**300 East Randolph**
**Chicago, IL 60601**

# GROUP ADMINISTRATION DOCUMENT

(Small Group Non-Grandfathered Insured Accounts)

**WHEREAS**, the "Policyholder" has purchased health care insurance from Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (hereinafter referred to as the "Plan") and has executed a Benefit Program Application; and

**WHEREAS**, the Benefit Program Application establishes the Group Number(s) of the Policyholder under the Policy and the Policy Effective Date; and

**WHEREAS**, the Plan hereby accepts such Benefit Program Application, subject to the financial and administrative relationships and responsibilities of both parties for the purpose of providing health care benefits on behalf of Covered Persons;

**NOW, THEREFORE**, the following provisions shall govern the relationship between the Plan and the Policyholder:

## I. ENTIRE POLICY AND CHANGES TO THIS POLICY

The entire Policy and changes to this Policy is comprised of:

- This Group Administration Document;
- The Certificate Booklet(s);
- The Benefit Program Application;
- The Individual Applications;
- The benefit program and premium notification letter, if any;
- The applicable rate summary(ies), if any; and
- All the above may include exhibits, appendices, information, riders, addenda and/or amendments, if any.

All statements made by the Policyholder and Covered Persons shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a claim under this Policy, unless it is contained in a written application. No change in this Policy shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

The issuance of this Group Administration Document supersedes all previous contracts between the Policyholder and the Plan which are in force on the Policy Effective Date.

## II. CERTIFICATE BOOKLETS

The Plan will issue to the Policyholder, for delivery to each Insured, a Certificate Booklet(s) stating the benefits, limitations, exclusions and requirements of this Policy.

## III. PREMIUM PROVISIONS

### A. Premium Rates

**1.** On the Policy Effective Date, the Individual Coverage premium (Insured only) and, when applicable, the Family Coverage premium (Insured and one or more

dependents) shall be the amounts specified in the Benefit Program Application and/or other appropriate document; and/or a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, which shall be attached hereto and made a part of this Policy.

Subsequent changes to the Individual and/or Family Coverage premiums shall be specified in the Benefit Program Application and/or other appropriate document; a benefit program and premium notification letter, if any; and/or applicable rate summary(ies), if any, which shall be attached hereto and made a part of this Policy.

**2.** If Insured contributions for coverage are not required, the Policyholder agrees that all Eligible Persons will become covered and such persons will make no contributions toward the cost of the coverage. If Insured contributions for coverage are required, the Policyholder agrees to give all Eligible Persons an opportunity to subscribe to the coverage and further agrees to pay the required premiums to the Plan and provide for the collection of any contributions from the persons to be covered through payroll withholding or otherwise. The term "Eligible Persons" as used herein shall mean, at a minimum, the percentage of enrolled eligible employees required for Policy issuance and renewal, as specified on the Benefit Program Application and/or other appropriate document. The Plan may limit its offering of coverage to an annual open enrollment period for those Policyholders in the small group market which fail to meet the Plan's standard minimum participation and contribution requirements, if any The Plan may also limit its offering of coverage in the small group market as otherwise permitted by applicable law or regulatory guidance.

**B. Payment of Premiums**

The Plan will bill new Policyholders for their first month's premium after coverage applications are approved. The Plan does not require initial premium payment (also called binder payment) at enrollment. The first premium payment and subsequent premium payments are due and payable on the due date, which is the first day of each Premium Period. The Premium Period is specified in the Benefit Program Application and/or other appropriate document.

**C. Premium Computation**

**1.** The premium payment due for this Policy on any premium due date is the aggregate amount composed of the Individual and Family Coverage premiums for all Insureds covered for the benefits provided under this Policy, as specified in the Benefit Program Application and/or other appropriate document; the benefit program and premium notification letter, if any; or applicable rate summary(ies), if any. Further, if an Eligible Person becomes a Covered Person during a Premium Period or if a Covered Person's coverage is terminated during a Premium Period, the Plan will determine the premium due for such Covered Person for such period.

**2.** The Plan may establish a new premium for any of the individual or aggregate benefits of this Policy on any of the following dates or occurrences, upon which further premium payments, including the one then due, will be computed:

**a.** Any Policy Anniversary Date, provided that the Plan notifies the Policyholder of such new premium at least sixty (60) days prior to such date;

**b.** Any premium due date, provided the Plan notifies the Policyholder of such new premium at least sixty (60) days in advance of such premium due date;

**c.** Whenever the benefits under this Policy are changed;

**d.** Whenever a class of persons is made eligible or is eliminated from eligibility;

**e.** Whenever the enrollment fluctuates by ten percent (10%) or more;

**f.** Whenever the Plan is obligated to pay any new taxes, Surcharges or other fees imposed upon or resulting from this Policy including, but not limited to, premium taxes or taxes on the Plan's benefits or services provided under this Policy; and

**g.** Whenever there is a legislative or regulatory mandate or requirement for a change in benefits or administrative services which would require additional premium or as otherwise permitted by law.

**3.** If the age, tobacco use, or geographic location, number of family members, or other factors, of a Covered Person under this Policy upon which a particular premium is based has been misstated, the Policyholder shall be responsible for paying the Plan an adjusted amount which will provide the Plan with the correct premium calculated from the Coverage Date of the particular Covered Person.

**4.** Premium rates are based upon the amount of taxes, fees, Surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, Surcharges or other amounts which the Plan is required to pay or remit are increased during the Policy year, to the extent and at the time permitted by applicable law, the Plan reserves the right, at its option, to charge Policyholder for such amounts or adjust the premium rates to reflect such increase, on the effective date of such increase. Upon request, Policyholder shall furnish to the Plan in a timely manner all information necessary for the calculation or administration of any such taxes, fees, Surcharges or other amounts.

**D. Grace Period and Termination for Non-Payment**

**1.** A grace period of thirty (30) days will be allowed for payment of any premium after the first payment. During such grace period this Policy will continue in force provided that the Policyholder has not, prior to the premium due date, given adequate timely written notice to the Plan that this Policy is to be terminated as of such premium due date.

In addition, if the Policyholder is in default of its obligation to make any premium payment as provided hereunder or if any other default hereunder or contract between Policyholder and the Plan has occurred and is continuing, then any indebtedness from the Plan to the Policyholder (including any and all contractual obligations of the Plan to the Policyholder) may be offset and/or recouped and applied toward the payment of the Policyholder's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Policyholder.

**2.** If the Policyholder does not pay the premium during the grace period, this Policy will be terminated, at the Plan's option, on the last day of the grace period and the Policyholder will be liable to the Plan for the payment of all premiums then due.

**E. Reinstatement**

After coverage is terminated for non-payment of premiums, the Plan or its duly authorized agents must affirmatively accept overdue premium payments, which may include a Reinstatement Fee, in order to fully reinstate the Policy. For purposes of this Section, mere receipt of a late premium payment does not constitute acceptance. Any reinstatement of the Policy shall not be deemed a waiver of either the Policyholder's requirement of timely premium payment or the Plan's right of termination for default in premium payment in the event of any future failure of the Policyholder to make timely premium payments. Terms and conditions of reinstatement may include a Reinstatement Fee determined by the Plan, and not to exceed one percent (1.0%) of unpaid premiums.

**F. Late Fee**

If the Policyholder fails to pay premiums when due, the Plan, at its option, may assess a Late Fee for the late premiums from the due date of any amount(s) payable to Plan by Policyholder. This Late Fee shall be an amount equal to the amount resulting from multiplying the past due premiums times the lesser of:

**1.** The rate of up to one percent (1%) per month which equates to an amount of twelve percent (12%) per annum; or

**2.** The maximum rate permitted by state law.

## IV. GENERAL PROVISIONS

**A. The Plan's Separate Financial Arrangements with Providers**

The Policyholder's experience account under this Policy, if any, the maximum amount of benefits payable by the Plan under this Policy and all required Deductible and Coinsurance amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or Provider's Claim Charge less the ADP for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Plan Provider and the Plan as referred to below.

The Plan hereby informs the Policyholder and all Covered Persons and the Policyholder and all Covered Persons hereby acknowledge that the Plan has contracts with Plan Providers for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates, group policies and contracts to which the Plan is a party, including the Covered Persons under this Policy. Pursuant to the Plan's contracts with Plan Providers, under certain circumstances described therein, the Plan may receive substantial payments from Plan Providers with respect to services rendered to all such persons for which the Plan was obligated to pay Plan Providers, or the Plan may pay Plan Providers substantially less than their Claim Charges for services, by discounts or otherwise, or may receive from Plan Providers other substantial allowances under the Plan's contracts with Plan Providers. The Policyholder understands and acknowledges that the Plan may receive such payments, discounts and/or other allowances during the term of this Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

**B. The Plan's Separate Financial Arrangements Regarding Prescription Drugs**

**1. The Plan's Separate Financial Arrangements with Participating Prescription Drug Providers**:

The Policyholder's experience account under this Policy, if any, the maximum amount of benefits payable by the Plan and all required Deductible and Coinsurance amounts under this Policy, shall be calculated on the basis of the

Provider's Eligible Charge or the agreed upon amount between the Participating Prescription Drug Provider as defined below, and the Plan, whichever is less.
The Plan hereby informs the Policyholder and all Covered Persons that it has contracts 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 Plan is a party, including the Covered Persons under this Policy, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive payments, discounts and/or allowances for prescription drugs dispensed to Covered Persons under this Policy.

The Policyholder understands that the Plan may receive such payments, discounts and/or allowances during the term of this Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or allowances in excess of any amount that may be reflected in the premium specified on the Benefit Program Application and/or other appropriate document; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, or that may be part of any experience rating refund, if applicable to this Policy, or otherwise.

**2. The Plan's Separate Financial Arrangements with Pharmacy Benefit Managers:**

The Plan hereby informs the Policyholder and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC ("Prime") and that the Plan 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 Plan is a party, including the Covered Persons under this Policy. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with the Plan. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime.

The Policyholder understands that the Plan may receive such rebates during the term of this Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such rebates in excess of any amount that may be reflected in the premium specified on the Benefit Program Application and/or other appropriate document; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, or that may be part of any experience rating refund, if applicable to this Policy, or otherwise.

## C. Inter-Plan Arrangements

### 1. Out-of-Area Services

**Overview**

The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees, referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Covered Persons access healthcare services outside the geographic area the Plan serves, the Claim for those services

may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area the Plan serves, Covered Persons obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Covered Persons may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. The Plan remains responsible for fulfilling the contractual obligation to Covered Persons. The Plan's payment practices in both instances are described below.

**2. BlueCard® Program**

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

**a. Liability Calculation Method Per Claim**

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

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

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

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

**iii.** An average price. An average price is a percentage of billed charges for Out-of-Area Covered Services in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues determine whether or not they will use an actual, estimated or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over or

underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for Claims already paid or anticipated to be paid to Providers or refunds received or anticipated to be received from Providers). However, the BlueCard Program requires that the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims. The method of Claims payment by Host Blues is taken into account by the Plan in determining the Policyholder's premiums.

**3. Negotiated Arrangements**

Instead of using the BlueCard Program, the Plan may process the Covered Person's Claims for Covered Services through Negotiated Arrangements.

If the Plan and Policyholder have agreed that (a) Host Blue(s) shall make available (a) Provider network(s) in connection with this Policy, then the terms and conditions set forth in the Plan's Negotiated Arrangement(s) with such Host Blue(s) shall apply.

If the Plan has entered into a Negotiated Arrangement with a Host Blue, Covered Person liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Subsection C.2. BlueCard Program) that the Host Blue makes available to the Plan that allows Policyholder's Covered Persons access to negotiated participation agreement networks of specified Participating Providers outside of the Plan service area.

**4. Special Cases: Value-Based Programs**

**a. BlueCard Program**

The Plan has included a factor for bulk distributions from Host Blues in the Policyholder's premium for Value-Based Programs when applicable under this Policy.

**b. Negotiated Arrangements**

If Plan has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Policyholder's Covered Persons, the Plan will follow the same procedures for Value-Based Programs as noted above for the BlueCard Program.

**5. Return of Overpayments**

Recoveries from a Host Blue or its Participating and Non-Participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, Provider/Hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied, in general, on a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Plan, they will be credited to Policyholder's account. In some cases, the Host Blue will engage a third party to assist in the identification or collection of overpayments. The fees of such a third-party may be charged to Policyholder as a percentage of the recovery.

**6. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

In some instances, federal or state laws or regulations may impose a Surcharge, tax or other fee that applies to insured accounts. If applicable, the Plan will include

any such Surcharge, tax or other fee in determining the Policyholder's premium.

**7. Non-Participating Providers Outside the Plan's Service Area**

**a. Covered Person's Liability Calculation**

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) a Covered Person pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangement required by applicable state law. In these situations, the Covered Person may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

**b. Exceptions**

In some exception cases, at the Policyholder direction, the Plan may pay Claims from Non-Participating healthcare Providers outside of the Plan service area based on the Provider's billed charge. This may occur in situations where a Covered Person did not have reasonable access to a Participating Provider, as determined by the Plan in sole and absolute discretion or by applicable state law. In other exception cases, at Policyholder's direction, the Plan may pay such Claims based on the payment the Plan would make if the Plan were paying a Non-Participating Provider inside of the Plan' service area, as described elsewhere in this Policy. This may occur where the Host Blue's corresponding payment would be more than the Plan's in-service area Non-Participating Provider payment. The Plan may choose to negotiate a payment with such a Provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Covered Person may be responsible for the difference between the amount that the Non-Participating healthcare Provider bills and payment the Plan will make for the Covered Services as set forth in this paragraph.

**8. Blue Cross Blue Shield Global® Core**

**General Information**

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

**Outpatient Services**

Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard Service Area will typically require Covered Persons to pay in full at the

time of service. Covered Persons must submit a Claim to obtain reimbursement for Covered Services.

**Submitting a Blue Cross Blue Shield Global Core Claim**
When Covered Persons pay for Covered Services outside the BlueCard Service Area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Covered Persons should complete a Blue Cross Blue Shield Global Core Claim form and send the Claim form with the Provider's itemized bill(s) to the service center address on the form to initiate Claims processing. The Claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If a Covered Person needs assistance with their Claim submissions, they should call the service center at 800-810-BLUE (2583) or call collect at 804 673 1177, 24 hours a day/seven days a week.

**D. Records of Covered Person Eligibility and Adjustments**

The Policyholder must furnish to the Plan data as may be required by the Plan regarding the Covered Persons who are to be covered under this Policy. Data includes, but is not limited to, records and information provided to the Plan by another party that determines eligibility and/or premiums for this Policy. Such data may include, without limitation, a list of Covered Persons who are to be covered under this Policy, completed application cards of the Insureds and information required by the Plan to identify dual coverage situations which are subject to MSP laws. It is the Policyholder's obligation to notify the Plan no later than thirty-one (31) days after the effective date of any change in a Covered Person's status under this Policy. All such notifications by the Policyholder to the Plan (including, but not limited to, forms and tapes) must be furnished in a format approved by the Plan and must include all information reasonably required by the Plan to effect such changes. It is also Policyholder's obligation to obtain the required consent(s) from Covered Persons for the Plan to contact Covered Persons by telephone, text, including by pre-recorded message, artificial voice, or by use of an automatic dialing system. Minor clerical errors in keeping or reporting data relative to coverage under this Policy will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. Examples of such minor clerical errors include, but are not limited to, errors appearing in an individual's name, address, or birth date as well as typographical errors. The term "minor clerical errors" as used herein does not include Policyholder errors which may materially affect an individual's coverage under this Policy. It is further understood and agreed that the Policyholder is liable for any substantive error made by the Policyholder in keeping or reporting data which may materially affect an individual's coverage under this Policy and for any benefits paid for a terminated Covered Person if the Policyholder had not timely notified the Plan of such Covered Person's termination. All such data is the sole property of, and owned by, the Plan.

No waiting period may exceed ninety (90) days unless permitted by applicable law or regulatory guidance. If the Plan's records show that Policyholder has a waiting period that exceeds the time period permitted by applicable law or regulatory guidance, then the Plan reserves the right to begin a Covered Person's coverage on a date that the Plan believes is within the required period.

During the term of this Policy and within one hundred eighty (180) days after the termination of this Policy, the Plan may, upon at least thirty (30) days prior written notice to the Policyholder, conduct reasonable audits of the Policyholder's membership records with respect to eligibility.

The Policyholder hereby agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs) or liability that may arise from or in connection with untimely and/or inaccurate data provided by the Policyholder or on the Policyholder's behalf to the Plan, or data furnished by the Policyholder or on the Policyholder's behalf to the Plan in a format not approved by the Plan.

**E. Providing Data to Policyholder's Vendor(s)**

**1.** If the Policyholder requests the Plan to provide data directly to Policyholder's third-party consultant and/or vendor (the "Policyholder's Vendor"), and the Plan agrees in its sole discretion, then the Policyholder acknowledges and agrees that it shall require Policyholder's Vendor(s) to execute the Plan's then-current data exchange agreement as required by the Plan. The Policyholder hereby acknowledges and agrees, and Policyholder's Vendor(s) shall acknowledge and agree:

**a.** That the requested documents, records and other information (for the purposes of this Section, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal the Plan's Business Confidential Information, defined below in Section U.

**b.** To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for the purposes of this Section, collectively, "Information") and to prevent unauthorized use or disclosure by Policyholder's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Policyholder, to the same extent that it protects its own confidential information.

**c.** To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed.

**d.** To maintain the Information in a specific location under its control and take reasonable steps to safeguard the Information.

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

**f.** To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Policy or as required by law.

**g.** To not sell, re-sell or lease the Information.

**h.** To securely return or securely destroy the Information at the direction of the Plan or within a reasonable time after the termination of this Policy, not to exceed sixty (60) days thereafter.

**i.** To notify the Plan in the event of any unauthorized access, impermissible disclosure or breach of Policyholder's Information.

**2.** Policyholder shall:

**a.** Provide the Plan in writing the names of any Policyholder's Vendor(s) with whom the Plan is authorized to release, disclose or exchange data, and provide written authorization and specific directions with respect to such release, disclosure, or exchange for Plan administration functions. If Policyholder's Vendor(s) is/are under contract to perform services that are not considered Plan administration functions and involve the use, access or disclosure of Protected Health Information as defined by Health Insurance Portability and Accountability Act ("HIPAA"), the Plan shall execute a HIPAA complaint Insured Group Certification ("IGC") that identifies the Policyholder's Vendor(s) and includes the other information requested in the IGC.

**b.** Indemnify, defend (at the Plan's request), and hold harmless the Plan 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 Plan in connection with any claim based upon the Plan's directed disclosure, including but not limited to disclosure of Protected Health Information, to the designated Policyholder's Vendor(s), if consistent with Policyholder's directions, of any information and/or documentation or breach by Policyholder's Vendor(s) of any obligation described in this Policy. In lieu of defense by Policyholder, the Plan 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 Policyholder.

**F. Termination of a Covered Person's Coverage**

**1.** The termination date specified by the Insured, if the Insured provides reasonable notice.

**2.** If an Insured, with or without cause, ceases to be an Eligible Person, such Insured's coverage (and the coverage of other Covered Persons under Family Coverage) will automatically terminate at the expiration of the period for which the premium has been paid.

**3.** If a Covered Person ceases to meet the definition of Covered Person, such Covered Person's coverage will automatically terminate on the date that the event occurs which causes the Covered Person to no longer meet this definition. However, if such date falls within a period for which premiums have been accepted by the Plan for such Covered Person, coverage will automatically terminate at the expiration of the period for which the premium has been paid.

**4.** A Covered Person's coverage under this Policy will automatically terminate at the expiration of the Premium Period in which such Covered Person becomes eligible for Medicare except for those benefits, if any, which are specifically provided under this Policy for Medicare eligible Covered Persons and coverage in accordance with MSP laws.

**5.** Termination of this Policy automatically terminates all the coverages of all Covered Persons. It is the responsibility of the Policyholder to notify all Covered Persons of the termination of this Policy, but all coverages will automatically

terminate as of the effective date of termination of this Policy regardless of whether such notice is given.

**6.** No benefits are available to a Covered Person for services or supplies rendered after the date of termination of such Covered Person's coverage under this Policy, except as otherwise specifically provided in the Certificate Booklet.

**G. Notice and Proof of Claim**

**1.** The Plan will not be liable under this Policy unless a Claim for benefits is furnished to the Plan at its office at 300 East Randolph Street, Chicago, Illinois, 60601-5099 on or before December 31st of the calendar year following the year in which Covered Services were rendered. For purposes of this paragraph, Covered Services furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.

**2.** Upon receipt of written request to the Plan, the Insured will be provided with the forms necessary for filing Claims under this Policy. If such forms are not furnished within fifteen (15) days of the Plan's receipt of such request, the Insured shall be deemed, with respect to the particular Claim, to have complied with the requirements of this Policy pertaining to Claim forms upon submitting to the Plan within the time limit specified above for filing Claims, written notice including the Covered Person's name, age, sex and identification card number, the name and address of the Provider, a specific itemized statement of the service(s) rendered or furnished (including appropriate codes), the date(s) of service(s), the Claim Charge, and any other information which the Plan may request in connection for such service(s). An expense will be considered to have been incurred on the date the service or supply for which the Claim is made was rendered or received.

**3.** Failure to furnish a Claim to the Plan within the time limit specified above for filing Claims shall not invalidate or reduce any Claim if it were not reasonably possible to furnish the Claim within such time limit, provided such Claim is furnished to the Plan, as soon as possible and in no event, except in the absence of legal capacity, later than one (1) year from the time the Claim is otherwise required.

**H. Payment of Claims and Assignment of Benefits**

All payments by the Plan for the benefit of any Covered Persons may be made directly to any Provider furnishing Covered Services for which such payments are due, and the Plan is authorized by such Covered Person to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Policy directly to the Covered Person, unless reasonable evidence of a properly executed and enforceable assignment of benefit payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the assignment of benefit payment.

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

Except for the assignment of benefit payment described above, coverage under this Policy and a Covered Person's Claims or rights under this Policy, including but not limited to Claims for payment for benefits, are expressly non-assignable and non-transferable in whole, or in part, to any person or entity, including any Provider, at any time. Any such

assignment or transfer of a Claim for payment of benefits or coverage shall be considered null and void. Coverage under this Policy is expressly non-assignable and non-transferable and will be forfeited if the Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under this Policy. However, if the Plan 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 Plan will have no obligation to pursue such payment.

**I. Covered Person/Provider Relationship**

**1.** The choice of a Provider is solely the choice of the Covered Person, and the Plan will not interfere with the Covered Person's relationship with any Provider.

**2.** It is expressly understood that the Plan does not itself undertake to furnish Hospital, medical, or dental service, but acts solely to make payment to a Provider for the Covered Services received by Covered Persons. The Plan 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 Plan. Any contractual relationship between a Provider and the Plan shall not be construed to mean that the Plan is providing professional service.

**3.** The use of an adjective such as Plan or Participating in modifying 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 Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

**4.** Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's ERISA Health Benefit Program.

**5.** The Plan may, in accordance with and subject to all applicable laws and regulations, utilize nationally recognized standards and guidelines to rate, and rank Physicians, and may publish and make available to Policyholder and Covered Persons certain physician-specific information that includes, and is not limited to, ratings, rankings, and other comparisons of a physician's performance against certain standards, measures and other physicians. Plan may publish and/or share such information with Policyholder, Covered Persons and other third parties. Notwithstanding this or any other provisions of this Policy to the contrary, in no event shall any reference or statement by Plan about a physician or Provider be construed as a recommendation or referral to such physician or Provider, or as a guarantee related to future services provided by any physician or Provider or the anticipated outcome of such services.

**J. Agency Relationships**

**1.** Nothing in this Policy shall be construed to constitute the Policyholder as an agent of the Plan. The Policyholder is the agent of the Covered Persons.

**2.** Providers are not employees, agents or other legal representatives of the Plan.

**K. MSP Provisions**

The Policyholder has certain obligations under the MSP statute.

**1.** For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") (P.L.110-173), the Plan shall serve as the Responsible Reporting Entity ("RRE") and shall 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 Plan can effectively coordinate health care payments consistent with the MSP rules. Policyholder hereby authorizes and directs the Plan to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so the Plan may make accurate primary/secondary MSP determinations. Policyholder agrees to timely and accurately respond to the Plan's requests for information.

**2.** It shall be Policyholder's responsibility to notify the Plan promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Policyholder 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 Policyholder that place it in, or take it out of, the scope of the MSP statute.

**3.** Policyholder acknowledges that Policyholder shall be responsible for any Civil Money Penalties ("CMP") imposed against the Plan as a result of Policyholder's failure to promptly notify the Plan of any change in the number of individuals employed by Policyholder or status of its Employees that might affect the order of payment under the MSP statute.

**4. Disclosure Statement**

The Policyholder acknowledges that the Plan has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare as Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Association and reviewed by CMS, which administers Medicare.

**5.** Notwithstanding any other provision herein, in instances where the Policyholder has carved out prescription drug coverage administration to an entity other than the Plan, the Plan shall not serve as the RRE for prescription drug coverage under the Policy.

**L. ERISA**

This Section applies to any Policyholder which implements any employee welfare benefit plan as defined by Section 3 (2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

**1.** The Policyholder (or (i) if the Policyholder is a trust, the grantor of such trust or (ii) if the Policyholder is an association, each member of such association who pays premiums under such Policy) has established and as sponsor maintains pursuant to other written documents a health benefit program ("Policyholder's ERISA Health Benefit Program"), affording benefits to its eligible employees or eligible members and their dependents through the purchase of insurance, which Policyholder's ERISA Health Benefit Program is an "employee welfare benefit plan" within the meaning of ERISA. Notwithstanding anything contained in the employee welfare benefit plan document of the Policyholder (or any Policyholder member, if the Policyholder is an association), the Policyholder agrees that no

allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Policyholder (or any Policyholder member, if the Policyholder is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in this Policy or as otherwise accepted in writing by the Plan. The administrator under ERISA for a Policyholder's ERISA Health Benefit Program is the Policyholder or such other persons (other than the Plan) appointed by the Policyholder (or (i) if the Policyholder is a trust, by the grantor of such trust or (ii) if the Policyholder is an association, by each member of such association who pays premiums under such Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Policy. The Plan will not be required to examine the provisions of a Policyholder's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.

**2.** This Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). This Policy is an asset of the Policyholder. No assets of the Plan or amounts which have been paid to the Plan under this Policy are assets of or under Policyholder's ERISA Health Benefit Program.

**M. Initial Plan Participation Requirements, Benefit Plan Status, Plan Documents, and Retaliation**

**1.** It is the Policyholder's responsibility, prior to the Policy Effective Date (i) to determine initial plan participation requirements and categories of coverage options for employees, former employees, officers and directors in compliance with all applicable law, including but not limited to discontinuing any waiting periods that are longer than permitted by applicable law; (ii) to comply with nondiscrimination requirements applicable to its benefit plan, including but not limited to those related to highly compensated individuals; and (iii) to determine its regulatory status, including but not limited to determining whether it meets the federal and state law (as applicable) definitions of "small group", "large group", "MEWA", and/or "Association". Policyholder will promptly notify the Plan of its determinations (and any changes thereto) and will promptly notify the Plan when a person has satisfied the initial participation requirements and also meets the definition of a Covered Person under this Policy. In addition, Policyholder (iv) is responsible for establishing and/or amending its own plan documents as necessary; (v) must not retaliate against any employee for engaging in activities protected by applicable law, including but not limited to receiving subsidized coverage under a qualified health plan through an exchange; and (vi) ensuring that Health Savings Accounts and Health Reimbursement Accounts are funded in accordance with the Policyholder's funding decisions that Policyholder has communicated to the Plan, if any. In no event will the Plan have responsibility for such initial plan participation or plan status determinations or for Policyholder's plan documents, its actual or alleged retaliation or funding decisions. Upon request, Policyholder will provide the Plan with information to substantiate such determinations and responsibilities. Policyholder hereby agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs) or liability resulting from the Policyholder's failure to carry out its responsibilities or obligations as set forth in this Policy. If a person is added to this Policy and later determined to have been ineligible, the Plan reserves the right to terminate or rescind such person's coverage to the extent permitted by applicable law. If a person is added to this

Policy and it is later determined that the Policyholder reported a Coverage Date earlier than what would apply, based on the waiting period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the Coverage Date for such person.

**2.** This Subsection M.2. applies to the extent that Policyholder directs the Plan to offer to Covered Persons who participate in a high Deductible group health plan coverage for drugs prior to satisfaction of the otherwise required Deductible (the "Preventive Drug Program"). Policyholder acknowledges that the Preventive Drug Program is a plan design decision of Policyholder in its role as plan sponsor and that certain drugs under the Preventive Drug Program may be either to treat disease or for a preventive purpose. The Plan does not provide legal or tax advice to Policyholder and Policyholder is not relying on the Plan for any tax or legal advice in connection with the Preventive Drug Program. As the Preventive Drug Program is a plan design decision of Policyholder, the Policyholder will indemnify the Plan against, and hold the Plan harmless from, any and all loss, damage, fine, penalty, tax, charge, liability, cost, and expense, including without limitation, attorneys' fees and disbursements, that may be incurred by, imposed upon, paid by or asserted against the Plan which is related to or arises from the Preventive Drug Program.

**N. Service Mark**

On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that this Policy constitutes a contract solely between the Policyholder and the Plan. The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The Association permits the Plan to use the Blue Cross and/or Blue Shield Service Mark(s) in the Plan's service area and the Plan is not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into this Policy based upon representations by any person other than authorized persons of the Plan and that no person, entity or organization other than the Plan shall be held accountable or liable to the Policyholder for any of the Plan's obligations to the Policyholder created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those obligations created under other provisions of this Policy.

**O. Applicable Law**

It is the intent of the parties to this Policy that it is issued, delivered, entered into, executed in and will be subject to and interpreted by the laws of the state of Illinois, and in the event of any controversy between the Policyholder and/or any Covered Person and the Plan, this provision will apply.

**P. Incontestability**

After this Policy has been in force two (2) years from the date of its issue, no statement of the Policyholder, except fraudulent misstatements, shall be used to void this Policy; and no statement by any Insured shall be used to reduce or deny a Claim after the insurance coverage, with respect to which a Claim has been made, has been in effect two (2) years or more.

**Q. Limitations of Actions**

No civil action shall be brought to recover under this Policy or any individual Certificate Booklet pursuant to this Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time a Claim is

required to be furnished to the Plan. No extension of the time granted under the Notice and Proof of Claim provisions of this Policy shall in any way extend this Limitation of Actions provision.

**R. New Insureds**

There shall be added from time to time to the group or class originally insured under this Policy, all new Eligible Persons of the Policyholder, members of the association or employees of members eligible for coverage and applying for coverage in such group or class in accordance with the terms of this Policy.

**S. Reimbursement Provision**

If an Insured or an Insured's covered dependent 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 Certificate Booklet, the Insured shall agree:

**1.** The Plan has the right to reimbursement for all benefits the Plan 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 Plan has provided benefits to the Covered Person, reduced by any ADP applicable to the Covered Person's Claim or Claims.

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

The Plan 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 Plan 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 Plan may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

**T. Severability**

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy, and this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

**U. Proprietary Materials**

**1.** **Types of materials as may be used by the Parties**. The Policyholder acknowledges that the Plan has developed, acquired, or owns certain Business Confidential Information. "Business Confidential Information" includes, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated Claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to Provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and

customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures and any other information that reasonably should be understood to be confidential whether developed or acquired before or after the Policy Effective Date. "Business Confidential Information" also includes modifications, enhancements, derivatives, and improvements of Business Confidential Information described in the preceding sentence.

The Policyholder shall not use or disclose to any third-party Business Confidential Information without prior written consent of the Plan. If the Policyholder believes it is required by law to disclose Business Confidential Information of the Plan, it shall provide written notice to the Plan, so that the Plan has the opportunity to object and ensure appropriate confidentiality protections are in place. 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 Plan may include the Policyholder in its list of clients.

**2.** **Plan/Association Ownership**. The Policyholder acknowledges that the Plan's Proprietary Marks and Business Confidential Information are the sole property of the Association or of the Plan and agrees not to contest the Association's or the Plan's ownership or the license granted to the Plan for use of such Proprietary Marks.

## V. Information and Medical Records

**1.** All Claim information, including, but not limited to, medical records, received by the Plan in the performance of its duties hereunder will be kept confidential by the Plan and except for reasonably necessary use by the Plan in connection with the performance of its duties hereunder, the Plan shall not disclose such confidential Claim information without the authorization of the Covered Person or as otherwise required or permitted by applicable law.

**2.** The Plan may release to the Policyholder Claim information regarding the provision of Covered Services to Covered Persons and copies of records to the extent required or permitted by applicable law, including but not limited to HIPAA. Any information so obtained by the Policyholder shall be kept confidential, as required by applicable law.

**3.** The Policyholder acknowledges that each Covered Person agrees it is the Covered Person's responsibility to ensure that any Provider, Blue Cross and/or Blue Shield Plan, insurance company, employee benefit association, governmental body or program, or any other person or entity having knowledge of or records relating to (1) any illness or injury for which a Claim or Claims for benefits are made under this Policy, (2) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan, or its agent, and agrees that any such Provider, person or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to other Providers, Blue Cross and/or Blue Shield Plans, insurance companies, governmental bodies or

other entities providing insurance-type benefits requesting the same. It is also the Covered Person's responsibility to furnish to the Policyholder and/or Plan information regarding the Covered Person's becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that the Plan be able to make Claim Payments in accordance with MSP laws.

**W. Premium Rebates or Premium Abatements**

**Rebate.** In the event federal or state law requires the Plan to rebate a portion of annual premiums paid, the Plan will provide any rebate as required or allowed by such federal or state law.

**Abatement.** The Plan may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s). Any abatement of premium by the Plan represents a determination by the Plan not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

**Administrative.** The Policyholder hereby gives the Plan assurances that Policyholder is obligated to, and will, pay or credit such rebates or abatements to its Insureds to the extent and in the manner required by applicable law. The Policyholder shall provide the Plan with any information, records and documentation that the Plan may require or request with regard to the subject matter of this Section in a time, form and manner specified by the Plan.

The Plan will rely upon such information, records and documentation as accurate and complete.

The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of the Policyholder and any Insured or former Insured (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws and regulations. The Policyholder shall assure appropriate notification to federal and state tax agencies and that any payment to the Insureds and former Insureds (if applicable) will be accompanied by appropriate federal and state documentation, e.g., Form 1099 or W-2.

The Policyholder agrees to indemnify and hold the Plan harmless against any and all claims, demands, costs, fines, losses, interest, settlements, judgments, damages, penalties, taxes, expenses (including reasonable attorneys' fees) or other liabilities resulting from the Policyholder's failure to carry out its responsibilities or obligations as set forth in this Policy.

**X. Overpayments**

If the Plan pays benefits under this Policy and it is found that the payment was more than it should have been, or was made in error ("Overpayment") the Plan has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan or (iii) any other persons, entities, or organizations, including but not limited to Providers. The Plan will follow its recovery processes, including, but not limited to those items described below ("Recovery Process(es)").

Unless otherwise agreed upon between the Plan and a Provider, if no refund is received, the Plan has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

1. any future benefit payment made to any person or entity under this Policy, whether for the same or a different person;

2. any future benefit payment made to any person or entity under another Plan-administered ASO benefit program and/or Plan-administered insured benefit program or Policy;

3. any future benefit payment made to any person or entity under another Plan-insured group benefit plan or individual policy;

4. any future benefit payment, other payment, made to any person or entity;

5. any future payment owed to one or more Providers; or,

6. for deductions for two (2) or more Overpayments collectively, from future payments owed to another policy or plan as part of a single transaction, resulting in Overpayment recovery amount, which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to offset as otherwise set forth in this Section.

Further, the Plan has the right to reduce this Policy's payment to a Provider by the amount necessary to recover another Plan policy's or plan's overpayment to the same Provider and to remit the recovered amount to the other Plan policy or plan. Policyholder authorizes and agrees to the Plan's recovery of Overpayments in accordance with its Recovery Process, and Policyholder has no separate or independent right to recover any Overpayments from the Plan, Providers, or another policy or plan.

**Y. Dispute Resolution**

Any dispute arising out of or related to this Policy shall be resolved in accordance with the procedures specified in this Section, which shall be the sole and exclusive procedures for the resolution of any such disputes.

1. **Initial Notice and Negotiation.** Policyholder or the Plan shall give written notice to the other party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the parties shall seek to resolve that dispute through informal discussions between authorized representatives of the parties with appropriate authority to approve any resolution. All negotiations pursuant to this Section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

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

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

   b. Arbitration shall be held in Chicago, Illinois.

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

**d.** The arbitrator shall be required to issue a written opinion resolving all disputes in any matter and designating one party as the prevailing party, regardless of the amount in controversy.

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

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

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

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

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

## V. NOTICES

Any notice given or required under this Policy, the Certificate Booklet, or any individual certificate will be a written notice by mail. The Plan may also provide such notices electronically, to the extent permitted by applicable law or regulatory guidance. If such notice is given to the Policyholder, it will be addressed to it at its office address stated in the Benefit Program Application and/or other appropriate document, if any, or to its address as it appears on the records of the Plan. If such notice is given to the Plan, it should be addressed to the Plan at its office at 300 East Randolph Street, Chicago, Illinois 60601-5099. If such notice is given by the Plan to a Covered Person, it will be addressed to the Covered Person at the address as it appears on the records of the Plan or in care of the Policyholder. The Policyholder and the Plan may, by written notice served on the other, indicate a new address for giving such notice.

## VI. RENEWABILITY OF THIS POLICY

This Policy shall be renewable, at the option of the Policyholder, with respect to all Covered Persons except in the following instances:

**A.** When the Policyholder has failed to pay the premiums or make contributions in accordance with the terms of this Policy, or the Plan has not received timely payments;

**B.** When the Policyholder has engaged in intentional fraud or made an intentional misrepresentation of material fact under the terms of coverage;

**C.** When the Plan discontinues offering group coverage in the small group market and acts in accordance with applicable laws, as described in Section VII below;

**D.** Where health insurance coverage is offered in the market through a network plan, there is no longer any Covered Person in the plan who lives, resides, or works in the network service area of the Plan or lives in the Plan's service area, and, in the case of the small group market, the Plan would deny enrollment with respect to such plan, and ninety (90) days advance notice (or such other notice, if any, required by applicable law) is given to the Policyholder and Covered Persons prior to discontinuations;

**E.** Noncompliance with the Plan's employer participation and/or contribution requirements, if any;

**F.** Cessation of Policyholder's membership in a bona fide association, but only if coverage is terminated uniformly without regard to the health status of any Covered Person; or,

**G.** Where otherwise permitted by applicable law or regulatory guidance.

## VII. DISCONTINUANCE OF COVERAGE

### A. Discontinuance of a Particular Product

The Plan may discontinue the Policyholder's benefit plan product under this Policy if the Plan:

**1.** Provides ninety (90) days advance notice to the Policyholder and Covered Persons (or such other notice, if any, required by applicable law or regulatory guidance);

**2.** Offers the Policyholder the option to purchase all or any other health insurance coverage currently offered by the Plan to other employers of similar circumstance, including, but not limited to, employer size; and

**3.** Acts uniformly without regard to the Claims experience of the Policyholder or the health status of any existing, new or potentially new Covered Persons.

The Plan may discontinue coverage under this Policy as otherwise permitted by applicable law or regulatory guidance.

### B. Discontinuance of All Coverage

The Plan may discontinue all coverage in the small group market in a state in accordance with applicable law and provided that the Plan:

**1.** Provides one-hundred eighty (180) days advance notice to the Policyholder and Covered Persons (or such other notice, if any, required by applicable law); and

**2.** Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the state in such market(s).

## VIII. UNIFORM MODIFICATION

The Plan may modify health insurance coverage for a product offered to a group health plan in the small group market, if, as to coverage available in such market other than only through one or more bona fide associations, the modification is consistent with the applicable law and effective uniformly among group health plans with that product.

## IX. POLICYHOLDER NOTIFICATION TO COVERED PERSONS

It is the responsibility of the Policyholder to notify all Covered Persons in the event of the Plan's uniform modification of coverage, uniform termination of coverage or discontinuance of coverage in a market segment.

## X. TERM AND TERMINATION OF THIS POLICY

**A.** The Policyholder may terminate this Group Administration Document and/or the entire Policy on the first Policy Anniversary Date or on any premium due date after the first Policy Anniversary Date by giving written notice to the Plan at least thirty (30) days prior to the last day of coverage.

**B.** This Policy will be terminated, at the Plan's option, for the Policyholder's non-payment of the appropriate premium when due and as otherwise required or permitted by this Policy or applicable law.

## XI. ELECTRONIC EXCHANGE OF DATA

In the event the Policyholder and the Plan exchange various data and information electronically, the Policyholder agrees to transfer on a timely basis all required data to the Plan via secure electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Plan, a copy of which shall be furnished to the Policyholder upon written request to the Plan. The Policyholder authorizes the Plan to submit reports, data, and other information to the Policyholder in the specified electronic format. In the event the Policyholder is unable or unwilling to transfer data in the specified electronic format, the Plan is under no obligation to receive or transmit the data in any other format, unless required to do so by law.

The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by the Plan to the Policyholder for delivery to each Insured. In the event the Plan, provides to the Policyholder an electronic file of any document describing the benefits under, or the administration of, this Policy for the Policyholder's use, including, but not limited to, the Policyholder's or the Plan's posting of such documents on the intranet and/or internet, the Policyholder acknowledges and agrees that such electronic file is not intended to meet the Policyholder's requirements for compliance under ERISA.

The Policyholder further acknowledges and agrees that it is solely responsible for providing employees access, via the intranet, internet, paper copy or otherwise, to the most current version of any electronic file provided to the Policyholder by the Plan. In addition, in all instances, the electronic file of the most current document issued to the Policyholder by the Plan for use by the Policyholder is the legal document used to administer this Policy and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Policyholder is solely responsible for, and holds the Plan harmless from, any and all claims for loss, liability or damages arising from the use or posting of the electronic file on the intranet and/or internet.

The Policyholder agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs), liability or claim that may arise from or in connection with the electronic transfer of data from the Policyholder or the Policyholder's third party consultant and/or vendor to the Plan or from the Plan to the Policyholder, pursuant to Section IV. E. of this Policy, the Policyholder's third party consultant and/or vendor, including liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information, including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmissions and for any Claim arising from the Policyholder's use or posting of electronic files on the intranet and/or internet.

## XII. MASSACHUSETTS HEALTH CARE REFORM ACT

Notwithstanding anything to the contrary in this Policy, with respect to the Policyholder's employees who live in Massachusetts (if any) the Policyholder represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Policyholder will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

## XIII. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

Additional definitions applicable to this Policy are contained in the Certificate Booklet and the Policyholder's Benefit Program Application and/or other appropriate document.

**"Average Discount Percentage ("ADP")"** means an estimated discount percentage on an averaged basis also known as a "network value adjustment" determined by the Plan 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 Plan to be relevant to the particular Claim. The ADP reflects the Plan'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 fifteen percent (15%) of such estimate, to reflect related costs. (See Section IV. A of this Policy entitled The Plan's Separate Financial Arrangements with Providers) In determining the ADP applicable to a particular Claim, the Plan will take into account differences among Hospitals and other facilities, the Plan'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.

**"Benefit Program Application ("BPA")"** means the document(s) and/or website entries and confirmations, through which the Policyholder has applied for health care insurance from the Plan and by which renewals and/or rate or other Policy changes are documented. The BPA may also include a benefit program and premium notification letter, applicable rate summary(ies) and information or decision gathering Form/website.

**"Certificate Booklet"** means the document issued by the Plan to the Policyholder, via an electronic file or access to an electronic file for delivery to each Enrollee.

**"Civil Union"** means a legal relationship between two persons of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act.

**"Claim"** means a properly completed notification in a form acceptable to the Plan, including but not limited to, form and content required by applicable law, that service(s) has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service(s) 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(s) rendered or furnished (including appropriate codes), the date(s) of service(s), the Claim Charge, and any other information which the Plan may request in connection for such service(s).

**"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 Plan and the particular Provider. (See Section IV. A. of this Policy entitled The Plan's Separate Financial Arrangements with Providers).

**"Claim Payment"** means the benefit payment calculated by the Plan, upon submission of a Claim, in accordance with the benefits specified in the Certificate Booklet plus any related Surcharges. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, irrespective of any separate financial arrangement

between the Plan and the particular Provider. (See Section IV. A. of this Policy entitled The Plan's Separate Financial Arrangements with Providers).

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

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

**"Coverage Date"** means the date on which a Covered Person's coverage under this Policy commences.

**"Covered Person"** means the Insured, and if Family Coverage is in force, the Insured's dependents as follows:

**(a)** The Insured's legal spouse, Domestic Partner, if indicated on the BPA, or party to a Civil Union.

**(b)** The children of the Insured or the Insured's legal spouse, Domestic Partner, or a party to a Civil Union, including newborn children, eligible foster children, children who are under the Insured's legal guardianship, children who are in the custody of the Insured pursuant to an interim court order of adoption or placement of adoption, whichever occurs first, vesting temporary care of the children in the Insured, and legally adopted children, who are under the Limiting Age specified in the Benefit Program Application and/or other appropriate document. Hereafter, the word "children" means a natural child, a stepchild, foster child, an adopted child (including a child involved in a suit for adoption,) a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

**(c)** Children, as specified in (b) above, who have attained such Limiting Age but are incapable of self-sustaining employment by reason of disability and are dependent upon the Insured or other care providers for support and maintenance, provided such children were Covered Persons prior to attaining the Limiting Age. Once the Plan has been notified of a Covered Person's disability and dependence, or from the date of the first Claim filed on behalf of such disabled and dependent Covered Person, it may require proof of such Covered Person's disability and dependency at reasonable intervals. For purposes of providing benefits under the Plan, Covered Person does not mean any person who is eligible for Medicare except as specifically stated in the Certificate Booklet.

**(d)** Such other definition of children as required by applicable laws or regulatory guidance.

**"Covered Service"** means a service and/or supply specified in the Certificate Booklet for which benefits will be provided.

**"Deductible"** means the amount of expense that the Covered Person must incur in Covered Services before benefits are provided.

**"Domestic Partner"** means a person with whom the Insured has entered into a Domestic Partnership.

**"Domestic Partnership"** means long-term committed relationship of indefinite duration with a person which meets the following criteria:

**(a)** Insured and Insured's Domestic Partner have lived together for at least six (6) months;

**(b)** Neither Insured nor Insured's Domestic Partner is married to anyone else or has another domestic partner;

**(c)** Insured's Domestic Partner is at least eighteen (18) years of age and mentally competent to consent to contract;

**(d)** Insured's Domestic Partner resides with you and intends to do so indefinitely;

**(e)** Insured and Insured's Domestic Partner have an exclusive mutual commitment similar to marriage; and

**(f)** Insured and Insured's Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**"Eligible Charge"** has the meaning set forth in the Certificate Booklet.

**"Eligible Person"** means an employee of the Policyholder as defined in the Benefit Program Application and/or other appropriate document.

**"Family Coverage"** means coverage for an Insured and one or more other Covered Persons under this Policy.

**"Group Number(s)"** means the number(s) specified on behalf of the Policyholder in the Benefit Program Application and/or other appropriate document.

**"Individual Coverage"** means coverage under this Policy for the Insured only.

**"Insured"** means the person employed by the Policyholder to whom coverage under this Policy has been extended by the Policyholder and to whom the Plan has directly or indirectly issued an identification card bearing the Group Number of the Policyholder. For purposes of providing benefits under this Policy, Insured does not mean any person who is eligible for Medicare and who has elected Medicare as his/her primary coverage except as specifically stated in the Benefit Program Application and/or other appropriate document.

**"Late Fee"** means a charge due to the Plan when Policyholders pay premiums past the due date.

**"Limiting Age"** means the age specified in the Benefit Program Application and/or other appropriate document at which coverage is automatically terminated for covered children.

**"Medicare"** means the programs established by Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

**"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. 1395y(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.

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

**"Plan"** means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

**"Policy"** means this Group Administration Document between the Plan and the Policyholder including any addenda attached hereto; the Certificate Booklet; the Benefit Program Application and/or other appropriate document; the benefit program and premium notification letter, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Insureds.

**"Policy Effective Date"** means the date specified by the Policyholder in the Benefit Program Application.

**"Policyholder"** means the: (1) employing entity, corporation, partnership, sole proprietor or other employer, (2) association, or (3) trust which has executed the Benefit Program Application and/or other appropriate document for this Policy. An ERISA health benefit program may not be a Policyholder hereunder, but a sponsor of or trust implementing an ERISA health benefit program may be a Policyholder hereunder.

**"Provider"** means any health care facility, person or entity duly licensed to render Covered Services to a Covered Person, operating within the scope of the applicable license.

**(a)** **"Plan Provider"** means a Provider which has a written agreement with the Plan to provide services to Covered Persons at the time services are rendered to a Covered Person.

**(b)** **"Non-Plan Provider"** means a Provider which does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.

**"Reinstatement Fee"** means a charge payable to the Plan to reinstate the Policy when termination occurs due to non-payment of premium.

**"Service Mark"** means the names Blue Cross and Blue Shield and the associated logos, along with all related or derivative marks including, but not limited to, any Blue Cross or Blue Shield formulations or designs.

**"Surcharges"** means local, state or federal taxes, surcharges or other fees or amounts paid by the Plan which are imposed upon or resulting from this Policy or are otherwise payable by the Plan. Surcharges may or may not be related to a particular Claim for benefits.

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

## XIV. NOTICE OF ANNUAL MEETING

The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, 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 scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois, 60601-5099, each year on the last Tuesday in October at 12:30 p.m. The Plan pays indemnification or advances expenses to directors, officers, employees, or agents consistent with the Plan's bylaws then in force and as otherwise required by applicable law. For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Insureds or Covered Persons under this Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in this Policy to "premium(s)" shall mean "charge(s)."

IN WITNESS WHEREOF, the Plan hereby accepts the Benefit Program Application of the Policyholder.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Plan President