Association or of the Claim Administrator and agrees not to contest the Blue Cross and Blue Shield

Association's or the Claim Administrator's ownership or the license granted to the Claim Administrator for use of such Proprietary Marks.

16.3 ***Infringement.*** The Claim Administrator agrees not to infringe upon, dilute or harm the Client's rights in its Proprietary Marks. The Client agrees not to infringe upon, dilute or harm the Blue Cross and Blue Shield Association's ownership rights or the Claim Administrator's rights as a licensee in its Proprietary Marks.

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

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

SECTION 17: ELECTRONIC DOCUMENTS

17.1 ***Client's consent/intended use.*** The Client consents to receive via an electronic file or access to an electronic file any document the Client requests from the Claim Administrator describing the benefits under, or the administration of, the Plan.

17.2 ***Client acknowledgement/responsibilities.*** The Client further acknowledges and agrees that it is responsible for providing employees access, via the intranet, internet, or otherwise, to the most current version of any electronic file provided to the Client by the Claim Administrator at the Client's request. In addition, in all instances, the electronic file of the most current document issued to the Client by the Claim Administrator for use by the Client is the legal document used to administer the Plan and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Client is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from the use or posting of the electronic file on the intranet and/or internet.

SECTION 18: RECORDS

All Claim records, excluding any and all of the Claim Administrator's Business Proprietary Information, in the possession of the Claim Administrator are and shall remain the property of the Client upon termination of this Agreement. The Claim Administrator shall return such property upon request in a form as agreed upon by the parties at the cost of preparing such property for transmittal to be borne by the Client. All such Claim records shall be retained by the Claim Administrator until the Claim Administrator receives a request from the Client for transmittal or for a period of ten (10) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 19: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of Illinois without regard to any state choice-of-law statutes, and any applicable federal law. All disputes arising out of this Agreement will be resolved in Illinois.

SECTION 20: ENTIRE AGREEMENT

20.1 ***Definition.*** This Agreement, including all Exhibits and Addenda, represents the entire agreement and understandings of the parties hereto and all prior agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof, including any proposal document submitted by the Claim Administrator to the Client pursuant to this Agreement, are and have been merged herein to the extent applicable. In the event of a conflict, the provisions of this Agreement and the Exhibits and Addenda of this Agreement shall prevail.

20.2 ***Components.*** The Exhibits and Addenda of this Agreement as of the Agreement's effective date are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Exhibit 3 - Recovery Litigation Authorization
- **d.** Exhibit 4 - ASO Benefit Program Application ("ASO BPA")
- **e.** Exhibit 5 - COBRA Health Benefits Continuation Coverage ("COBRA")

20.3 ***Amending.*** This Agreement may be amended or altered in any of its provisions, including the addition or deletion of any Exhibits and/or Addenda as provided herein, by the parties hereto and any such change shall become effective when reduced to writing and signed by an authorized representative of the parties or at such time as said amendment may provide.

SECTION 21: LIMITATIONS

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

SECTION 22: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement, the Client and the Claim Administrator agree to give one another written notice (pursuant to Section 26 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such.

SECTION 23: LIMITATION OF LIABILITY

Liability for any errors or omissions by the Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited to the maximum benefits which should have been paid under this Agreement had the errors or omissions not occurred (including the Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence or intentional breach of a duty under this Agreement by the Claim Administrator.

SECTION 24: DISPUTE RESOLUTION/ARBITRATION

24.1 ***Initial negotiation.*** Any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 24, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 24 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

24.2 ***Deferring to arbitration/selecting an arbitrator.*** In the event the parties fail to agree with respect to any matter covered herein, the question in dispute shall be submitted for arbitration in Illinois. The arbitrator shall be selected as follows:

a. Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;

b. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of $200, the American Arbitration Association shall recommend an arbitrator; or

c. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is $200 or less, the Claim Administrator shall select an independent third party to be the arbitrator.

24.3 ***Expectations.*** The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Arbitration Association then in effect.

SECTION 25: OBLIGATION TO CONTINUE PERFORMANCE

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

SECTION 26: NOTICES

26.1 ***How to notify.*** All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current Exhibit 4 - ASO BPA of this Agreement.

26.2 ***Change of address.*** Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party.

SECTION 27: SEVERABILITY

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

SECTION 28: ENFORCEMENT

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

SECTION 29: FORCE MAJEURE

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

SECTION 30: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Agreement, the Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Agreement and for other purposes required or permitted by applicable law (the "Permitted Purposes" as defined herein). For purposes of this

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

SECTION 31: CLAIM ADMINISTRATOR USE OF THIRD PARTY RECOVERY VENDOR

Recoveries from healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, data mining, utilization review refunds, and unsolicited refunds. The Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments and Net Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to the Claim Administrator's refund recovery policies, which generally require correction on a Claim-by Claim basis. Third parties' reasonable audit fees associated with such audits and the Claim Administrator's reasonable fee for its related administrative expenses to support such third party audits will be paid by the Client.

SECTION 32: NOTICE OF ANNUAL MEETING

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

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

SECTION 33: ETHICS

33.1 The Claim Administrator hereby represents that it is not at this time excluded from participation in any health care program, as defined at 42 U.S.C. § 1320a-7b(f), including Medicare and Medicaid. The Claim Administrator hereby agrees to notify Client within ten (10) business days of any, actual exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that the Claim Administrator or any of its subcontractors is excluded from participation in any federal health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that the Claim Administrator is in breach of this Section, the Client may terminate this Agreement immediately upon notice to the Claim Administrator as provided in Section 13.

33.2 Client and all of its facilities are Equal Employment Opportunity and Affirmative Action employers. The parties hereby incorporate by reference the provisions of Executive Order 11246, as amended, and 41 C.F.R. § 60-1.4(a); the Rehabilitation Act of 1973, as amended, and 41 C.F.R. § 60-741.5(a); the Vietnam Era Veterans' Readjustment Assistance Act, as amended, and 29 C.F.R. § 60-250.5(a); and Executive Order 13496 and 29 C.F.R. Part 471, Appendix A to Subpart A. The Claim Administrator represents and warrants that unless exempted under the terms of these applicable laws, it will comply with the foregoing Executive Orders, statutes, rules and regulations and all amendments thereto.

33.3 The Claim Administrator recognizes that it is essential to the core values of Client that all persons and entities contracting with Client at all times conduct themselves in compliance with the highest standards of business ethics and integrity and applicable legal requirements as reflected in the Catholic Health Initiatives Standards of Conduct, as may from time to time be amended by the Client. As of the date of the Agreement, the Catholic Health Initiatives Standards of Conduct are set forth in Our Values & Ethics at Work Reference Guide ("Reference Guide"), which is available at the following website: http://www.catholichealthinitiatives.org/corporate-responsibility.

33.4 The Claim Administrator acknowledges that it has electronically accessed, obtained or otherwise received a copy of the Reverence Guide and has read and understands the same, and hereby agrees that, so long as the Agreement remains in effect, the Claim Administrator shall act in a manner consistent with, and shall at all times abide by, such Standards of Conduct, to the extent the same are applicable to the Claim Administrator in the performance of the Agreement.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

  Examination of Claims and determination of payment levels, including data entry of Claims by Claims departments, maintenance of Claims experience files, use of medical consultants, review of utilization and reasonable and customary charges; and, if dental benefits coverage is elected on the most current Exhibit 4 - ASO BPA, use of dental consultants and review of Usual and Customary Fees; and Coordination of Benefits (COB).

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Handling of inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment, Net Claim Payment or Claim denial (including providing notice in writing through the EOB when a Claim for benefits has been denied which notice shall set forth the reasons for the denial and the right to a full and fair review of the denial under the terms of the Plan and shall otherwise satisfy applicable regulatory requirements, including, but not limited to, those of ERISA and related law applicable to the Plan, governing the notice of a denied Claim and external review of appeals consistent with applicable law. Notwithstanding any provision of this Agreement to the contrary, Client has the right to reasonably direct the Claim Administrator with respect to any claims under the Plan in any particular case or circumstance, subject to Claim Administrator's right to disregard such Client's direction consistent with applicable law), such prudent customer service shall be provided by Claim Administrator at a level consistent with industry standards and reasonable due diligence.

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Client agrees to participate in other performance based reimbursement and alternative provider compensation arrangements as applicable based on Covered Person criteria established by Claim Administrator. Client agrees that certain benefits will be covered at Redacted when a Covered Person meets these criteria and participates in a medical home program, and will make any necessary benefit plan changes.

- **ENROLLMENT SERVICE**

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

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

  e. ***Medical Pre–notification Helpline.*** For those services described in the Plan and provided in writing to Claim Administrator that require pre–notification, advance Claim Administrator review of medical

necessity of such services covered under the Plan; access to toll–free medical pre–notification helpline for Covered Persons and their health care providers to call for assistance.

- **MEMBERSHIP VALIDATION**

  Verification of membership by wire, listing, electronic on–line query or other method prior to or during adjudication.

- **MEMBERSHIP FILE UPDATES**

  Maintenance of membership status files, processing of inter–plan transfers and processing of contract changes; and, if elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA, processing of contract conversions, subject to conversion fee set forth therein.

- **OTHER MEMBERSHIP SERVICES**

  Contact Client and/or Covered Employees regarding adding, changing or renewing coverage.

- **STANDARD REPORTS**

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

- **STOP LOSS COORDINATION**

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

- **REPORTING SERVICES**

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

- **ACTUARIAL AND STATISTICAL**

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

- **FINANCIAL SERVICES**

  Financial functions such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlement and wire transfers.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Client of findings and proof of fraud; address any related recovery litigation as set forth in Exhibit 3 of the Agreement.

- **BLUE ACCESS® FOR EMPLOYERS**

  Provides Client on–line access to conduct a variety of secure membership, enrollment, reporting, administrative and billing transactions faster, more accurately and in real–time.

- **BLUE ACCESS® FOR MEMBERS**

  An on–line resource for personalized information about a Covered Person's health care coverage, including, but not limited to, Claims status, email notification when a Claim has been finalized, access to health and wellness information, verification of dependents covered on their plan and health risk assessment and such other services as become available.

- **PROVIDER NETWORK(S)**

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

- **CERTIFICATE OF CREDITABLE COVERAGE (*If elected on the most current Exhibit 4 - ASO BPA)***

  Issuance of Certificates of Creditable Coverage.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current Exhibit 4 - ASO BPA)***

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

- **DISEASE/CARE MANAGEMENT PROGRAM(S)**

  Any disease and/or care management program(s) as elected on the most current Exhibit 4 - ASO BPA.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  (If elected on the most current Exhibit 4 - ASO BPA)

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

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 2, Section 17 entitled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED CHECKS**

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

- **ADDITIONAL SERVICES NOT SPECIFIED**

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

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current Exhibit 4 - ASO BPA of the Agreement. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA; and iii) the date the Agreement is terminated.

Inter-Plan Program Fees:

i. **BlueCard® Program/Network access fees* (as applicable):** Additional information is available upon request; included in the Medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such Medical Administrative Charge(s);

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

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

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

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 2 AGREEMENT DEFINITIONS of the Agreement.

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

2.2 "Employer Payment Method" means the method elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement by which Employer Payments will be made.

2.3 "Employer Payment Period" means the time period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement.

2.4 "Medicare Secondary Payer ("MSP")" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Section 17 of this Exhibit titled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING.")

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

2.6 "Run–Off Period" means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, during which the Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 "Termination Administrative Charge" means the consideration indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement that is required by the Claim Administrator upon termination of the Agreement, including any services that may be performed by the Claim Administrator during the Run-Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of service charges.*** The Client will pay service charges to the Claim Administrator, in accordance with the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, as compensation for the processing of Claims and administrative and other services provided to the Client.

3.2 ***Determining service charges.*** The service charges, which are guaranteed for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, have been determined in accordance with the Claim Administrator's current regulatory status and the Client's existing benefit program.

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

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, provided that sixty (60) days prior written notice is given by the Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase the Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by the Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies +/- ten percent (10%) from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by the Client.

3.4 ***Service charges upon termination.*** In the event the Agreement is terminated in accordance with the "TERM AND TERMINATION" provisions of the Agreement, the Client will Timely pay the Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement.

3.5 ***Additional service charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement, the Claim Administrator may charge the Client for:

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

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

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

SECTION 4: CLAIM PAYMENTS

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

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

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

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

SECTION 5: EMPLOYER PAYMENT

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

5.2 ***Confirmation or notification of amount due and payment due date.*** The Client shall confirm with the Claim Administrator or the Claim Administrator shall notify the Client's Financial Division, of the Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with the Employer Payment Method elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and the following:

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

5.3 ***Federal Regulation of Client.*** Beginning in 2014 (or such other date required by law), Client will be responsible for contributing to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. In no event will Claim Administrator be responsible for the reinsurance contribution. If required by applicable law, Client will promptly forward to Claim Administrator all such contributions (or successor or alternate program amounts) and all information necessary for the calculation or administration of such contributions (or successor or alternate program amounts).

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

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining what Client owes.*** A Claim Settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement. The Claim Settlement shall reflect the sum of the following:

- **a.** All Net Claim Payments calculated on the basis of Claim Payments paid by the Claim Administrator in the particular Claim Settlement Period.

b. All Net Claim Payments calculated on the basis of Claim Payments paid by the Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim Settlement.

c. The Administrative Charges and Credits and other applicable service charges as indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and any applicable Supplemental Charge(s).

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

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

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

SECTION 7: LATE PAYMENTS AND REMEDIES

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

a. Suspend Claim Payments; or

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

7.2 ***When Claim Administrator fails to timely notify.*** Pursuant to Section 28 "ENFORCEMENT" of the Agreement, the Claim Administrator's failure to provide the Client with timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from the Client.

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

a. The rate of Redacted per day which equates to an amount of Redacted) per annum; or

b. The maximum rate permitted by state law

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

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run-off Claims.*** The Client hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 13 of the Agreement, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to the Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Claim Administrator ("Run-Off Claims"). The Client shall be responsible for the reimbursement of all Run-Off Claims, whether or not such Claims have been submitted, or whether or not Net Claim Payments calculated on the basis of Claim Payments for such Claims have been made by the Claim Administrator, as of the date of termination, including, but not limited to, Claim Payments and/or Net Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other

applicable service charges indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). The Client shall be liable to the Claim Administrator for all Claim Payments, Net Claim Payments and the applicable service charges for such Extended Benefits.

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

8.3 ***Final Settlement.*** A Final Settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This Final Settlement shall compare the Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the Final Settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if the Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the Final Settlement, the Claim Administrator shall pay such difference to the Client after applying the difference against amounts, if any, then owed to the Claim Administrator by the Client.

8.4 ***Uncashed checks.*** As of the date of termination of the Agreement, any outstanding checks that are or become "stale" (over 365 days old) will be escheated by the Claim Administrator, on the Client's behalf, less any amount(s) owed by such checks' payees to the Claim Administrator, in accordance with the applicable state's unclaimed property law.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

The Client represents that it acknowledges and has communicated the provisions stated in each of the following sections of this Exhibit 2 to its Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim payment assignment.*** All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or Provider furnishing Covered Services. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

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

10.3 ***Plan coverage assignment.*** Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non–assignable or non–transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

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

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

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

a. ***Physician Selection.***

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

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

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

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

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

SECTION 12: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current Exhibit 4 - ASO BPA of the Agreement. The Client acknowledges that when Covered Persons elect to utilize the services of a non–Network professional Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network professional Provider are not based upon the amount billed. The basis of the benefit payment will be determined according to the Plan's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after the Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance and deductible amounts. A Covered Person may obtain further information about the Network status of professional Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

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

13.1 All amounts payable to the Claim Administrator by the Client for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Provider's Eligible Charge or Provider's Claim Charge less the ADP, unless otherwise directed in writing by the Client, for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Administrator Provider or the Client and the Claim Administrator.

13.2 The Client acknowledges that the Claim Administrator has contracts with certain Providers ("Administrator Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates, agreements and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Administrator Providers, under certain circumstances described therein, the Claim Administrator may receive substantial payments from Administrator Providers with respect to services rendered to all such persons for which the Claim Administrator was obligated to pay Administrator Providers, or the Claim Administrator may pay Administrator Providers less than their Claim Charges for services, by discounts or otherwise, or may receive from Administrator Providers other allowances under the Claim Administrator's contracts with them. The Client acknowledges that in negotiating the service charges set forth in the Agreement, it has taken into consideration that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the Agreement and that the service charges specified in the Agreement reflect the amount of additional consideration expected to be received by the Claim Administrator in the form of such payments, discounts or allowances. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP as part of any Claim Settlement or otherwise except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

13.3 The Claim Administrator's compensation for its services under the Agreement shall include the difference between the Net Claim Payments reimbursed to the Claim Administrator by the Client under the Agreement and the net amounts paid to Providers by the Claim Administrator after giving effect to the Claim Administrator's Separate Financial Arrangements with Providers.

Section 14: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

14.1 All amounts payable to the Claim Administrator by the Client for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required Copayment, deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Outpatient Prescription Drug Program Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Claim Administrator, whichever is less.

14.2 The Claim Administrator hereby informs the Client and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual network savings achieved by the Client will vary. Some rates are currently based on Average Wholesale Price ("AWP"), which is determined by a third party and is subject to change.

14.3 The Client understands that the Claim Administrator may receive such discounts during the term of the Agreement. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics

LLC ("Prime") through the Pharmacy Benefit Management (PBM) Agreement, will be passed-through to the Client for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator (and ultimately to the Client as described above). For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which is reflected in the administrative fee charged by Claim Administrator to the Client. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing. The allowable amount reimbursed for prescriptions obtained at out-of-network pharmacies is determined by the Client's benefit design, but is usually based on 75% of the cost of the prescription if it were obtained at an in-network pharmacy.

14.4 "Weighted paid claim" refers to the methodology of counting claims for purposes of determining the Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, Claim Administrator pays Prime a Program Management Fee ("PMF") on a per paid claim basis. "Funding Levers" means a mechanism through which Claim Administrator funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by Claim Administrator, may include rebates and retail spread. Claim Administrator's net fee owed to Prime for core services will be offset by the Funding Levers. Claim Administrator pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

14.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to the Employer as expenses, or accrue to the benefit of the Employer, unless otherwise specifically set forth in the Agreement. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and other Blue Plan operating divisions.

Section 15: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

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

15.2 Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator, but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). Expected Rebate amounts, are calculated based on the Client-specific demographics and projected rebates, interest earnings and utilization. Based upon previous experience with such rebates, the Claim Administrator has estimated that any drug rebate for the Client would be based on an average dollar amount per prescription ("Expected Rebate"). One–hundred percent (100%) of the Expected Rebate is shared with employers based

upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Client is determined by multiplying the sum of the estimated dollars times the expected number of annual prescriptions dispensed, then divided by the expected number of Covered Employees, then divided by twelve (12) months. The Expected Rebate amount is reflected as a prescription drug rebate credit per Covered Employee per month. Although no true-up is done at the end of the Client's contract period, the re-calculation of the Expected Rebate for the renewal period takes into account the prior period's actual demographics, utilization, rebates and interest earnings. The rebate credits do not continue if the Client terminates.

15.3 The Client understands that the Claim Administrator may receive such rebates during the term of the Agreement. Neither the Client nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

SECTION 16: INTER-PLAN ARRANGEMENTS

16.1 ***Out-of-Area Services***

Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Persons access healthcare services outside the geographic area Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to Claim Administrator for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this Agreement are described generally below. Claim Administrator's services under this Agreement are governed by and subject to the Inter-Plan Programs policies in effect during the term of this Agreement.

Typically, Covered Persons, when accessing care outside the geographic area Claim Administrator serves, obtain care from healthcare providers that have a contractual agreement (i.e., are "participating healthcare providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Persons may obtain care from non-participating healthcare providers. Claim Administrator's payment practices in both instances are described below.

16.2 ***BlueCard® Program***

Under the BlueCard® Program, when Covered Persons access Covered Services within the geographic area served by a Host Blue, Claim Administrator will remain responsible to Client for fulfilling Claim Administrator's contractual obligations. However, in accordance with 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 healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

a. ***Liability Calculation Method Per Claim***

The calculation of the Covered Person's liability on Claims for Covered Services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to Claim Administrator by the Host Blue.

The calculation of Client's liability on Claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to Claim Administrator by the Host Blue. Sometimes, this negotiated price may be greater than or equal to billed charges. Examples of this are (i) when a Host Blue has negotiated with its participating healthcare provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services, and (ii) when such negotiated price is necessary or appropriate, as determined by the Host Blue, to provide for a Host Blue's geographic access or availability of particular types of health care services.

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

(1) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

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

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

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs 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 or received from providers). However, the amount paid by the Covered Person and Client 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 Claim Administrator is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

If a Host Blue uses either an estimated price or an average price on a Claim, the Host Blue is required to hold any difference between the amount paid to the provider and the amount that Client pays in a variance account, pending settlement with its participating healthcare providers. Because all amounts paid are final, neither variance account funds held to be paid, nor the funds expected to be received, are due to or from Client. Such payable or receivable would be eventually exhausted by healthcare provider settlements and/or through prospective adjustment to the negotiated prices. *Some Host Blues may retain interest earned, if any, on funds held in variance accounts.*

In some instances federal law or the laws of a small number of states require Host Blues either (i) to use a basis for determining Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or (ii) to add a surcharge.

Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Claim Administrator would then calculate Covered Person's liability and Client's liability in accordance with applicable law.

b. ***Return of Overpayments***

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be charged to the Client. Recovery amounts determined in the ways noted above will be applied so that corrections will be made, in general, on either a Claim-by-Claim or prospective basis.

Unless otherwise agreed to by the Host Blue, Claim Administrator may request adjustments from the Host Blue for full refunds from healthcare providers due to the retroactive cancellation of membership but only for one year after the date of the Inter-Plan financial settlement process for the original Claim. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery conflicts with the Host Blue's state law or healthcare provider contracts or would jeopardize the Host Blue's relationship with its healthcare providers.

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

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under the BlueCard Program to pay to the Host Blues, to the Blue Cross and Blue Shield Association (BCBSA), and/or to BlueCard Program vendors, as described below. Fees and compensation under the BlueCard Program may be revised in accordance with the Program's standard procedures for revising such fees and compensation, which do not provide for prior

approval by Client. Such revisions typically are made annually as a result of Program policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

Claim Administrator will charge these fees as follows:

It is expected that, unless the number of Client's Blue enrolled contracts falls below 50,000, that the access fee and all other BlueCard Program-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

In the event that the number of Client's Blue enrolled contracts falls below Redacted, only the BlueCard Program access fee may be charged separately each time a Claim is processed through the BlueCard Program. If one is charged, it will be a percentage of the discount/differential Claim Administrator receives from the Host Blue, based on the current rate in accordance with the Program's standard procedures for establishing the access fee rate. The access fee will not exceed Redacted for any Claim. In this situation the access fee is set forth in the Agreement's Fee Schedule. All other BlueCard Program-related fees will then be factored into Claim Administrator's determination of its general administrative fee, also set forth in the Agreement's Fee Schedule.

(1) BlueCard Program Access Fees

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

(2) How the BlueCard Program Access Fee Affects Client

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Client as a Claim expense or as a separate amount. The access fee will not exceed Redacted) for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Client a Claim expense credit or a separate credit. Instances may occur in which the Claim payment is zero or Claim Administrator pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Claim Administrator will pay the Host Blue's access fee and pass it along to Client as stated above even though Client paid little or had no Claim liability.

16.3 ***Negotiated National Account Arrangements***

As an alternative to the BlueCard Program, some of Client's Covered Persons' Claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue. Pursuant to such negotiated arrangements, the Host Blue(s) [has/have] agreed to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of the Client receiving Covered Services in the state and/or service area of the Host Blues. Pursuant to the agreement between the Claim Administrator and the Host Blues, the Claim Administrator has agreed to reimburse each Host Blue for all Claim Payments made on the Claim Administrator's behalf for those Covered Persons of the Client receiving Covered Services in the state and/or service area of such Host Blue.

If Claim Administrator and Client have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in Claim Administrator's negotiated National Account arrangement(s) with such Host Blue(s) shall apply, unless otherwise agreed in the Agreement's Fee Schedule. In negotiating such arrangement(s), Claim Administrator is not acting on behalf of or as an agent for Client, Client's Plan or Client's Covered Persons.

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

Covered Person liability calculation will be based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under 16.2.a., BlueCard Program) made available to Claim Administrator by the Host Blue that allows Client's Covered Persons access to negotiated participation agreement networks of specified participating healthcare providers outside of Claim Administrator's service area.

Client's liability calculation will be based on the negotiated price (refer to the description of negotiated

price under 16.2.a., BlueCard Program).

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

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

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

b. *Fees and Compensation*

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the Programs' standard procedures for revising such fees and compensation, which do not provide for prior approval by Client. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

In addition, the participation agreement with the Host Blue may provide that Claim Administrator must pay an administrative and/or a network access fee to the Host Blue, and Client further agrees to reimburse Claim Administrator for any such applicable administrative and/or network access fees. For this type of negotiated participation arrangement, any such administrative and/or network access fees will not be greater than the comparable fees that would be charged under the BlueCard Program.

Claim Administrator will charge these fees as follows:

It is expected that the access fee and all other Negotiated National Account Arrangement-related fees are included in Claim Administrator's Administrative Charge set forth in the Agreement's Fee Schedule.

Client acknowledges that Host Blues may have contracts with certain Providers in their service areas ("Host Blues' participating Providers") for the provision of, and payment for, health care services. As a result of these contracts with their Providers, Host Blues are able to make provider networks available to persons and entities, including Claim Administrator, entitled to health care benefits under various health policies and contracts to which the Host Blue is a party. Such network availability extends to Covered Persons covered under the Agreement.

All other Inter-Plan Program fees related to this negotiated National Account arrangement are factored into Claim Administrator's determination of its Administrative Charge, also set forth in the Agreement's Fee Schedule.

The Claim Administrator hereby informs the Client, and the Client acknowledges, that the Claim Administrator's, the Host Blues' participating Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers and the Host Blues' participating Providers may result in

minor deviations in Claim processing and/or pricing of Claims for some services. From time-to-time, Claim Administrator, Host Blues and their respective vendors may receive compensation in connection with services provided by Claim Administrator to our group customers, which are not necessarily passed on to our group customers or to members. Additional information about these types of fees, the amount of these fees and the sources of these fees is available upon request.

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

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

(1) In General

When Covered Services are provided outside of Claim Administrator's service area by non-participating healthcare providers, the amount(s) a Covered Person pays for such services will be calculated using the methodology described in the Agreement for non-Participating providers located inside our service area. The Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, Claim Administrator may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating healthcare provider on an exception basis.

b. ***Fees and Compensation***

Client understands and agrees to reimburse Claim Administrator for certain fees and compensation which Claim Administrator is obligated under applicable Inter-Plan Programs requirements to pay to the Host Blues, to the Blue Cross and Blue Shield Association, and/or to Inter-Plan Programs vendors. Fees and compensation under applicable Inter-Plan Programs may be revised in accordance with the specific Program's standard procedures for revising such fees and compensation, which do not provide for prior approval by Client. Such revisions typically are made annually as a result of Inter-Plan Programs policy changes and/or vendor negotiations. These revisions may occur at any time during the course of a given calendar year, and they do not necessarily coincide with Client's benefit period under this Agreement.

In addition, Claim Administrator must pay an administrative fee to the Host Blue, and Client further agrees to reimburse Claim Administrator for any such administrative fee as set forth below.

Claim Administrator will charge these fees as follows:

All fees related to Claims for Covered Services delivered by non-participating healthcare providers outside Claim Administrator's service area are factored into Claim Administrator's determination of its Administrative Charge, which is set forth in the Agreement's Fee Schedule.

SECTION 17: MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING

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

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

17.3 The Client agrees that the Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Claim Administrator's files concerning Covered Persons and the number of individuals employed by the Client. The Client agrees to use its best efforts in responding promptly and accurately to the Claim Administrator's requests for information including, but not limited to, information contained on the Employer Acknowledgement Form ("EAF") to be provided to the Claim Administrator by the Client on at least an annual basis, and more frequently, if the information provided on the last EAF received by the Claim Administrator changes, or as requested by the Claim

Administrator; and to require and facilitate its Covered Persons' cooperation in responding promptly and accurately to such requests.

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

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

SECTION 18: REIMBURSEMENT PROVISION

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

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

a. The Claim Administrator on behalf of the Client has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to the Covered Person, reduced by any Average Discount Percentage ("ADP") applicable to the Covered Person's Claim or Claims.

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

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

SECTION 19: MEMBER DATA SHARING

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

Covered Person's personal information and may also provide other general information relating to Covered Person's coverage under the Plan and which the Client has with Claim Administrator to the extent reasonably necessary to enable the relevant Host Blues to offer a Covered Person coverage continuity through replacement coverage.

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

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

1. The Claim Administrator shall have the right to select and retain legal counsel.
2. Any lawsuit filed or arbitration initiated by the Claim Administrator will be done in the name of the Claim Administrator for its own benefit, as well as on behalf of the Client and possibly other parties. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Client and/or the Plan without the Client's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Client and/or the Plan with attorneys identified as counsel for the Client or in the name of two or more parties, including the Client and the Claim Administrator, with attorneys identified as counsel for the Client, the Claim Administrator and possibly other parties.
3. The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including providing appropriate authority to communicate with the Client concerning issues pertaining to any class actions and pursuant to which the Client specifically declines representation by class litigation counsel.
4. The Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.
5. The Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.
6. Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Claim Administrator on any reasonable basis it deems appropriate.
7. Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney–client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. The Client shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of the Claim Administrator.
8. The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.
9. Nothing in the provisions of this Exhibit shall require the Claim Administrator to assert any claims on behalf of the Client and/or the Plan.
10. Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, the Client acknowledges that the efforts of the Claim Administrator may not result in recovery or in full recovery in any particular case.
11. The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Claim Administrator to assert any claims on the Client's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Claim

Administrator has asserted a claim on behalf of the Client and/or the Plan but before any recovery, the Claim Administrator may continue to pursue the claim or discontinue the claim.

12. If the Client should desire to participate in a class or multi-district settlement rather than defer to the Claim Administrator, the Client may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 26 NOTICES of the Agreement.
13. The Client further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Section 26 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Client and/or the Plan, consistent with Section 2 above to:
    a. Pursue claims that the Claim Administrator pursues on its own behalf in class action litigation, federal multi-district litigation, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
    b. Opt out of any class action settlement or keep the Client and/or the Plan in the class, if the Claim Administrator believes it is in the best interest of the parties to do so;
    c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.
14. The Client further acknowledges and agrees that the Claim Administrator's decision to pursue recovery in connection with particular claims shall be in the Claim Administrator's discretion and the Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of the Client and/or the Plan when, as, and if, the Claim Administrator determines that such claims may be pursued in the common interest of the parties.
15. The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail.

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

EXHIBIT 5: COBRA HEALTH BENEFITS CONTINUATION COVERAGE

1. DEFINITIONS

In the event that there is a conflict between the definitions set forth below and those found under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA") or under the Internal Revenue Code of 1986, and the regulations thereunder, as may be amended, the statutory definitions shall control.

1.1 **"Health Benefits Continuation Coverage"** shall mean the administrative services Claim Administrator offers to assist the Client in fulfilling its responsibilities under the Consolidated Omnibus Budget Reconciliation Act of 1985.

1.1A **"Client"** means Catholic Health Initiatives, any predecessor thereto, its successor or assigns, permitted pursuant to Section 14.4 in the Agreement or any corporation resulting in any manner from a reorganization of the Employer or any individual, firm or corporation which shall assume the Health Benefits Continuation Coverage obligations of the Employer.

1.2 **"COBRA"** shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended.

1.3 **"Continuation of Coverage Provisions"** shall mean continuation of group health care coverage provisions mandated by COBRA.

1.4 **"Covered Employee"** shall mean an individual who is *(or was)* provided coverage under the Plan by virtue of the individual's employment or previous employment with an Employer.

1.5 **"Qualified Beneficiary"** shall mean:

A. In general, the term **"Qualified Beneficiary"** shall mean, with respect to a Covered Employee under the Plan, any individual who, on the day before the qualifying event for that employee, is a beneficiary under the Plan:

1. as the spouse of the Covered Employee, or
2. as the dependent child of the Covered Employee.

B. In the case of a qualifying event which is caused by termination *(other than by reason for such* employee's *gross misconduct)*, or reduction of hours, of the Covered Employee's employment, the term **"Qualified Beneficiary"** includes the Covered Employee.

1.6 **"Qualifying Event"** shall mean, with respect to any Covered Employee, any of the following events which, but for the continuation coverage required, would result in the loss of coverage of a Qualified Beneficiary:

A. The death of the Covered Employee;

B. The termination (other than by reason of such employee's gross misconduct) or reduction of hours, of the Covered Employee's employment;

C. The divorce or legal separation of the Covered Employee from the employee's spouse;

D. The Covered Employee becoming entitled to benefits under Title XVIII of the Social Security Act;

E. A dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan; or

F. A determination made under the Social Security Act that the Covered Employee is disabled.

1.7 **"Applicable Premium"** shall mean the amount a Plan will require a Qualified Beneficiary to pay, for any period of COBRA continuation coverage, that does not exceed one hundred and Redacted of the applicable premium for that period or does not exceed one hundred and Redacted of the applicable premium after the 18th month of coverage for Qualified Beneficiaries eligible for extended

coverage due to disability. The applicable premium is defined in Section 4980B(f)(4) of the Internal Revenue Code of 1986.

1.8 **"Employer"** means the Client, along with various other affiliates, subsidiaries, divisions or similar which have employees, and which entity is either (i) designated by the Client to the Claim Administrator either for services under this Agreement or (ii) is a participating employer under the Plan with respect to a Covered Employee as determined by the Client.

1.9 **"Plan Administrator"** shall have the meaning given the term **"administrator"** by Section 3(16)(a) of the Employee Retirement Income Security Act of 1974.

2. SERVICES TO BE PROVIDED BY CLAIM ADMINISTRATOR

During the term of this Agreement, Claim Administrator will perform such services as are set forth in Schedule I attached hereto and made a part hereof.

3. RESPONSIBILITIES OF THE CLIENT

3.1 The Client retains full and final authority and responsibility with respect to compliance with COBRA Continuation of Coverage Provisions and except as provided in Article IV of this Exhibit, the Client shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules and laws including, but not limited to: any licensing; filing; reporting and disclosure requirements as they may apply to its Health Benefits Continuation Coverage or COBRA Continuation Provisions; and all costs, expenses and fees relating thereto.

3.2 Subject to the terms of 5.3 of the Agreement, the Client shall undertake the defense of any action against it and/or Claim Administrator and shall be responsible for the costs of defense; provided, however, that Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Client.

3.3 It is understood by The Client that COBRA imposes penalties on an employer or Plan Administrator who fails to accurately comply with the COBRA Continuation of Coverage Provisions. Subject to the terms of 5.3 of the Agreement it is further understood by the Client that Claim Administrator shall in no way be responsible for any said penalties nor does Claim Administrator agree to be liable for damages resulting from any said penalties which may be imposed on the Client or Plan Administrator for non-compliance of COBRA Continuation of Coverage Provisions. The penalties may include, but are not limited to: loss of federal tax deduction for expenses paid or incurred for any Plan maintained by the Client; failure to notify the employee of continuation rights, either initially or upon a Qualifying Event resulting in a penalty payment of up to Redacted per Qualified Beneficiary per day of delay; and highly compensated individuals who participate in a Plan for which The Client fails to follow the COBRA requirements may not be permitted to exclude from income the amount contributed by the Client in his or her behalf for such coverage.

3.4 The Client hereby agrees to identify the employee who shall act as the sole contact between the Client and Claim Administrator in regard to COBRA Health Benefits Continuation Coverage matters under this Agreement.

3.5 The Client hereby agrees to be solely responsible for providing the initial notice regarding Health Benefits Continuation Coverage under COBRA and for providing and updating their Summary Plan Descriptions regarding COBRA.

3.6 Unless an insurance policy issued by Claim Administrator is in force, The Client understands that Claim Administrator does not insure or underwrite the liability of the Client for the Health Benefits Continuation Coverage it offers pursuant to COBRA. The Client retains the ultimate responsibility for claims made under the Health Benefits Continuation Coverage and all expenses incident to the Health Benefits Continuation Coverage, except as specifically assumed in this Agreement by Claim Administrator.

3.7 The Client shall furnish on a timely basis to Claim Administrator certain information concerning the Client's Plan descriptions and employees and dependents covered under the Health Benefits Continuation Coverage including Qualified Beneficiaries entitled to the Health Benefits Continuation Coverage as may from time to time be required by Claim Administrator for the performance of its duties including, but not limited to, the following:

All documents by which the Health Benefits Continuation Coverage is established and any amendments or changes to the Health Benefits Continuation Coverage as may from time to time be adopted including thirty *(30)* days prior written notification to Claim Administrator when the Client plans a reduction in force, lay-off, strike, or shutdown or filing for bankruptcy, or makes changes to any of the following: its Health Benefits Continuation Coverage; benefit pricing; or benefit carriers.

All data as may be required by Claim Administrator regarding the Qualified Beneficiaries who are to be covered under this Agreement.

a. Such data may include, without limitation, a list of Qualified Beneficiaries who are to be covered under this Agreement, and completed Health Benefits Continuation Coverage applications.

Further, the Client will notify Claim Administrator of the effective date of coverage for all Qualified Beneficiaries who are to be covered under this Agreement. Clerical errors or delays in keeping or reporting data relative to coverage under this Agreement will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. However, the Client is liable for any benefits paid for a terminated Qualified Beneficiary if the Client had not timely notified Claim Administrator as required by COBRA of such Qualified Beneficiary's termination or ineligibility under COBRA.

b. All such notification by the Client to Claim Administrator must be furnished on forms or in a format approved by Claim Administrator and must include all information reasonably required by Claim Administrator to effect such changes.

Such information as to Health Benefit Continuation Coverage benefits as will enable Claim Administrator to accurately prepare any reports required under this Agreement. The Client, furthermore, shall use its best efforts to cooperate with and assist Claim Administrator as applicable, in the performance of its duties hereunder.

4. RESPONSIBILITIES OF CLAIM ADMINISTRATOR

4.1 Claim Administrator is empowered to act on behalf of the Client in connection with the Health Benefits Continuation Coverage only as expressly stated in this Agreement or as mutually agreed to in writing by the parties hereto.

4.2 Claim Administrator shall have no responsibility for the compliance of the Health Benefits Continuation Coverage or COBRA Continuation of Coverage Provisions with any applicable federal, state or local rule or law.

4.3 Claim Administrator shall be responsible for expenses arising out of its performance of the services described in Schedule I.

4.4 Claim Administrator hereby agrees to assume full responsibility for timely and complete notice to Qualified Beneficiaries of their respective rights under COBRA provided that the Plan Administrator has given timely and complete notice of the Qualifying Event to Claim Administrator. Notification shall be made in accordance with the notice and time requirements specified in the Consolidated Omnibus Budget Reconciliation Act of 1985. Upon notice of a Qualifying Event from the Plan Administrator, Claim Administrator will provide a notification package to the Qualified Beneficiary.

5. TERM AND TERMINATION OF COBRA SERVICES

5.1 This Exhibit shall run concurrent with the Agreement and shall terminate when the Agreement terminates, subject to Run-Out provisions. In the event of such termination Claim Administrator agrees to use its best efforts to assist the Client in notifying Qualified Beneficiaries, transferring data, files, and all other relevant information to the Client or its delegate. Unless agreed otherwise in writing by the parties, in the event of such termination, the Client shall have responsibility for current and future COBRA Qualified Beneficiaries Applicable Premium billing and collection services and all other responsibilities contained in this Exhibit.

5.2 In the event that the Client ceases to have an obligation under COBRA to provide Health Benefit Continued Coverage to all covered employees and all Qualified Beneficiaries, the Client will provide Claim Administrator with at least ten *(10)* days advance written notice of the cessation of its obligations. Upon receipt of such notice, Claim Administrator at its sole option, has the right to terminate this Agreement upon ten *(10)* days written notice to the Client. In the event of such termination by Claim Administrator, the Client shall immediately have complete responsibility for current and future COBRA Qualified Beneficiaries Applicable Premium billing and collection services and all other responsibilities contained in this Agreement. Further, in the event of such termination, the Client agrees to notify all Qualified Beneficiaries.

5.3 Termination of COBRA services by either the Client or Claim Administrator shall not terminate any other terms and/or conditions of this Agreement unless provided in this Agreement.

6. NOTICES

All notices, directions or requests under this Exhibit shall be in writing and shall either be delivered or mailed to the parties as follows.

If to the Claim Administrator:

Health Care Service Corporation,
P.O. Box 1180
Marion, IL 62959-7680

or if to the Client:

The Client address indicated on Exhibit 4, the Benefit Program Application ("BPA").

SCHEDULE I

Claim Administrator will perform the following services:

1. Claim Administrator will provide notice to Qualified Beneficiaries of their COBRA rights.
2. Claim Administrator will, within the time frames required by COBRA, produce and mail monthly COBRA premium bills for the Qualified Beneficiaries.
3. Claim Administrator will post premium payments received.
4. Claim Administrator will produce and mail late and/or insufficient premium notices within the time frames required by COBRA, when appropriate, that advise Qualified Beneficiaries that they are in jeopardy of losing their Health Benefits Continuation Coverage.
5. Where premiums are not paid in full or in a timely fashion as defined by COBRA, Claim Administrator will produce and mail a cancellation letter. Unless otherwise agreed to in writing by the parties, Claim Administrator will deem payments that are less than [Redacted] of the premium to be insufficient and cancel coverage.
6. Claim Administrator will send out conversion letters 90 days prior to the end of eligibility period.
7. Claim Administrator will respond to written or phone inquiries relating to COBRA.
8. Claim Administrator will, within 14 days after receipt of the enrollment form from the Qualified Beneficiary, produce and mail the initial COBRA benefit continuation billing.
9. Claim Administrator will, upon receipt of an enrollment form and initial premium payment, update membership for that Qualified Beneficiary. Once premiums have been received, claims will be processed through normal claims processing channels.
10. Claim Administrator will on a monthly basis furnish a check payable to the Client in the amount of COBRA premiums received less COBRA Administration fees described in Schedule II. A detailed report of premiums collected broken down by individual carrier(s) will accompany this remittance.

SCHEDULE II

Administrative Fee

The Client will pay a separate and distinct Administrative Fee to Claim Administrator as payment for the Administrative Services Claim Administrator provides under this Agreement. This Administrative Fee will be due and payable as follows:

1. The Client will pay Claim Administrator Redacted monthly administrative fee. The sum of Redacted will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the Redacted fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

2. The Client will pay Claim Administrator a sum of Redacted per Qualified Beneficiary on a monthly basis as the payment for the billing and Applicable Premium collection services Claim Administrator provides under this Agreement. The sum of Redacted per Qualified Beneficiary per month will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the Redacted per Qualified Beneficiary per month fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

3. The Client will pay Claim Administrator a sum of Redacted per Qualified Beneficiary for each notice to Qualified Beneficiaries of their COBRA rights. The sum of Redacted per Qualified Beneficiary notice will be deducted from the monthly remittance to the Client, pursuant to Schedule I, paragraph 10. If the Redacted per Qualified Beneficiary notice fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

4. The Client will pay Claim Administrator a sum of Redacted per hour for any system programming costs associated with non-standard administration services. The sum of Redacted per hour will be deducted from the monthly remittance to the Client pursuant to Schedule I, paragraph 10. If the Redacted fee exceeds the amount of premium received, the excess will be due and payable to Claim Administrator upon receipt of a monthly invoice.

Exhibit 2

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 008591

Group Number(s): Refer to the account structure

Section Number(s): Refer to the account structure

Legal Employer Name: Catholic Health Initiatives

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED.)

ERISA Regulated Group Health Plan*: ☒ Yes ☐ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒ Yes
If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: Catholic Health Initiatives

Plan Administrator's Address: 3900 Olympic Blvd, Suite 400, Erlanger, KY 41018

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Select legal reason ; If applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/Day/Year) 01 / 01 / 2019

Anniversary Date: (Month/Day/Year) 01 / 01 / 2020

Account Information — NO CHANGES — SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 8062

Employer Identification Number (EIN): 47-0617373

Address: 3900 Olympic Blvd, Suite 400

City: Erlanger

State: KY

ZIP: 41018

Administrative Contact: AdamBenedict

Title: Director, Health & Welfare Plans

Email Address: AdamBenedict@CatholicHealth.net

Phone Number: 859.594.3867

Fax Number: 859.594.3119

Wholly Owned Subsidiaries:

Affiliated Companies:

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Blue Access for Employers (BAE) Contact: Michelle Hines

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: ShelleyHines@catholichealth.net>

Phone Number: 859-594-3256

Fax Number: 859-594-3119

☐ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

Schedule of Eligibility — NO CHANGES — SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:
   - ☐ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of: *(name of union)*
   - ☐ A part-time employee of the Employer.
   - ☐ A retiree of the Employer. Define criteria: _____
   - ☒ Other: Varies by MBO

Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No
If yes, please identify the classes and describe the exclusion: _____

2. Employee Definitions

Full-Time Employee means:
☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
☒ Other: Varies by MBO

Part-Time Employee means:
☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
☒ Other: Varies by MBO

3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
☐ The date such person ceases to meet the definition of Eligible Person.
☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other:

4. Select an effective `date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
☐ The date of employment.
☐ The day of employment.
☐ The day of the month following month(s) of employment.
☐ The day of the month following days of employment.
☐ The day of the month following the date of employment.
☒ Other: Varies by MBO
Is the waiting period requirement to be waived on initial group enrollment? ☒ Yes ☐ No
Are there multiple new hire waiting periods? ☒ Yes ☐ No
If yes, please attach eligibility and contribution details for each section.

5. Domestic Partners covered: ☒ Yes ☐ No
If yes: a Domestic Partner is eligible to enroll for coverage.
If yes, are Domestic Partners eligible for continuation of coverage? ☒ Yes ☐ No
If yes, are dependents of Domestic Partners eligible to enroll for coverage? ☒ Yes ☐ No
If yes, are dependents of Domestic Partners eligible for continuation of coverage? ☒ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Domestic Partners.

6. Civil Union Partners covered:
i. ☐ The Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, a Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Employer's Plan.
ii. For all other Employers, ☐ Yes ☒ No
If yes: A Civil Union Partner and his or her dependents are eligible to enroll for coverage.
If yes, are Civil Union Partners and his or her dependents eligible for continuation of coverage? ☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Civil Union Partners.

7. Limiting Age for covered Children: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

   If Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code, this Limiting Age is extended to thirty (30) years, for unmarried eligible military personnel as described in the Employer's Plan.

8. Termination of coverage upon reaching the Limiting Age:
   - ☐ The last day of coverage is the day prior to the birthday.
   - ☒ The last day of coverage is the last day of the month in which the limiting age is reached.
   - ☐ The last day of coverage is the last day of the billing month.
   - ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   - ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee? ☐ Yes ☒ No

   However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify HCSC of such requirements.*

9. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

   ☒ Yes (specify number of days below) ☐ No

   Temporary Layoff: As determined by the CHI/MBO days Disability: As determined by the CHI/MBO days Leave of Absence: As determined by the CHI/MBO days

   However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify HCSC of such requirements.

10. Enrollment:

    Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

    An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

    Specify Open Enrollment Period: CHI will have two distinct 2019 annual enrollment periods. Group 1 will occur between 10/10/2018 thru 10/31/2018 and Group 2 will occur between 10/17/2018-11/7/2018.

11. * Does COBRA Auto Cancel apply? ☐ Yes ☒ No

    Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

    ** Not recommended for accounts with automated eligibility.*

Lines of Business (Check all applicable services)	NO CHANGES See Additional Comments
Medical Plan Services: ☒ Participating Provider Option (PPO) ☐ Blue Choice Select PPO ☐ Blue Choice Options ☐ Blue Distinction® Flexible Network **Additional Services:** ☐ Blue Care Connection® ☒ Wellbeing Management ☐ Wellness Incentives ☐ Health Advocacy Solutions ☐ Well onTarget® ☐ Blue Directions (Private Exchange) *(If selected, the Blue Directions Addendum is attached and made a part of the Agreement.)* ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other	**Consumer Driven Health Plan:** ☐ Health Care Account (HCA) Administrative Services *(if purchased, complete separate HCA BPA)* ☐ BlueEdge℠ FSA (Vendor: Select Vendor) ☒ HSA Eligible Health Plan (Vendor: Other) **Prescription Drugs:** ☐ Covered under a pharmacy benefit *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)* ☐ Covered under the medical benefit or Blue Script Pharmacy Network (Select one): ☐ Traditional Select Network ☐ Advantage Network ☐ Preferred Network (Not offered with Blue Script) ☐ Elite Network (Not offered with Blue Script) ☐ Network on PBM Fee Schedule Addendum PPO Drug List: Select Drug List Other (please specify): **Prescription Drug Program Clinical Programs** ☐ MTM (Retrospective) (Included with HAS) **Ancillary Services:** ☐ Dental Plan Services ☐ Vision Plan Services ☐ Stop Loss *(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)* ☐ Dearborn National Life Insurance *(if selected, complete separate Life application)* ☐ COBRA Administrative Services *(if selected, complete separate COBRA Administrative Services Addendum to the BPA)*

FEE SCHEDULE

Payment Specifications	NO CHANGES PROVISIONS	SEE ADDITIONAL

Employer Payment Method: ☐ Online Bill Pay ☒ Electronic ☐ Auto Debit ☐ Check

Employer Payment Period: ☒ Weekly (cannot be selected if Check is selected as payment method above)
☐ Semi Monthly ☐ Monthly

Claim Settlement Period: ☒ Monthly

Run-Off Period: Employer Payments are to be made for 12 months following end of Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: 12 Months

Administrative Per Employee Per Month (PEPM) Charges	NO CHANGES PROVISIONS	SEE ADDITIONAL		
	All Benefit Agreements (PPO and HDHP)	New MBO		
Administrative Fee	$Redacted	Redacted	$____	$____
Dental	$____	$____	$____	$____
Limited Fiduciary Services	$____	$____	$____	$____
Health Advocacy Solutions	$____	$____	$____	$____
Wellbeing Management	$Included in Admin Fee	$Included in Admin Fee	$____	$____
Management of the Virtual Visits Program	$____	$____	$____	$____
*Rebate Credit for the Prescription Drug Program	$____	$____	$____	$____
MTM (Retrospective) **(No cost if both HAS and Prescription Drug Program are elected)**	$____	$____	$____	$____
Commissions	$____	$____	$____	$____
Other: Other Services List Service: Reverse Eligibility and Shared Accums	$Redacte	$Redacte	$____	$____
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Other: Select Service Category List Service:	$	$	$	$
Miscellaneous:	$	$	$	$
Miscellaneous:	$	$	$	$
Total	$Redacted	$Redacted	$	$

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager (PBM) to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate

Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Data Exchange List Service: File Feeds for CIN	Annual If applicable, describe other: $ Redacted	$Redacted
Other: Data Exchange List Service: _____	Annual If applicable, describe other: $Redacted	Redacted
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
	Total:	$Redacted

Claim Administrator Provider Access Fee(s) NO CHANGES SEE ADDITIONAL PROVISIONS
Group Number(s):
☐ % of ADP Savings: %
☐ $ per Covered Employee per month: $
☐ ***Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO plans):*** **Group Number(s):**
☐ % of ADP Savings: %
☐ $ per Covered Employee per month: $
BlueCard Program/Network access fees: Available upon request.

Other Service and/or Program Fee(s) NO CHANGES SEE ADDITIONAL PROVISIONS
External Review Coordination: ☒ Yes ☐ No If yes, coordination fee: $Redacted for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects the following process: ☐ State of Illinois External Review Process ☒ Federal Affordable Care Act Process
Reimbursement Service: ☒ Yes ☐ No If yes: The Employer has elected to utilize the reimbursement service offered by the Claim Administrator, the Corporate Reimbursement Subrogation department. It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.
Claim Administrator's Third Party Recovery Vendors and Law Firms (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by Claim Administrator's Third Party Recovery Vendor. Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third party law firm.
Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☐ Yes ☒ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via video or audio only (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.

ii. ***For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Agreement or partial termination of Covered Employees,*** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

Other Provisions **NO CHANGES** **SEE ADDITIONAL PROVISIONS**

1. Summary of Benefits & Coverage:

   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?

   ☐ Yes. Please answer question b. The SBC Addendum is attached.
   ☒ No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

   b. Will Claim Administrator distribute the Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

   ☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.

   ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. Massachusetts Health Care Reform Act:

   Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

   If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. Case Management Program: ☒ Yes ☐ No *The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, and other health care management programs.*

4. Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☒ Yes ☐ No If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. Essential Health Benefits ("EHB") Election:

   Employer elects EHBs based on the following:

   ☐ 1. EHBs based on a HCSC state benchmark: ☐ Illinois ☐ Oklahoma ☐ Montana ☐ Texas ☐ New Mexico

   ☐ 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
   If so, indicate the state's benchmark that Employer elects: ___

   ☒ 3. Other EHB, as determined by Employer

   In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Illinois benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation

   The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: 2019 Changes to the CHI plans as follows.

The following is the list of changes we will be implementing for 2019:

- 100% coverage for retinal eye exam screenings and nephropathy screenings on the medical plan for diabetic members
- CHI employer HSA funding increase Redacted
- Transform Diabetes Care program powered by Livongo sponsored by CVS (diabetic management program with free meter and supplies)
- Vision plan changes $0 co-pay (changed from Redacted for eye exams & 12 month frame frequency (changed from 24 months)
- Expanding our eligibility for our wellness program to all benefit eligible employees (exception Tacoma will only offer to medical plan participating employees and spouses)

• Weight watchers discount for all medical plan eligible employees and medical plan participating spouses (exception Tacoma will only offer to medical plan participating employees and spouses)

ABA Therapy coverage as any other Mental Health services.

Exclude artificial insemination from fertiltiy benefit.

Catholic Health Initiatives (CHI) has informed Claim Administrator that Employer has made a good faith determination that although Employer and Employer's benefit plan are regulated by Section 1557 of the Affordable Care Act, including but not limited to the related Final Rule, Employer represents that enforcement of the gender identity dysphoria/gender reassignment and termination of pregnancy provisions of Section 1557 or other applicable laws would violate Constitutional and federal and state statutory protections for the Employer's religious freedom, and that the U.S. Department of Health and Human Services is currently enjoined from enforcing such Section 1557 provisions against Employer and the Employer's benefit plan pursuant to the Order issued by the U.S. District Court for the Northern District of Texas in Franciscan Alliance v Burwell. Accordingly, Employer represents that it is not required to provide coverage for services related to gender identity dysphoria/gender reassignment or termination of pregnancy (i) under applicable law, or (ii) under the terms of Employer's plan documents. Employer acknowledges that Employer, and not Claim Administrator, is responsible for providing members with proper notice of Employer's benefit decisions and changes.

Employer has directed BCBSIL to process claims with dates of services on or after January 1, 2017 to exclude coverage of the above items and services. In no event shall Claim Administrator be responsible or liable for any legal, tax, or other ramifications related to or arising from Employer's decisions, directions, or its interpretations or application of applicable law. Employer confirms that it has consulted with its own legal advisors with respect to any of the matters described in this Section, including, but not limited to, discrimination laws. Employer will promptly notify Claim Administrator if the legal basis for Employer's coverage exclusions in this Section changes.

Employer shall indemnify and hold harmless Claim Administrator and any of its directors, officers, affiliates and employees ("Claim Administrator Parties") against any and all claims, losses, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs), and/or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements, or judgments brought or asserted against Claim Administrator Parties in connection with any of the matters described in this Section of the BPA, including, but not limited to, Employer's interpretation and application of applicable laws and any directives to Claim Administrator regarding same. Employer agrees to defend Claim Administrator Parties, using counsel acceptable to Claim Administrator, in any claim, lawsuit, demand, governmental inquiry or action, settlement, or judgment to which this Section applies, and to promptly file with any court at Employer's cost a motion to dismiss any of the Claim Administrator Parties as an improper party. Moreover, Claim Administrator, at its sole discretion, may elect to participate in the defense of its own interests in any such action for which it is entitled to indemnification hereunder, using attorneys selected by Claim Administrator at Claim Administrator's expense. Notwithstanding the above, Employer's obligation to indemnify the Claim Administrator Parties under this section of the BPA shall not include any amount, cost or obligation that Claim Administrator has paid or incurred on its own behalf (and not on behalf of Employer), including attorneys' fees and costs, and/or other costs or obligations of Claim Administrator, resulting from or arising out of Claim Administrator's payment or agreement to pay for an Employer benefit plan participant's services related to gender identity dysphoria/gender reassignment that is not directed, authorized or approved by Employer; however, for avoidance of doubt, this sentence shall not apply to payments or costs paid or incurred by Claim Administrator related to properly adjudicated claims for benefits, including but not limited to settling baseless allegations.

Signature

Telisa Drake
Sales Representative

01163 2173704151
District Phone & FAX Numbers

806
Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Adam W. Benedict
Signature of Authorized Purchaser

Adam W. Benedict
Print Name

System Director, H&W Plans
Title

11/13/2018
Date

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: 008591 By: Adam N. Benedict
Print Signer's Name Here

➡ Adam W. Benedict System Director, H&W Plans
Signature and Title

Group Name: Catholic Health Initiatives

Address: 3900 Olympic Blvd, Suite 400

City: Erlanger State: KY ZIP: 41018

Dated this 13 day of November 2018
Month Year

Exhibit 3

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF F WASHINGTON

AT TACOMA

C.P., by and through his parents, Patricia Pritchard and Nolle Pritchard and PATRICIA PRITCHARD,

Plaintiffs,

vs.) No. 3:20-cv-06145-RJB

BLUE CROSS BLUE SHIELD OF ILLINOIS,

Defendant.

ZOOM VIDEO DEPOSITION UPON ORAL EXAMINATION

OF

TELISA DRAKE 30(B)(6)

9:30 a.m.

May 13, 2022

REPORTED BY: Pat Lessard, CCR #2104

A P P E A R A N C E S

FOR THE PLAINTIFFS:

MS. ELEANOR HAMBURGER
Sirianni, Youtz, Spoonemore & Hamburger
3101 Western Avenue, Suite 350
Seattle, Washington 98121
206.223.0303
ele@sylaw.com

MR. OMAR GONZALEZ-PAGAN, pro hac vice
Lamda Legal Defense and Education Fund
120 Wall Street, 19th Floor
New York, NY 1005
212.809.9585
ogonzalez-pagan@lambdalegal.org

MS. JENNIFER PIZER, pro hac vice
Lambda Legal Defense and Education Fund
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
213.382.7600
jpizer@lambdalegal.org.

A P P E A R A N C E S

FOR THE DEFENDANT:

MS. GWENDOLYN PAYTON
MS. STEPHANIE BEDARD
Kilpatrick Townsend
1420 Fifth Avenue, Ste. 3700
Seattle, WA 98101
206.467.9600
gpayton@kilpatricktownsend.com

ALSO PRESENT:
WARREN BREY, Videographer

E X A M I N A T I O N

E X H I B I T I N D E X

E X H I B I T I N D E X

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Exhibit 17	4/14/16 letter from Blue Cross Blue Shield of Illinois to Kevin Hatfield re Important Updates.	121
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Exhibit 40	Document titled Your Health Care Benefit Program.	42

indemnification for all of the ones that have exclusions?" the answer would have been "Yes."

But the way you asked it is "Did you look at them all?" and she said "No."

And they're probably not all exactly the same, you know, because counsel always likes to mess with things.

But they all have one. They may not be verbatim word for word but you could ask that question.

MS. HAMBURGER: Okay.

MS. PAYTON: It just wasn't asked right.

MS. HAMBURGER: Ready to do on the record?

MS. PAYTON: We are on the record, I thought.

MS. HAMBURGER: I don't think we had started yet.

THE VIDEOGRAPHER: Yes, we're on.

MS. HAMBURGER: Oh, okay.

MS. PAYTON: I hope we're on because I wanted that all to be on the record.

Q. (By Ms. Hamburger) Ms. Drake, the indemnity language that is contained in the BPAs for CHI, are they contained in the BPAs of other ASO plans that have gender-affirming care exclusions?

MS. PAYTON: Object to the form of the question.

A. I'm not aware of all of the exclusions in their, you know, their additional provisions in their BPAs.

Q. (By Ms. Hamburger) Do you understand that similar indemnity clauses are contained in the BPAs of other ASOs that have gender-affirming care exclusions?

MS. PAYTON: Object to the form.

A. I don't feel like I can answer that question because I've not reviewed all of them.

Q. (By Ms. Hamburger) Have you been told by someone?

MS. PAYTON: Hold on. Let's take a break. Let's take a one-minute break.

MS. HAMBURGER: It really shouldn't be, you know, trying to answer the precise question.

MS. PAYTON: The problem is the way you asked the question. It was so loaded with --

MS. HAMBURGER: This is not how we play that game, okay?

MS. PAYTON: Hey, Ele --

MS. HAMBURGER: You can take a break.

MS. PAYTON: Yeah. Let me just finish.

There were too many clauses in there. So

let me just -- I think she's prepared to answer the question but it was the BPA and that language, is the language the same part of the question that was throwing it off.

MS. HAMBURGER: That's not true. It's the same or similar.

MS. PAYTON: Okay. Let's take a quick break.

THE VIDEOGRAPHER: We're going off the record at 1:01 p.m.

(Recess.)

THE VIDEOGRAPHER: Stand by, please.

We're now back on the record at 1:03 p.m.

You may proceed.

Q. (By Ms. Hamburger) Does Blue Cross Blue Shield of Illinois have an indemnity provision with other ASO plans that have gender-affirming care exclusions?

MS. PAYTON: I'm going to just object because you said "Counsel" at the beginning of the question. You're asking Telisa, right?

MS. HAMBURGER: I didn't say "Counsel."

MS. PAYTON: Oh, sorry. Maybe it just -- it's just that it sounded like that to me and I apologize.

Okay. No objection.

A. Yes.

Q. (By Ms. Hamburger) And does Blue Cross Blue Shield of Illinois always have an indemnity provision whenever it is asked to administer a gender-affirming care exclusion?

A. Yes.

Q. And does the indemnity provision require the ASO employer to pay for any losses or liability incurred as a result of the gender-affirming care exclusion?

MS. PAYTON: Objection, calls for a legal conclusion.

A. We would administer whatever legal counsel tells us to.

Q. (By Ms. Hamburger) That's not my question.

Does the indemnity provision say that the plan for an employer will pay for any losses incurred by Blue Cross Blue Shield of Illinois as a result of administering the exclusion?

MS. PAYTON: Objection, calls for a legal conclusion.

A. Yes, if that's what's written in the language.

Q. (By Ms. Hamburger) And is it your

understanding that that's the written language in all of these indemnity provisions?

A. Yes.

Q. Can we turn to Plaintiffs' Exhibit 23.

(Marked Deposition Exhibit No. 23.)

Q. (By Ms. Hamburger) Are you there?

A. I'm there.

Q. Okay. Do you know what Exhibit 23 is?

A. Yes. It's an email from March of 2017 to Kim Norton, who is the representative of Catholic Health Initiatives, from myself that was a result of a call that we had that they were asking for the medical policy to be able to review for transgender services.

And that attached policy was copy and pasted from our link on the public website into an email for their review.

Q. Okay. And was the call about the named plaintiffs in this matter?

A. It was not. We standardly have calls with this particular client with all of their TPAs. And that would have been a result of that particular call where they were to ask everyone to do the same thing.

Q. Okay. Is Kimberly Norton an attorney?

A. She is not.

Q. Is Trisha Beal an attorney?