PROFESSIONAL SERVICES AGREEMENT

EMPLOYER SPONSORED HEALTH INSURANCE BENEFITS

BETWEEN

COOK COUNTY GOVERNMENT

AND

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

CONTRACT NO. 1518-14008

APPROVED BY BOARD OF
COOK COUNTY COMMISSIONERS

OCT 28 2015

PROFESSIONAL SERVICES AGREEMENT

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AGREEMENT

This Agreement is made and entered into by and between the County of Cook, a public body corporate of the State of Illinois, on behalf of Office of the Chief Procurement Officer hereinafter referred to as "County" and Blue Cross and Blue Shield of Illinois ("BCBSIL"), a division of Health Care Service Corporation, a Mutual legal Reserve Company, an Illinois corporation hereinafter referred to as "BCBSIL", pursuant to authorization by the Cook County Board of Commissioners on October 28, 2015, as evidenced by Board Authorization letter attached hereto as Exhibit 11.

BACKGROUND

The County of Cook issued a Request for Proposals "RFP" for the provision of health benefits to Cook County Employees. Proposals were evaluated in accordance with the evaluation criteria published in the RFP. BCBSIL was selected based on the proposal submitted and evaluated by the County representatives.

WHEREAS, the County offers a health maintenance organization benefit plan ("HMO") and a preferred provider organization benefit plan ("PPO") to its employees; and

WHEREAS, the County has selected BCBSIL to provide the aforementioned plans to its employees, in accordance with the Plan Designs attached hereto as Attachment A to Exhibit 1, Scope of Work; and

WHEREAS, BCBSIL represents that it has the professional experience and expertise to provide the necessary Services (as described herein) and further agrees that it is ready, willing and able to perform in accordance with the terms and conditions as set forth in this Agreement; and

WHEREAS, in consideration of the Services provided by BCBSIL, the County agrees to pay BCBSIL an amount not to exceed Eight Hundred Eighty Four Million One Hundred Ninety Five Thousand Five Hundred Dollars ($884,195,500), for the initial three year term of this Agreement as provided herein; and

WHEREAS, the County's funding type elections (self-funded or fully insured) for the Services described herein shall be made on an annual basis as memorialized in the Benefit Program Applications, attached hereto in Exhibit 2; and

WHEREAS, the County's Director of Risk Management has requested authorization by the Cook County Board of Commissioners (the "County Board") to make these annual funding type elections by executing the Benefit Program Applications; and

WHEREAS, such authorization by the County Board is evidenced in Exhibit 11, Board Authorization; and

NOW, THEREFORE, the County and BCBSIL agree as follows:

TERMS AND CONDITIONS

ARTICLE 1) INCORPORATION OF BACKGROUND

The Background information set forth above is incorporated by reference as if fully set forth herein.

ARTICLE 2) DEFINITIONS

a) Definitions

The following words and phrases have the following meanings for purposes of this Agreement:

"**Additional Services**" means those Services which are within the general scope of Services of this Agreement, but beyond the description of Services required under Article 3. Any Additional Services requested by the Using Agency require the approval of the Chief Procurement Officer in a written amendment to this Agreement before BCBSIL is obligated to perform those Additional Services and before the County becomes obligated to pay for those Additional Services.

"**Agreement**" means this Professional Services Agreement, including all Exhibits attached to it and incorporated in it by reference, and all amendments, modifications or revisions made in accordance with its terms, unless specified otherwise.

"Business Proprietary Information" means the following: operating manuals, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, technology, technical documentation, techniques, product or service specifications or strategies, operational plans and methods, automated claims processing systems, payments systems, membership systems, security measures, cost or pricing information, business plans and strategies, symbols, trademarks, service marks, designs, know-how, data, databases, processes, plans, procedures, and information, whether developed or acquired before or after the Effective Date of this Agreement when (i) marked as such by BCBSIL, (ii) BCBSIL advises the County or its representatives as such, or (iii) a reasonable person would consider from the nature of the information, as such. The County will use reasonable efforts to identify Business Proprietary Information. "Business Proprietary Information" also includes modifications, enhancements, derivatives and improvements of the Business Proprietary Information described in the preceding sentence.

"**Chief Procurement Officer**" means the Chief Procurement Officer for the County of Cook and any representative duly authorized in writing to act on his behalf.

"Core Services" means claims determinations, network management, utilization reviews, case management, appeal determinations, or customer service involving any direct contact with the members. Core Services does not include the work necessary to support the infrastructure for these functions (including, but not limited to, phone systems, computer,

software, facilities, database or information management, quality or security services) and does not include Backroom Operations. "Backroom Operations" are those activities that do not involve direct contact with the County's covered persons.

"Proprietary Marks" means the name, symbols, copyrights, trademarks or service marks of BCBSIL.

"**Services**" means, collectively, the services, duties and responsibilities described in Article 3 of this Agreement but does not include the work necessary to support the infrastructure for these functions (including, but not limited to, phone systems, computer, software, facilities, database or information management, quality or security services) and does not include Backroom Operations.

"**Subcontractor**" means a third party with whom BCBSIL contracts directly to provide any part of the Core Services.

"Using Agency" shall mean the Cook County Department of Risk Management

b) Interpretation

i) The term "**include**" (in all its forms) means "include, without limitation" unless the context clearly states otherwise.

ii) All references in this Agreement to Articles, Sections or Exhibits, unless otherwise expressed or indicated are to the Articles, Sections or Exhibits of this Agreement.

iii) Words importing persons include firms, associations, partnerships, trusts, corporations and other legal entities, including public bodies, as well as natural persons.

iv) Any headings preceding the text of the Articles and Sections of this Agreement, and any tables of contents or marginal notes appended to it are solely for convenience or reference and do not constitute a part of this Agreement, nor do they affect the meaning, construction or effect of this Agreement.

v) Words importing the singular include the plural and vice versa. Words of the masculine gender include the correlative words of the feminine and neuter genders.

vi) All references to a number of days mean calendar days, unless expressly indicated otherwise.

c) Incorporation of Exhibits

The following attached Exhibits are made a part of this Agreement:

Exhibit 1	Statement of Work
Exhibit 2	Benefit Program Applications
Exhibit 3	Schedule of Compensation
Exhibit 4	Minority and Women Owned Business Enterprise Commitment
Exhibit 5	Evidence of Insurance
Exhibit 6	HMO Cost Plus Group Administration Document
Exhibit 7	HMO 151-Plus Grandfathered Group Administration Document
Exhibit 8	PPO Group Administration Document
Exhibit 9	PPO Administrative Services Agreement
Exhibit 10	Business Associate Agreement and HIPAA Insured Certifications (collectively, the "HIPAA Documents")
Exhibit 11	Board Authorization
Exhibit 12	Identification of Subcontractor/Supplier/Subconsultant Form
Exhibit 13	Economic Disclosure Statement

In the event that the terms and conditions in the body of this Agreement shall be in conflict with any of the Exhibits with respect to any matter, the provisions of the Exhibits shall prevail with respect to such matter, except that where a conflict exists between any Exhibit and the Business Associate Agreement as provided in Exhibit 10, then the Business Associate Agreement shall prevail except that the parties acknowledge and agree that if Business Proprietary Information also contains Protected Health Information (as defined in the Business Associate Agreement), BCBSIL retains its ownership of such Business Proprietary Information.

ARTICLE 3) DUTIES AND RESPONSIBILITIES OF BCBSIL

a) Scope of Services

This description of Services is intended to be general in nature and is neither a complete description of BCBSIL's Services nor a limitation on the Services that BCBSIL is to provide under this Agreement. BCBSIL must provide the Services in accordance with the standards of performance set forth in Section 3)c). The Services that BCBSIL must provide include, but are not limited to, those described in Exhibits 1, Scope of Work, in accordance with the terms of this Agreement and Exhibits 6-9 as applicable, which are attached to this Agreement and incorporated by reference as if fully set forth herein.

b) Deliverables

In carrying out its Services, BCBSIL must prepare or provide to the County various Deliverables. "**Deliverables**" include work product, such as reports and analyses, produced by BCBSIL for the County.

The County may reject Deliverables that do not include relevant information or data, or do not include all documents or other materials specified in this Agreement or reasonably necessary for the purpose for which the County made this Agreement or for which the

County intends to use the Deliverables. If the County reasonably determines that BCBSIL has failed to comply with the foregoing standards, it has 30 days from the discovery to notify BCBSIL of its failure. If BCBSIL does not correct the failure, if it is commercially reasonable to do so, within 10 days after receipt of notice from the County specifying the failure, then the County, by written notice, may treat the failure as a default of this Agreement under Article 9.

Partial or incomplete Deliverables may be accepted for review only when required for a specific and well-defined purpose and when consented to in advance by the County. Such Deliverables will not be considered as satisfying the requirements of this Agreement and partial or incomplete Deliverables in no way relieve BCBSIL of its obligations under this Agreement.

c) Standard of Performance

BCBSIL must perform all Services required of it under this Agreement with that degree of skill, care and diligence normally shown by a contractor performing services of a scope and purpose and magnitude comparable with the nature of the Services to be provided under this Agreement. BCBSIL acknowledges that it is entrusted with or has access to valuable and confidential information and records of the County and will protect that information as described in this Agreement. If the County elects BCBSIL to be the limited claims and appeals fiduciary for the administration of PPO Services under this Agreement, then the language in Exhibit 9, PPO Administrative Services Agreement, Sections 5-7 (REFERRAL OF CERTAIN CLAIMS/INQUIRIES, CLAIM DISPUTE RESOLUTION, and FINAL DETERMINATION OF CLAIMS/INQUIRIES (respectively)) and Section 13.4 (Claim Administrator's limited fiduciary responsibility) will apply. If the County does not elect BCBSIL to be the limited claims and appeals fiduciary for the administration of its PPO Services under this Agreement, then the language in Exhibit 9 Section 8 (CLAIMS/INQUIRIES) and Section 13.3 (In relation to Claim Administrator's Responsibilities) will apply.

BCBSIL must assure that all Services that require the exercise of professional skills or judgment are accomplished by professionals and it reasonably believes are qualified and competent in the applicable discipline and appropriately licensed to practice, if required by law. BCBSIL must provide copies of any such licenses upon request. BCBSIL remains responsible for the professional and technical accuracy of all Services or Deliverables furnished, whether by BCBSIL or its Subcontractors or others on its behalf, unless the professional and technical inaccuracy or error was caused by inaccurate information being supplied by the County. All Deliverables must be prepared in a form and content consistent with this Agreement and delivered in a timely manner consistent with the requirements of this Agreement.

If BCBSIL fails to comply with the foregoing standards, BCBSIL must perform again, at its own expense, all Services required to be re-performed as a direct or indirect result of that failure. Any review, approval, acceptance or payment for any of the Services by the County does not relieve BCBSIL of its responsibility for the professional skill and care and

technical accuracy of its Services and Deliverables. This provision in no way limits the County's rights against BCBSIL either under this Agreement, at law or in equity.

d) Personnel

i) **Adequate Staffing**

BCBSIL must, upon receiving a fully executed copy of this Agreement, assign and maintain during the term of this Agreement and any extension of it an adequate staff of competent personnel that is fully equipped, licensed as required, available as needed, qualified and assigned to perform the Services. BCBSIL must include among its staff the Key Personnel and positions as identified below. The level of staffing may be revised from time to time by notice in writing from Consultant to the County. If the County fails to object to the revision within 14 days after receiving the notice, then the revision will be considered accepted by the County.

ii) **Key Personnel**

BCBSIL must not reassign or replace Key Personnel without the written consent of the County, which consent the County will not unreasonably withhold. "**Key Personnel**" means those job titles and the persons assigned to those positions in accordance with the provisions of this Section 3)d)ii). The Using Agency may at any time in writing notify BCBSIL that the County will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice BCBSIL must promptly suspend the services of the key person or persons and must replace him or them in accordance with the terms of this Agreement.

List of Key Personnel as of the date of execution of this Agreement:

Name: Danielle Steele
Title: Major/National Strategic Account Executive

Name: Robert Miller
Title: Divisional Vice President
Municipal and Major Accounts

iii) **Salaries and Wages**

BCBSIL and Subcontractors must pay all salaries and wages due all employees performing Services under this Agreement unconditionally and at least once a month without deduction or rebate on any account, except only for those payroll deductions that are mandatory by law or are permitted under applicable law and regulations. If in the performance of this Agreement BCBSIL underpays any such salaries or wages, the Comptroller for the County may withhold, out of payments due to BCBSIL, an amount sufficient to pay to employees underpaid the difference between the salaries or wages required to be paid under this Agreement and the salaries or wages actually paid these employees for the total number of

hours worked. The amounts withheld may be disbursed by the Comptroller for and on account of BCBSIL to the respective employees to whom they are due. The parties acknowledge that this Section 3)d)iii) is solely for the benefit of the County and that it does not grant any third party beneficiary rights.

e) Minority and Women's Business Enterprises Commitment

In the performance of this Agreement, including the procurement and lease of materials or equipment, BCBSIL must abide by the minority and women's business enterprise commitment requirements of the Cook County Ordinance, (Article IV, Section 34-267 through 272) except to the extent waived by the Compliance Director, which are set forth in Exhibit 4. BCBSIL's completed MBE/WBE Utilization Plan evidencing its compliance with this requirement are a part of this Agreement, in Form 1 of the MBE/WBE Utilization Plan, upon acceptance by the Compliance Director. BCBSIL must utilize minority and women's business enterprises at the greater of the amounts committed to by BCBSIL for this Agreement in accordance with Form 1 of the MBE/WBE Utilization Plan.

f) Insurance

BCBSIL must provide and maintain at BCBSIL's own expense, during the term of this Agreement and any time period following expiration if BCBSIL is required to return and perform any of the Services or Additional Services under this Agreement, the insurance coverages and requirements specified below, insuring all operations related to this Agreement.

i) **Insurance To Be Provided**

(1) Workers Compensation and Employers Liability

Workers Compensation Insurance, as prescribed by applicable law, covering all employees who are to provide a service under this Agreement and Employers Liability coverage with limits of not less than $500,000 each accident or illness. BCBSIL policy shall contain a waiver of subrogation. BCBSIL will require Subcontractors to carry and maintain Workers' Compensation insurance when prescribed by applicable law, who are on County premises (owned, leased or rented). Waiver of subrogation shall also be awarded to any property manager or landlord of record.

(2) Commercial General Liability (Primary and Umbrella)

Commercial General Liability Insurance or equivalent with limits of $2,000,000 per occurrence for bodily injury, personal injury and property damage liability. Coverages must include the following: Premises and operations, products/completed operations, separation of insureds, defense and contractual. Cook County is to be named as an additional insured on a

primary, non-contributory basis on the BCBSIL policy. BCBSIL policy shall contain a waiver of subrogation

BCBSIL will require Subcontractors who are on County premises (owned, leased, or rented) to maintain limits of no less than $1,000,000 per occurrence. Additional insured status and waiver of subrogation shall also be awarded to any property manager or landlord of record.

(3) Automobile Liability (Primary and Umbrella)

When any motor vehicles (owned, non-owned and hired) are used in connection with Services to be performed, BCBSIL must provide Automobile Liability Insurance with limits of not less than $1,000,000 per occurrence limit, for bodily injury and property damage. The County is to be named as an additional insured on the BCBSIL policy. BCBSIL policy shall contain a waiver of subrogation.

BCBSIL will require Subcontractors who utilize motor vehicles who are on County premises (owned, leased, or rented) to maintain limits of no less than $1,000,000 per occurrence. The County is to be named as an additional insured. Waiver of subrogation and additional insured status shall also be awarded to any property manager or landlord of record.

(4) Professional Liability

Professional Liability Insurance covering acts, errors or omissions must be maintained with limits of not less than $2,000,000. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, start of Services on this Agreement. A claims-made policy which is not renewed or replaced must have an extended reporting period of 2 years.

Subcontractors performing professional services for must maintain limits of not less than $1,000,000 with the same terms in this Section.

ii) **Additional Requirements**

(1) BCBSIL must furnish the County of Cook, Cook County, Office of the Chief Procurement Officer, 118 N, Clark St., Room 1018, Chicago, IL 60602, Certificates of Insurance to be in force on the date of this Agreement, and Renewal Certificates of Insurance, or such similar evidence, if the coverages have an expiration or renewal date occurring during the term of this Agreement. BCBSIL must submit evidence of insurance on ACORD or equivalent prior to the effective date of this Agreement. The receipt of any certificate does not constitute agreement by the County that the insurance requirements in this Agreement have been fully met or that the insurance policies indicated on the certificate are in compliance with all

Agreement requirements. The failure of the County to obtain certificates or other insurance evidence from BCBSIL is not a waiver by the County of any requirements for BCBSIL to obtain and maintain the specified coverages. Non-conforming insurance does not relieve BCBSIL of the obligation to provide insurance as specified in this Agreement. Nonfulfillment of the insurance conditions may constitute a violation of this Agreement, and the County retains the right to terminate this Agreement or to suspend this Agreement until proper evidence of insurance is provided.

(2) Deductibles or self-insured retentions on referenced insurance coverages must be borne by BCBSIL. BCBSIL agrees that insurers waive their rights of subrogation against the County of Cook, its employees, elected officials, agents or representatives on the Commercial General Liability, Auto Liability and Workers Compensation policies. BCBSIL will provide 30 days notice to the Office of the Chief Procurement Officer in the event coverage is materially changed, canceled or non-renewed and when the policy is not replaced or reinstated.

(3) The coverages and limits furnished by BCBSIL in no way limit BCBSIL's liabilities and responsibilities specified within this Agreement or by law. Any insurance or self-insurance programs maintained by the County of Cook apply in excess of and do not contribute with insurance provided by BCBSIL under this Agreement.

(4) The required insurance is not limited by any limitations expressed in the indemnification language in this Agreement or any limitation placed on the indemnity in this Agreement given as a matter of law.

(5) BCBSIL must require all Subcontractors to provide the insurance required in this Agreement, or BCBSIL may provide the coverages for Subcontractors. Subcontractors are subject to the same insurance requirements as BCBSIL unless otherwise specified in this Agreement. If BCBSIL or Subcontractor desires additional coverages, the party desiring the additional coverages is responsible for its acquisition and cost. BCBSIL will contact County Risk Management for approval of any variances or differences from Subcontractors insurance requirements.

(6) The County's Risk Management Office maintains the rights to modify, delete, alter or change these requirements. "**Risk Management Office**" means the Risk Management Office, which is under the direction of the Director of Risk Management and is charged with reviewing and analyzing insurance and related liability matters for the County. Any agreed to modifications by BCBSIL will be added to this Agreement by a signed addendum.

g) Liability

(i) **BCBSIL's Obligation to Indemnify.** BCBSIL covenants and agrees to indemnify and save harmless the County and its commissioners, officials, employees, and representatives, and their respective heirs, and permitted successors and assigns, from and against any and all costs, expenses, attorney's fees and costs, losses, damages and liabilities incurred or suffered directly from any claims arising out of or incident to the performance or nonperformance of This Agreement by BCBSIL, or the acts or omissions of the officers, agents, employees, Subcontractors, licensees or invitees of BCBSIL, if and to the extent caused by the fault or negligence of BCBSIL, (i) mutually agreed to by the parties, (ii) determined pursuant to Article 6 (Notice and Satisfaction, Disputes) of this Agreement, or (iii) as found by a court of competent jurisdiction. BCBSIL expressly understands and agrees that any Performance Bond or insurance protection required of BCBSIL, or otherwise provided by BCBSIL, shall in no way limit the responsibility to indemnify the County as hereinabove provided.

(ii) **The County's Liability**. The County acknowledges that it will be liable to BCBSIL for costs, expenses, attorney's fees and costs, losses, damages and liabilities incurred or suffered directly from any claims arising out of or incident to the performance or nonperformance of this Agreement by the County, or the acts or omissions of the officers, agents, employees, contractors, Subcontractors, licensees or invitees of the County, unless caused by the fault or negligence of BCBSIL, if and to the extent so found by a court of competent jurisdiction.

1. If the County elects HMO Cost Plus Insured, the following sections of Exhibit 6, HMO Cost Plus Group Administrative Document, will also apply:
    a. Section IV.D.2
    b. Section O
    c. Section XI
2. If the County elects HMO 151 Plus Insured, the following sections of Exhibit 7, HMO 151-Plus Grandfathered Group Administrative Document, will also apply:
    a. Section IV.D.4
    b. Section IV.O
    c. Section IV.U
    d. Section X
3. If the County elects PPO Insured, the following sections of Exhibit 8, PPO Group Administrative Document, will apply:
    a. Section IV.L
    b. Section IV.S
    c. Section X
4. If the County elects PPO Administrative Services Only ("ASO"), Section 9 of Exhibit 9, PPO Administrative Service Agreement, will also apply.

h) Confidentiality and Ownership of Documents and Other Property

BCBSIL acknowledges and agrees that information provided to BCBSIL by the County regarding this Agreement is confidential and shall not be disclosed, or used by BCBSIL in any way, whether during the term of this Agreement or at any time thereafter, except solely as required in the course of BCBSIL's performance hereunder, or as may be necessary in connection with BCBSIL's regulatory compliance and reporting obligations, or as authorized in this Agreement or as may be required or permitted by law. The foregoing notwithstanding, the parties acknowledge that the parties have entered into various HIPAA Documents. The Business Associate Agreement will only apply to any self-funded benefit plan and the HIPAA Certifications will apply to fully insured benefit plans. Nothing in this Agreement shall limit the permitted use or disclosure of PHI and other information as described in such HIPAA Documents, as amended or replaced from time-to-time. For avoidance of doubt, the parties acknowledge and agree that if Business Proprietary Information is also Protected Health Information (as defined in the Business Associate Agreement), BCBSIL retains its ownership of such Business Proprietary Information.

The County shall be granted a revocable, royalty-free, non-exclusive, non-transferable license to use claims data received by BCBSIL under this Agreement, excluding Business Proprietary Information of BCBSIL and BCBSIL's Subcontractors, for the County's administration of the benefits under the County's benefit plan. The form and format of such claims data shall be mutually agreed to by the parties.

Notwithstanding anything in this Agreement to the contrary, the County acknowledges that BCBSIL's Proprietary Marks are the sole property of the Blue Cross and Blue Shield Association or of BCBSIL and agrees not to contest the Blue Cross and Blue Shield Association's or BCBSIL's ownership or the license granted to BCBSIL for use of such Proprietary Marks. The County agrees not to infringe upon, dilute or harm the Blue Cross and Blue Shield Association's ownership rights or BCBSIL's rights as a licensee in its Proprietary Marks. The County will cooperate with BCBSIL to obtain appropriate confidentiality and protective orders for BCBSIL's Business Proprietary Information.

The County must maintain as confidential and protect from unauthorized disclosure all Business Proprietary Information of BCBSIL and its Subcontractors, except as specifically authorized in this Agreement.

i) Patents, Copyrights and Licenses

BCBSIL agrees to hold harmless and indemnify the County, its officers, employees and affiliates from and defend, as permitted by Illinois law, at its own expense (including reasonable attorneys', accountants' and consultants' fees), any suit or proceeding brought against County based upon a claim that the ownership and/or use of equipment, hardware and software or any part thereof provided to the County or utilized in performing BCBSIL's services constitutes an infringement of any patent, copyright or license or any other property right. Where applicable, the County shall notify BCBSIL in writing of any such suit or proceeding or significant threat thereof.

In the event the use of any equipment, hardware or software or any part thereof is enjoined, BCBSIL with all reasonable speed and due diligence shall provide or otherwise secure for County, at BCBSIL's election, one of the following: the right to continue use of the equipment, hardware or software; an equivalent system having the Specifications as provided in this Agreement; or BCBSIL shall modify the system or its component parts so that they become non-infringing while performing in a substantially similar manner to the original system, meeting the requirements of this Agreement.

j) Examination of Records and Audits

BCBSIL agrees that the Cook County Auditor or the County's duly authorized third party auditor (collectively, the "Auditor") shall, upon ninety (90) days prior written notice during the term of this Agreement and during the three (3) years after the final payment under this Agreement, have access and the right to examine any books, documents, papers, canceled checks, bank statements, purveyor's and other invoices, and records of BCBSIL related to the Services performed under this Agreement, or to BCBSIL's compliance with any term, condition or provision thereof, unless such access is limited or prohibited by applicable law or contract. BCBSIL will provide a reasonable alternative in the event access to certain records is limited by a contract. BCBSIL shall be responsible for establishing and maintaining records sufficient to document the costs associated with performance under the terms of this Agreement. The audit must be free of bias, influence or conflict of interest. Audit samples will be limited to a reasonable sample size mutually agreed to between BCBSIL and the County. The County will be responsible for its own costs and the cost of the Auditor. The audit will be limited to the immediately preceding twenty-four (24) calendar months. 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 Auditor that has access to the information and files maintained by BCBSIL will agree not to disclose any proprietary or confidential information and an Audit Agreement will be mutually agreed to by the parties that sets forth the terms and conditions of the audit. In the event that an Audit Agreement is executed by the County, the authorized signatory shall be the Cook County Auditor. The County agrees to require any third party auditor to hold harmless and indemnify BCBSIL in writing of any liability from disclosure of such information prior to engaging in any audit. The County will also provide BCBSIL with written authorization for the authorized third party auditor to conduct the audit and written approval of the scope of the audit. The County agrees that their employees, officers, representatives and agents will have access to and utilize such information disclosed to them solely for the purpose of carrying out the audit for the County.

BCBSIL further agrees that it shall include in all of its Subcontracts hereunder a provision to the effect that the Subcontractor agrees that BCBSIL, BCBSIL's internal and external auditors or any other third party retained by BCBSIL shall for up to three years after termination of the Subcontractor's agreement, have access and the right to examine all relevant records and data relating to the Services delegated by BCBSIL to the Subcontractor.

In addition to the BCBSIL audit rights contained in the Exhibits, during the term of this

Agreement and within one hundred eighty (180) days after its termination, BCBSIL may, upon at least thirty (30) days prior written notice to the County, conduct reasonable audits of the County's membership records with respect to eligibility.

In the event BCBSIL receives payment under this Agreement, reimbursement for which is later disallowed by the County and the amount of which has been mutually agreed to by BCBSIL, BCBSIL within 60 business days shall refund the disallowed amount to the County on request, or at the County's option, the County may credit the amount disallowed from the next payment due or to become due to BCBSIL under any contract with the County. BCBSIL shall only be responsible for the correction of errors identified in specific Claim Payments and Net Claim Payments subject to the terms and conditions of this Agreement and shall not be obligated to reimburse the County for alleged errors calculated, using extrapolation methodologies, to exist in a population of Claim Payments and Net Claim Payments based on an error rate in a sample drawn from that population. If a pattern of error is identified, BCBSIL shall identify claims with similar errors and BCBSIL agrees to correct such claims with similar errors. Further, BCBSIL has the right to implement reasonable administrative practices in the administration of Claims.

k) Third Party Data Release

In the event the County requests BCBSIL to provide data directly to its third party consultant and/or vendor, and BCBSIL agrees, the County acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

1. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 3)k), is "Confidential Information").
2. Release of the Confidential Information may also reveal BCBSIL's or Subcontractor's Business Proprietary Information.
3. To maintain the confidentiality of the Confidential Information and any Business Proprietary Information (for purposes of this Section 3)k), collectively, "Information"). The third party consultant and/or vendor shall:
   a. Use and copy the Information only for the purpose of complying with the terms and conditions of its agreement with BCBSIL, to the extent consistent with applicable law.
   b. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
   c. 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.
5. Not to 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.
6. The third party consultant and/or vendor shall execute BCBSIL's then-current confidentiality agreement.
7. The County shall designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

8. County shall provide BCBSIL with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

The County shall be liable to BCBSIL for 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 BCBSIL in connection with any claim based upon BCBSIL's disclosure to the third party consultant and/or vendor (consistent with the County's directions) of any information and/or documentation regarding any of the County's covered person at the direction of the County or breach by the third party consultant and/or vendor of any obligation described in this subsection (k).

l) Subcontracting or Assignment of Agreement or Agreement Funds

Once awarded, except as otherwise provided in this Agreement, this Agreement shall not be subcontracted or assigned to a Subcontractor, in whole or in part, without the advance written approval of the Chief Procurement Officer, which approval shall not be unreasonably withheld. In no case, however, shall such approval relieve BCBSIL from its obligations or change the terms of this Agreement. BCBSIL shall not transfer or assign any Agreement funds or any interest therein due or to become due without the advance written approval of the Chief Procurement Officer. The unauthorized subcontracting or assignment of this Agreement, in whole or in part, or the unauthorized transfer or assignment of any Agreement funds, either in whole or in part, or any interest therein, which shall be due or are to become due BCBSIL shall have no effect on the County and are null and void.

Anything in this Agreement notwithstanding, at the time of a telephone call to BCBSIL customer service, if a member elects to interact with BCBSIL in a non-English language, then that call could be handled by a third party with access to confidential information and such third party's employees may be located outside of the U.S..

Prior to the commencement of this Agreement, the BCBSIL shall identify in writing to the Chief Procurement Officer the names of any and all Subcontractors it intends to use in the performance of this Agreement by completing the Identification of Subcontractor/Supplier Form ("ISF"). The Chief Procurement Officer shall have the right to disapprove any Subcontractor which shall not be unreasonably withheld. All Subcontractors shall perform services in accordance with the terms of this Agreement.

BCBSIL must disclose the name and business address of each Subcontractor, lobbyist, BCBSIL has retained or expects to retain in connection with this Agreement, as well as the nature of the relationship, and the total amount of the fees paid or estimated to be paid. BCBSIL is not required to disclose employees who are paid or estimated to be paid. BCBSIL is not required to disclose employees who are paid solely through BCBSIL's regular payroll. "Lobbyist" means any person or entity who undertakes to influence any legislation or administrative action on behalf of any person or entity other than: (1) a not-for-profit entity, on an unpaid basis, or (2), himself.

"Lobbyist" also means any person or entity any part of whose duties as an employee of another includes undertaking to influence any legislative or administrative action. If BCBSIL is uncertain whether a disclosure is required under this Section, BCBSIL must either ask the County, whether disclosure is required or make the disclosure.

The County reserves the right to prohibit any person from entering any County facility for any reason, unless prohibited by applicable law. BCBSIL and any Subcontractor of BCBSIL while on any County property shall abide by all health and safety rules reasonably imposed by the County or any other rules and regulations provided by the County in writing to BCBSIL and its Subcontractor.

m) Professional Social Services
[Intentionally Omitted]

ARTICLE 4) TERM OF PERFORMANCE

a) Term of Performance

This Agreement takes effect when approved by the Cook County Board and its term shall begin on December 1, 2015 ("**Effective Date**") and continue until November 30, 2018 or until this Agreement is terminated in accordance with its terms, whichever occurs first.

b) Timeliness of Performance

i) BCBSIL must provide the Services and Deliverables and the County must perform its obligations, within the term and within the time limits required under this Agreement. Further, the parties acknowledges that TIME IS OF THE ESSENCE and that the failure of a party to comply with the time limits described in this Section 4.b may result in economic or other losses to the other party.

ii) Neither BCBSIL nor BCBSIL's agents, employees nor Subcontractors are entitled to any damages from the County, nor is any party entitled to be reimbursed by the County, for damages, charges or other losses or expenses incurred by BCBSIL by reason of delays or hindrances in the performance of the Services, whether or not caused by the County, except as otherwise provided in this Agreement or under applicable law.

c) Agreement Extension Option

The Chief Procurement Officer may at any time before this Agreement expires elect to renew this Agreement for up to two additional one-year periods under the same terms and conditions as this original Agreement, except as provided otherwise in this Agreement, by 180 calendar days notice or as mutually agreed to by the parties. After notification by the

Chief Procurement Officer, this Agreement must be modified to reflect the time extension in accordance with the provisions of Section 10.c.

ARTICLE 5) COMPENSATION

a) Basis of Payment

The County's funding type elections for the Services shall be made on an annual basis on or before September 1 of each year as memorialized in the Benefit Program Applications, mutually agreed to by the parties. The County shall notify BCBSIL on or before September 1 of each year of any decision to change funding option(s). A copy of the Benefit Program Applications for the plans elected by the County is attached hereto in Exhibit 2. The Benefit Program Applications will be incorporated into this Agreement upon execution by the County, without further need to amend this Agreement in accordance with Article 10 (c).

The County will pay BCBSIL as set forth in:

1. The most current BPA(s);
2. Exhibit 6, HMO Cost Plus Group Administration Document, Section III;
3. Exhibit 7, HMO 151-Plus Grandfathered Group Administration Document, Section III;
4. Exhibit 8, PPO Group Administration Document, Section III (if applicable); and
5. Exhibit 9, PPO Administrative Services Agreement, Appendix 2 (if applicable).

If the County elects HMO Cost Plus and/or PPO Self-funded funding arrangement(s) for its benefit plan(s), BCBSIL is willing to extend a grace period of two (2) months beyond the payment due date. If the County elects HMO Fully Insured and/or PPO Fully-insured funding arrangement(s) for its benefit plan(s), BCBSIL is willing to extend a grace period of two (2) months beyond the premium payment due date. If the County fails to pay the amounts owed to BCBSIL during the grace period, the County will have ten (10) days from the date of the BCBSIL's written notice of payment default to cure. Interest payments may be charged in accordance with Section 9)b)2 of this Agreement.

If the County modifies (or chooses not to modify) a plan or the Services in such manner that BCBSIL can demonstrate an increase in BCBSIL's cost of performing the Services or if any legislation, rule, regulation or other governmental action is enacted or taken which obligates BCBSIL to pay or make arrangements to pay to the government any new taxes or other new governmental fees, surcharges or amounts, BCBSIL must provide notice thereof to the County. Thereafter, the County shall amend the Agreement in accordance with this Section 10)c) of this Agreement to equitably adjust BCBSIL's compensation within one hundred twenty (120) days of the notice, by BCBSIL

Likewise, in the event of a change in federal or state laws or regulations affecting the Services provided under the terms of this Agreement, BCBSIL may propose changes to the Agreement, including the Exhibits, with thirty (30) days prior written notice to the County.

In the event that the actual number of the County's covered employees (in total, by product,

or by benefit plan), varies by +/- 10% from BCBSIL's projections or the information upon which BCBSIL's projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate, BCBSIL reserves the right to adjust the compensation owed by the County at the time of the annual renewal as reflected in the Benefit Program Applications in Exhibit 2.

If, during the contract year (December 1 through November 30), BCBSIL determines an adjustment to the compensation is required, the adjustment will be incorporated into the following contract year's compensation.

In accordance with Section 34-177 of the Cook County Procurement Code, the County shall have a right to set off and subtract from any invoice(s) or Agreement compensation, a sum equal to any fines and penalties, including interest, for any tax or fee delinquency and any debt or obligation owed by BCBSIL to the County upon thirty (30) days prior written notification to BCBSIL.

BCBSIL acknowledges its duty to ensure the accuracy of all invoices submitted to the County for payment. In the event that it is discovered that the County is entitled to a reimbursement or credit from BCBSIL, whether due to inaccuracy in an invoice submitted for payment or for any other reason, BCBSIL shall apply such credit or otherwise reimbursement the County for the mutually agreed upon amounts due within sixty (60) days of written notice by the County. When BCBSIL receives any payment from the County for any supplies, equipment, goods, or services, it has provided to the County pursuant to this Agreement, BCBSIL must make payment to its subcontractors within 15 days after receipt of payment from the County to the extent required by applicable law, provided that such subcontractor has satisfactorily provided the supplies, equipment, goods or services in accordance with this Agreement and provided BCBSIL with all of the documents and information required of BCBSIL. BCBSIL may delay or postpone payment to a subcontractor when the subcontractor's supplies, equipment, goods, or services do not comply with the requirements of this Agreement, BCBSIL is acting in good faith, and not in retaliation for a subcontractor exercising legal or contractual rights. For purposes of this Section, "subcontractor" means a third party that BCBSIL hired solely for the County Services under this Agreement. Except for adjustments related to Claims and Administrative Fees, all one time payments and annual performance guarantee settlements will be made by BCBSIL by check or wire transfer to the County, unless otherwise agreed by the parties.

b) Funding

The source of funds for payments under this Agreement is identified in Exhibit 3, Schedule of Compensation. Payments under this Agreement must not exceed Eight Hundred Eighty Four Million, One Hundred Ninety Five Thousand Five Hundred Dollars ($884,195,000) for the initial three year term without a written amendment in accordance with Section 10.c.

c) Non-Appropriation

If no funds or insufficient funds are appropriated and budgeted in any fiscal period of the County for payments to be made under this Agreement, then the County will notify BCBSIL in writing of that occurrence, and either party may terminate on the earlier of the last day of the fiscal period for which sufficient appropriation was made or whenever the funds appropriated for payment under this Agreement are exhausted. In the event that no funds are appropriated, the County shall make payments for Services completed and claims cost incurred up to the start of the next fiscal year as defined in Cook County's Code of Ordinances 34-1. In the event that there are insufficient funds then the County shall make payments for Services completed and claims costs incurred up to the date that appropriated funds are exhausted. No other payments will be made or due to BCBSIL and under this Agreement beyond those amounts appropriated and budgeted by the County to fund payments under this Agreement.

d) Taxes

The County has informed BCBSIL that (i) Federal Excise Tax does not apply to materials purchased by the County by virtue of Exemption Certificate No. 36-75-0038K, and (ii) Illinois Retailers' Occupation Tax, Use Tax and Municipal Retailers' Occupation Tax do not apply to deliverables, materials or services purchased by the County by virtue of statute. The price or prices quoted herein shall include any and all other federal and/or state, direct and/or indirect taxes which apply to this Agreement. The County's State of Illinois Sales Tax Exemption Identification No. is E-9998-2013-07.

e) Price Reduction
[Intentionally Omitted]

f) BCBSIL Credits

BCBSIL credits, if any, are set forth in Exhibit 1 Statement of Work.

ARTICLE 6) NOTICE AND SATISFACTION, DISPUTES

a) **Notice and Satisfaction.** Prior to excising any rights under Article 9 (Events of Default, Remedies, Termination, Suspension, and Right to Offset), the County, through its Director of Risk Management and the Key Personnel of BCBSIL agree to give one another written notice of any complaint or concern the other party may have about the performance of obligations under this Agreement, including any concern regarding an invoice presented by BCBSIL pursuant to this Agreement and any potential event of default as described in Article 9. If the County reasonably disputes an invoice, the County must pay the undisputed amount when due and submit written notice of the disputed amount (with details of the nature of the dispute and the invoice(s) disputed) within five (5) business days of receipt of the invoice. If BCBSIL disagrees with the County's written reason for failing to pay the disputed portions of the invoice, and finds that the failure to pay the disputed portions is an event of default as set forth in Section 9)a)2.(i) it shall issue a notice pursuant to this Section and to the County. Such notice will allow the County ten (10) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action as provided

in Article 9 If the County fails to make the requested payment of the disputed amount after the ten (10) day dispute period described in this Section, BCBSIL shall have the right to issue a Notice to Cure in accordance with Article 9)b)2. (Notices by BCBSIL) and the parties shall exercise all remedies set forth in Article 9)b)2. (Notices by BCBSIL).

Any other notice of potential event of default set forth under Article 9.a) will 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 as provided in Article 9.

b) **Disputes.** Any dispute arising out of or relating to this Agreement that is not resolved pursuant to Section 6)a) shall be reviewed by the Chief Procurement Officer. The complaining party shall submit a written statement detailing the dispute and specifying the specific relevant Agreement provision(s) to the Chief Procurement Officer. Upon request of the Chief Procurement Officer, the party complained against shall respond to the complaint in writing within five business days of such request. The Chief Procurement Officer will reduce her recommendations to writing and mail or otherwise furnish a copy thereof to BCBSIL and the Director of Risk Management within thirty (30) days. BCBSIL shall continue to discharge all its obligations, duties and responsibilities set forth in the Agreement during any dispute resolution proceeding unless otherwise agreed to by the Director of Risk Management or her designee in writing. Notwithstanding the preceding, the parties do not waive, then either party may exercise their right to bring suit in court as set forth in Section 6)c) below if a dispute cannot be resolved by the means set forth here. All negotiations, as well as any recommendations by the Chief Procurement Officer, pursuant to this Article 6 are confidential, except to the extent disclosure is required by law, and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

The parties agree that their representatives will meet whenever necessary to promptly resolve any problems that occur relating to the administration or performance of this Agreement. The parties will exercise commercially reasonable efforts to resolve in good faith any such problems. All reasonable requests for information, not otherwise inconsistent with the terms of this Agreement, made by one party to the other in the course of attempting to resolve disputes will be honored.

c) **Exhaustion of Mandatory Dispute Resolution Provisions**. If the parties have exhausted the mandatory dispute resolution provisions described in this Article 6)a) and b), and a dispute still remains between them, either party may pursue any remedy in a court of competent jurisdiction in Cook County, Illinois, provided, however, that if a party elects to pursue litigation, the party shall provide the other party notice at least ten (10) business days before the litigation is filed.

ARTICLE 7) COOPERATION WITH INSPECTOR GENERAL AND COMPLIANCE WITH ALL LAWS

The County and BCBSIL, Subcontractor, licensees, grantees or persons or businesses who have a County contract, grant, license, or certification of eligibility for County contracts shall abide by all

of the applicable provisions of the Office of the Independent Inspector General Ordinance (Section 2-281 et. seq. of the Cook County Code of Ordinances). Failure to cooperate as required may result in monetary and/or other penalties.

The County and BCBSIL shall observe and comply with the laws, ordinances, regulations and codes of the Federal, State, County and other local government agencies applicable to performance of its respective duties under this Agreement including, but not limited to, those County Ordinances set forth in the Certifications attached hereto and incorporated herein. Assurance of compliance with this requirement by BCBSIL's employees, agents or Subcontractors shall be the responsibility of BCBSIL.

BCBSIL shall secure and pay for all federal, state and local licenses, permits and fees that are required for it to provide Services under this Agreement. The County has the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations that apply to it or to any of its benefit plans, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements, 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.

Illinois Department of Insurance Approval. The obligations of BCBSIL pursuant to this Agreement, with respect to HMO and insured PPO plans, are conditioned upon BCBSIL procuring all required approvals by the Director of the Illinois Department of Insurance ("DOI"). BCBSIL will inform the County in the event the DOI does not approve the Agreement, and the parties will enter into good faith negotiations to amend this Agreement in accordance with Section 10)c).

ARTICLE 8) SPECIAL CONDITIONS

a) Representations

In connection with signing and carrying out this Agreement, BCBSIL:

i) agrees that BCBSIL is appropriately licensed under Illinois law to perform the Services required under this Agreement and will perform no Services for which a professional license is required by law and for which BCBSIL is not appropriately licensed;

ii) agrees it is financially solvent; based upon its knowledge after diligent inquiry, it and each of its employees, agents and Subcontractors of are competent to perform the Services required under this Agreement; and BCBSIL is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

iii) agree that it will not knowingly use the services of any ineligible consultant or Subcontractor for any purpose in the performance of its Services under this Agreement that has been declared ineligible as described under the applicable

provisions of: (i) the Cook County Code of Ordinances Section 34-170 and 34-179 or (ii) Article IV of the Cook County Procurement Code;

iv) represents that BCBSIL and, based upon its knowledge after diligent inquiry, its Subcontractors are not in default at the time this Agreement is signed, and has not been considered by the Chief Procurement Officer to have, within 5 years immediately preceding the date of this Agreement, been found to be in default on any contract awarded by the County;

v) represents that it has carefully examined and analyzed the provisions and requirements of this Agreement; it understands the nature of the Services required; from its own analysis it has satisfied itself as to the nature of all things needed for the performance of this Agreement; this Agreement is feasible of performance in accordance with all of its provisions and requirements;

vi) represents that BCBSIL and, based upon its knowledge after diligent inquiry, its Subcontractors are not in violation of the provisions of the Illinois Criminal Code, 720 ILCS 5/33E as amended; and

vii) acknowledges that any certification, affidavit or acknowledgment made under oath in connection with this Agreement is made under penalty of perjury and, if false, is also cause for termination under Sections 9)a) and 9)c).

b) Ethics

i) In addition to the foregoing representations, BCBSIL agrees, based upon its knowledge after diligent inquiry:

(1) no officer, agent or employee of the County is employed by BCBSIL or has a financial interest directly or indirectly in this Agreement or the compensation to be paid under this Agreement except as may be permitted in writing by the Board of Ethics.

(2) no payment, gratuity or offer of employment will be made in connection with this Agreement by or on behalf of any Subcontractors to BCBSIL or higher tier Subcontractors or anyone associated with them, as an inducement for the award of a subcontract or order.

c) Joint and Several Liability

If BCBSIL, or its successors or assigns, if any, is comprised of more than one individual or other legal entity (or a combination of them), then under this Agreement, each and without limitation every obligation or undertaking in this Agreement to be fulfilled or performed by BCBSIL is the joint and several obligation or undertaking of each such individual or other legal entity.

d) Business Documents

At the request of the County, BCBSIL must provide copies of its latest articles of incorporation, by-laws and resolutions, or partnership or joint venture agreement, as applicable and as may be allowed under law or by contract.

e) Conflicts of Interest

i) Based upon BCBSIL's knowledge after diligent inquiry, no member of the governing body of the County or other unit of government and no other officer, employee or agent of the County or other unit of government who exercises any functions or responsibilities in connection with the Services to which this Agreement pertains is permitted to have any personal interest, direct or indirect, in this Agreement. Based upon BCBSIL's knowledge after diligent inquiry, no member of or delegate to the Congress of the United States or the Illinois General Assembly and no Commissioner of the Cook County Board or County employee is allowed to be admitted to any share or part of this Agreement or to any financial benefit to arise from it.

ii) BCBSIL represents that it, and based upon its knowledge after diligent inquiry, its Subcontractors if any (collectively, "**Consulting Parties**"), presently have no direct or indirect interest and will not acquire any interest, direct or indirect, in any project or contract that conflicts with the performance of its Services under this Agreement.

iii) Furthermore, if any federal funds are to be used to compensate or reimburse BCBSIL under this Agreement, BCBSIL represents that it is and will remain in compliance with federal restrictions on lobbying set forth in Section 319 of the Department of the Interior and Related Agencies Appropriations Act for Fiscal year 1990, 31 U.S.C. § 1352, and related rules and regulations set forth at 54 Fed. Reg. 52,309 ff. (1989), as amended. If federal funds are to be used, the County must notify BCBSIL prior to the use of such funds and BCBSIL must execute a Certification Regarding Lobbying, which will be attached as an exhibit and incorporated by reference as if fully set forth here.

f) Non-Liability of Public Officials

BCBSIL and any assignee or Subcontractor of BCBSIL must not charge any official, employee or agent of the County personally with any liability or expenses of defense or hold any official, employee or agent of the County personally liable to them under any term or provision of this Agreement or because of the County's execution, attempted execution or any breach of this Agreement.

ARTICLE 9) EVENTS OF DEFAULT, REMEDIES, TERMINATION, SUSPENSION AND RIGHT TO OFFSET

a) Events of Default Defined

1. The following constitute events of default by BCBSIL:

i) Any material misrepresentation, whether negligent or willful and whether in the inducement or in the performance, made by BCBSIL to the County.

ii) BCBSIL's failure to perform any of its obligations under this Agreement to the level that such failure constitutes a material breach of this Agreement, including, but not limited to, the following:

(a) Failure due to a reason or circumstances within BCBSIL's reasonable control to perform the Services with sufficient personnel and equipment or with sufficient material to ensure the performance of the Services;

(b) Failure to perform the Services in the manner set forth in this Agreement as a result of insolvency, filing for bankruptcy or assignment for the benefit of creditors;

(c) Failure to promptly re-perform, as required by this Agreement, within a reasonable time Services that were rejected by the County as permitted by this Agreement;

(d) Discontinuance of the Services for reasons within BCBSIL's reasonable control; and

(e) Failure to comply with any other material term of this Agreement, including the provisions concerning insurance and nondiscrimination.

iii) BCBSIL's default under any other agreement it may presently have or may enter into with the County during the life of this Agreement. BCBSIL acknowledges and agrees that in the event of a default under this Agreement the County may also declare a default under any such other Agreements.

v) Failure to comply with Article 7 in the performance of this Agreement.

vi) BCBSIL's repeated or continued violations of County ordinances unrelated to performance under this Agreement that in the opinion of the Chief Procurement Officer indicate a willful or reckless disregard for County laws and regulations..

2. The following constitute events of default by the County:

i) County's failure to timely pay any amount due under this Agreement;

ii) Any material misrepresentation, whether negligent or willful and whether in the inducement or in the performance, made by the County to BCBSIL;

iii) Malfeasance, misfeasance, negligence or fraud by the County or its agents with respect to this Agreement; and

iv) County's failure to perform any of its obligations under this Agreement to the level that such failure constitutes a material breach of this Agreement.

b) Remedies

1. **Notices by the County**. The occurrence of any event of default set forth under Section 9)a)1. permits the County, at the County's sole option, to declare BCBSIL in default. The Chief Procurement Officer may in his sole discretion give BCBSIL an opportunity to cure the default within a certain period of time, which period of time must not be less than a reasonable time nor exceed sixty (60) days, unless extended by the Chief Procurement Officer. Whether to declare BCBSIL in default after the dispute resolution process outlined in Article 6 is exhausted is within the sole discretion of the Chief Procurement Officer but nothing shall impair the ability or rights of BCBSIL to dispute the basis for that decision to declare default or seek damages arising from a default declaration that is wrongful in a court of competent jurisdiction.

   The Chief Procurement Officer will give BCBSIL written notice of the default, either in the form of a cure notice ("**Cure Notice**"), or if the default is impossible to cure, then such notice may be in the form of a default notice ("**Default Notice**"). If the Chief Procurement Officer gives a Default Notice, he will also indicate any present intent he may have to terminate this Agreement, and the decision to terminate (but not the decision not to terminate) is final and effective upon giving the notice. The Chief Procurement Officer may give a Default Notice if BCBSIL fails to affect a cure within the cure period given in a Cure Notice. When a Default Notice with intent to terminate is given as provided in this Section 9)b) and Article 11, BCBSIL must discontinue any Services, unless otherwise directed in the notice or as otherwise provided in this Agreement, and upon reasonable request BCBSIL shall deliver all County Owned Property.

2. **Notices by BCBSIL**. The occurrence of any event of default set forth under Section 9)a)2 permits BCBSIL, at its sole option, to declare County in default, either in the form of a Cure Notice, or, if the default is impossible to cure, then such notice may be in the form of a Default Notice. If BCBSIL gives a Default Notice, it will also indicate any present intent it may have to terminate this Agreement, and the decision to terminate (but not the decision not to terminate) is final and effective upon giving the notice by delivery to the County of written notice of the default in the form of a cure notice ("County Cure Notice") The County will have ten (10) days to cure a default of Section 9)a)2.(i). If the County defaults under Sections 9)a)2.(ii)-(iv) then the County will have thirty (30) days to cure. With respect to any default under Sections 9)a)2.(i) or 9)a)2.(ii), BCBSIL may, at its option, (but at no time during the dispute process described under Article 6)a)) include in the

Cure Notice an assessment of a late charge at a rate equal to the lesser of (i) .0329% per day (which equates to an amount of twelve percent (12%) per annum), or (ii) the maximum rate permitted by state law, which shall be applied if the County fails to cure within 10 days Notwithstanding the foregoing, late charges may be assessed without electing to declare the County in default. If either party makes a good faith determination that an event of default set forth in the Cure Notice or Default Notice did not occur, it may challenge the default determination under the Disputes provision of this Agreement at Section 6)b). BCBSIL may give a Default Notice if the County fails to effect a cure within the applicable cure period as set forth above.

3. **Exercise of Remedies.** After giving a Default Notice, and, the defaulting party fails to cure during the specified cure period in accordance with Sections 9)a)1. or 9)a)2. above, the non-defaulting party may invoke any or all of the following remedies:

i) The right to terminate this Agreement as to any or all of the Services yet to be performed effective at a time specified by the non-defaulting party;

ii) The right of specific performance, an injunction or any other appropriate equitable remedy;

iii) The right to money damages;

iv) In the case of default by BCBSIL, the right to withhold all or any part of BCBSIL's compensation under this Agreement;

v) In the case of default by BCBSIL, the right to consider BCBSIL non-responsible in future contracts to be awarded by the County.

Notwithstanding the non-defaulting party's ability to assert any of the remedies in this section, nothing in this section 9)b)3. prohibits the other party from pursuing its rights under the dispute resolution provisions of Article 6.

4. **Reservation of Rights**. If a party considers it to be in its best interests, it may elect not to declare default or to terminate this Agreement. The parties acknowledge that this provision is solely for the benefit of the non-defaulting party and that if (i) the County permits BCBSIL to continue to provide the Services despite one or more events of default by BCBSIL, BCBSIL is in no way relieved of any of its responsibilities, duties or obligations under this Agreement, nor does the County waive or relinquish any of its rights, or (ii) BCBSIL continues to provide the Services despite one or more events of default by County, the County is in no way relieved of any of its responsibilities, duties or obligations under this Agreement, nor does BCBSIL waive or relinquish any of its rights.

5. **Non-Exclusivity of Remedies**. The remedies under the terms of this Agreement, including any rights under Article 6, are not intended to be exclusive of any other

remedies provided, but each and every such remedy is cumulative and is in addition to any other remedies, existing now or later, at law, in equity or by statute. No delay or omission to exercise any right or power accruing upon any event of default impairs any such right or power, nor is it a waiver of any event of default nor acquiescence in it, and every such right and power may be exercised from time to time and as often as the party considers expedient.

c) Early Termination

In addition to termination under Sections 9)a) and 9)b) of this Agreement, either party may terminate this Agreement, or all or any portion of the funding types in accordance with following provisions:

1. For terminations of the HMO Cost Plus Insured benefit plan, the termination language in Exhibit 6 Sections III.G.2 and V will apply.
2. For terminations of the HMO 151 Plus Insured benefit plan, the termination language in Exhibit 7 Section VI.A will apply.
3. For terminations of the PPO Insured benefit plan, the termination language in Exhibit 8 Section IX.A will apply.
4. For terminations of the PPO Administrative Services Only benefit plan, the termination language in Exhibit 9 Section 11.1a will apply.

The terminating party will give notice to the other party in accordance with the provisions of Article 11. The effective date of the termination will be the date stated in the notice when consistent with this Agreement. If the County elects to terminate this Agreement in full, all Services to be provided under it must cease and all County-Owned Property must be delivered, upon request, to the County effective 60 days after the effective date of such termination, or such other date mutually agreed to by the parties.

After BCBSIL receives a termination notice from the County, BCBSIL must restrict its activities, and those of its Subcontractors, to winding down any reports, analyses, or other activities previously begun. No costs incurred after the effective date of the termination are allowed, except as otherwise provided by this Agreement. Payment for any Services actually and satisfactorily performed before the effective date of the termination is on the same basis as set forth in Article 5 The settlement and financial obligations upon termination of the Agreement will be resolved in accordance with the following sections:

1. If a party elects to terminate the HMO Cost Plus Insured benefit plan, the following Sections of Exhibit 6 will apply:
    a. Sections III.C.2.
    b. Section III.E.3.
    c. Section III.G
2. If a party elects to terminate the HMO 151 Plus Insured benefit plan, Section II.D of Exhibit 7.
3. If a party elects to terminate the PPO Insured benefit plan, Section III.D. of Exhibit 8 will apply.

4. If a party elects to terminate the PPO Administrative Services Only benefit plan, the following Sections of Exhibit 9 will apply:
    a. Appendix 2 Section 3.4.
    b. Appendix 2 Section 8.

BCBSIL agrees that any early termination by the County complies with the terms of this Agreement, BCBSIL will not make any early termination claims against the County based on any Subcontractor's claims against BCBSIL or the County to the extent inconsistent with this provision.

If a party's election to terminate this Agreement for default under Sections 9)a) and 9)b) is determined under the dispute resolution process in Article 6 or a court of competent jurisdiction to have been wrongful, then the termination is to be considered to be an early termination under this Section 9)c).

d) Right to Offset

In connection with performance under this Agreement, either party may offset upon thirty (30) days notice as provided below:

i) if a party terminates this Agreement for default or any other reason resulting from the other party's performance or non-performance;

ii) if a party exercises any of its remedies under Sections 9)a and 9)b of this Agreement;
or

iii) if a party has any amounts past due after applicable grace period under this Agreement; however, BCBSIL's right to offset amounts it owes to the County from amounts due from the County under this subsection (d)(iii) is limited to withholding payment, unless otherwise mutually agreed to by the parties.

Either party may offset these excess costs by use of any payment due before termination of this Agreement or before the exercise of any remedies. If the amount offset is insufficient to cover those excess costs, the other party is liable for and must promptly remit to the County offsetting party the balance upon written demand for it. This right to offset is in addition to and not a limitation of any other remedies available to the a party.

e) Delays

BCBSIL agrees that no charges or claims for damages shall be made by BCBSIL for any delays or hindrances during the progress of any portion of this Agreement, except that BCBSIL may assert charges or claims for damages for delays or hindrances caused solely by the County, where such delays are related to, eligibility information, benefit design, approval of benefit booklets and funding type decisions ("Delay Claims"). Any Delay Claims pursuant to this subsection 9)e) shall not exceed Seven Hundred Fifty Thousand Dollars

($750,000) in any one benefit year during the term of this Agreement.

Notwithstanding the foregoing, this subsection 9)e) shall not apply to any delayed payments by the County, adjustments to premiums or fees, or unrecovered payments to providers.

f) Prepaid Fees

In the event this Agreement is terminated by either party, for cause or otherwise, and the County has prepaid for any Deliverables, BCBSIL shall refund to the County, on a prorated basis to the effective date of termination, all amounts prepaid for Deliverables not actually provided as of the effective date of the termination. The refund shall be made within thirty (30) days of the effective date of termination.

g) Subrogation

Upon written notice of the County, BCBSIL shall immediately cooperate with and provide all support necessary and practical for the County's subrogation program for claims arising out of accidental injuries, including support to transition the program to the County. This cooperation and support shall include, but shall not be limited to, the following components:

A. Inclusion of the County's enhanced subrogation language for all self-funded plans, as provided in Exhibit 9, Administrative Service Agreement.

B. Communication and transmission of the following information, in such form and manner as established by the Plan Administrator:

- A daily download of all completed claims submitted which carry an accident-related diagnosis, in the 1600-byte format containing the fields necessary to identify the claim, participant, and provider. The file format shall be that used by existing Municipal Account customers. The codes shall be defined in the ICD-9 list, including E-Codes, and the replacement ICD-10 codes when implemented. BCBSIL shall also include claims with accident checkboxes on HCFA-submitted claims.
- Access to image reproduction of claims for the purpose of the subrogation program documenting its third-party demands.

C. Real-time access of the claims data (Blue-Chip system) to persons designated by the County, so they can research and compile all accident-related claims.

D. BCBSIL shall cooperate with County personnel or the County's subrogation vendor to deliver necessary information.

E. BCBSIL shall provide the County notification of all refunds sent from providers on account of accident reimbursements or coordination of benefits on accident insurance.

BCBSIL shall implement set off of future benefits on the County's determination that the participant received third-party funds without reimbursing the Plan.

ARTICLE 10) GENERAL CONDITIONS

a) Entire Agreement

i) General

This Agreement, and the Exhibits attached to it and incorporated in it, constitute the entire Agreement between the parties and no other warranties, inducements, considerations, promises or interpretations are implied or impressed upon this Agreement that are not expressly addressed in this Agreement.

ii) No Collateral Agreements

BCBSIL acknowledges that, except only for those representations, statements or promises expressly contained in this Agreement and the Exhibits attached to it and incorporated by reference in it, no representation, statement or promise, oral or in writing, of any kind whatsoever, by the County, its officials, agents or employees, has induced BCBSIL to enter into this Agreement or has been relied upon by BCBSIL, including any with reference to:

(a) statements as to the meaning, correctness, suitability or completeness of any provisions or requirements of this Agreement;
(b) the nature of the Services to be performed;
(c) the nature, quantity, quality or volume of any materials, equipment, labor and other facilities needed for the performance of this Agreement;
(d) the general conditions which may in any way affect this Agreement or its performance;
(e) statements as to the compensation provisions of this Agreement; or
(f) any other matters, whether similar to or different from those referred to in (a) through (e) immediately above, affecting or having any connection with this Agreement, its negotiation, any discussions of its performance or those employed or connected or concerned with it.

iii) No Omissions

Each party acknowledges that it was given an opportunity to review all documents forming this Agreement before signing this Agreement in order that it might request inclusion in this Agreement of any statement, representation, promise or provision that it desired or on that it wished to place reliance. The parties state that they each did so review those documents, and either every such statement, representation, promise or provision has been included in this Agreement or else, if omitted, the parties relinquishes the benefit of any such omitted statement, representation, promise or provision and is willing to perform this Agreement in its entirety without claiming reliance on it or making any other claim on account of its omission.

b) Counterparts

This Agreement is comprised of several identical counterparts, each to be fully signed by the parties and each to be considered an original having identical legal effect.

c) Amendments

The parties may during the term of this Agreement make amendments to this Agreement but only as provided in this Section. Such amendments shall only be made by mutual agreement in writing.

The Chief Procurement Officer may agree with BCBSIL to amend this Agreement without Board approval provided that any such amendment does not extend this Agreement by more than one (1) year, and further provided that the total cost of all such amendments does not increase the total amount of this Agreement beyond $150,000. Such action may only be made with the advance written approval of the Chief Procurement Officer. If the amendment extends this Agreement beyond one (1) year or increases the total award amount beyond $150,000, then Board approval will be required.

Except with regard to the execution of the Benefit Program Applications by the Director of Risk Management, which shall not be considered amendments pursuant to this Section 10)c), no Using Agency or employee thereof has authority to make any amendments to this Agreement. Any amendments to this Agreement made without the express written approval of the Chief Procurement Officer is void and unenforceable.

BCBIL is hereby notified that, except for amendments which are made in accordance with this Section 10)c) Amendments, no Using Agency or employee thereof has authority to make any amendment to this Agreement.

d) Governing Law and Jurisdiction

This Agreement shall be governed by and construed under the laws of the State of Illinois. The parties irrevocably agrees that, except as provided in Article 6 any action or proceeding in any way, manner or respect arising out of this Agreement, or arising from any dispute or controversy arising in connection with or related to this Agreement, can be litigated only in courts within the Circuit Court of Cook County, State of Illinois, and BCBSIL consents and submits to the jurisdiction thereof. In accordance with these provisions, the parties waive any right it may have to transfer or change the venue of any litigation brought related to this Agreement.

e) Severability

If any provision of this Agreement is held or considered to be or is in fact invalid, illegal, inoperative or unenforceable as applied in any particular case in any jurisdiction or in all cases because it conflicts with any other provision or provisions of this Agreement or of any constitution, statute, ordinance, rule of law or public policy, or for any other reason, those circumstances do not have the effect of rendering the provision in question invalid,

illegal, inoperative or unenforceable in any other case or circumstances, or of rendering any other provision or provisions in this Agreement invalid, illegal, inoperative or unenforceable to any extent whatsoever. The invalidity, illegality, inoperativeness or unenforceability of any one or more phrases, sentences, clauses or sections in this Agreement does not affect the remaining portions of this Agreement or any part of it.

f) Assigns

All of the terms and conditions of this Agreement are binding upon and inure to the benefit of the parties and their respective legal representatives, successors and assigns.

g) Cooperation

Each party must at all times cooperate with the other in connection with their respective rights and obligations under this Agreement. If this Agreement is terminated for any reason, or if it is to expire on its own terms, the parties must take commercially reasonable efforts to promote an orderly transition to another provider of the Services, if any, orderly demobilization of its own operations in connection with the Services, uninterrupted provision of Services during any transition period and must otherwise comply with the reasonable requests and requirements of the other party in connection with the termination or expiration.

h) Waiver

Nothing in this Agreement authorizes the waiver of a requirement or condition contrary to law or ordinance or that would result in or promote the violation of any federal, state or local law or ordinance.

Whenever under this Agreement authority party waives the other party's performance in any respect or waives a requirement or condition to either the County's or BCBSIL's performance, the waiver so granted, whether express or implied, only applies to the particular instance and is not a waiver forever or for subsequent instances of the performance, requirement or condition. No such waiver is a modification of this Agreement regardless of the number of times a party may have waived the performance, requirement or condition. Such waivers must be provided to the other party in writing.

i) Independent Contractor

This Agreement is not intended to and will not constitute, create, give rise to, or otherwise recognize a joint venture, partnership, corporation or other formal business association or organization of any kind between BCBSIL and the County. The rights and the obligations of the parties are only those expressly set forth in this Agreement. BCBSIL must perform under this Agreement as an independent contractor and not as a representative, employee, agent, or partner of the County.

j) Governmental Joint Purchasing Agreement

Pursuant to Section 4 of the Illinois Governmental Joint Purchasing Act (30 ILCS 525) and the Joint Purchase Agreement approved by the Cook County Board of Commissioners (April 9, 1965), other units of government may purchase goods or services similar to those provided pursuant to this Agreement.

In the event that other agencies participate in a joint procurement, the County reserves the right to seek to renegotiate the financial terms of this Agreement to accommodate the larger volume.

k) Comparable Government Procurement

[Intentionally Omitted]

l) Force Majeure

Neither BCBSIL nor County shall be liable for failing to fulfill any obligation under this Agreement if such failure is caused by an event beyond such party's reasonable control and which is not caused by such party's fault or negligence. Such events shall be limited to acts of God or nature, acts of war, terrorism, fires, lightning, floods, epidemics, or riots.

m) Change in Ownership or Control

BCBSIL will inform the Cook County Chief Procurement Officer and the County's Director of Risk Management of any change in ownership or control of BCBSIL and shall be required to provide updated written disclosures of ownership or control pursuant to the Cook County Code of Ordinances Article 7, Division 2, Subdivision VI, Section 610.

n) Service Mark Regulation

i) If the County elects HMO Cost Plus Insured, HMO 151 Plus Insured and/or PPO Insured benefit plan(s), then on behalf of the County and its covered persons, the County hereby expressly acknowledges its understanding that the policy constitutes a contract solely between the County and BCBSIL. BCBSIL is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits BCBSIL to use the Blue Cross and Blue Shield Service Mark in BCBSIL's service area and BCBSIL is not contracting as the agent of the Association. The County further acknowledges and agrees that it has not entered into the policy based upon representations by any person other than authorized persons of BCBSIL and that no person, entity or organization other than BCBSIL shall be held accountable or liable to the County for any of BCBSIL's obligations to the County created under a policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSIL, other than those created under other provisions of the applicable Group Administration Document.

ii) If the County elects PPO self-funded benefit plan, then the County acknowledges that that BCBSIL's Proprietary Marks and Business Proprietary Information are the sole property of the Blue Cross and Blue Shield Association or of BCBSIL and agrees not to

contest the Blue Cross and Blue Shield Association's or BCBSIL's ownership or the license granted to the BCBSIL for use of such Proprietary Marks.

ARTICLE 11) NOTICES

All notices required pursuant to this Agreement shall be in writing and addressed to the parties at their respective addresses set forth below. All such notices shall be deemed duly given if hand delivered or if deposited in the United States mail, postage prepaid, registered or certified, return receipt requested, or by national overnight courier. Notice as provided herein does not waive service of summons or process.

If to the County:

Cook Count Department of Risk Management
County Building
118 North Clark Street, Room 1072
Chicago, Illinois 60602-1304
Attention Director of Risk Management

and

Cook County Chief Procurement Officer
118 North Clark Street. Room 1018
Chicago, Illinois 60602
(Include County Contract Number on all notices)

If to BCBSIL: Robert Miller
Divisional Vice PresidentBlue Cross and Blue Shield of Illinois
300 E. Randolph Street, 22nd Floor
Chicago, Illinois 60601-5099

With Copies to: Blue Cross and Blue Shield of Illinois Legal Department
28th Floor
300 East Randolph Street
Chicago, Illinois 60601
Attention: General Counsel

Changes in these addresses must be in writing and delivered in accordance with the provisions of this Article 11. Notices delivered by mail are considered received three days after mailing in accordance with this Article 11. Notices delivered personally are considered effective upon receipt. Refusal to accept delivery has the same effect as receipt.

ARTICLE 12) AUTHORITY

Each party's execution of this Agreement is duly authorized by that party's respective and applicable processes. The County is authorized to enter into this Agreement based upon the authorizations of the Cook County Board on October 28, 2015. The signature(s) on behalf of BCBSIL has been made with complete and full authority to commit BCBSIL to all terms and conditions of this Agreement, including each and every representation, certification and warranty

contained in it, including the representations, certifications and warranties collectively incorporated by reference.

[Signature Page and Exhibits follow.]

EXHIBIT 1

Statement of Work

Exhibit 1
SCOPE OF SERVICES/Statement of Work

1.1 General

Cook County (the "County") has identified Blue Cross Blue Shield of Illinois ("BCBSIL") as an administrator that can provide quality administrative and insurance services for the County's benefit plans in a cost-effective manner in a rapidly changing health-care environment. BCBSIL was selected based on a combination of competitive fees, strong networks, innovative program offerings and excellent member and client service.

The County requires that BCBSIL match the County's current plan designs as reflected in the annual Benefit Program Applications (BPA). However, the County is currently engaged in the collective bargaining process with all unions and benefit plans designs are subject to the collective bargaining process. Negotiated plan design changes resulting from the collective bargaining process will require implementation effective December 1, 2015 for certain members of the County's benefit plan(s) and a future date for additional members of the County's benefit plan(s). Plan designs are included as Attachment A to this document. All such benefit design changes and funding type elections are governed by the terms and conditions of the Agreement.

A. BCBSIL resources include a sufficient number of staff and phone lines and adequate backup capability.

B. BCBSIL shall maintain a website for the County's members and plan administrators. Members can access tools, activities, and resources at www.BCBSIL.com/cookcounty/, or such other website established by BCBSIL.

C. BCBSIL shall have a Disaster Recovery Plan and procedures, including off-site storage of critical data and specific provisions for responses to inquiries, continuation of customer service, access to eligibility files, claims processing, and financial data.

D. BCBSIL agrees to accept the transfer of pharmacy claims data from the County's Pharmacy Benefit Manager ("PBM") at no additional cost, for purposes of accumulating total claims toward plan out-of-pocket maximums and for purposes of administering health promotion programs.

E. BCBSIL will provide weekly eligibility full-file FTP feeds to Caremark, subject to the requirements of the "Third Party Data Release" subsection of the PSA, at no additional cost.

1.2 Account Management

A. BCBSIL shall provide a designated account manager to handle day-to-day requests from the County and any service issues that may arise.

B. BCBSIL will allow the County the ability to request a change in account management and the ability to interview and approve any key account staff changes.

a. Previously, four (4) BCBSIL team members provided support to the County. Under the terms of this Agreement, the BCBSIL team supporting the County has expanded to seven (7) team members to include support from the following:
    i. Strategic Account Executive
    ii. Tactical Account Executive
    iii. Implementation Manager
    iv. Marketing Service Representative
    v. Two Group Benefit Specialists
    vi. Municipal Accounts Vice President
b. By leveraging the team members listed above, BCBSIL will:
    i. Provide the Services under this Agreement in an efficient manner;
    ii. Track and identify trends;
    iii. Increase its visibility at various County locations; and
    iv. Provide a solution to issues raised by the County.

C. BCBSIL will provide onsite assistance at various County locations to provide reasonable levels of worksite wellness and account support to resolve County and member issues in a timely and efficient manner and will deliver BCBSIL wellness education and programs, as determined by the County, in addition (D) below.

D. BCBSIL will provide staff knowledgeable of the County's plans/programs to participate in open enrollment meetings and wellness fairs each year, which currently are anticipated to annually include a minimum of 5 benefits fairs and 14 open enrollment meetings, though needs may change from year to year upon mutual agreement of the parties.

1.3 Implementation

A. Implementation Milestones
a. County approval on account structure – August 17, 2015
b. County determining funding for PPO benefit plan – September 1, 2015
c. Member Open Enrollment: To be held in October, 2015
d. Eligibility File received by County – November 3, 2015
e. New HDHP design coded and implemented – November 13, 2015
f. Eligibility transfer to H.S.A. bank and Caremark – November 13, 2015
g. Renewal (benefit, rate changes, , etc.) processed – November 15, 2015
h. Issuance of ID cards – mailed by November 17, 2015
i. BVA implemented – ready for production November 27, 2015, begins December 1, 2015
j. Banking arrangement in place – December 1, 2015
k. Claim testing and validation – complete by January 1, 2016

B. In the event of a significant addition of new employees, dependents, or product offerings, a dedicated municipal accounts implementer will work with the County to implement the transition by the agreed to start date.

C. BCBSIL will provide $125,000 in implementation credits for year one and $150,000 in communication and/or Wellness credits per year for three years to the County. The County may use the communication and/or Wellness credits to fund programs, communications, and/or projects that promote the member experience and wellness.

D. Examples of wellness activities that are designed to promote a healthier lifestyle or that tie to the health of the employee, improving baseline biometrics, health education to maintain or improve it include but are not limited to:

a. Chef demonstration
b. Flu shots
c. Custom banners
d. Payroll stuffers
e. Custom communications, design, postage
f. Wellness giveaways
g. Wellness education
h. Educating members on programs available to them on Blue Access for Members ("BAM")

E. BCBSIL fee includes all costs associated with implementation services. No additional charges will apply.

F. BCBSIL will provide educational materials to members on how to use the BCBSIL website including the system tools and capabilities. ID cards for new groups and renewal groups with benefit changes will be mailed within seven (7) business days following the receipt of all necessary information from the County and submission to BCBSIL's vendor. When member changes occur during the plan year, new ID cards are generally mailed in less than seven (7) business days following BCBSIL's receipt of the new information, approval of the County, and submission of such information to the BCBSIL's vendor.

G. BCBSIL will provide reasonable customization to the ID card at no additional charge. The card will include the County's logo and custom message based on the benefit programs offered, to the extent permitted by the BCBSA ID Card rules. Currently, the following information may also be customized:

a. company name, logo, and Web URL
b. descriptive titles (subscriber, member, ID number)
c. copayment descriptions and values
d. appropriate client-specific contact phone numbers
e. various messages on the card carrier

G. Anti-Fraud Program. BCBSIL will maintain an Anti-Fraud Program.

H. Fiduciary Responsibility:

a. (Self-Insured) BCBSIL will continue to accept claim processing fiduciary responsibility for an additional fee of $1.00 per employee per month.
b. (Fully Insured) BCBSIL accepts claim fiduciary responsibility at no additional charge. BCBSIL accepts all risk of claims for benefits insured under the policy.

I. The County authorizes BCBSIL to coordinate with a preferred HSA banking vendor for the County's H.S.A. Administration and to transfer eligibility data to the preferred HSA banking vendor. BCBSIL will provide HSA administration materials as needed.

1.4 Eligibility & Enrollment

A. Auditing eligibility data

BCBSIL will update its eligibility system within two days of receiving valid and complete enrollment data from the County. Once the County transmits the data to BCBSIL, the assigned BCBSIL FSU will be notified electronically and data quality checks will be performed to assess whether the data is complete. The FSU will then correct any errors on the file, if the necessary information is available, and add the eligibility records to the BCBSIL system. The complexity of the eligibility error may require a sequence of edits resulting in a maximum of five business days to fully assess the eligibility file. If a manual paper application is received it could take up to seven business days to process.

B. Transfer of eligibility data to the County's other vendors (e.g. PBM)

BCBSIL will transfer eligibility data to the County's PBM (currently CVS Caremark) as well as other vendors as designated by the County, subject to the requirements of the "Third Party Data Release" subsection of the PSA, and manage the resolution of any errors or discrepancies at no additional cost and on a reasonable timeframe. BCBSIL will allow one standard file lay out with a preferred vendor for eligibility and claims for fully insured and ASO funding.

1.5 Member Services

A. All BCBSIL customer advocates have been trained in claims processing and have the authority to authorize adjudication of claims, with varying degrees of authority. Customer advocates can access claims history/status, SPDs/plan documents and the history and status of member questions/complaints, when available, to respond to member inquiries.

B. BCBSIL shall provide toll-free telephone, TDD access and IVR for member service. Rockford Full Service Unit ("FSU") is the current FSU. The current hours of operation for the FSU are Monday through Friday, from 8:00 a.m. to 6:00 p.m., Central Time, and the current hours of operation for the Chicago FSU are Monday through Friday, from 8:00 a.m. to 5:30 p.m., Central Time.

C. Customer Advocate Training

Customer Advocates will be trained in BCBSIL's systems, policies and procedures. BCBSIL will provide specific training in Cook County plans, policies and procedures to customer advocates. BCBSIL will work with the County to develop member service scripts to deliver customized messaging, where appropriate, to individuals covered under the County's benefit plans.

D. Customer service inquiry tracking and reporting

The information provided below is applicable to the County's PPO and HMO FSUs.

- All calls are currently recorded

- Calls are currently archived for 7 years
- All calls and inquiries are documented
- Currently, up to 150 member service calls are audited for each customer advocate annually.

E. Call transfers

As part of the Blue Care Connection team, BCBSIL customer advocates will provide direct referrals to the program for PPO members, answer members' initial questions, and assist members in accessing a Blue Care Advisor. BCBSIL will accept warm transfers from and provide a warm transfer to the County's other vendors mutually agreed to by the parties. Additionally, other vendors can be selected as options through the IVR system.

Warm transfers are not provided for HMO care management, as BCBSIL delegates this function to the IPA.

1.6 Web Capabilities

Members can:	
1. Access provider credentialing/statistical information	Y
2. Access provider directories or check whether providers are in the network. This should include hospitals, physicians and urgent care centers.	Y
3. Access provider directories with driving instructions	Y
4. Change a PCP	Y for HMO; N/A for PPO
5. Access provider quality information	Y
6. Participate in community forums	Y
7. Access benefit plan summaries	Y
8. Check eligibility	Y
9. Order replacement ID cards	Y
10. View and print ID cards from the website	Y
11. "Talk" to providers (i.e., "Ask-the-Physician")	N
12. Research symptoms, medical conditions or wellness information	Y
13. File a claim	Y
14. Review a history of medical claims	Y
15. Download printable versions of claim forms	Y
16. Check claim status	Y
17. Submit appeals	Y
18. Access cost estimators	Y, PPO only

19. Submit inquiries to member service via email	Y
20. Ability to access and complete satisfaction surveys	N
21. Access to download smart phone applications	Y
Plan Sponsor/Employer Support	
Cook County can:	
22. Check claim status online	Y
23. Update eligibility online	Y
24. Create reports online	Y

1.7 Care Management (Case Management, Utilization Management, Disease Management & Wellness Programs)

BCBSIL will provide a PPO Case Management Program that assesses, plans, implements, coordinates, monitors, and evaluates options and services designed to meet members' medical, functional, psychosocial, financial, and vocational needs. Case managers will coordinate and promote transition of care by providing members with information about available resources that promote quality and cost-effective outcomes. They will also serve as the member's resource and provide information about any unmet needs that could act as barriers and prevent the member from achieving their highest level of medical wellness or functional autonomy.

Case managers will work towards the following goals:

- coordination and access to required services
- maximize appropriate, efficient, and cost-effective utilization of resources
- promote continuity of care across the health care continuum
- reduce unnecessary ambulatory sensitive inpatient admissions and readmissions
- reduce unnecessary emergency room (ER) encounters
- increase member self-care and management of diagnosed diseases and conditions when appropriate
- increase use of appropriate alternative settings

Case management staff receives referrals from various sources. Within one business day of referral to case management, a Blue Care Advisor, who has experience in case management, will contact the member and provider; provided, however, that if a member is deemed to be "hard to reach", BCBSIL's responsibility is as outlined below in Section 1.7.E . Each case will be reviewed by case management and screened for case management opportunities, such as medical/surgical, catastrophic, obstetrical, neonatal/pediatric, and transplant.

BCBSIL will make available the Benefit Value Advisor (BVA) program, at no additional cost.

HMO Case Management

Case management services will be provided collaboratively between BCBSIL and the contracting IPAs. This case management process must include the assessment of the patient's health care needs, development of a discharge treatment plan, evaluation of treatment plan, and evaluation of the outcome. HMO care management will include providing a range of disease management and quality improvement programs, embedded (at no additional cost) in the HMO product. These programs offer incentive compensation to contracting IPAs based on improved outcomes. In addition to the disease management programs, BCBSIL will offer a wellness program and preventive care and condition-specific programs for HMO members.

A. Post-hospitalization follow-up and post-hospitalization care

PPO

BCBSIL will coordinate with the hospital with respect to discharge planning and post-hospitalization services that the provider is recommending for County members so that benefits available for the place of service for care after a hospitalization has been factored into the provider's and member's decisions about place of treatment.

HMO

The IPA will designate an individual who is responsible for identifying and implementing discharge plans/needs.

B. BCBSIL will offer, at a minimum, the following disease/condition management programs:

Disease/Condition	Offered? (Y/N)
Arthritis	Y, managed as co-morbidity for PPO members.
Asthma	Y
Cancer	Y, managed through our case management benefit for PPO members.
Cerebrovascular Disease	Y, managed through our case management benefit for PPO members.
CHF	Y
COPD	Y
Coronary Artery Disease	Y
Depression	Y, managed as co-morbidity for PPO members.
Diabetes	Y
GERD	Y, managed as co-morbidity for PPO members.
High Risk Pregnancy	Y, managed through our case management benefit for PPO members.
HIV/Aids	Y, managed through our case management benefit for PPO members.
Hypercholesterolemia	Y, managed as co-morbidity for PPO members.
Joint Disorders	Y, managed as co-morbidity for PPO members.
Low Back Pain	Y, managed as co-morbidity for PPO members.

Pain Management	Y, managed as co-morbidity for PPO members.
Renal Failure	Y, managed through our case management benefit for PPO members.
Smoking Cessation	Y, managed through our Lifestyle Management program for PPO and HMO members
Weight Management	Y, managed through our Lifestyle Management program for PPO and HMO members
Stress Management	Y, managed through our Lifestyle Management program for PPO and HMO members

C. BCBSIL will provide case coordinate services for members with certain multiple conditions or enrolled in more than one disease/condition management program, when agreed to by the member.

D. **Call transfers**

As part of the Blue Care Connection team, BCBSIL advocates will provide direct referrals to the program for PPO members, answer members' initial questions, and assist members in accessing a Blue Care Advisor. BCBSIL will accept warm transfers from and provide a warm transfer to the County's other vendors mutually agreed to by the parties. Additionally, other vendors can be selected as options through the IVR system. BCBSIL will provide referrals to programs based on member needs (i.e., lifestyle management member to a condition management program).

Warm transfers are not provided for HMO care management, as this function is delegated to the IPA.

BCBSIL will work with the County to establish a regular schedule of customer service engagement campaigns at no additional cost.

E. **Efforts currently in place to contact hard-to-reach members**

BCBSIL will make initial outreach to a member with an introductory letter stating a Blue Care Advisor will be calling them. Approximately one week after a letter is sent, two outreach calls will be made to member. If the member is not reached after two attempts and there is no response from messages left for the member, an unable to reach letter is then mailed to the member asking the member to call the Blue Care Advisor. A minimum of three interactions are conducted within a six-month period for enrolled members. Members who were engaged and at the time of their follow-up interaction could not be reached are sent a "Lost to Follow-up" letter.

If BCBSIL does not have accurate information for outreach, BCBSIL will use commercial databases to attempt to identify alternative contact information. For those members who remain with unimproved contact information, a phone number search firm will be used to attempt to enhance contact results.

Specific to the HMO benefit, this function is delegated to the IPA.

For the Lifestyle Management Program, three outreach attempts are made to eligible members to engage in the Lifestyle Management Program. After the first unsuccessful outreach attempt, the system generates a letter to the member informing them of the program. A minimum of six interactions are conducted within a nine to 12 month period for enrolled members. Members who were engaged and at the time of their follow-up interaction could not be reached are sent a "Lost to Follow-up" letter.

For the maternity program, potential participants identified through the preauthorization may receive outreach; however, this program is generally a self-referral program. Engaged members complete a pregnancy-specific assessment telephonically or online.

(1) Based on information stored in a customer/member profile, a Condition Management Program
(2) Lifestyle Management Program

For all members, BCBSIL can offer wellness consultants to support a results-oriented Wellness Program. For HMO members, additional outreach is delegated to the IPA.

F. BCBSIL agrees to provide quarterly reports on members participating in the PPO programs as well as those BCBSIL is unable contact and those declining participation.

G. 24/7 Nurse Line

For HMO members, participating IPAs are contractually required to have a 24-hour answering service and have a physician respond to any emergency call within 30 minutes.

For PPO members, BCBSIL provides a Nurse Line 24 hours a day, seven days a week, to answer members general health questions and guide members to their primary care physician, urgent care center, the ER or other care as necessary.

H. Health coaching

BCBSIL will provide members with a Lifestyle Management Program within Blue Care Connection, or a successor program, on health issues including tobacco cessation, weight management, and metabolic syndrome, as well as via its wellness portal, on issues including tobacco cessation, weight management, stress management, nutrition, and physical activity programs. Based on member need, severity, or request, the member will be contacted with up to six follow up calls for additional support, re-assessment, and modification of goals. Individuals enrolled in the coaching program will work with one health coach throughout the time that they are enrolled in the program.

I. Web based health management tools

BCBSIL will provide health management tools including Care onTarget, or a successor program, so that members can use to learn about and manage their condition.

J. Preventive care

BCBSIL will provide its Well onTarget solution, or a successor program, that encompasses wellness coaching, online tools and resources, fitness programs, wellness consulting services, premium communication packages, and onsite health events and screenings.

K. Additional wellness programs

In addition to the programs already noted, BCBSIL will provide Blue Care Advisors, predictive modeling tool, the Blue Resource[SM] program, the Worksite Wellness program, BlueExtras[SM].

L. HMO Wellness Information

Health and wellness initiatives are a joint responsibility of BCBSIL and the contracted medical groups and IPAs. BCBSIL will provide tools to support health and wellness, including a health risk assessment, provides member education including health and wellness information (the member newsletter and preventive care reminders), QI Fund (Quality Improvement Fund) payments to motivate IPAs to be actively engaged in health and wellness initiatives, and employer-specific wellness initiatives through the customer service Campaign Manager program.

M. Wellness program promotion

BCBSIL will provide supporting communications that can be made available either electronically or in print to support the ongoing education of plan members. BCBSIL will provide a senior communication consultant to meet with the County's benefits communication team and develop a 12-month employee communication campaign based on both communication objectives and health care management goals. BCBSIL will provide resources to supplement the campaign including print-on-demand enrollment guides, rich media such as flash and/or video, fliers, email campaigns, and brochures that support purchased services and programs. Additional costs may be applicable.

For HMO, members will receive targeted mailings. The primary engagement efforts come from the individual medical groups, IPAs, and physicians providing care to the identified members.

i. <u>On-site health promotion programs</u>

BCBSIL offers the following on-site Worksite Wellness Events and will work with the County to incorporate any of the below offerings in an annual plan:

- ***Health Fairs***-The County can host onsite learning opportunities to educate employees on various health topics. These seminars are four to six hours in length, are fully staffed, and include relevant displays. The following topics are available: blood pressure screening,

body fat/BMI analysis, stress management, physical activity, heart healthy, nutrition, preventive health and self-exams, sanitize for safety, or tobacco awareness.

- ***Health Education Classes***-The County can educate its employees either onsite or online on wellness topics. Onsite and online (webinar) programs are taught by a health educator and last one hour. Class topics available include: stress management, physical activity, heart health, tobacco awareness, nutrition, wellness for men and wellness for women, the power of preventive health care, effects of sleep deprivation, back health, and New Year's resolutions. Recommended for at least 20 to 25 participants. Specific wellness classes not listed above can also be requested at an additional fee.
- ***Injury Prevention Screenings and Classes***-The County can organize both injury prevention classes, as well as onsite sessions, where employees can undergo a musculoskeletal assessment that evaluates flexibility, movement, mobility (side to side, front to back, and rotational), and balance. After these assessments employees receive educational feedback including a customized exercise program designed to improve their musculoskeletal health. Recommended for at least 10 participants per hour, with a four hour minimum.
- ***Onsite Fitness Classes***-The County can purchase onsite fitness classes led by certified professionals, who can instruct on a range of 30- to 90-minute physical movement classes. The class choices include: Boot Camp, Aerobics, Stretch and Tone, Pilates, Zumba, and Yoga. A minimum of eight class hours is required.
- ***Onsite Biometric Screenings***-Basic onsite biometric screenings can be offered as an independent event or as part of a health fair offering. This enhanced service includes screenings for height/weight, BMI, blood pressure, waist circumference, and our basic finger stick which includes: total cholesterol, high density lipoprotein (HDL), and random glucose followed by immediate onsite coaching. Immediate onsite coaching lasts for approximately 10 minutes (enough time to fully review all results and for the employee to receive recommendations), and hourly coaching services by a degreed specialist can also be purchased. The additional hourly coaching can be done one-on-one or in a group.

  Biometric screenings are a good way to reach those employees who may not seek regular medical care and identify individuals who are at risk for—or in the early stages of—certain common conditions or diseases. The opportunity to learn more about their current health status in a familiar setting is appealing to many people who might not otherwise take this first step.
- ***Flu Vaccines***-BCBSIL offers immunizations to the County's employees and dependents enrolled in the County's plan.
- ***Tobacco Cessation***-BCBSIL will educate the County's members on Tobacco Cessation programs available to them on Blue Access for Members ("BAM").
- ***Wellness Coordinator***-The primary role of this service is to coordinate client wellness activities and build health promotion activities. This will facilitate behavior changes, maximize engagement, and promote customer satisfaction. The wellness coordinators will conduct most of their activities onsite at the client's workplace.

ii. **Wellness Communications**

Additionally, BCBSIL will provide BlueResource, a series of employee communications on a variety of health and wellness topics intended to help educate and motivate employees to make and sustain positive behavioral changes. Some of the available communications support onsite events, such as the Worksite Wellness Toolkit, which provides poster copy and additional "how to" support in planning a health fair.

iii. **Wellness Reporting**

All locations that have held a worksite wellness event are eligible for the report; in alignment with HIPAA requirements, a 30-person minimum participation threshold is applicable for any of the reports. Three types of reports are available to clients:

- by site – if there is more than one event
- by the date of the event – if the events span multiple days
- aggregate report – combines multiple events by client

The reports will be made available 20 business days after the date of the last worksite wellness event. External reporting will initiate communication with the Account Executives to determine the reporting needs prior to the worksite wellness event date.

iv. **Wellness incentive programs**

BCBSIL will leverage data already in-house (claims, condition management, and lifestyle management) to develop mutually agreed upon short-term and long-term incentives strategies to increase employee participation. It will also track the claims and activities for those actively engaged in health promotion programs.

N. Member Satisfaction

BCBSIL will survey and report on member satisfaction at least annually.

1.8 Communication & Education

A. Open Enrollment Communication

BCBSIL will draft communication pieces for the County. The annual communication credit may be used for printing and mailing.

B. Plan booklets and customization

BCBSIL will produce plan booklets at the request of the County.

Communication materials are included in the proposed fee; however, to print the following hard copy communications:

- Plan Booklets: $3.75 per booklet, hard copy reprints to one location
- Provider Directories: $10.00 per hard copy directory
- Customized Communication Materials: $100 per hour

Plan booklets and other contractual documents may be customized by working with the County's account team.

BCBSIL will, upon request, provide member communication material as requested regarding the PPO Network providers.

C. Legislative or regulatory changes reporting and updating

BCBSIL will communicate any legislative or regulatory changes related to plan operations to the County within 60 days of any applicable law going into effect or regulation adopted. BCBSIL will update plan booklets at no additional cost to the County.

D. Co-branded communications

BCBSIL will provide co-branding of existing electronic communications or other minor modifications at no additional expense.

E. Mobile Technology Applications

BCBSIL will provide a free iPhone and Android app that gives members access to Blue Access for Members, provider directories, and payment options.

BCBSIL will provide notice to the County as additional mobile applications become available (Health Family, My Doctors, AlwaysOn, etc.).

1.9 Network Management

BCBSIL agrees to offer coverage for retail clinic visits and urgent care facilities, when available, for the PPO Network.

A limited supply of printed directories is available to the County upon request, and at open enrollment for members' use. Printed directories are updated annually for PPO plans and quarterly for HMO plans; therefore, BCBSIL encourages the use of its website for the most up-to-date information. Members who do not have access to the Web may call the customer service toll-free number at any time to obtain current information on provider status.

- The cost for Provider Directories is $10.00 per hard copy directory

A. "Must have" providers

BCBSIL is willing to recruit "must have" providers.

B. PPO

BCBSIL is willing to accept written provider nominations from the County and/or the County's members. The nominated providers must meet credentialing standards and accept the contractual terms of our PPO program.

It takes approximately 30 business days to process a provider's contract/application. The provider's state medical license in which he or she is practicing must be active with no restrictions. The Corporate Compliance database, which consists of federal and state governmental databases, is checked to ensure the provider is not sanctioned from any governmental program.

C. HMO

A large number of physicians already participate in our HMO provider networks. The HMOs contract with multi-specialty IPAs that are responsible for contracting with physicians; therefore any physician nominations should be directed to participating IPAs. All nominated physicians must meet the HMOs' strict provider selection criteria.

D. CCHHS

BCBSIL will actively work towards inclusion of CCHHS in all networks.

E. Quality

BCBSIL will monitor the quality, cost-effectiveness and efficiency of providers and make this information available to members.

BCBSIL will provide access to Blue Distinction Centers Plus program for identified conditions for PPO members.

1.10 Reporting and Data

A. BCBSIL will provide all plan experience and financial data resulting from the administration of all plans (HMO and PPO) to the County. BCBSIL has agreed to quarterly reviews. BCBSIL will make specific team members available for these reviews at the request of the County.

B. Standard reporting package and Frequency

BCBSIL will offer the County access to its Web-based reporting application called Blue Insight℠. Blue Insight allows the County to define data by member, account, sub-populations, time dimensions, and much more. Key analyses within the reporting application include utilization trend, financial analysis, provider, and plan analysis. Features of this reporting application include:

- Billed charges
- Not Covered Charges
- Covered Charges
- Allowed Charges

- Deductible
- Coinsurance amounts
- Copayment amounts
- Subrogation amounts
- COB amounts
- Other adjustment amounts
- Net paid amounts
- Customized reports to include logos
- Standard executive summary reports
- 24/7 online access
- Drill-down and reach through functionality
- Benchmarking data against the Plan's book of business
- Multiple security levels
- Monthly data loads with rolling 38 months of data

C. Blue Insight will be available to the County's designated account manager to complete any ad hoc reporting needs. Data and reports are available 15 days after the close of the reporting period. A one-page monthly report of all paid claims, individual stop loss (ISL) and aggregate stop loss (ASL) violations, and administration expenses is provided if BCBSIL provides stop loss. Customization reports by plan, locations, unions, or other fields will be made available as deemed necessary. Custom reports can be created.

BCBSIL is in the process of updating and finalizing all of the custom data fields that will be available within the Blue Insight application. The application is targeted to have over 200 data fields that will be used as standard fields and/or custom fields. In addition, there will be custom reporting segments that will allow the user to create custom metrics and dimensions that define and categorize members into groups and reporting on these specific groupings. Other key customized data fields will be available within the four major views: financial, claims, enrollment, and utilization. These updates are expected to be implemented September 1, 2015.

D. Online reporting system

BCBSIL will provide group-specific reporting information to empower the County to manage and analyze health care data as needed. While this application provides standard reporting capabilities, such as incurred claims, paid claims, and large claims notifications, it also allows for ad hoc and custom reporting based on the County's needs. Should the County require any custom reports in the future that are not available through Blue Insight, BCBSIL will work with the County to create any reports necessary.

Online reports are pushed out to clients 15 days after the close of the reporting period.

E. BCBSIL will provide a designated client consultant to support the County's reporting needs. Report analytics and outcomes will be discussed on a quarterly basis. Meetings should be scheduled at the beginning of the year for each quarter.

1.11 Reinsurance

BCBSIL does not contract/interface with any external or third party reinsurer. If Stop Loss coverage is carved out to an external reinsurer, BCBSIL will provide a standard reporting package directly to the account and it will be the responsibility of the account to provide the reports to the external or third party reinsurer.

ATTACHMENT A

HEALTH PLAN DESIGNS

HMO

	Benefits Effective until 11/30/2015	**Benefits Effective 12/1/2015***
Classic Blue Option	In Effect	Eliminated
Out of Pocket Maximum	Drug Copays do not accumulate to OOP Max	All Copays accumulate to OOP Max
Out of Pocket Maximum	$1,500 single / $3,000 family	$1,600 single / $3,200 family
Inpatient Facility	$100 copay per admit	$100 copay per admit
Preventive	$10 copay	$0 copay (100% Covered)
Other PCP / Urgent Care	$10 copay	$15 copay
Specialists	$10 copay	$20 copay
X-Ray / Diagnostic tests (performed in lab or hospital)	$0 copay	$0 copay
Accident / illness	$10 copay	$15 copay
Emergency Room	$40 copay	$75 copay

* Eligibility for plan requires union ratification and/or approval of Board of Commissioners.

High Deductible PPO

	Benefits Effective until 11/30/2016	Benefits Effective 12/1/2016 **
Deductible and Out of Pocket Maximum	Not Applicable	Copay and Deductibles do accumulate to OOP Max
Annual Deductible	Not Applicable	Tier 1: $1,500 / $3,000 Tier 2: $2,500 / $5,000 Tier 3: $5,000 / $12,000 (Single / Family)
Out of Pocket Maximum	Not Applicable	Tier 1: $3,000 / $6,000 Tier 2: $5,000 / $10,000 Tier 3: $10,000 / $20,000 (Single / Family)
Inpatient/Outpatient Admission	Not Applicable	Tier 1: 90% Tier 2: 80% Tier 3: 70%
Preventive	Not Applicable	100% Covered
PCP	Not Applicable	Tier 1: 90% Tier 2: 80% Tier 3: 70%
Specialists	Not Applicable	Tier 1: 90% Tier 2: 80% Tier 3: 70%
Urgent Care	Not Applicable	90% Coinsurance In/Out of Network
Emergency Room	Not Applicable	90% Coinsurance In/Out of Network
All Prescriptions	Not Applicable	90%

** Eligibility for plan limited to non-union employees.

EXHIBIT 2

Benefit Program Applications and Summary of Benefits and Coverage Addendums

BlueCross BlueShield of Illinois

The HMOs of Blue Cross and Blue Shield of Illinois

Benefit Program Application ("BPA")

(All items are applicable to 151-Plus Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)

Employer Account Number: _____

HMO Illinois Employer Group Number(s): _____

HMO Illinois Section Number(s): _____

BlueAdvantage® HMO Employer Group Number(s): _____

BlueAdvantage HMO Section Number(s): _____

Employer Name: _____

(Specify the Employer, the employee trust, or the association applying for coverage. Names of subsidiary or affiliated companies to be covered must also be included below. An employee benefit plan may not be named.)

Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address (if different from above): _____

Employer Identification Number ("EIN"): _____

City: _____ State: _____ Zip Code: _____

Wholly Owned Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, attached to this BPA, and is made a part of the Policy.)

Administrative Contact: _____ Phone: _____ Fax : _____ Email: _____

Blue Access for Employers ("BAE") Contact: _____

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: _____ Phone: _____ Fax : _____ Email: _____

Policy Effective Date: _____ Policy Anniversary Date: _____ / _____ / _____
Month Day Year

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA

provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☐

If Yes, specify ERISA Plan Year*: Beginning Date: __/__/__ End Date: __/__/__ (month/day/year)

ERISA Plan Sponsor*: _____

(If the Employer is required to file Form 5500 Schedule A with the IRS, the following ERISA items must be completed):

ERISA Plan Administrator*: _____

ERISA Plan Administrator's Address: _____

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: __/__

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☐ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations.

1. Eligible Person means a person who resides in the Service Area of a Participating IPA and is:
   - ☐ A full-time employee of the Employer.
   - ☐ A member of (name of union or association): _____
   - ☐ Other (please specify): _____
2. Full-Time Employee means:
   - ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and is on the payroll of the Employer.
   - ☐ Other (please specify): _____
3. Civil Union Partner Coverage:

   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 Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union Partners.

4. Domestic Partner Coverage: ☐ Yes ☐ No

   If Yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Covered Employees with Domestic Partner Coverage.

   Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but are eligible for continuation coverage similar to that available to spouses under COBRA continuation.

   Domestic Partner Coverage Continuation (only available if Domestic Partners are covered): ☐ Yes ☐ No

5. **The Limiting Age for covered children is twenty-six (26) years.** Hereafter, covered children means a natural child, a stepchild, an eligible 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.

   To cover children age twenty-six (26) or over, you may select option (a) or (b) below:

(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26 or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

Coverage will terminate:

☐ At the end of the period for which premium has been accepted.
☐ At the end of the month in which the Limiting Age is reached.
☐ At the end of the calendar year in which the Limiting Age is reached.
☐ On the Limiting Age Birthday.
☐ Other (please specify): _____.

However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

6. Total number of employees: (indicate the total number of actual employees, not enrollees)
Of the Employer _____ Illinois employees _____ National employees _____

7. **Eligibility Date:** All current and new employees must satisfy the required waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

☐ The date of employment.
☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
☐ The _____ day (select 1st or 15th) of the month following _____ days (option of up to 60 days) of employment.
☐ The _____ day of the month following the date of employment.
☐ Other (please specify): _____**Note:** This may not exceed ninety-one (91) calendar days.

A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first (1st) and fifteenth (15th) day of the Premium Period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth (16th) day and the end of the Premium Period.

8. **Special Enrollment:** An Eligible Person may apply for coverage, Family coverage or add dependents within thirty one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when 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 Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage. In the case of a Special Enrollment event due to loss of coverage under Medicaid or a state children's health insurance program, however, this enrollment opportunity is not available unless the Eligible Person requests enrollment within sixty (60) days after such coverage ends.

Open Enrollment: Specify Open Enrollment Period:_____. 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 Blue Cross and Blue Shield of Illinois, A Division of Health Care Service Corporation, A Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the open enrollment period.

9. Effective Date of Termination for a person who ceases to meet the definition of an 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 (please specify): _____.

10. Extension of Benefits due to Temporary Layoff, Disability or Leave of Absence:

Temporary Layoff: _____ days; Disability: _____ days; Leave of Absence: _____ days

☐ Other (please specify): _____

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.

11. Funding Arrangement: ☐ Premium Prospective (complete section 12.) ☐ Cost Plus (complete section 15.)

12. **STANDARD PREMIUM INFORMATION:**
The following elections apply to both Grandfathered and Non-Grandfathered Groups:
Premium Period:
☐ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO Coverage.)
☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not available for any coverage if the Employer has BlueCare Dental HMO Coverage.)

13. **MINIMUM EMPLOYER CONTRIBUTION INFORMATION:**

(a) **The following elections apply to Grandfathered and Non-Grandfathered Groups:**

Employer Contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
☐ _____% of the Individual Coverage Premium, and _____% of the Family Coverage Premium.
☐ Other (please specify): _____.

(b) **The following applies to Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**

HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of twenty five percent (25%). In the event the group is unable to maintain the contribution requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the twenty five percent (25%) minimum employer contribution is met. Employer will promptly notify HCSC of any change in Employer contribution.

14. Essential Health Benefits ("EHB") Definition Election:

Employer elects EHBs based on the following:

☐ a. EHBs based on a HCSC state benchmark:
☐ Illinois ("IL") ☐ Oklahoma ("OK")
☐ Montana ("MT") ☐ Texas ("TX")
☐ New Mexico ("NM")

☐ b. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

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

Premium Rates: *(Indicate "N/A" in any rate field that does not apply)*

Health Coverage		
1. Employee only	HMO Illinois $_____	BlueAdvantage HMO $_____
2. Employee plus one dependent (i.e. Employee plus one spouse or one child)	HMO Illinois $_____	BlueAdvantage HMO $_____
3. Employee plus two or more dependents	HMO Illinois $_____	BlueAdvantage HMO $_____
4. Employee plus Spouse	HMO Illinois $_____	BlueAdvantage HMO $_____
5. Employee plus Child(ren) (i.e. Employee plus one or more children)	HMO Illinois $_____	BlueAdvantage HMO $_____
6. Family	HMO Illinois $_____	BlueAdvantage HMO $_____
Single Tier rate structure – complete item 1.		
Two Tier rate structure – complete items 1. and 6.		
Three Tier rate structure – complete items 1., 2., and 3.		
Four Tier rate structure – complete items 1., 4., 5., and 6.		
Medicare Eligible Rates (When HCSC is Secondary Payer)		
Single Coverage	HMO Illinois $_____	BlueAdvantage HMO $_____
Family Coverage	HMO Illinois $_____	BlueAdvantage HMO $_____

15. Cost Plus Program:

a) Service Charges for Claim Payments:
☐ HMO Illinois: _____% of Claim Payments; $_____ per Enrollee per month for health Claim Payments.
☐ BlueAdvantage HMO: _____% of Claim Payments; $_____ per Enrollee per month for health Claim Payments.

b) Physician's Services Fees:
☐ HMO Illinois: $_____ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents.

☐ BlueAdvantage HMO: $_____ per month per single Enrollee; $_____per month per Enrollee with one or more Dependents.

c) ☐ HMO Managed Care Fee: $_____ per HMO enrollee per month.

d) ☐ Transfer Payment Method:

☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify): _____

Tentative Final Settlement Period - Transfer payments required after termination for:

☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

e) ☐ Post Payment Method

f) Payment Period:
☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

g) Claim Settlement Period:
☐ Monthly ☐ Quarterly ☐ Other (please specify) _____

h) Prescription Drug Rebate:
$_____ per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and on behalf of the Employer offers to purchase the benefit program as outlined in the proposal document submitted to the Employer by the Sales Representative. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the proposal document and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first premium by HCSC.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid to the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative hereby acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) 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 that (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the employee welfare benefit plan of the Employer (or any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by HCSC are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Group Administrative Document to which this BPA is attached under the section titled "The Plan's Separate Financial Arrangements Regarding Prescription Drugs.").

OTHER PROVISIONS:

1. Certificate of Creditable Coverage: ☐ Yes ☐ No (The "yes/no" option is applicable to one hundred (100) plus only; A Certificate of Creditable Coverage is issued automatically under one hundred (100) lives to the extent required by applicable law.)

   If yes: It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996, to the extent required by applicable law. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

   If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Policy.

2. Summary of Benefits and Coverage ("SBC"):

   a) HCSC will create SBC?

   ☐ Yes. If Yes, please answer question (b). The SBC Addendum is attached and made a part of the Policy.

   ☐ No. If No, then the Policyholder acknowledges and agrees that the Policyholder is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will HCSC have any responsibility or obligation with respect to the SBC. HCSC may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations. The Plan is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Policyholder's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question (b).)

   b) HCSC will distribute SBC to participants and beneficiaries?

   ☐ No. The Plan will create SBC (only for benefits the Plan insures under the Policy) and provide SBC to the Policyholder in electronic format. Policyholder will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

   ☐ Yes. The Plan will create SBC (only for benefits the Plan insures under the Policy) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

3. BlueEdge FSA (Vendor: ConnectYourCare) purchased: ☐ Yes ☐ No

4. It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain twenty five percent (25%) of any recovered amounts (under cost-plus funding) or deduct twenty five percent (25%) of any recovered amounts from the amount credited to the group's experience (under premium funding), other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

5. Excess Loss Coverage purchased: ☐ Yes ☐ No
   If yes: Complete separate Application for Excess Loss Coverage.

6. Blue Directions (Private Exchange) purchased: ☐ Yes ☐ No

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) 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 HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee".
Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Except for the Cost Plus Program, your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees. The Cost Plus HMO premium includes the Health Insurer Fee. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or

guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners, but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, 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.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

_____

Sales Representative	Signature of Authorized Purchaser
District Phone No.	Title
Producer Representative	Date
Signature of Producer Representative	Witness
Producer Firm	
Producer Address	$_____ Amount Submitted (not required for renewals)
Producer Tax ID No.	

INTERNAL USE ONLY	UNDERWRITING AUTHORIZATION
	Date BPA approved by Underwriting: _____ Printed Name and Signature of Underwriter _____

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 shall 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 mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No(s).: _____

By: _____

Print Signer's Name Here

➡ _____

Signature and Title

Group Name: _____

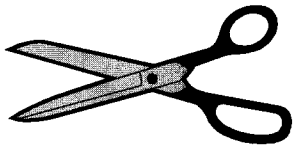
Address: _____

City: _____

State: _____ Zip Code: _____

Dated this: _____ day of _____, _____
Month Year

Cut along dotted lines



[redacted] BlueCross BlueShield of Illinois

[redacted]

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to 151-Plus Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)

Employer Account Number: _____ Employer Group Number(s):_____

Section Number(s): _____

Employer Name: _____
(Specify the employer, the employee trust, or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Address: _____ City: _____ State: _____ Zip Code: _____

Billing Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Employer Identification Number ("EIN"): _____

Wholly Owned Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, attached to this BPA, and is made a part of the Policy.)

Administrative Contact: _____ Phone: _____ Fax : _____ Email: _____

Blue Access for Employers ("BAE") Contact: _____

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: _____ Phone: _____ Fax: _____ Email: _____

Policy Effective Date: _____ Policy Anniversary Date: _____ / _____ / _____
Month Day Year

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☐
If Yes, specify ERISA Plan Year*: Beginning Date: __/__/__ End Date: __/__/__ (month/day/year)
ERISA Plan Sponsor*: _____

(If the Employer is required to file Form 5500 Schedule A with the IRS, the following ERISA items must be completed):
ERISA Plan Administrator*: _____
ERISA Plan Administrator's Address: _____
City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: __/__

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☐ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the State, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

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

ELIGIBILITY
1 Eligible Person:
Employer has decided that Eligible Person means:

- ☐ A Full-Time employee of the Employer.
- ☐ A Full-Time employee who is a member of: _____ (name of union or association)
- ☐ Other (please specify): _____

Full-Time Employee means:

- ☐ An Employee of the Employer who is regularly scheduled to work a minimum of _____ hours per week..
- ☐ Other (please specify): _____
- ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____

The term "Employee" shall have the meaning set forth under ERISA and applicable law. HCSC reserve the right to audit Employer's initial and ongoing eligibility determinations.

Civil Union Partner Coverage:
A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. Domestic Partner Coverage: ☐ Yes ☐ No
If Employer elects Yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but are eligible for continuation coverage similar to that available to spouses under COBRA continuation.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☐ No

4. **The Limiting Age for covered children:**
Hereafter, covered children means a natural child, a stepchild, an eligible 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.

To cover children age twenty-six (26) or over, you may select option (a) or (b) below:
(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26 or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

5. **Eligibility Date:** All current and new employees must satisfy the required substantive eligibility criteria and waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☐ The date of employment.
☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
☐ The _____ day (select 1st or 15th) of the month following _____ days (option of up to 60 days) of employment.
☐ The _____ day of the month following the date of employment.
☐ Other (please specify): _____. **Note:** This may not exceed ninety-one (91) calendar days.

Substantive eligibility criteria.

Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.
Check all that apply:

☐ An Orientation Period that:

1)Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
2)If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

☐ A Cumulative hours of service requirement that does not exceed 1200 hours

☐ An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

1)Starts between the employee's date of hire and the first day of the following month;
2)Does not exceed 12 months; and
3)Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

☐ Other substantive eligibility criteria not described above; please describe: _____

6. Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

Annual Open Enrollment: ☐ Yes ☐ No

If Yes, specify Annual Open Enrollment Period:_____. 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 Annual 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 Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:
Temporary Layoff: _____ days Disability: _____ days Leave of Absence: _____ days
(However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.)

8. **FUNDING ARRANGEMENT**

☐ Standard Premium – Prospective
☐ Standard Premium – Retrospective
☐ Minimum Premium Program ("MPP")
☐ Cost Plus Program
☐ Contingent Premium - Separate Agreement

9. **STANDARD PREMIUM INFORMATION:**
The following elections apply to both Grandfathered and Non-Grandfathered Groups:
Premium Period:
☐ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage)
☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not

available for any coverage if the Employer has BlueCare Dental HMO coverage.)

10. **MINIMUM PARTICIPATION AND EMPLOYER CONTRIBUTION INFORMATION:**

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
Employer contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
☐ Other (please specify): _____.

(b) **The following applies to both Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**
HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 25%, and at least a 70% participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the 25% minimum employer contribution is met and at least 70% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(d) **The following applies to Grandfathered Groups:**
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 25% of the Eligible Persons, and for Family Coverage 75% of the Eligible Persons with eligible dependents, have enrolled for coverage.

11. Essential Health Benefits ("EHB") Definition Election:
Employer elects EHBs based on the following:

☐ a. EHBs based on a HCSC state benchmark:
☐ Illinois ("IL") ☐ Oklahoma ("OK")
☐ Montana ("MT") ☐ Texas ("TX")
☐ New Mexico ("NM")

☐ b. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

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

STANDARD PREMIUM RATES ☐ Yes ☐ No						
	For Internal Use Only - BlueStar Ben.Agree#: _____ Health Coverage:	For Internal Use Only - BlueStar Ben.Agree#: _____ PPO/Indemnity Dental Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Variable Vision Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Coverage:	Total
1. Employee only:	$_____	$_____	$_____	$_____	$_____	$_____
2. Employee plus one dependent:	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Spouse:	$_____	$_____	$_____	$_____	$_____	$_____
5. Child(ren):	$_____	$_____	$_____	$_____	$_____	$_____
6. Family:	$_____	$_____	$_____	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$_____	$_____	$_____	$_____	$_____	$_____
Family Coverage:	$_____	$_____	$_____	$_____	$_____	$_____

MINIMUM PREMIUM PROGRAM ☐ Yes ☐ No
Monthly Minimum Premium: ☐ Rate per Employee or ☐ Single and Family Rates Health Coverage: $_____ Dental Coverage: $_____
Monthly CAP (Claims as Paid) Maximum: ☐ Rate per Employee or ☐ Single and Family Rates Health Coverage: $_____ Dental Coverage: $_____
Individual Pooling Limit per Covered Person: $_____
Terminal Liability Payment: $_____; ☐ Rate per Employee or ☐ Single and Family Rates
Terminal Administrative Fee: $_____; ☐ Rate per Employee or ☐ Single and Family Rates or ☐ N/A
Rates are based on an enrollment of: _____Single Coverage Units and _____ Family Coverage Units

COST - PLUS PROGRAM

☐ Yes ☐ No

Service Charges:

☐ _____% of Net Claim Payments or $_____ per employee per month
☐ Applies to all coverage(s)
☐ Different percentage(s) or amount(s) for the following types of coverage(s). Please specify below:

For _____ Coverage: _____% of _____ Claim Payments or $_____per employee per month
For _____ Coverage: _____% of _____ Claim Payments or $_____per employee per month
Other (please specify): _____

Blue Care Connection® ("BCC"):

BCC Program (may select one):
☐ Blue Care Advisor
☐ Please refer to Additional Provisions

☐ Fee: $_____ per covered employee per month for administration of the program.
☐ Fee is included in the Service Charges.

Blue Care Custom:

☐ Health Dialog (may select one) Health Dialog Fee: $_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways (may select one)
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	Package A - Fees	Package B - Fees	Package C - Fees
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment, Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer
☐ Other (please specify): _____

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify): _____

Claim Settlement: ☐ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

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:_____.

Prescription Drug Rebate: $_____ per covered employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

Termination Administrative Charge

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

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination,*** 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 and the Policy participation of the two (2) months immediately preceding the termination date. Such aggregate amount will be due the Plan within ten (10) days of the Plan's notification to the Policyholder 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,*** the Termination Administrative Charge will be such service charges in effect at the time of termination to be applied and billed by the Plan, and paid by the Policyholder, in the same manner as prior to termination.

Termination Administrative Charges assume the continuation of the Policy benefit program(s) and the administrative services in effect prior to termination. Should such Policy benefit program(s) and/or administrative services change, or in the event the average Policy enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Plan reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

APPLICABLE TO MINIMUM PREMIUM ("MPP") AND COST-PLUS PROGRAMS ONLY:
PLAN PROVIDER ACCESS FEE(S): ☐ Yes ☐ No

Group Number(s): _____

☐ % of ADP Savings: _____%

☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:

Group Number(s): _____

☐ % of ADP Savings: _____%

☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first premium by HCSC.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) 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 that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities

thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by HCSC are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Group Administrative Document to which this BPA is attached under the section titled "The Plan's Separate Financial Arrangements Regarding Prescription Drugs.").

OTHER PROVISIONS:

(a) Reimbursement Provision: ☐ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain twenty five percent (25%) of the net recovery (under cost-plus funding) or deduct twenty five percent (25%) of the net recovery from the amount credited to the group's experience (under premium funding), after attorneys' fees, if any, have been paid.

(b) Summary of Benefits and Coverage ("SBC"):

1) HCSC will create SBC?

☐ Yes. If Yes, please answer question #2. The SBC Addendum is attached and made a part of the Policy.

☐ No. If No, then the Policyholder acknowledges and agrees that the Policyholder is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will the Plan have any responsibility or obligation with respect to the SBC. The Plan may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations. The Plan is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Policyholder's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question #2.)

2) HCSC will distribute SBC to participants and beneficiaries?

☐ No. The Plan will create SBC (only for benefits the Plan insures under the Policy) and provide SBC to the Policyholder in electronic format. Policyholder will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

☐ Yes. The Plan will create SBC (only for benefits the Plan insures under the Policy) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

(c) BlueEdge FSA (Vendor: ConnectYourCare) purchased: ☐ Yes ☐ No

(d) BlueCare® Dental HMO Coverage purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(e) Dearborn National purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(f) Blue Directions (Private Exchange) purchased: ☐ Yes ☐ No (if yes, The Blue Directions Addendum is attached and made a part of the Policy.)

(g) Excess Loss Coverage purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(h) Case Management: ☐ Yes ☐ No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(i) Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet, or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(j) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer 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.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) 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 HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee".
Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Except for the Cost Plus Program, your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees. There are no ACA fees included in the Cost Plus PPO premium. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners, but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, 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.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

Sales Representative	Signature of Authorized Purchaser
District	Title
Producer Representative	Date

Signature of Producer Representative

Witness

Producer Firm

Producer Address

$_____ Amount Submitted

Producer Tax I.D. No.

UNDERWRITING USE ONLY

Date BPA approved: _____
Signature of Underwriter

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 shall 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 mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No(s).: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____, _____
Month Year

[redacted] BlueCross BlueShield of Illinois

[redacted]

BENEFIT PROGRAM APPLICATION ("BPA")

(All items are applicable to 151-Plus Grandfathered and Non-Grandfathered Insured Group Accounts unless otherwise specified.)

Employer Account Number: _____ Employer Group Number(s):_____

Section Number(s): _____

Employer Name: _____

(Specify the employer, the employee trust, or the association applying for coverage. List subsidiary or affiliated companies to be covered below. An employee benefit plan may not be named.)

Address: _____ City: _____ State: _____ Zip Code: _____

Billing Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Employer Identification Number ("EIN"): _____

Wholly Owned Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, attached to this BPA, and is made a part of the Policy.)

Administrative Contact: _____ Phone: _____ Fax : _____ Email: _____

Blue Access for Employers ("BAE") Contact: _____

(The BAE Contact is the employee of the account authorized by the Employer to access and maintain its account via BAE.)

Title: _____ Phone: _____ Fax: _____ Email: _____

Policy Effective Date: _____ Policy Anniversary Date: _____ / _____ / _____

Month Day Year

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health Plan*: Yes ☐ No ☐
If Yes, specify ERISA Plan Year*: Beginning Date: __/__/__ End Date: __/__/__ (month/day/year)
ERISA Plan Sponsor*: _____

(If the Employer is required to file Form 5500 Schedule A with the IRS, the following ERISA items must be completed):
ERISA Plan Administrator*: _____
ERISA Plan Administrator's Address: _____
City: _____ State: _____ Zip Code: _____
ERISA Plan Administrator's Email: _____

Please provide your Non-ERISA Plan Month/Year: __/__

If you contend ERISA is inapplicable to your group health plan, please give legal reason for exemption*:

- ☐ Federal Governmental Plan (e.g., the government of the United States or agency of the United States)
- ☐ Non-Federal Governmental Plan (e.g., the government of the State, an agency of the State, or the government of a political subdivision, such as a county or agency of the State)
- ☐ Church Plan (complete and attach a Medical Loss Ratio Assurance form)
- ☐ Other, please specify: _____

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

ELIGIBILITY
1 Eligible Person:
Employer has decided that Eligible Person means:

- ☐ A Full-Time employee of the Employer.
- ☐ A Full-Time employee who is a member of: _____ (name of union or association)
- ☐ Other (please specify): _____

Full-Time Employee means:

- ☐ An Employee of the Employer who is regularly scheduled to work a minimum of _____ hours per week..
- ☐ Other (please specify): _____
- ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____

The term "Employee" shall have the meaning set forth under ERISA and applicable law. HCSC reserve the right to audit Employer's initial and ongoing eligibility determinations.

Civil Union Partner Coverage:
A Civil Union partner, as defined in the Policy, and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Certificate Booklet. The Employer as Policyholder is responsible for providing notice of possible tax implications to those Insureds with coverage for Civil Union partners.

3. Domestic Partner Coverage: ☐ Yes ☐ No
If Employer elects Yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner Coverage.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, Domestic Partners are not eligible for continuation coverage under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but are eligible for continuation coverage similar to that available to spouses under COBRA continuation.

Domestic Partner Coverage Continuation (only available if Domestic Partners are covered) ☐ Yes ☐ No

4. **The Limiting Age for covered children:**
Hereafter, covered children means a natural child, a stepchild, an eligible 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.

To cover children age twenty-six (26) or over, you may select option (a) or (b) below:
(a) ☐ Limiting Age for covered children age twenty-six (26) or over, ☐ who are married ☐ who are unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

(b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26 or over, ☐ who are married ☐ who unmarried ☐ regardless of marital status, is years (twenty-seven (27) – thirty (30) are the available options). If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

5. **Eligibility Date:** All current and new employees must satisfy the required substantive eligibility criteria and waiting period indicated below before coverage will become effective. No waiting period may result in an effective date that exceeds ninety-one (91) calendar days from the date that an employee becomes eligible for coverage, unless otherwise permitted by applicable law.

Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☐ The date of employment.
☐ The _____ day of employment. **Note:** This may not exceed ninety-one (91) calendar days.
☐ The _____ day (select 1st or 15th) of the month following _____ month(s) (option of 1 or 2 months) of employment.
☐ The _____ day (select 1st or 15th) of the month following _____ days (option of up to 60 days) of employment.
☐ The _____ day of the month following the date of employment.
☐ Other (please specify): _____. **Note:** This may not exceed ninety-one (91) calendar days.

Substantive eligibility criteria.

Provide a representation below regarding the terms of any eligibility conditions (other than any applicable waiting period already reflected above) imposed before an individual is eligible to become covered under the terms of the plan. If any of these eligibility conditions change, Employer is required to submit a new BPA to reflect that new information.
Check all that apply:

☐ An Orientation Period that:

1)Does not exceed one month (calculated by adding one calendar month and subtracting one calendar day from an employee's start date); and
2)If used in conjunction with a waiting period the waiting period begins on the first day after the orientation period.

☐ A Cumulative hours of service requirement that does not exceed 1200 hours

☐ An hours of service per period (or full-time status) requirement for which a Measurement period is used to determine the status of variable-hour employees, where the measurement period:

1)Starts between the employee's date of hire and the first day of the following month;
2)Does not exceed 12 months; and
3)Taken together with other eligibility conditions does not result in coverage becoming effective later than 13 months from the employee's start date plus the number of days between a start date and the first day of the next calendar month (if start day is not the first day of the month).

☐ Other substantive eligibility criteria not described above; please describe: _____

6. Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

Annual Open Enrollment: ☐ Yes ☐ No

If Yes, specify Annual Open Enrollment Period:_____. 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 Annual 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 Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

7. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:
Temporary Layoff: _____ days Disability: _____ days Leave of Absence: _____ days
(However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.)

8. **FUNDING ARRANGEMENT**

☐ Standard Premium – Prospective
☐ Standard Premium – Retrospective
☐ Minimum Premium Program ("MPP")
☐ Cost Plus Program
☐ Contingent Premium - Separate Agreement

9. **STANDARD PREMIUM INFORMATION:**
The following elections apply to both Grandfathered and Non-Grandfathered Groups:
Premium Period:
☐ The first (1st) day of each calendar month through the last day of each calendar month. (This option applies to all coverages if the Employer has BlueCare® Dental HMO coverage)
☐ The _____ day of each calendar month through the _____ day of the next calendar month. (This option is not

available for any coverage if the Employer has BlueCare Dental HMO coverage.)

10. **MINIMUM PARTICIPATION AND EMPLOYER CONTRIBUTION INFORMATION:**

(a) **The following elections apply to both Grandfathered and Non-Grandfathered Groups:**
Employer contribution:

☐ One hundred percent (100%) of the Individual Coverage Premium and an amount equal to one hundred percent (100%) of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
☐ Other (please specify): _____.

(b) **The following applies to both Grandfathered and Non-Grandfathered Groups:**
HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

(c) **The following applies to Non-Grandfathered Groups:**
HCSC reserves the right to take any or all of the following actions: 1) initial rates will be finalized for the effective date of the policy based on the enrolled participation and employer contribution levels; 2) after the policy effective date the group will be required to maintain a minimum Employer contribution of 25%, and at least a 70% participation of eligible employees (less valid waivers). In the event the group is unable to maintain the contribution and participation requirements, then the rates will be adjusted accordingly; and/or 3) non-renew or discontinue coverage unless the 25% minimum employer contribution is met and at least 70% of eligible employees (less valid waivers) have enrolled for coverage. Employer will promptly notify HCSC of any change in participation and Employer contribution.

(d) **The following applies to Grandfathered Groups:**
It is understood that no Policy will be issued or renewed on a contributory basis unless at least 25% of the Eligible Persons, and for Family Coverage 75% of the Eligible Persons with eligible dependents, have enrolled for coverage.

11. Essential Health Benefits ("EHB") Definition Election:
Employer elects EHBs based on the following:

☐ a. EHBs based on a HCSC state benchmark:
☐ Illinois ("IL") ☐ Oklahoma ("OK")
☐ Montana ("MT") ☐ Texas ("TX")
☐ New Mexico ("NM")

☐ b. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX

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

STANDARD PREMIUM RATES ☐ Yes ☐ No						
	For Internal Use Only - BlueStar Ben.Agree#: _____ Health Coverage:	For Internal Use Only - BlueStar Ben.Agree#: _____ PPO/Indemnity Dental Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Variable Vision Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Coverage:	For Internal Use Only - BlueStar Ben.Agree #: _____ Coverage:	Total
1. Employee only:	$_____	$_____	$_____	$_____	$_____	$_____
2. Employee plus one dependent:	$_____	$_____	$_____	$_____	$_____	$_____
3. Employee plus two or more dependents:	$_____	$_____	$_____	$_____	$_____	$_____
4. Spouse:	$_____	$_____	$_____	$_____	$_____	$_____
5. Child(ren):	$_____	$_____	$_____	$_____	$_____	$_____
6. Family:	$_____	$_____	$_____	$_____	$_____	$_____
7. Other: _____	$_____	$_____	$_____	$_____	$_____	$_____
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$_____	$_____	$_____	$_____	$_____	$_____
Family Coverage:	$_____	$_____	$_____	$_____	$_____	$_____

MINIMUM PREMIUM PROGRAM ☐ Yes ☐ No
Monthly Minimum Premium: ☐ Rate per Employee or ☐ Single and Family Rates Health Coverage: $_____ Dental Coverage: $_____
Monthly CAP (Claims as Paid) Maximum: ☐ Rate per Employee or ☐ Single and Family Rates Health Coverage: $_____ Dental Coverage: $_____
Individual Pooling Limit per Covered Person: $_____
Terminal Liability Payment: $_____; ☐ Rate per Employee or ☐ Single and Family Rates
Terminal Administrative Fee: $_____; ☐ Rate per Employee or ☐ Single and Family Rates or ☐ N/A
Rates are based on an enrollment of: _____Single Coverage Units and _____ Family Coverage Units

COST - PLUS PROGRAM

☐ Yes ☐ No

Service Charges:

☐ _____% of Net Claim Payments or $_____ per employee per month
☐ Applies to all coverage(s)
☐ Different percentage(s) or amount(s) for the following types of coverage(s). Please specify below:

For _____ Coverage: _____% of _____ Claim Payments or $_____per employee per month
For _____ Coverage: _____% of _____ Claim Payments or $_____per employee per month
Other (please specify): _____

Blue Care Connection® ("BCC"):

BCC Program (may select one):
☐ Blue Care Advisor
☐ Please refer to Additional Provisions

☐ Fee: $_____ per covered employee per month for administration of the program.
☐ Fee is included in the Service Charges.

Blue Care Custom:

☐ Health Dialog (may select one) Health Dialog Fee: $_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways (may select one)
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	Package A - Fees	Package B - Fees	Package C - Fees
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☐ Post Payment

If Transfer Payment, Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer
☐ Other (please specify): _____

Payment Period: ☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly
☐ Other (please specify): _____

Claim Settlement: ☐ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

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:_____.

Prescription Drug Rebate: $_____ per covered employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

Termination Administrative Charge

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

i. ***For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination,*** 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 and the Policy participation of the two (2) months immediately preceding the termination date. Such aggregate amount will be due the Plan within ten (10) days of the Plan's notification to the Policyholder 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,*** the Termination Administrative Charge will be such service charges in effect at the time of termination to be applied and billed by the Plan, and paid by the Policyholder, in the same manner as prior to termination.

Termination Administrative Charges assume the continuation of the Policy benefit program(s) and the administrative services in effect prior to termination. Should such Policy benefit program(s) and/or administrative services change, or in the event the average Policy enrollment during the three (3) months immediately preceding termination varies by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Plan reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

APPLICABLE TO MINIMUM PREMIUM ("MPP") AND COST-PLUS PROGRAMS ONLY:
PLAN PROVIDER ACCESS FEE(S): ☐ Yes ☐ No

Group Number(s): _____

☐ % of ADP Savings: _____%

☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:
Group Number(s): _____

☐% of ADP Savings: _____%

☐ $ Per Employee per month (For MPP, this amount also included in Monthly Minimum Premium): $_____

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this BPA and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by HCSC. Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail. No coverage will begin until receipt of the first premium by HCSC.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) 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 that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities

thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by HCSC are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Group Administrative Document to which this BPA is attached under the section titled "The Plan's Separate Financial Arrangements Regarding Prescription Drugs.").

OTHER PROVISIONS:

(a) Reimbursement Provision: ☐ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain twenty five percent (25%) of the net recovery (under cost-plus funding) or deduct twenty five percent (25%) of the net recovery from the amount credited to the group's experience (under premium funding), after attorneys' fees, if any, have been paid.

(b) Summary of Benefits and Coverage ("SBC"):

1) HCSC will create SBC?

☐ Yes. If Yes, please answer question #2. The SBC Addendum is attached and made a part of the Policy.

☐ No. If No, then the Policyholder acknowledges and agrees that the Policyholder is responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will the Plan have any responsibility or obligation with respect to the SBC. The Plan may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations. The Plan is not obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Policyholder's contact information. A new clause (e) is added to Subsection C. in the Additional Provisions as follows: "(e) the SBC". (Skip question #2.)

2) HCSC will distribute SBC to participants and beneficiaries?

☐ No. The Plan will create SBC (only for benefits the Plan insures under the Policy) and provide SBC to the Policyholder in electronic format. Policyholder will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

☐ Yes. The Plan will create SBC (only for benefits the Plan insures under the Policy) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Policyholder.

(c) BlueEdge FSA (Vendor: ConnectYourCare) purchased: ☐ Yes ☐ No

(d) BlueCare® Dental HMO Coverage purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(e) Dearborn National purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(f) Blue Directions (Private Exchange) purchased: ☐ Yes ☐ No (if yes, The Blue Directions Addendum is attached and made a part of the Policy.)

(g) Excess Loss Coverage purchased: ☐ Yes ☐ No (If yes, complete separate application.)

(h) Case Management: ☐ Yes ☐ No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(i) Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet, or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(j) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer 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.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Policyholder shall provide HCSC with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Group Policy, and Policyholder represents and warrants that such Form is true, complete and accurate. If Policyholder fails to timely provide HCSC with any requested grandfathered health plan information, HCSC may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the BPA includes any retiree only plans and/or excepted benefits, then Policyholder represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by HCSC to the terms and conditions of coverage. In no event shall HCSC be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Policyholder shall indemnify and hold harmless HCSC and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) 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 HCSC in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Policyholder, (d) any provision of inaccurate information, (e) the SBC, (f) any plan's design (including but not limited to any directions, actions and interpretations of the Policyholder, and/or (g) Employer's selection of EHB definition for the purpose of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

ACA FEE NOTICE: ACA established a number of taxes and fees that will affect our customers and their benefit plans. Two of those fees are: (1) the Annual Fee on Health Insurers or "Health Insurer Fee"; and (2) the Transitional Reinsurance Program Contribution Fee or "Reinsurance Fee".
Section 9010(a) of ACA requires that "covered entities" providing health insurance ("health insurers") pay an annual fee to the federal government, commonly referred to as the Health Insurer Fee. The amount of this fee for a given calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums written with respect to health insurance on certain health risk during the preceding calendar year. This fee will go to help fund premium tax credits and cost-sharing subsidies offered to certain individuals who purchase coverage on health insurance exchanges.

In addition, ACA Section 1341 provides for the establishment of a temporary reinsurance program(s) (for a three (3) year period (2014-2016)) which will be funded by Reinsurance Fees collected from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how these fees are calculated. Federal regulations establish a flat, per member, per month fee. The temporary reinsurance programs funded by these Reinsurance Fees will help stabilize premiums in the individual market.

Except for the Cost Plus Program, your premium, which already accounts for current applicable federal and state taxes, includes the effects of the Health Insurer Fees and Reinsurance Fees. There are no ACA fees included in the Cost Plus PPO premium. These rates may be adjusted on an annual basis for any incremental changes in Health Insurer Fees and Reinsurance Fees.

Notwithstanding anything in the Policy or Renewal(s) to the contrary, HCSC reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require HCSC to pay, submit or forward, on its own behalf or on the Policyholder's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

Renewals Only: If this BPA is blank, it is intentional and this BPA is an addendum to the existing BPA. In such case, all terms of the existing BPA as amended from time to time shall remain in force and effect. However, beginning with the Policyholder's first renewal date on or after September 23, 2010, the provisions of paragraphs A-C (above) shall be part of (and be in addition to) the terms of the existing BPA as amended from time to time.

Any reference in this BPA to eligible dependents may include Domestic Partners or Civil Union partners, but will include dependent covered children under the Limiting Age of twenty-six (26), or election made above.

Any reference in this BPA to the Limiting Age for covered children means twenty-six (26) years, or election made above, regardless of presence or absence of a child's financial dependency, residency, student status, employment, 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.

Any reference in this BPA to the "Employee plus one dependent" rate structure means "Employee plus one spouse (includes Civil Union partner and/or, if elected, Domestic Partner) or one child."

Any reference in this BPA to the "Employee plus Child(ren)" rate structure means "Employee plus one or more children."

Sales Representative	Signature of Authorized Purchaser
District	Title
Producer Representative	Date

Signature of Producer Representative

Witness

Producer Firm

Producer Address

$_____ Amount Submitted

Producer Tax I.D. No.

UNDERWRITING USE ONLY
Date BPA approved: _____ Signature of Underwriter

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 shall 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 mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No(s).: _____ By: _____
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____, _____
Month Year

Summary of Benefits and Coverage Addendum
To ASO Benefit Program Application (ASO BPA)

Employer Name: Account Number:

Effective/ Renewal Date: First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"):

The Affordable Care Act ("ACA") requires group health plans to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Employer's election indicated on the most current ASO BPA, to have Blue Cross and Blue Shield of Illinois (BCBSIL) create and/or distribute the SBC, as of the First Open Enrollment Date, the Employer acknowledges and agrees:

1. BCBSIL's SBC services do not include the creation or distribution of coverage information for benefits it does not administer under the Agreement, unless otherwise agreed to in the ASO BPA or this Addendum.

2. Employer is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Employer is responsible for SBC services performed by Employer's third party vendors.

4. The Employer must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the ASO BPA relieves the Employer or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSIL's operations shall not be considered to be in breach of the Agreement to the extent BCBSIL has worked diligently and in good faith to implement a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. Employer agrees to furnish to BCBSIL in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSIL, and (ii) any person the employer tells us is eligible or may become eligible. Employer's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSIL's SBC services and BCBSIL is relieved of its SBC obligations.

7. Employer shall be liable to BCBSIL and its directors, officers and employees for any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) 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 BCBSIL in connection with the SBC (and Employer's or its vendors' distribution of the SBC).

Summary of Benefits and Coverage Addendum
To Benefit Program Application

Employer Name: Account Number:

Effective/ Renewal Date: First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"):

The Affordable Care Act ("ACA") requires group health plans and/or insurance issuers to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Policyholder's election on the most current BPA, to have Blue Cross and Blue Shield of Illinois (BCBSIL) create and/or distribute the SBC, as of the First Open Enrollment Date, Policyholder acknowledges and agrees:

1. BCBSIL's SBC services do not include the creation or distribution of coverage information for benefits it does not insure under the Policy, unless otherwise agreed to in the BPA or this Addendum.

2. Policyholder is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).

3. The Policyholder is responsible for SBC services performed by Policyholder's third party vendors.

4. The Policyholder must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the Policy relieves the Policyholder or its group health plan of their respective legal and regulatory obligations with respect to the SBC.

5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSIL's operations shall not be considered to be in breach of this Addendum or the Policy to the extent BCBSIL has worked diligently and in good faith to provide the SBC services, based on a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.

6. Policyholder agrees to furnish to BCBSIL in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSIL, and (ii) any person the employer tells us is eligible or may become eligible. Policyholder's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSIL's SBC services and BCBSIL is relieved of its SBC obligations.

7. BCBSIL may, but is not required to, monitor Policyholder's performance of its SBC obligations, audit the Policyholder with respect to the SBC, request and receive information, documents and assurances from Policyholder with respect to the SBC, provide its own SBC (or SBC corrections) to participants and beneficiaries, communicate with participants and beneficiaries regarding the SBC, respond to SBC-related inquiries from participants and beneficiaries, and/or take steps to avoid or correct potential violations of applicable laws or regulations.). Policyholder will notify BCBSIL of any actual or potential non-compliance with the SBC Requirements.

8. Policyholder shall be liable to BCBSIL and its directors, officers and employees for any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) 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 BCBSIL in connection with the SBC (and Policyholder's or its vendors' distribution of the SBC).

EXHIBIT 3

Schedule of Compensation

EXHIBIT 3

SCHEDULE OF COMPENSATION

- Total not-to exceed value of contract
- Projected enrollment as of 7/30/15

	2016 Estimate		2017 Estimate		2018 Estimate		Total 3 Year Pricing Estimate
HMO	$ 155,401,913		$ 167,057,056		$ 179,586,335		
PPO	$ 118,289,865		$ 127,161,605		$ 136,698,725		
	$ 273,691,778		**$ 294,218,661**		**$ 316,285,061**		**$ 884,195,500**

FULLY-INSURED QUOTE FOR ALL CURRENT PLANS AND HDPPO

- Rates do not need to stand alone

Component	HMO (mirroring Blue Advantage network)			HMO (mirroring Classic Blue network)			PPO			HSA Compatible PPO			Comments
	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	
Insured Premium (Monthly)													
Pre Medicare													
Single	$ 467.75	TBD**	TBD**	$ 526.10	TBD**	TBD**	$ 654.67	TBD**	TBD**	$488.91	TBD**	TBD**	**BCBSIL will not provide multi-year guarantees on premium rates. Premium rates will be calculated on a annual basis and may increase or decrease depending on per memeber claim cost, medical trend, etc.
Single +1	$ 947.18			$ 1,065.34			$ 1,287.33			$961.38			
Family	$ 1,342.43			$ 1,509.90			$ 1,811.22			$1,352.62			
Medicare Eligible													
Single +1	$ 452.78			$ 509.19			$ 654.67			$488.91			
Family	$ 1,299.40			$ 1,461.34			$ 1,811.22			$1,352.62			

SELF-INSURED QUOTE FOR ALL CURRENT PLANS AND HDPPO

- Rates do not need to stand alone

Component	HMO (mirroring Blue Advantage network)			HMO (mirroring Classic Blue network)			PPO			HSA Compatible PPO			Comments
	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	
ASO fee (PEPM)	$27.76	$28.59	$29.45	$27.76	$28.59	$29.45	$ 30.94	$ 31.98	$ 33.05	$ 30.94	$ 31.98	$ 33.05	HMO fees are representative of the Cost Plus funding where as the PPO and HSA are true ASO funding. PPO and HSA base admin fees do not include care and case management. See Care Management for details.

	2016	2017	2018	2016	2017	2018
Single	$184.58	$190.12	$195.82	$228.11	$234.95	$242.00
Family	$491.35	$506.09	$521.27	$615.42	$633.88	$652.90

The Physician Service Fee guarantee is null and void if the demographic mix of single/family or the age/gender factor changes by 10% or more.

Component	HMO (mirroring Blue Advantage network)			HMO (mirroring Classic Blue network)			PPO			HSA Compatible PPO			Comments
	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	
Individuals Stop Loss Premium on 12/15 Basis													
Deductible of $500,000	$10.84	TBD**	TBD**	$9.02	TBD**	TBD**	$17.23	TBD**	TBD**	$17.23	TBD**	TBD**	**Stop Loss fees will be recalculated on a annual basis.
Deductible of $750,000	$6.88	TBD**	TBD**	$5.73	TBD**	TBD**	$9.53	TBD**	TBD**	$9.53	TBD**	TBD**	

* Rates do not need to stand alone (assumes all plans are on self insured basis and request stop loss)

CARE MANAGEMENT AND OTHER FEES

Component	HMO (mirroring Blue Advantage network)			HMO (mirroring Classic Blue network)			PPO			HSA Compatible PPO			Comments
	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	Plan Year 2016	Plan Year 2017	Plan Year 2018	
Care & case management fees*:													
PEPM	Integrated BCC Enhanced	Integrated BCC Enhanced	Integrated BCC Enhanced	Integrated BCC Enhanced	Integrated BCC Enhanced	Integrated BCC Enhanced	$3.60	$3.60	$3.60	$3.60	$3.60	$3.60	$3.60 for BCC Enhanced (Not included in the Base ASO Admin Fee) (Included in Premium Rates)
Per case													
Per service													
Flat fee													
Other (describe basis in comments)	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Integrated In and Out BH	Inpatient and Outpatient Behavioral Health Pre-Certification. (Included in Base ASO Admin Fee and Included in Premium Rates)
Other (describe basis in comments)													
Wellness program fees	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	Included in Enh BCC	
Network access fee (describe basis in comments)	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Network access fee is built into the base admin fee shown on Scenario 3 and 4. The network access fee is also accounted for and built into the fully insured rates shown on Scenario 1 and 2.
Miscellaneous fees (describe basis in comments)**													

HEALTH SAVINGS ACCOUNT FEES

Component	Plan Year 2016	Plan Year 2017	Plan Year 2018	Comments
▪ New Account Set Up Fee	None	None	None	
▪ Account Maintenance Fee (indicate annual or monthly)	Under 10,000 HSAs $2 PAPM Over 10,000 HSAs $1.75 PAPM Over 25,000 HSAs $1.50 PAPM	Under 10,000 HSAs $2 PAPM Over 10,000 HSAs $1.75 PAPM Over 25,000 HSAs $1.50 PAPM	Under 10,000 HSAs $2 PAPM Over 10,000 HSAs $1.75 PAPM Over 25,000 HSAs $1.50 PAPM	All account maintenance fees are per account, per month. Rates held for length of contract.
▪ Account Closing Fee	$25.00	$25.00	$25.00	
▪ Excess Contribution	None	None	None	
▪ Debit Card/Transaction Fee	$2.00 at ATM and at Point of Sale with use of PIN	$2.00 at ATM and at Point of Sale with use of PIN	$2.00 at ATM and at Point of Sale with use of PIN	
▪ Debit Card Replacement	$6.00	$6.00	$6.00	
▪ Insufficient Funds	None	None	None	Debit card transactions are denied without charge when funds are insufficient. A check drawn on the HSA when funds are insufficient will result in an overdraft and incur a fee as listed below.
▪ Overdraft	$30.00 when drawn on HSA	$30.00 when drawn on HSA	$30.00 when drawn on HSA	
▪ Stop Payment	None	None	None	
▪ Return Item	None	None	None	
▪ New Check Book Fee	$7.95	$7.95	$7.95	Fee is for 50 duplicate-style checks and 10 deposit slips.
▪ Check Processing Fee	$10.00	$10.00	$10.00	Applies when accountholder requests disbursement by check written by HSA Bank. There is no fee for writing checks against the account.
▪ Rollover Transfer Fees	None	None	None	No fee when transferring into an HSA Bank HSA. Transfers out will incur an account
▪ Investment fees	Varies	Varies	Varies	HSA Bank is not charging investment fees, however, Devenir charges a $24.00 annual fee for access to its group of no-load and load waived mutual fees. TD Ameritrade charges a fee per transaction, with certain exceptions including no-fee ETFs and certain other investments. Check the TD Ameritrade fees listed on its website for latest information.
▪ Termination of Debit Card Access	$6.00	$6.00	$6.00	Per request.
Miscellaneous fees** (describe basis in comments)	None	None	None	

ANCILLARY FEES

Service	Included	Ancillary Fee – specify unit (Per member, Per claim, Per feed, Per report, etc.)
1. Implementation fees	Included	
2. Member submitted run-out claims for 12 months	Not included	Typically, service charges and/or access fees will be billed on a per employee per month fee basis at the time of termination. The fee will be equal to 10% of the annualized charges based on the service charges in effect as of the termination date and the plan participation of two months immediately preceding the termination date.
3. Eligibility file maintenance & provider certification	Included	
4. Member service (800#, web, IVR)	Included	
5. Standard management reports	Included	
6. Ad hoc reports	Included	
7. Claims data tapes	Included	
8. Claims data warehouse & predictive modeling	Not Included	Data warehousing is not applicable to our proposed offering. Predictive modeling is included in our BCC products.
9. Integration with carve-out PBM	Included	
10. Integration with carve-out care management or wellness vendor	Included	
11. Integration with carve-out behavioral health or	Included	
12. Integration with carve-out (not your preferred relationship) stop loss vendor	Included	We do not contract/interface with any external or third-party reinsurer. If Stop Loss coverage is carved out to an external reinsurer, we will provide our standard reporting package directly to the account and it will be the responsibility of the account to provide the reports to the external or third-party reinsurer.
13. Integration with carve-out data warehouse	Included	Standard claims extracts are included. If additional integration is required then there may be additional charges.
14. Integration with carve-out subrogation vendor	Not Included	Subrogation can not be carved out of the HMO or Fully Insured PPO.
15. Website for members & prospective members	Included	
16. Website access for member services	Included	
17. SPD production, review & sign-off	Included	
18. Communication production for installation	Included	
19. Communication production for communication of future plan changes/new programs	Included	
20. Communications bulk shipping & handling	Included	
20. Communications shipping and handling to	Included	
21. Customized ID card	Included	
22. ID card production	Included	
23. Replacement ID card	Included	
24. Member services first level response to appeals	Included	
25. Full fiduciary assumption	Not included for self-insured	BCBSIL will accept claim processing fiduciary responsibility for an additional fee of $1.00 per employee per month.
26. Subrogation	Not included	The standard administration fee for the Corporate Reimbursement/Subrogation Department's administration is 25 percent of a case's recovery.
27. Collection & reimbursement of overpayments	Included	
28. Banking	Included	
29. Support of RDS program		$5700 for reporting annually
30. Collection & aggregation of ERRP data	Included	
31. Plan compliance reviews / support	Included	
32. Quarterly management reporting & meetings	Included	
33. Physician profiling	Included	
34. Other (please specify)		

TARGET CLAIMS INFORMATION

- **Applicable only to ASO PPO**

The methodology for Cook County 12/1/2015 – 11/30/2016 guarantee will use as its base the allowed incurred claims from December 1, 2014, through November 30, 2015, and paid through February 29, 2016.

The allowed incurred claims will then be divided by the enrollment for the period December 1, 2014, through November 30, 2015. The resulting claim figure will be input into the formula as the base allowed incurred claims. The base allowed incurred claims will then be adjusted by the following:

1. A **trend** factor will be included to project the base allowed incurred claims into the next plan year.

   For the plan year beginning December 1, 2015, the trend factor will be as follows: 7.5% (PPO)

   This factor will be negotiated and agreed to by both parties during each renewal rating process.

2. A **plan relative value** factor reflects the benefit differential between the plan sponsor's plan of benefits for the current plan year and subsequent plan years. This factor will also reflect the changes in value of the benefits caused by enrollment shifts between Cook County's benefit plan levels. This factor will be negotiated and agreed to by both parties once all changes are determined for the beginning of each plan year. For illustrative purposes, a factor of 1.00 will be used.

3. A **geographic adjustment** has been included to reflect the impact of shifts in enrollment. For each plan year, this factor will be calculated by developing a ratio of the area factors for the plan year compared to the prior plan year. The July enrollment by location from the plan year multiplied by appropriate geographic factors will be compared to the July enrollment from the preceding plan year multiplied by appropriate geographic factors. For illustrative purposes, a factor of 1.00 will be used.

4. An **age/sex dependent mix** factor has been included to recognize changes in demographics that may be caused by shifts in enrollment. For each plan year, this factor will be calculated by developing a ratio of the age/sex dependent mix factors for the plan year compared to the prior plan year. The July enrollment from the plan year multiplied by the TBD age/sex dependent mix factors will be compared to the July enrollment from the preceding plan year multiplied by the TBD age/sex dependent factors. For purposes of this formula, we will assume this factor to be 1.00.

   * Cook County and its consultant reserve the right to review the appropriateness of all actuarial factors, the development of those factors, and the Target Claims Cost.

TARGET CLAIMS INFORMATION (continued)

The actual allowed incurred claims for the plan year will be compared against the TCC for that plan year. Payouts will be determined based on the following payment schedule:

12/01/2015-11/30/2016

Target Claim Cost Standards	
Risk Sharing Corridors	**Administrative Fee Impact***
If TCC Claims are	then
greater than or equal to 106% of TCC	BCBSIL will return 10% of the Medical Claims Admin Fee to Cook County
105% to 106% of TCC	BCBSIL will return 8% of the Medical Claims Admin Fee to Cook County
104% to 105% of TCC	BCBSIL will return 6% of the Medical Claims Admin Fee to Cook County
103% to 104% of TCC	BCBSIL will return 4% of the Medical Claims Admin Fee to Cook County
102% to 103% of TCC	BCBSIL will return 2% of the Medical Claims Admin Fee to Cook County

TARGET CLAIMS INFORMATION (continued)

Conditions:

Notwithstanding anything in the RFP or Proposal to the contrary, BCBSIL reserves the right to revise or withdraw our offer or to change our administrative fees, including but not limited to changing or terminating the Target Claim Cost (TCC) guarantee, at any time before or during the projected coverage period noted above:

- If any local, state or federal legislation, regulation, rule or guidance (or amendments or clarifications thereto) is enacted or becomes effective/implemented, which would increase projected claim costs or BCBSIL's expenses or cost of plan administration, or would otherwise require BCBSIL to pay, on its own behalf or on the Account's behalf, any additional tax, surcharge, fee or other amount.
- If any changes or benefit variances in the Account's Plan, its administration, or the level of benefit valuation would increase the BCBSIL's cost of administration;
- If the number of Covered Employees enrolled in the Account's Plan changes by an amount equal to ten percent (10%) or more of total Non-Medicare enrollment.
- If the demographic make-up of the population administered by BCBSIL during the "base year" (meaning the 12-month period immediately preceding the guarantee period, as more fully described in the TCC) changes, such as through migration of Covered Employees to other coverage (whether individual, group or otherwise) or to an Exchange (public or private) or changes resulting from other decisions made by the Account (including but not limited to discontinuing coverage or changing funding types);
- If Cook County changes funding type to offer benefit designs/plans on an exchange then the TCC will not apply. If this occurs in the middle of a policy year then the TCC is null/void for the policy year.
- If Cook County implements value based models (Affordable Care Organizations, Medical Homes, etc.), network changes, benefit design changes or contributions that will have an impact on claims cost then the TCC is subject to change by BCBSIL.
- An effective date no later than 12/01/2015.
- BCBSIL UM/CM and BCC programs are fully implemented.
- Cook County must utilize BCBSIL standard out of network reimbursement levels.
- Trend Adjustment will not be group specific.
- Trend calculation will be based on the number of employees enrolled at the beginning of the plan year and those added through the normal course of hiring during the plan year.
- BCBSIL and Cook County will come to a mutual agreement on how to adjust the TCC if Cook County announces any layoffs/downsizing that impacts more than 5% of the population, which may create a run on benefits.
- All Medicare members are not included.
- BCBSIL will exclude all claimants in excess of $100,000.
- BCBSIL will exclude all claims the Employer authorizes to be paid on an exception basis; Medicare claims; claims with COB; Prescription Drug claims, Specialty Rx claims not covered/processed by BCBS; and claims for non-contracted providers paid at the in-network level of benefits.
- BCBSIL reserves the right to void or revise this TCC agreement if there are less than 5,583 employees enrolled the plan.
- Guaranteed trend will be reviewed and negotiated annually at the time of renewal.

DISCOUNT GUARANTEE

- **Applicable only to ASO PPO**

Cook County Actives
December 1, 2015 -
November 30, 2016 Network
Discount Guarantee

Medical Claims Only
Claims Paid 12/01/15 Through 11/30/16

Guaranteed Discount Percentage 55.0%

(Applicable only to ASO PPO)

Actual Discounts			Admin Fee Penalty
54.00%	or Higher		0.0%
53.00%	to	53.99%	4.0%
52.00%	to	52.99%	8.0%
51.99%	or Lower		10.0%

1. The formula for the Overall Network Discount Percentage calculation is as follows:
   (Eligible/Covered Claims less Allowed Claims equals the Provider Savings. The Provider Savings divided by the Eligible/Covered Claims equals the Overall Network Discount %).
2. Both In-Network and Out-of-Network claims are included in the Overall Network Discount Percentage calculation.
3. Network Discount Guarantee applies only to eligible employees and retirees who enroll in the proposed BCBS benefit plans.
4. BCBS will exclude any one claim in excess of $100,000, claims the Employer authorizes to be paid on an exception basis, Medicare claims, claims with COB, Prescription Drug claims, Specialty Rx, claims not covered/processed by BCBS, and claims for non-contracted providers paid at the in-network level of benefits.
5. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if participation changes by +/- 10.0%, and/or the distribution of enrolled employees between geographic areas, the single/family mix, or age/gender composition of the group changes significantly.
6. BCBS reserves the right to void this Network Discount Guarantee if there are less than 5583 employees enrolled in the plan.
7. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if Medicare changes its payment systems during the term of this Network Discount Guarantee.
8. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if there is a change in the benefit plan design.
9. BCBS reserves the right to re-evaluate and re-establish the Guaranteed Discount Percentage if a narrow or high performance network is elected.
10. Administrative Fee at Risk will be finalized upon sale of the Network Discount Guarantee.
11. Administrative Fee at Risk is the Medical Administration fee only. It does not include any additional elected services such as Fiduciary, BCC, etc.
12. Any penalty paid will be dollar for dollar up to the maximum amount at risk for each tier.
13. Guaranteed Discount Percentage will be reviewed and negotiated annually at the time of renewal.

*Amount at Risk is based on current enrollment of 6,203 HCSC Primary employees. Actual amount at risk is subject to change based on final enrollment of employees who select BCBS coverage.

EXHIBIT-PG HMO
Cook County Actives
Group Numbers: B50000 and H89805

Effective for the Settlement Period beginning **December 1, 2015**, and ending **November 30, 2016**
Effective for the Settlement Period beginning **December 1, 2016**, and ending **November 30, 2017**
Effective for the Settlement Period beginning **December 1, 2017**, and ending **November 30, 2018**

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **13,876** Covered Employees. Performance measurement will begin **December 1, 2015**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
Account Management	**Account Management** means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Client Satisfaction Survey.	Composite Score 4.0 - 5.0 3.0 - 3.9 0- 2.9	 0% 3% 6%
Claim Processing Accuracy	**Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Health Plan. Claim Processing Accuracy refers to Claims without processing errors such as: 1. Coding - incorrect claim data entry. 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Health Plan. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.	97.0% - 100% 96.0% - 96.9% 0% - 95.9%	0% 2.5% 5%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
Claim Financial Accuracy	**Claim Financial Accuracy** means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims paid during the Settlement Period. Total dollars overpaid and total dollars underpaid are projected over each stratum. Claim Financial Accuracy is computed by summing the projected overpayments and the projected underpayments (*absolute value*) from each stratum and dividing by the total dollars paid in the population. The end result is subtracted from one for the accuracy rate. Measurement is based on an audit of Employer-specific Claims.	99.0% - 100% 98.0% - 98.9% 0% - 97.9%	0% 2.5% 5%
Customer Service	**First Contact Closure** is defined as the percent of calls closed on the same date as the date of the caller's initial contact. Standard is measured using participant calls from those customers assigned to the Unit.	90.0% - 100% 0% - 89.9%	0% 3%
Customer Satisfaction	**Overall Satisfaction** is defined as the percent of the enrolled members who respond to the Continuous Tracking Program, rating the overall performance of their health plan as Excellent, Very Good, or Good. Standard is measured on an Employer-specific basis. Employer must maintain minimum of 5,000 enrollees for the Participant Satisfaction Survey measure to apply.	85.0%-100% 0%-84.9%	0% 6%
Total Medical			**25%**

1. Dollars at risk are based on the indicated percentage of the HMO administration fees.

EXHIBIT-PG PPO

EMPLOYER NAME: Cook County
Employer Group Number: 289801
Effective for the Settlement Period beginning December 1, 2015, and ending November 30, 2016
Effective for the Settlement Period beginning December 1, 2016, and ending November 30, 2017
Effective for the Settlement Period beginning December 1, 2017, and ending November 30, 2018

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **5,583** Covered Employees. Performance measurement will begin **December 1, 2015**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Account Management	**Account Management** means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Client Satisfaction Survey.	Composite Score 4.0 - 5.0 3.0 - 3.9 0-2.9	 0% 3% 6%
Claim Processing Accuracy	**Claim Processing Accuracy** is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Health Plan. Claim Processing Accuracy refers to Claims without processing errors such as: 6. Coding - incorrect claim data entry. 7. Failure to adhere to the Employer's health care benefit program design. 8. Failure to adhere to the administrative procedures. 9. System generated errors, benefit programming errors, calculation errors. 10. Excluding: d. Any administrative inaccuracies that do not impact claims disposition or customer reporting; e. Errors entered by providers of service; f. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Health Plan. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.	97.0% - 100% 96.0% - 96.9% 0% - 95.9%	0% 2.5% 5%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Claim Payment Accuracy	**Claim Payment Accuracy** means the percent of claims paid without over or under payments in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Payment Accuracy percentage is calculated for each stratum by dividing the number of accurately paid Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Payment Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Employer-specific Claims.	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 2.5% 5%
Customer Service	**First Contact Closure** is defined as the percent of calls closed on the same date as the date of the caller's initial contact. Standard is measured using participant calls from those customers assigned to the Unit.	90.0%-100% 0%-89.9%	0% 3%
Customer Satisfaction	**Overall Satisfaction** is defined as the percent of the enrolled members who respond to the Continuous Tracking Program, rating the overall performance of their health plan as Excellent, Very Good, or Good. Standard is measured on an Employer-specific basis. Employer must maintain minimum of 5,000 enrollees for the Participant Satisfaction Survey measure to apply.	85.0%-100% 0%-84.9%	0% 6%
Total Medical			**25%**

FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Trend / Claim Cost (Applicable Only to ASO PPO)	**Trend / Claim Cost** is defined as the percentage increase in Claim Cost per employee for services incurred during the settlement period over the previous 12 month period. Method of measurement: See the attached Financial Exhibit for sample calculation. Base year Claim Cost will be calculated using incurred claim data from the prior 12 month period and must be available by March 31. Claim Administrator reserves the right to re-evaluate and re-establish the guaranteed Claims Cost percentages if the enrollment changes by more than plus or minus 10%, with a minimum enrollment of 5,583. Claim Administrator will exclude all claims with total paid in excess of $100,000 and claims the Employer authorizes to be paid on an exception basis. Claim Administrator must be the only carrier offered for medical coverage.	See Attached Financial Exhibit	See Attached Financial Exhibit
Network Discount Savings (Applicable Only to ASO PPO)	**Network Discount Savings** is defined as the percentage of total eligible provider billed charges saved due to Network Provider discounts. Method of measurement: Total Eligible billed amount less total Allowed amount equals Provider Savings. The total Provider Savings divided by the Eligible billed amount equals the overall Network Discount Savings. Excluded from measurement are Medicare-related claims, claims with Coordination of Benefits, prescription drug claims, claims with total paid in excess of $100,000. Employer must maintain a minimum of 5,583 enrolled in the Plan.	See Attached Financial Exhibit	See Attached Financial Exhibit

EXHIBIT-PG

EMPLOYER NAME: COOK COUNTY
Employer Account Number: Group Number: 289801

Effective for the Settlement Period beginning **December 1, 2015, and ending November 30, 2016**

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than **5,583** Covered Employees. Performance measurement will begin **December 1, 2015**. Performance Guarantees are measured and settled annually.

MEDICAL MANAGEMENT – BCC	Defined Performance Guarantees **Requirements:** Performance Guarantees are applicable if the following occurs: 1. Employer must have a documented communication strategy (at least 4 communications per year) and offer incentives to members that support engagement with the clinical programs for which fees are at risk. 2. Documentation of the communication strategy and incentives must be provided, and mutually agreed upon by both parties, prior to the beginning of the settlement period. If the requirements are not met, these guarantees will not be in effect.	Performance Guarantee	Percentage of the BCC Administrative Charge at Risk
Participation (Applicable only to ASO PPO)	**Care Management Participation** is defined as the percentage of targeted members who are actively engaged in Condition/ Case management. Actively engaged means the member or member's provider is actively participating in bi-directional communication with the claim administrators designated clinician/member care coordinator.	30% or more 15% - 29.9% 0% - 14.9%	0% 6.5% 13%
Condition Management Gap Closure Rates (Applicable only to ASO PPO)	**Gap Closure Rate** is defined as the percentage of gaps closed on the population of members engaged in Condition Management. The gaps included are: Diabetes and: • No HbA1C in the past 12 months • No physician office visit in 6 months • No LDL level in the past 12 months • No test for microalbuminuria in the past 12 months and with Hypertension and not on ACE inhibitors or ARB in the past 6 months Asthma and not on controller medication Chronic Obstructive Pulmonary disease (COPD) - Bronchodilator adherence Coronary Artery Disease (CAD) and no LDL level in the past 12 months Congestive Heart Failure (CHF) and no physician office visit in 6 months Gaps including medication adherence apply to accounts with Prime Rx or who provide ongoing files to HCSC in the required format.	30% or more 15% - 29.9% 0% - 14.9%	0% 3.5% 7%

MEDICAL MANAGEMENT – BCC	**Defined Performance Guarantees** **Requirements:** Performance Guarantees are applicable if the following occurs: 1. Employer must have a documented communication strategy (at least 4 communications per year) and offer incentives to members that support engagement with the clinical programs for which fees are at risk. 2. Documentation of the communication strategy and incentives must be provided, and mutually agreed upon by both parties, prior to the beginning of the settlement period. If the requirements are not met, these guarantees will not be in effect.	**Performance Guarantee**	**Percentage of the BCC Administrative Charge at Risk**
	All measures will exclude members who were identified as not appropriate for the program or have missing or invalid phone numbers.		
Total Medical Management	The level of performance guarantee is based on Employer-specific results. However, if the denominator for the above measures is less than 30, any resulting penalties will not apply.		**20%**

ATTACHMENT 1

ADDENDUM PG
PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Professional Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current fee schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current fee schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and Exhibit 3 - Schedule of Compensation.

SECTION I
TIMING

A. The period for which BCBSIL's performance will be measured and for which the County may receive a refund is referred to as the Settlement Period and is indicated in Exhibit 3 – Schedule of Compensation.

B. The measurement of Performance Guarantees will begin on the date indicated in Exhibit 3 – Schedule of Compensation provided all of the requirements listed below are completed. The requirements are as follows:

1. Benefit information and claims administrative procedures have been provided by the County to BCBSIL,

2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto BCBSIL's claims processing system,

3. Accurate and complete membership information has been received and loaded onto BCBSIL's claims processing system, and

4. Transfer payment procedures have been established in accordance with the Agreement.

SECTION II
DETERMINATION

A. BCBSIL agrees to guarantee performance levels as indicated in Exhibit 3 – Schedule of Compensation. In the event that the BCBSIL's level of performance is determined to be less than any of the standards described in Exhibit 3 –Schedule of Compensation during a Settlement Period for which BCBSIL's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts BCBSIL's normal business operation, BCBSIL will be responsible for reimbursing the County a portion of the administrative charge.

B. BCBSIL will measure Performance Guarantees and report the measurement results to the County, and any refund amounts due in accordance with this Addendum PG within 120

days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

C. BCBSIL will not be obligated to measure Performance Guarantees and will not be obligated to refund the County based thereon until the Agreement (including Exhibit 3 – Schedule of Compensation) has been executed and is on file with BCBSIL by the close of the applicable Settlement Period.

D. BCBSIL will not be obligated to measure Performance Guarantees and will not be obligated to refund the County based thereon for any portion of the Settlement Period in which the County:

1. Fails to provide BCBSIL with Timely changes in enrollment or membership information or any other reports or information as may be necessary for BCBSIL to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or

2. Fails to pay administrative charges in accordance with the terms of the Agreement or comply with all established Transfer Payment procedures.

E. BCBSIL will not be obligated to measure any Performance Guarantee impacted by changes requested in writing by the County during the time period required to modify BCBSIL's system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to BCBSIL in accordance with the Agreement.

F. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by BCBSIL, Medicare payment systems, or if the enrollment of the Plan's benefit coverage administered by BCBSIL varies in number of enrolled covered employees as indicated in Exhibit 3-Schedule of Compensation attached to and made a part of this Addendum during any Settlement Period, BCBSIL reserves the right to re-evaluate and renegotiate the level of performance and/or the administrative charges at risk in this Addendum PG and the attached Exhibit 3 – Schedule of Compensation

G. If for any reason the Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and the County will not receive any refund, based on that part of the Settlement Period in which the Agreement was in effect.

H. If (i) changes to the formula, methodology or manner in which a third-party benchmark (such as AWP) is calculated or reported take effect, or (ii) such third party ceases to publish such benchmark, then the performance guarantees and/or standards based on such benchmark in this Agreement, if any, shall be re-evaluated and adjusted or converted to an alternative benchmark by BCBSIL or its designee at the time of such change to return the parties to their respective economic positions with respect to such guarantees and/or standards as they existed under the Agreement immediately prior to such change.

EXHIBIT 4

Minority and Women Owned Business Enterprise Commitment

I. THE COUNTY POLICY AND GOALS

A. It is the policy of the County of Cook to prevent discrimination in the award of or participation in County Contracts and to eliminate arbitrary barriers for participation in such Contracts by local businesses certified as a Minority Business Enterprise (MBE) and Women-owned Business Enterprise (WBE) as both prime and sub-contractors. In furtherance of this policy, the Cook County Board of Commissioners has adopted a Minority- and Women-owned Business Enterprise Ordinance (the "Ordinance") which establishes annual goals for MBE and WBE participation as outlined below:

Contract Type	**Goals**	
	MBE	**WBE**
Goods and Services	25%	10%
Construction	24%	10%
Professional Services	35% Overall	

B. **The County shall set contract-specific goals, based on the availability of MBEs and WBEs that are certified to provide commodities or services specified in this solicitation document. The MBE/WBE participation goals for this Agreement is 35%.** A Bid, Quotation, or Proposal shall be rejected if the County determines that it fails to comply with this General Condition in any way, including but not limited to: (i) failing to state an enforceable commitment to achieve for this contract the identified MBE/WBE Contract goals; or (ii) failing to include a Petition for Reduction/Waiver, which states that the goals for MBE/WBE participation are not attainable despite the Bidder or Proposer Good Faith Efforts, and explains why. If a Bid, Quotation, or Proposal is rejected, then a new Bid, Quotation, or Proposal may be solicited if the public interest is served thereby.

C. To the extent that a Bid, Quotation, or Proposal includes a Petition for Reduction/Waiver that is approved by the Office of Contract Compliance, the Contract specific MBE and WBE participation goals may be achieved by the proposed Bidder or Proposer's status as an MBE or WBE; by the Bidder or Proposer's enforceable joint-venture agreement with one or more MBEs and/or WBEs; by the Bidder or Proposer entering into one or more enforceable subcontracting agreements with one or more MBE and WBE; by the Bidder or Proposer establishing and carrying out an enforceable mentor/protégé agreement with one or more MBE and WBE; by the Bidder or Proposer actively engaging the Indirect Participation of one or more MBE and WBE in other aspects of its business; or by any combination of the foregoing, so long as the Utilization Plan evidences a commitment to meet the MBE and WBE Contract goals set forth in (B) above, as approved by the Office of Contract Compliance.

D. A single Person, as defined in the Procurement Code, may not be utilized as both an MBE and a WBE on the same Contract, whether as a Consultant, Subcontractor or supplier.

E. Unless specifically waived in the Bid or Proposal Documents, this Exhibit; the Ordinance; and the policies and procedures promulgated thereunder shall govern. If there is a conflict between this Exhibit and the Ordinance or the policies and procedures, the Ordinance shall control.

F. A Consultant's failure to carry out its commitment regarding MBE and WBE participation in the course of the Contract's performance may constitute a material breach of the Contract. If such breach is not appropriately cured, it may result in withholding of payments under the Contract, contractual penalties, disqualification and any other remedy provided for in Division 4 of the Procurement Code at law or in equity.

II. REQUIRED BID OR PROPOSAL SUBMITTALS

A Bidder or Proposer shall document its commitment to meeting the Contract specific MBE and WBE participation goals by submitting a Utilization Plan with the Bid or Proposal. The Utilization Plan shall include (1) one or more Letter(s) of Intent from the relevant MBE and WBE firms; and (2) current Letters of Certification as an MBE or WBE. Alternatively, the Bidder or Proposer shall submit (1) a written Petition for Reduction/Waiver with the Bid, Quotation or Proposal, which documents its preceding Good Faith Efforts and an explanation of its inability to meet the goals for MBE and WBE participation. The Utilization Plan shall be submitted at the time that the bid or proposal is due. **Failure to include a Utilization Plan will render the submission not Responsive and shall be cause for the CPO to reject the Bid or Proposal.**

A. MBE/WBE Utilization Plan

Each Bid or Proposal shall include a complete Utilization Plan, as set forth on Form 1 of the M/WBE Compliance Forms. The Utilization Plan shall include the name(s), mailing address, email address, and telephone number of the principal contact person of the relevant MBE and WBE firms. If the Bidder or Proposer submits a Bid or Proposal, and any of their subconsultants, suppliers or consultants, are certified MBE or WBE firms, they shall be identified as an MBE or WBE within the Utilization Plan.

1. Letter(s) of Intent

Except as set forth below, a Bid or Proposal shall include, as part of the Utilization Plan, one or more Letter(s) of Intent, as set forth on Form 2 of the M/WBE Compliance Forms, executed by each MBE and WBE and the Bidder or Proposer. The Letter(s) of Intent will be used to confirm that each MBE and WBE shall perform work as a Subcontractor, supplier, joint venture, or consultant on the Contract. Each Letter of Intent shall indicate whether and the degree to which the MBE or WBE will provide goods or services directly or indirectly during the term of the Contract. The box for direct participation shall be marked if the proposed MBE or WBE will provide goods or services directly related to the scope of the Contract. The box for Indirect participation shall be marked if the proposed MBE or WBE will not be directly involved in the Contract but will be utilized by the Bidder or Proposer for other services not related to the Contract. Indirect

Participation shall not be counted toward the participation goal. Each Letter of Intent shall accurately detail the work to be performed by the relevant MBE or WBE firm, the agreed dollar amount, the percentage of work, and the terms of payment.

Failure to include Letter(s) of Intent will render the submission not Responsive and shall be cause for the CPO to reject the Bid or Proposal.

All Bids and Proposals must conform to the commitments made in the corresponding Letter(s) of Intent, as may be amended through change orders.

The Contract Compliance Director may at any time request supplemental information regarding Letter(s) of Intent, and such information shall be furnished if the corresponding Bid or Proposal is to be deemed responsive.

2. Letter(s) of Certification

Only current Letter(s) of Certification from one of the following entities may be accepted as proof of certification for MBE/WBE status, provided that Cook County's requirements for certification are met:

- County of Cook
- City of Chicago

Persons that are currently certified by the City of Chicago in any area other than Construction/Public Works shall also complete and submit a MBE/WBE Reciprocal Certification Affidavit along with a current letter of certification from the City of Chicago. This Affidavit form can be downloaded from www.cookcountyil.gov/contractcompliance.

The Contract Compliance Director may reject the certification of any MBE or WBE on the ground that it does not meet the requirements of the Ordinance, or the policies and rules promulgated thereunder.

3. Joint Venture Affidavit

In the event a Bid or Proposal achieves MBE and/or WBE participation through a Joint Venture, the Bid or Proposal shall include the required Joint Venture Affidavit, which can be downloaded from www.cookcountyil.gov/contractcompliance. The Joint Venture Affidavit shall be submitted with the Bid or Proposal, along with current Letter(s) of Certification.

B. Petition for Reduction/Waiver

In the event a Bid or Proposal does not meet the Contract specific goals for MBE and WBE participation, the Bid or Proposal shall include a Petition for Reduction/Waiver, as set forth on Form 3. The Petition for Reduction/Waiver shall be supported by sufficient

evidence and documentation to demonstrate the Bidder or Proposer's Good Faith Efforts in attempting to achieve the applicable MBE and WBE goals, and its inability to do so despite its Good Faith Efforts.

Failure to include Petition for Reduction/Waiver will render the submission not Responsive and shall be cause for the CPO to reject the Bid or Proposal.

III. REDUCTION/WAIVER OF MBE/WBE GOALS

A. Granting or Denying a Reduction/Waiver Request.

1. The adequacy of the Good Faith Efforts to utilize MBE and WBE firms in a Bid or Proposal will be evaluated by the CCD under such conditions as are set forth in the Ordinance, the policies and rules promulgated thereunder, and in the "Petition for Reduction/Waiver of MBE/WBE Participation Goals" – Form 3 of the M/WBE Compliance Forms.

2. With respect to a Petition for Reduction/Waiver, the sufficiency or insufficiency of a Bidder or Proposer's Good Faith Efforts shall be evaluated by the CCD as of the date upon which the corresponding Bid or Proposal was due.

3. The Contract Compliance Director or his or her duly authorized Waiver Committee may grant or deny the Petition for Reduction/Waiver based upon factors including but not limited to: (a) whether sufficient qualified MBE and WBE firms are unavailable despite good faith efforts on the part of the Bidder or Proposer; (b) the degree to which specifications and the reasonable and necessary requirements for performing the Contract make it impossible or economically infeasible to divide the Contract into sufficiently small tasks or quantities so as to enable the Bidder or Proposer to utilize MBE and WBE firms in accordance with the applicable goals; (c) the degree to which the prices or prices required by any potential MBE or WBE are more that 10% above competitive levels; and (d) such other factors as are determined relevant by the Contract Compliance Director or the duly authorized Waiver Committee.

4. If the Contract Compliance Director or the duly authorized Waiver Committee determines that the Bidder or Proposer has not demonstrated sufficient Good Faith Efforts to meet the applicable MBE and WBE goals, the Contract Compliance Director or the duly authorized Waiver Committee may deny a Petition for Reduction/Waiver, declare the Bid or Proposal non-responsive, and recommend rejection of the Bid, Quotation, or Proposal.

IV. CHANGES IN CONSULTANT'S UTILIZATION PLAN

A. A Consultant, during its performance of the Contract, may not change the original MBE or WBE commitments specified in the relevant Utilization Plan, including but not limited to, terminating a MBE or WBE Contract, reducing the scope of the work to be performed by a MBE/WBE, or decreasing the price to a MBE/WBE, except as

otherwise provided by the Ordinance and according to the policies and procedures promulgated thereunder.

B. Where a Person listed under the Contract was previously considered to be a MBE or WBE but is later found not to be, or work is found not to be creditable toward the MBE or WBE goals as stated in the Utilization Plan, the Consultant shall seek to discharge the disqualified enterprise, upon proper written notification to the Contract Compliance Director, and make every effort to identify and engage a qualified MBE or WBE as its replacement. Failure to obtain an MBE or WBE replacement within 30 business days of the Contract Compliance Director's written approval of the removal of a purported MBE or WBE may result in the termination of the Contract or the imposition of such remedy authorized by the Ordinance, unless a written Petition for Reduction/Waiver is granted allowing the Consultant to award the work to a Person that is not certified as an MBE or WBE.

V. NON-COMPLIANCE

If the CCD determines that the Consultant has failed to comply with its contractual commitments or any portion of the Ordinance, the policies and procedures promulgated thereunder, or this Exhibit, the Contract Compliance Director shall notify the Consultant of such determination and may take any and all appropriate actions as set forth in the Ordinance or the policies and procedures promulgated thereunder which includes but is not limited to disqualification, penalties, withholding of payments or other remedies in law or equity.

VI. REPORTING/RECORD-KEEPING REQUIREMENTS

The Consultant shall comply with the reporting and record-keeping requirements in the manner and time established by the Ordinance, the policies and procedure promulgated thereunder, and the Contract Compliance Director. Failure to comply with such reporting and record-keeping requirements may result in a declaration of Contract default. Upon award of a Contract, a Consultant shall acquire and utilize all Cook County reporting and record-keeping forms and methods which are made available by the Office of Contract Compliance. MBE and WBE firms shall be required to verify payments made by and received from the prime Consultant.

VII. EQUAL EMPLOYMENT OPPORTUNITY

Compliance with MBE and WBE requirements will not diminish or supplant other legal Equal Employment Opportunity and Civil Rights requirements that relate to Consultant and Subcontractor obligations.

Any questions regarding this section should be directed to:
Contract Compliance Director
Cook County
118 North Clark Street, Room 1020
Chicago, Illinois 60602
(312) 603-5502

OFFICE OF CONTRACT COMPLIANCE
JACQUELINE GOMEZ
DIRECTOR
118 N. Clark, County Building, Room 1020 ● Chicago, Illinois 60602 ● (312) 603-5502

October 2, 2015

Ms. Shannon Andrews
Chief Procurement Officer
County Building, Room 1018
Chicago, IL 60602

Re: Contract #1518-14008
Employer-Sponsored Health Insurance Benefits

Dear Ms. Andrews:

The following bid for the above reference contract has been reviewed for compliance with the General Conditions regarding the Minority- and Women-owned Business Enterprises Ordinance and has been found to be responsive to the professional service goal of 35% overall MWBE participation.

Bidder: Blue Cross & Blue Shield of Illinois
Bid Amount: $884,195,500.00 (MBE/WBE participation based off $20,343,776.00 Administrative Services Only)

MWBE	Status	Certifying Agency	Commitment
Action Bag Company	WBE-7	City of Chicago	2% Direct
Innovative Systems Group, Inc.	MBE-8	City of Chicago	8% Indirect
Instant Technology, LLC	WBE-7	City of Chicago	7% Indirect
Kairos Consulting Worldwide, LLC	MWBE-6	City of Chicago	3% Direct
Montenegro Paper Ltd.	MBE-9	Cook County	2% Direct
My Wellness Community, Inc.	MBE-6	City of Chicago	4% Direct
VIVA USA Inc.	MWBE-8	City of Chicago	9% Indirect
			35%

The Office of Contract Compliance has been advised by the Requesting Department that no other bidders are being recommended for award. Additionally, please note that revised forms were used in the determination of the responsiveness of this contract.

Sincerely,

Jacqueline Gomez

Jacqueline Gomez
Director

JG/la

Cc: Deanna Zalas, Risk Management

MBE/WBE UTILIZATION PLAN - FORM 1

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions – Section 19.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

- [ ] Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of current Letter of Certification)
- [ ] Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs. (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available online at www.cookcountyil.gov/contractcompliance)
- [x] Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either directly or indirectly in the performance of the Contract. (If so, complete Sections II below and the Letter(s) of Intent – Form 2).

II. [X] **Direct Participation of MBE/WBE Firms** [X] **Indirect Participation of MBE/WBE Firms**

NOTE: Where goals have not been achieved through direct participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission. Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs that will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: Instant Technology, LLC

Address: 200 W Adams St, Suite 1440, Chicago, IL 60606

E-mail: rrouhoff@instanttechnology.com

Contact Person: Rona Borre Phone: 312-582-2600

Dollar Amount Participation: $ 1,401,001

Percent Amount of Participation: 7 %

*Letter of Intent attached? Yes X No ____
*Current Letter of Certification attached? Yes X No ____

MBE/WBE Firm: Montenegro Paper Ltd

Address: 400 W Lake St, Suite 214, Roselle, IL 60172

E-mail: info@montenegropaper.com

Contact Person: Irma Bates Phone: 630-894-0350

Dollar Amount Participation: $ 400,286

Percent Amount of Participation: 2 %

*Letter of Intent attached? Yes X No ____
*Current Letter of Certification attached? Yes X No ____

Attach additional sheets as needed.

*** Letter(s) of Intent and current Letters of Certification must be submitted at the time of bid.**

MBE/WBE UTILIZATION PLAN - FORM 1

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions – Section 19.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

- ☐ Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of current Letter of Certification)
- ☐ Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs. (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available online at www.cookcountyil.gov/contractcompliance)
- ☑ Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either directly or indirectly in the performance of the Contract. (If so, complete Sections II below and the Letter(s) of Intent – Form 2).

II. ☐ **Direct Participation of MBE/WBE Firms** ☒ **Indirect Participation of MBE/WBE Firms**

NOTE: Where goals have not been achieved through direct participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission. Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs that will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: VIVA USA, Inc.

Address: 3601 Algonquin Rd, Suite 425, Rolling Meadows, IL 60008

E-mail: vilangovan@viva-it.com

Contact Person: Vasanthi Ilangovan Phone: 847-368-0860

Dollar Amount Participation: $ 1,800,287

Percent Amount of Participation: 9 %

*Letter of Intent attached? Yes X No _____
*Current Letter of Certification attached? Yes x No _____

MBE/WBE Firm: _____

Address: _____

E-mail: _____

Contact Person: _____ Phone: _____

Dollar Amount Participation: $ _____

Percent Amount of Participation: _____ %

*Letter of Intent attached? Yes _____ No _____
*Current Letter of Certification attached? Yes _____ No _____

Attach additional sheets as needed.

*** Letter(s) of Intent and current Letters of Certification must be submitted at the time of bid.**

MBE/WBE UTILIZATION PLAN - FORM 1

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions – Section 19.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

☐ Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of current Letter of Certification)

☐ Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs. (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available online at www.cookcountyil.gov/contractcompliance)

☑ Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either directly or indirectly in the performance of the Contract. (If so, complete Sections II below and the Letter(s) of Intent – Form 2).

II. [X] **Direct Participation of MBE/WBE Firms** [X] **Indirect Participation of MBE/WBE Firms**

NOTE: Where goals have not been achieved through direct participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission. Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs that will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: Action Bag Company

Address: 1001 Entry Drive, Bensenville,IL 60106

E-mail: info@actionbag.com

Contact Person: Nancy Cwynar Phone: 800-824-2247

Dollar Amount Participation: $ 400,286

Percent Amount of Participation: 2 %

*Letter of Intent attached? Yes X No ____
*Current Letter of Certification attached? Yes X No ____

MBE/WBE Firm: Innovative Systems Group, Inc

Address: 799 Roosevelt Road, Building 4 Suite 109, Glen Ellyn, IL 60137

E-mail: cindym@innovativesys.com

Contact Person: Joselito Salas Phone: 630-858-8500

Dollar Amount Participation: $ 1,601,144

Percent Amount of Participation: 8 %

*Letter of Intent attached? Yes X No ____
*Current Letter of Certification attached? Yes X No ____

Attach additional sheets as needed.

*** Letter(s) of Intent and current Letters of Certification must be submitted at the time of bid.**

MBE/WBE UTILIZATION PLAN (SECTION 1)

BIDDER/PROPOSER HEREBY STATES that all MBE/WBE firms included in this Plan are certified MBEs/WBEs by at least one of the entities listed in the General Conditions.

I. **BIDDER/PROPOSER MBE/WBE STATUS:** (check the appropriate line)

☐ Bidder/Proposer is a certified MBE or WBE firm. (If so, attach copy of appropriate Letter of Certification)

☐ Bidder/Proposer is a Joint Venture and one or more Joint Venture partners are certified MBEs or WBEs. (If so, attach copies of Letter(s) of Certification, a copy of Joint Venture Agreement clearly describing the role of the MBE/WBE firm(s) and its ownership interest in the Joint Venture and a completed Joint Venture Affidavit – available from the Office of Contract Compliance)

☑ Bidder/Proposer is not a certified MBE or WBE firm, nor a Joint Venture with MBE/WBE partners, but will utilize MBE and WBE firms either directly or indirectly in the performance of the Contract. (If so, complete Sections II and III).

II. ☑ **Direct Participation of MBE/WBE Firms** ☐ **Indirect Participation of MBE/WBE Firms**

Where goals have not been achieved through direct participation, Bidder/Proposer shall include documentation outlining efforts to achieve Direct Participation at the time of Bid/Proposal submission. Indirect Participation will only be considered after all efforts to achieve Direct Participation have been exhausted. Only after written documentation of Good Faith Efforts is received will Indirect Participation be considered.

MBEs/WBEs that will perform as subcontractors/suppliers/consultants include the following:

MBE/WBE Firm: Kairos Consulting Worldwide, LLC ✓

Address: 1 South Dearborn Street, Suite 2100

E-mail: lynn.sutton@kairosworldwide.com

Contact Person: Lynn Sutton Phone: 312-757-5197

Dollar Amount Participation: $ 600,429

Percent Amount of Participation: 3 %

*Letter of Intent attached? Yes ☑ No ☐

*Letter of Certification attached? Yes ✓ No ☐

MBE/WBE Firm: My Wellness Community, Inc

Address: 542 S. Dearborn Street, 8th Floor

E-mail: csmith@mywellnesscommunity.com

Contact Person: Charles Smith Phone: 312-724-8358

Dollar Amount Participation: $ 800,572

Percent Amount of Participation: 4 %

*Letter of Intent attached? Yes ☑ No ☐

*Letter of Certification attached? Yes ✓ No ☐

Attach additional sheets as needed.

***Additionally, all Letters of Intent, Letters of Certification and documentation of Good Faith Efforts omitted from this bid/proposal must be submitted to the Office of Contract Compliance so as to assure receipt by the Contract Compliance Administrator not later than three (3) business days after the Bid Opening date.**

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Action Bag Company

Address: 1001 Entry Drive

City/State: Bensenville/IL Zip 60106-3314

Phone: 800-824-2247 Fax: 630-766-2063

Email: nc@actionbag.com

Certifying Agency: City of Chicago

Certification Expiration Date: 9/1/2019

FEIN #: 36-3074665

Contact Person: Nancy Cwynar

Contract #:

Participation: [✓] Direct [ ] Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

[✓] No [ ] Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Marketing and Promotional Materials

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

2% 400,286

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (M/WBE)

Nancy Cwynar

Print Name

Action Bag Company

Firm Name

7/18/15

Date

Subscribed and sworn before me

this 18th day of July, 2015

Notary Public

SEAL

Notary Public State of Florida
William E Even
My Commission EE 166407
Expires 02/10/2016

Signature (Prime Bidder/Proposer)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

7/20/15

Date

Subscribed and sworn before me

this 20th day of July, 2015

Notary Public

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Innovative Systems Group, Inc.

Certifying Agency: City of Chicago

Address: 799 Roosevelt Road, Bldg 4-109

Certification Expiration Date: 1/1/2019

City/State: Glen Ellyn, IL Zip 60137

FEIN #: 36-3795159

Phone: 630-858-8500 Fax: 630-858-8532

Contact Person: Gerry Schoenneman

Email: GerryS@innovativesys.com

Contract #:

Participation: ☐ Direct ☑ Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

☑ No ☐ Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Provides information technology resources as needed on a temporary basis.

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

8% 1,601,144

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (M/WBE)

Gerry Schoenneman

Print Name

Innovative Systems Group, Inc.

Firm Name

3-16-2015

Date

Subscribed and sworn before me

this 16 day of March, 2015.

Notary Public Cynthia Muse

SEAL

OFFICIAL SEAL
CYNTHIA MUSE
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:02/27/17

Signature (Prime Bidder/Proposer)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

7/20/15

Date

Subscribed and sworn before me

this 20th day of July, 2015.

Notary Public Sandra R. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Instant Technology, LLC

Certifying Agency: City of Chicago

Address: 200 W Adams Street, Suite 1440

Certification Expiration Date: 3/15/2018

City/State: Chicago, IL Zip 60606-5224

FEIN #: 36-4482911

Phone: 312-582-2600 Fax: 312-582-2699

Contact Person: Rona Borre

Email: rborre@instanttechnology.com

Contract #:

Participation: ☐ Direct ☑ Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

☑ No ☐ Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Computer systems design consulting services

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

7% 1,401,001

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (*M/WBE*)

Rona Borre

Print Name

Instant Technology, LLC

Firm Name

3/20/2015

Date

Subscribed and sworn before me

this 20 day of March, 2015.

Notary Public Heather Deacon-Ziemann

SEAL

OFFICIAL SEAL
HEATHER DEACON-ZIEMANN
Notary Public - State of Illinois
My Commission Expires Sep 20, 2017

Signature (*Prime Bidder/Proposer*)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

7/20/15

Date

Subscribed and sworn before me

this 20th day of July, 2015.

Notary Public Sandra R. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Kairos Consulting Worldwide, L

Certifying Agency: City of Chicago

Address: 1 S Dearborn Street, Suite 2100

Certification Expiration Date: 2/15/2020

City/State: Chicago Zip 60603

FEIN #: 73-1717532

Phone: 312-757-5197 Fax: 312-757-5492

Contact Person: Lynn Sutton

Email: lynn.sutton@kairosworldwide.com

Contract #:

Participation: ☑ Direct ☐ Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

☑ No ☐ Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Develop and implement a comprehensive communication plan that will enhance the Hea
Wellness Program Promotion with Cook County.

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

~~FBA~~ 3% 600,429
Paid upon invoice rece

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (*M/WBE*)

Lynn E. Sutton
Print Name

Kairos Consulting Worldwide, LLC
Firm Name

September 25, 2015
Date

Subscribed and sworn before me
this 25 day of September, 2015
Notary Public

SEAL

OFFICIAL SEAL
DANIEL W WINSTON
Notary Public - State of Illinois
My Commission Expires Sep 20, 2017

Signature (*Prime Bidder/Proposer*)

LaTonya Fourte-Lyles
Print Name

Blue Cross Blue Shield of Illinois
Firm Name

9/28/15
Date

Subscribed and sworn before me
this 28th day of September, 2015
Notary Public Sandra L. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Montenegro Paper Ltd.

Address: 400 West Lake Street, Suite 214

City/State: Roselle/IL Zip 60172

Phone: 630-894-0350 Fax: 630-894-0095

Email: Irma.Bates@montenegropaper.com

Certifying Agency: Cook County

Certification Expiration Date: 4/2/2016

FEIN #: 36-4113264

Contact Person: Irma Bates

Contract #: 630-894-0350

Participation: [✓] Direct [ ] Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

[✓] No [ ] Yes – Please attach explanation. Proposed Subcontractor: _____

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Commercial Printing Paper, Envelopes and Packaging Materials

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

2% 400,286

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (*M/WBE*)

Edgar R Enciso - President

Print Name

Montenegro Paper Ltd.

Firm Name

7/17/15

Date

Subscribed and sworn before me

this 17 day of July, 20 15.

Notary Public Sandra A. Breymeyer

SEAL

OFFICIAL SEAL
SANDRA A BREYMEYER
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires Jan. 26, 2019

Signature (*Prime Bidder/Proposer*)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

7/20/15

Date

Subscribed and sworn before me

this 20th day of July, 20 15

Notary Public Sandra R. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: My Wellness Community

Certifying Agency: Cook County

Address: 542 S. Dearborn St., 8th Floor

Certification Expiration Date: 1/1/2016

City/State: Chicago Zip 60605

FEIN #: 46-0627141

Phone: 312-724-8358 Fax: 312-566-0965

Contact Person: Charles Smith

Email: csmith@mywellnesscommunity.com

Contract #:

Participation: [✓] Direct [ ] Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

[✓] No [ ] Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Provide Health and Wellness Program Promotion, which includes Tobacco Cessation, Health Coaching and Preventative Wellness

Indicate the **Dollar Amount**, or **Percentage**, and the **Terms of Payment** for the above-described Commodities/ Services:

~~for~~ 490 800,572

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (*M/WBE*)

Charles Smith

Print Name

My Wellness Community, Inc.

Firm Name

9/25/2015

Date

Subscribed and sworn before me

this 25 day of September, 20 15

Notary Public J Robinson

SEAL

J ROBINSON
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
July 20, 2019

Signature (*Prime Bidder/Proposer*)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

9/28/15

Date

Subscribed and sworn before me

this 28th day of September 20 15

Notary Public Sandra R. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

COOK COUNTY GOVERNMENT LETTER OF INTENT (SECTION 2)

M/WBE Firm: Viva USA Inc.

Certifying Agency: City of Chicago

Address: 3601 Algonquin Road Ste 425

Certification Expiration Date: 4/23/2016

City/State: Rolling Meadows Zip IL

FEIN #: 36-4077368

Phone: 847-368-0860 Fax: 847-368-0864

Contact Person: Vasanthi Ilangovan

Email: vilangovan@viva-it.com

Contract #:

Participation: ☐ Direct ☑ Indirect

Will the M/WBE firm be subcontracting any of the performance of this contract to another firm?

☑ No ☐ Yes – Please attach explanation. Proposed Subcontractor:

The undersigned M/WBE is prepared to provide the following Commodities/Services for the above named Project/ Contract:

Computer systems design consulting services

Indicate the Dollar Amount, or Percentage, and the Terms of Payment for the above-described Commodities/ Services:

9% 1,800,287

Paid upon invoice received net 30 days

(If more space is needed to fully describe M/WBE Firm's proposed scope of work and/or payment schedule, attach additional sheets)

THE UNDERSIGNED PARTIES AGREE that this Letter of Intent will become a binding Subcontract Agreement conditioned upon the Bidder/Proposer's receipt of a signed contract from the County of Cook. The Undersigned Parties do also certify that they did not affix their signatures to this document until all areas under Description of Service/ Supply and Fee/Cost were completed.

Signature (*M/WBE*)

Ilango Radhakrishnan

Print Name

Viva USA, Inc.

Firm Name

07/17/2015

Date

Subscribed and sworn before me

this 17th day of July, 2015.

Notary Public Alicia Therese Simmons

SEAL

"OFFICIAL SEAL"
Alicia Therese Simmons
Notary Public, State of Illinois
My Commission Expires 7/27/2016

Signature (*Prime Bidder/Proposer*)

LaTonya Fourte-Lyles

Print Name

Blue Cross Blue Shield of Illinois

Firm Name

7/20/15

Date

Subscribed and sworn before me

this 20th day of July, 2015.

Notary Public Sandra R. York

SEAL

OFFICIAL SEAL
SANDRA R YORK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:05/06/16

PETITION FOR REDUCTION/WAIVER OF MBE/WBE PARTICIPATION – FORM 3

A. BIDDER/PROPOSER HEREBY REQUESTS:

☐ **FULL MBE WAIVER** ☐ **FULL WBE WAIVER**

☐ **REDUCTION (PARTIAL MBE and/or WBE PARTICIPATION)**

_____% of Reduction for MBE Participation
_____% of Reduction for WBE Participation

B. REASON FOR FULL/REDUCTION WAIVER REQUEST

Bidder/Proposer shall check each item applicable to its reason for a waiver request. Additionally, supporting documentation shall be submitted with this request.

☐ (1) Lack of sufficient qualified MBEs and/or WBEs capable of providing the goods or services required by the contract. **(Please explain)**

☐ (2) The specifications and necessary requirements for performing the contract make it impossible or economically infeasible to divide the contract to enable the contractor to utilize MBEs and/or WBEs in accordance with the applicable participation. **(Please explain)**

☐ (3) Price(s) quoted by potential MBEs and/or WBEs are above competitive levels and increase cost of doing business and would make acceptance of such MBE and/or WBE bid economically impracticable, taking into consideration the percentage of total contract price represented by such MBE and/or WBE bid. **(Please explain)**

☐ (4) There are other relevant factors making it impossible or economically infeasible to utilize MBE and/or WBE firms. **(Please explain)**

C. GOOD FAITH EFFORTS TO OBTAIN MBE/WBE PARTICIPATION

■ (1) Made timely written solicitation to identified MBEs and WBEs for utilization of goods and/or services; and provided MBEs and WBEs with a timely opportunity to review and obtain relevant specifications, terms and conditions of the proposal to enable MBEs and WBEs to prepare an informed response to solicitation. **(Attach of copy written solicitations made)**

☒ (2) Used the services and assistance of the Office of Contract Compliance staff. **(Please explain)**

☒ (3) Timely notified and used the services and assistance of community, minority and women business organizations. **(Attach of copy written solicitations made)**

☒ (4) Followed up on initial solicitation of MBEs and WBEs to determine if firms are interested in doing business. **(Attach supporting documentation)**

☒ (5) Engaged MBEs & WBEs for direct/indirect participation. **(Please explain)**

D. OTHER RELEVANT INFORMATION

Attach any other documentation relative to Good Faith Efforts in complying with MBE/WBE participation.

EXHIBIT 5

Evidence of Insurance

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
08/20/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA INC. 540 W. MADISON CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 J05515-GAWU-ALL-14-15	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED HEALTH CARE SERVICE CORPORATION AND ITS SUBSIDIARIES 300 EAST RANDOLPH STREET CHICAGO, IL 60601	INSURER A : Zurich American Insurance Company — NAIC # 16535 INSURER B : N/A — N/A INSURER C : Safety National Casualty Corp. — 15105 INSURER D : N/A — N/A INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** CHI-006393567-01 **REVISION NUMBER:** 3

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:			GLO 9377127 11 (AOS)	11/01/2014	11/01/2015	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 1,000,000 $ 10,000 $ 2,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			BAP 9377126 11	11/01/2014	11/01/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
C	IL - EXCESS WC			SP 4051838 SIR: $450,000	11/01/2014	11/01/2015	WORKERS COMP: STATUTORY EMPLOYERS LIABILITY	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: PROFESSIONAL SERVICES 15-18-14008

COUNTY OF COOK IS AN ADDITIONAL INSURED ON A PRIMARY, NON-CONTRIBUTORY BASIS ON THE COMMERCIAL GENERAL LIABILITY POLICY WHEN REQUIRED BY WRITTEN AGREEMENT. COUNTY OF COOK IS AN ADDITIONAL INSURED ON THE AUTO LIABILITY POLICY WHEN REQUIRED BY WRITTEN AGREEMENT. COMMERCIAL GENERAL LIABILITY, AUTO LIABILITY AND WORKERS' COMPENSATION POLICIES PROVIDE A WAIVER OF SUBROGATION WHEN REQUIRED BY WRITTEN AGREEMENT.

CERTIFICATE HOLDER	CANCELLATION
COUNTY OF COOK, COOK COUNTY OFFICE OF THE CHIEF PROCUREMENT OFFICER 118 N. CLARK ST., ROOM 1018 CHICAGO, IL 60602	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Manashi Mukherjee Manashi Mukherjee

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 08/20/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA INC. 540 W. MADISON CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 J05515-PL.-PL-15-16	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Travelers Casualty and Surety Company of America — 31194 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :
INSURED HEALTH CARE SERVICE CORP. AND ITS SUBSIDIARIES 300 EAST RANDOLPH STREET CHICAGO, IL 60601-5655	

COVERAGES **CERTIFICATE NUMBER:** CHI-006393566-01 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	PROFESSIONAL LIABILITY/E&O			103996357	01/01/2015	01/01/2016	LIMIT OF LIABILITY	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: PROFESSIONAL SERVICES 15-18-14008

CERTIFICATE HOLDER

COUNTY OF COOK, COOK COUNTY
OFFICE OF THE CHIEF PROCUREMENT OFFICER
118 N. CLARK ST., ROOM 1018
CHICAGO, IL 60602

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee — Manashi Mukherjee

EXHIBIT 6

HMO Cost Plus Group Administration Document

BlueCross BlueShield of Illinois

EXHIBIT 6

HMO COST PLUS GROUP ADMINISTRATION DOCUMENT

(This Exhibit is applicable when the County elects cost-plus funding for its HMO benefit plan(s) as described in the Professional Service Agreement, to which this GAD is attached.)

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, the Effective Date of the Policy, and the Payment method ("Post Payment" or "Transfer Payment") under the Policy: 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 eligible Covered Persons;

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

I. ENTIRE POLICY AND CHANGES TO THE POLICY

The entire Policy and changes to the Policy are comprised of:

- This Group Administration Document;
- The Professional Service Agreement (the "Agreement")
- The Certificate Booklet(s);
- The Benefit Program Application;
- The Benefit Program Application Change Form, if any;
- The Individual Applications, if any;
- 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 the Policy, unless it is contained in a written application. No change in the 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 the Policy or to waive any of its provisions.

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

II. CERTIFICATE BOOKLETS

The Plan will issue a Certificate Booklet directly to the Enrollees; such Certificate Booklet will state the benefits, limitations, exclusions and requirements of the Policy. A Certificate Booklet also will be included as part of the Policy issued to the Policyholder.

III. PAYMENT PROVISIONS

The payment method ("Post Payment or Transfer Payment") is specified on the Benefit Program Application or other appropriate document.

A. Post Payment

In consideration of the Plan's obligations as set forth in this Group Administration Document and in recognition of the fact that Claim Payments will be made by the Plan prior to any reimbursement by the Policyholder, the Policyholder will pay to the Plan the amount of Claim Payments made pursuant to this Group Administration Document for which reimbursement has not been previously made by the Policyholder to the Plan, plus the applicable Service Charges following each period as specified on the Benefit Program Application or other appropriate document (the "Payment Period"), as detailed in the Claim Settlement. This payment shall be referred to as Post Payment.

B. Transfer Payment

In consideration of the Plan's obligations as set forth in this Group Administration Document and at the end of each Transfer Payment Period, the Policyholder shall transfer to the Plan's account an amount equal to the prior Transfer Payment Period's Claim Payments plus the applicable Services Charges. This payment shall be referred to as the Transfer Payment. For purposes of this Group Administration Document, the Transfer Payment Period shall be as specified on the Benefit Program Application or other appropriate document (the "Payment Period"). The Plan shall advise the Policyholder's Financial Division by e-mail or facsimile (at an e-mail address or a facsimile number to be furnished by the Policyholder prior to the Effective Date of this Group Administration Document) of the amount of Claim Payments made pursuant to this Group Administration Document for which reimbursement has not been previously made by the Policyholder to the Plan, plus the applicable Service Charges. If any day on which a Transfer Payment is due is a holiday, such payment will be made on the next business day.

C. Service Charges

1. The Policyholder will pay a Service Charge to the Plan for the processing of Claims and administrative and other services provided to the Policyholder. Service Charges are specified_on the Benefit Program Application or other appropriate document and will be applied in accordance with the provisions of this Group Administration Document.

   The Service Charges will be computed and payable in accordance with the Section below entitled "Claim Settlements."

2. The Service Charges, which are guaranteed for a twelve (12) month period from the Effective Date of this Group Administration Document, have been determined in accordance with the Plan's current regulatory status and the existing benefit program. Should future legislation or administrative rule or regulation (i) obligate the Plan to pay any new taxes, Surcharges or other fees imposed upon or resulting from this Group Administration Document, or (ii) mandate a new or modify a current benefit, then the Plan reserves the right, upon at least sixty (60) days written notice to the Policyholder, to adjust the Service Charges within such twelve (12) month period. In the event Service Charges are adjusted as stated herein, such adjustments will be deemed effective as of the

effective date of such obligation, mandate or modification. Further, in the event of termination of this Group Administration Document or the entire Policy, the Plan reserves the right to adjust the Service Charges applicable to the processing of Claims after the date of termination.

Please see Section III.H. below for additional taxes and fee information. In addition to the provisions of this Section III.C., the Plan also reserves the rights in Section III.H.

D. Claim Settlements

1. A Claim Settlement shall be determined at the end of each period as specified on the Benefit Program Application or other appropriate document. Such period shall be referred to as the Claim Settlement Period. The Claim Settlement shall reflect the sum of the following:
   a. All Claim Payments paid by the Plan in the particular Claim Settlement Period.
   b. All Claim Payments paid by the Plan in prior Claim Settlement Periods that have not been included in a prior Claim Settlement.
   c. The Service Charge as computed on the total of a. and b. above.

   The sum of a., b., and c. above shall be referred to as the Claim Settlement Total.
2. If, within the Claim Settlement Period, the Claim Settlement Total exceeds the Post Payments or Transfer Payments, the Policyholder will pay the difference to the Plan. The Claim Settlement shall be determined within sixty (60) days from the last day of the Claim Settlement Period. All sums due the Plan shall be paid no later than one (1) month after the Plan furnishes notice of a Claim Settlement to the Policyholder. The Plan is willing to extend a grace period of two (2) months beyond the Claim Settlement due date. If the Policyholder fails to pay the Claim Settlement amounts owed to the Plan during the grace period, the Plan will have ten (10) days from the date of the Plan's written notice of payment default to cure.
3. If the Post Payments or Transfer Payments exceed the Claim Settlement Total, the Plan may, at its option, pay the difference to the Policyholder, apply the difference against amounts then owed the Plan by the Policyholder, or authorize a reduction equal to that difference from the next Claim Settlement due the Plan from the Policyholder.

E. Claim Payments and~~,~~ Audits

1. Upon receipt of a Claim, the Plan will make a Claim Payment provided that all payments due the Plan under the terms of the Policy are paid before the end of the applicable cure period, and provided further, that the Policyholder performs all of its other obligations under the Policy.
2. Any reasonable determination by the Plan in adjudicating a Claim under the Policy that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of the Policyholder to the Plan for such Claim Payment pursuant to Section III.D. above entitled "Claim Settlements."
3. During the term of the Policy and within one hundred eighty (180) days after the termination of the 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.

F. Late Payments and Remedies

1. [Intentionally Omitted]
2. [Intentionally Omitted]
3. If the Plan terminates the Policy for failure of the Policyholder to make any payment or payments due the Plan and/or for failure to perform any other obligation, duty or act required by the Policy, the Policyholder agrees to notify all the Enrollees. The Policyholder and the Plan agree that the Policyholder will give such notice because the Policyholder

maintains direct and ongoing communication with, and maintains current addresses for, all such Enrollees. With regard to the specific remedies and late payments under this Exhibit, the parties shall comply with Article 9), Events of Default, Remedies, Termination, Suspension, and Right to Offset, of the Agreement.

4. The foregoing remedies of the Plan will not be deemed exclusive, but will be cumulative and will be in addition to all other remedies in the Plan's favor existing at law or in equity. Any waiver by the Plan of any right in regard to any overdue payment will extend only to that particular default and will not operate as a waiver of any future default or of the terms for payment due to the Plan.

G. Term and Termination of Policy

1. The Policyholder may terminate this Group Administration Document or the entire Policy on the first Policy anniversary or at the end of any month after the first Policy anniversary by giving prior written notice to the Plan of at least thirty (30) days. In the event of such termination the Policyholder agrees to notify all Enrollees in accordance with the provisions of Section III.F.3.
2. The Policyholder hereby acknowledges that on the date of termination of the Policy in accordance with the provisions of either Sections III.F. or G. of this Group Administration Document, 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 Plan for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Plan. The Policyholder shall be responsible for the payment of all Claim Payments for services rendered or furnished to a Covered Person prior to the date of termination, whether or not Claims for such services have been submitted, including but not limited to Claim Payments made in accordance with MSP laws, and for the Service Charges applicable to the processing of such Claims after the date of termination.
3. Post Payment

   In consideration of Plan's continuing to make Claim Payments in accordance with Section III.E. above, the Policyholder shall continue to make Post Payments after the date of termination of this Group Administration Document for Claims incurred prior to the termination date of the Policy and paid after such date.

   The Policyholder further acknowledges that the Plan may make Claim Payments for services rendered or furnished prior to the termination date, including but not limited to Claim Payments made in accordance with MSP laws. The Plan will bill the Policyholder periodically, but not more frequently than monthly, for the total of those Claim Payments and the Service Charges applicable to the processing of claims after the date of termination. All sums due the Plan will be paid in full by the Policyholder no later than one (1) month after the Policyholder's receipt of the Plan's invoice for such payment. The Plan is willing to extend a grace period of two (2) months beyond the payment due date. If the Policyholder fails to pay the amounts owed to the Plan during the grace period, the Policyholder will have ten (10) days from the date of the Plan's written notice of payment default to cure.
4. Transfer Payment

   In consideration of Plan's continuing to make Claim Payments in accordance with Section III.E. above, the Policyholder shall continue to make Transfer Payments for the period as specified on the Benefit Program Application or other appropriate document following the termination of this Group Administration Document for Claims incurred prior to the termination date of the Policy and paid after such date (such period shall be referred to as the "Tentative Final Settlement Period").

A Final Settlement shall be made within sixty (60) days after the last day of the Tentative Final Settlement Period. This Final Settlement shall compare the Transfer Payments against the Claims Settlement Total for the Tentative Final Settlement Period. The difference shall be paid or applied as set forth in Section III.D. of this Group Administration Document. However, if the Transfer Payments exceed the Claim Settlement Total for the Tentative Final Settlement Period, the Plan shall pay such difference to the Policyholder after applying the difference against amounts, if any, then owed to the Plan by the Policyholder.

The Policyholder further acknowledges that the Plan may make Claim Payments after the Tentative Final Settlement is computed for services rendered or furnished prior to the termination date, including but not limited to Claim Payments made in accordance with MSP laws. The Plan will bill the Policyholder periodically, but not more frequently than monthly, for the total of those Claim Payments and the Service Charges applicable to the processing of claims after the date of termination. All sums due the Plan will be paid in full by the Policyholder no later than one (1) month after the Policyholder's receipt of the Plan's invoice for such payment. The Plan is willing to extend a grace period of two (2) months beyond the payment due date. If the Policyholder fails to pay the amounts owed to the Plan during the grace period, the Policyholder will have ten (10) days from the date of the Plan's written notice of payment default to cure.

H. If the age of a Covered Person under the 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.

The Service Charges 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 Plan Year, 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 amounts.

Policyholder is hereby notified that beginning in 2014, the Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding calendar year. Beginning with your bill for January 1, 2014 coverage, your Service Charges will be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

IV. GENERAL PROVISIONS

A. The Plan's Separate Financial Arrangements with Providers

The Policyholder's experience account under the Policy, shall be calculated on the basis of the Provider's Charge 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 that it has contracts with certain Providers (``Plan Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates and group policies and contracts to which the Plan is a party, including the Covered Persons under the 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 the Plan Provider, or the Plan may pay Plan Providers substantially less than their Claim Charges for

services, by discount or otherwise, or may receive from Plan Providers other substantial allowances under the Plan's contracts with them. The Policyholder understands that the Plan may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances as part of any experience rating refund, if applicable to the Policy, or otherwise. Any copayments and/or deductibles payable by a Covered Person are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

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 the Policy and all required Copayment and Coinsurance amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost 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, 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 Plan is a party, including the Covered Persons under the Policy, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for prescription drugs dispensed to Covered Persons under the Policy.

   The Policyholder understands that the Plan may receive such discounts during the term of the Policy. Neither the Policyholder 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 on the Benefit Program Application.

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 and that the Plan has entered into one or more agreements with Prime Therapeutics LLC 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 the 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.

   Based upon previous experience with such rebates, the Plan has estimated that any drug rebate for the Policyholder would be based on an average dollar amount per prescription ("Expected Rebate"). One-hundred percent (100%) of the Expected Rebate is shared with Policyholders based upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Policyholder 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 Enrollees, then divided by twelve (12) months. The Expected Rebate amount is reflected as a prescription drug rebate credit per Enrollee per month.

   The Policyholder understands that the Plan may receive such rebates during the term of the Policy. Neither the Policyholder 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 on the Benefit Program Application.

C. Inter-Plan Arrangements

1. Out-of Area Services

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation (herein called "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 available to Covered Persons under this contract 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 (i.e., are "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 non-participating healthcare Providers. The Plan's payment practices in both instances are described below.

The Plan covers only limited healthcare services received outside of the Plan's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care, follow-up care obtained outside the geographic area the Plan serves. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Covered Person's Primary Care Physician ("PCP"). Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Covered Person's Primary Care Physician ("PCP") or Women's Principal Health Care Provider ("WPHCP").

2. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, the Plan will remain responsible to the Policyholder for fulfilling the Plan's contractual obligations. 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.

a. Emergency Care Services:

If Covered Persons experience a Medical Emergency while traveling outside the Blue Cross and Blue Shield of Illinois service area, go to the nearest Emergency, Urgent Care facility, or other licensed Provider.

b. Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Covered Person's liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program will be based on the lower of the healthcare 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 healthcare Provider contracts. The negotiated price made available to the Plan by the Host Blue may represent one of the following.

(1) an actual price. An actual price is a negotiated rate of payment in effect at the time the claim is processed without any other increases or decreases, or

(2) an estimated price. An estimated price is a negotiated rate of payment in effect at the time the 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

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

Host Blues determine whether or not they will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Policyholder pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

c. Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and nonparticipating healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in these ways will generally require correction on a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Plan, they will be credited to Policyholder account.
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 Policyholder as a percentage of the recovery.

The Plan hereby informs the Policyholder, and the Policyholder acknowledges, that the Plan's and the Host Blue's Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing ITS software used to process Claims for services rendered by the Plan's and the Host Blue's Providers may result in minor deviations in Claim processing and/or pricing of claims for the same services.

3. Non-Participating Healthcare Providers Outside the Plan's Service Area

For non-participating healthcare Providers outside the Plan's service area, please refer to the corresponding section in the benefit booklet issued to Covered Persons under this Certificate.

4. BlueCard Worldwide® Program 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"), they may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, the Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Covered Persons contact the BlueCard Worldwide Service Center for assistance, hospitals will not require Covered Persons to pay for covered inpatient hospital services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the BlueCard Worldwide Program contracting hospital will submit Covered Persons claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a claim to obtain reimbursement for Covered 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 BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. The claim form is available from the Plan, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If Covered Persons need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

D. Records of Covered Person Eligibility and Adjustments

1. 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 the 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 be to be covered under the Policy, completed application cards of the Enrollees and information required by the Plan to identify dual coverage situations which are subject to Medicare Secondary Payer ("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 the 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. Minor clerical errors in keeping or reporting data relative to coverage under the 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 the 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 the 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.

2. The Policyholder shall be liable to 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 to the Plan in a format not approved by the Plan.

E. New Enrollees

There shall be added from time to time to the group or class originally covered under the Policy, all new employees 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 the Policy.

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 Enrollee, with or without cause, ceases to be an Eligible Person, such Enrollee's coverage (and the coverage of other Covered Persons under Family Coverage) will automatically terminate on the date specified by the Policyholder in the Benefit Program Application.
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.
4. A Covered Person's coverage under the Policy will automatically terminate at the expiration of the Payment Period in which such Covered Person becomes eligible for Medicare except for those benefits, if any, which are specifically provided under the Policy for Medicare eligible Covered Persons and coverage required in accordance with MSP laws.
5. Termination of the 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 the Policy, but all coverages will automatically terminate as of the effective date of termination of the 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 the Policy, except as otherwise specifically provided in Benefit Sections of the Certificate Booklet.
7. If a Covered Person whose insurance terminates is entitled to exercise the conversion privilege specified in the Conversion Privilege section of the Certificate Booklet, it is the Policyholder's responsibility to present written notice of the existence of the conversion privilege to the Enrollee or to mail such notice to the Enrollee's last known address.

G. Disenrollment with a Participating IPA

A Participating IPA may request that an Enrollee be removed from the rolls of that Participating IPA. Such request must be made to the Plan, in writing, and specify the reasons for the request. In no case will the health status of a Covered Person or the type, amount or cost of services required be accepted by the Plan as sufficient cause for such removal. When other reasons for removal are presented and substantiated by the Participating IPA, the Enrollee will be offered, within thirty (30) days of Plan acceptance of the request for removal, enrollment in any other Participating IPA (with capacity to receive such enrollment) or enrollment in any other health care coverage then being provided by the Policyholder, subject to the terms and conditions of such other coverage. Should such Enrollee decide to enroll in another Participating IPA, written notice of that decision must be received by the Plan within thirty (30) days of the Enrollee's having received the offer. Failure to respond to the Plan within thirty (30) days will result in termination of the Enrollee's coverage under the Policy.

H. Failure of a Participating IPA to Perform Under Its Contract

In the event that a Participating IPA should fail to perform under the terms of its contract with the Plan, as determined by the Plan, or fail to renew its contract with the Plan, the benefits of the Policy will be provided to the Covered Persons enrolled with that Participating IPA for Covered Services received from other Providers limited to Covered Services received during a thirty (30) day period beginning on the date of the Participating IPA's failure to perform or failure to renew its contract with the Plan. During this thirty (30) day period, the Enrollees of that Participating IPA will be given the option of (i) enrolling with any other Participating IPA which then has the capacity for such enrollment, or (ii) transferring to any other health care coverage then being offered by the Policyholder, subject to the terms and conditions of such other coverage. Such transferred enrollment or coverage will be effective thirty-one (31) days from the date the Participating IPA failed to perform or failed to renew its contract with the Plan.

I. Notice and Proof of Claim

1. The Plan will not be liable under the Policy unless a Claim for benefits on account of the rendering of Covered Services is furnished to the Plan at its office at 300 East Randolph Street, Chicago, Illinois, 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 written request to the Plan, the Enrollee will be provided with the forms necessary for filing Claims under the Policy. If such forms are not furnished within fifteen (15) days of the Plan's receipt of such request, the Enrollee shall be deemed, with respect to the particular Claim, to have complied with the requirements of the 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, the diagnosis or diagnoses, a specific itemized statement of the services rendered, including all dates of service, and the Claim Charge. 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.

J. Payment of Claims and Assignment of Benefits

1. All benefit payments may be made by the Plan directly to any Provider furnishing

the Covered Services for which such payment is due, and the Plan is authorized by each 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.

2. 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 will be given effect. In addition, the Plan will have no liability to the Covered Person or any other person because of its rejection of such request.
3. Except for the assignment of benefit payment described above, neither this policy nor a Covered Person's Claim for payment of benefits under this policy is assignable in whole or in part to any person or entity at any time, and 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 aid or attempt to aid any other person in fraudulently obtaining coverage.

K. 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 provide health care services, but solely to arrange for the provision of health care services and make payments to Providers 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 are not provided by the Plan and can only be legally performed by a Provider. Any contractual relationship between a Provider and the Plan shall not be construed to mean that the Plan is providing professional service.
3. Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's ERISA Health Benefit Program.

L. Agency Relationships

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

M. Medicare Secondary Payer ("MSP") Provisions

1. **The MSP Law**

   The Policyholder has certain obligations under the Medicare Secondary Payer ("MSP") statute.

   a. Scope of the Statute:

      The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

      i. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

ii. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

iii. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the MSP statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on "current employment status," as defined in the MSP statute and regulations.

b. The Non-Discrimination Provisions: Age and Disability:

The MSP statute prohibits GHPs from "take[ing] into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy), or which supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, "Medigap" and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status," and thus the MSP provisions do not apply.

c. ESRD:

The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and end 30 months later. During this period, the GHP must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., "carve-out") or "Medigap" coverage in this context.**

d. Policyholder Obligations:

It is the obligation of the Policyholder to ensure that Covered Persons covered by the MSP statute are not improperly enrolled in "carve-out" or "Medigap" coverage under this Policy.

2. **The New Information System**

Improved Information Gathering:

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain Blue Cross and Blue Shield Plans together with the Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, are developing or have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a timely and current fashion, information necessary for the Plan to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular claim.

Under the system, the Plan will provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that CMS can better detect dual coverage situations.

The Policyholder understands that the Plan may provide CMS periodically the information identified below pertaining to Medicare-eligible Covered Persons under the Policy. The Policyholder further agrees to cooperate and to require and facilitate its employees' cooperation in supplying the Plan the following information.

Information on Medicare-Eligible Covered Persons

- Beneficiary Name
- Date of Birth
- Sex
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Insured (e.g., Insured, spouse of Insured, child of Insured, other relationship to Insured)
- Reason for Medicare Entitlement (e.g., age, disability or ESRD)
- **Information on Insured**
- Insured Name
- Social Security Number
- Individual Certificate Number of Insured
- Current Employment/Retirement Status
- Coverage Effective Date
- Coverage Termination Date
- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only)
- Coverage (e.g., individual, family, family but not spouse)

Information on the Policyholder/Employer

- Name and address of employer that pays the bill for coverage

The Policyholder agrees that the Plan's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Plan's files concerning Covered Persons. The Policyholder agrees to use best efforts in responding promptly and accurately to the Plan's requests for information and to require and facilitate its employees' cooperation in responding promptly and accurately to such requests.

Further, to assure the continuing accuracy of the Plan's files, the Policyholder agrees that it is the Policyholder's responsibility to notify the Plan promptly of any change in the size of the Policyholder's work force or status of its employees that might effect the order of

payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Policyholder's work force that place it in, or take it out of, the scope of the MSP statute. If the Plan does not receive such information from the Policyholder, the Plan will assume that all relevant factors remain unchanged and will process claims accordingly. The Policyholder acknowledges and agrees that the Plan will be using the information provided by the Policyholder and Covered Persons to update the Plan'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.

The Plan may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in this Policy shall be construed as obligating the Plan to continue its participation in the Data Match system.

3. **Disclosure Statement**

   The Policyholder acknowledges that the Plan 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 administer Medicare.

N. ERISA

This Section (N.) applies to any Group Policy 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 Group Policy) has established and as sponsor maintains pursuant to other written documents a health benefit program (``Policyholder's ERISA Health Benefit Program'') through the purchase of insurance for the benefit of its eligible employees or eligible members and their dependents, 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 Group (or any Group member, if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in the 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 Group Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Group 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. The Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Policy is an asset of the Policyholder. No assets of the Plan or amounts which have been paid to the Plan under the Policy are assets of or under Policyholder's ERISA Health Benefit Program.

O. Initial Plan Participation Requirements; Benefit Plan Status; Plan Documents; Retaliation

It is the Policyholder's responsibility, prior to the Effective Date of the Policy (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 the Policy. In addition, Policyholder (iv) is responsible for establishing and/or amending its own plan documents as necessary; and (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. In no event will the Plan have responsibility for such initial plan participation or plan status determinations or for Policyholder's plan documents or its actual or alleged retaliation. Upon request, Policyholder will provide the Plan with information to substantiate such determinations and responsibilities. Policyholder shall be liable to 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 the 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.

P. Service Mark Regulation

On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that the 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 (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits the Plan to use the Blue Cross and Blue Shield Service Mark 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 the 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 the Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those created under other provisions of this Group Administration Document.

Q. Incontestability

After the 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 the Policy; and no statement by any Enrollee 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.

R. Limitations of Actions

No civil action shall be brought to recover under the Policy or any individual certificate pursuant to the Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of the 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 the Policy shall in any way extend this ``Limitation of Actions" Provision.

S. Physical Examinations and Autopsy

The Plan at its own expense shall have the right and opportunity to examine the person of a Covered Person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

U. 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 Average Discount Percentage ("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.

V. Right to Recover Overpayments

If the Plan has made any overpayment of benefits under the Policy, including but not limited to duplicate payments or payments made for services or supplies that fall within the Exclusions Sections of the Certificate Booklet or are not Covered Services under the Certificate Booklet, the Plan shall have the right to recover the amount of such overpayment from Covered Persons or anyone to whom such overpayment was made on the Covered Persons behalf.

A Covered Person is required to furnish any information or assistance and to provide any documents that the Plan may request in order to recover overpayments under this provision.

W. Right to Recovery

The Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Plan for that sickness or injury. You are 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

X. 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 reasonable 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 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 the 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 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.

V. TERMINATION OF THE POLICY

The Policy may be terminated in accordance with the provisions in Sections III.F. and G. above.

VI. RENEWABILITY OF THE POLICY

The 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 large group market and acts in accordance with state 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 large group market, the Plan would deny enrollment with respect to such plan, and ninety (90) days advance notice 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: or

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.

VII. DISCONTINUANCE OF COVERAGE

A. Discontinuance of a Particular Product

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

1. Provides ninety (90) days advance notice to the Policyholder and Covered Persons;

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.

B. Discontinuance of All Coverage

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

1. Provides one-hundred eighty (180) days advance notice to the Policyholder and Covered Persons; and
2. Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the sate 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 large 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 state 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. ELECTRONIC DATA AND DOCUMENTS

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 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.

In the event the Plan provides to the Policyholder an electronic file of any document describing the benefits under, or the administration of, the Policy for the Policyholder's use, including, but not limited to, the Policyholder'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 the 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 shall be liable to 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

or pursuant to Section 3.k) of the Agreement, 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.

XI. INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Policy, the Plan may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Policy 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 Policyholder de-identification (unless the work is being done in connection with the Policyholder's Policy). Solely for the Permitted Purposes, the Plan 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 (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to the Plan-assigned Policyholder Group and Identification numbers.

XII. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

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

"Benefit Program Application (BPA)" means the document, including any addenda attached thereto, through which the Policyholder has applied for HMO Cost Plus health care insurance from the Plan and by which renewals and/or rate or other Policy changes are documented.

"Certificate Booklet" means the document, including any addenda or riders attached thereto, issued to the Policyholder and its Enrollees by the Plan. The Certificate Booklet describes the health care benefit program purchased by the Policyholder and being administered by the Plan.

"Claim" means notification in a form acceptable to the Plan 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 and the Claim Charge for such service.

"Claim Charge" means the amount which appears on a Claim as the Provider's 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 Group Administration Document regarding *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 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 Group Administration Document regarding *The Plan's Separate Financial Arrangements with Providers*).

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

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

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

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

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

(b) The children of the Enrollee or the Enrollee's legal spouse, Domestic Partner, or a party to a Civil Union, including newborn children, eligible foster children, children who are under the Enrollee'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 Enrollee, and legally adopted children, who are under the Limiting Age specified in the Benefit Program Application 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 Enrollee 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 mental retardation or physical handicap and are dependent upon the Enrollee 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.

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

"Domestic Partner" means a person with whom you have entered into a Domestic Partnership.

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

(i) You and your Domestic Partner have lived together for at least six (6) months;

(ii) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

(iii) Your Domestic Partner is at least eighteen (18) years of age and mentally competent to consent to contract;

(iv) Your Domestic Partner resides with you and intends to do so indefinitely;

(v) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and

(vi) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

"Effective Date of Policy" means the date specified by the Policyholder in the Benefit Program Application or other appropriate document.

"Eligible Charge" means (1) in the case of a Provider which has a written agreement with the Plan to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (2) in the case of a Provider which does not have a written agreement with the Plan to provide care to a Covered Person at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of the Plan:

(a) the charge which the particular Participating Prescription Drug Provider or facility usually charges a Covered Person for Covered Services, or

(b) the agreed upon cost between the Participating Prescription Drug Provider and the Plan for a prescription drug, whichever is lower.

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

"Eligibility Date" means the date, as determined in the Benefit Program Application, on which an Enrollee becomes eligible for coverage under the Policy.

"Enrollee" means an Eligible Person who has applied for coverage under the Policy and to whom the Plan has directly or indirectly issued an identification card bearing the group number of the Policyholder.

"Family Coverage" means coverage for an Enrollee and one or more other Covered Persons under the Policy.

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

"Individual Coverage" means coverage under the Policy for the Enrollee only.

"Individual Practice Association (IPA)" means a partnership, association, corporation or other legal entity which delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish such health care services.

"Insured" means the Enrollee.

"Limiting Age" means the age specified in the Benefit Program Application at which coverage is automatically terminated for covered unmarried children.

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

"Medicare Secondary Payer" or "MSP" means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 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.

"Participating IPA" means any IPA which has in force a contract or agreement with the Plan to provide professional and ancillary services to Covered Persons enrolled under the Policy.

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

"Policy" means this Group Administration Document between the Plan and the Policyholder, including any addenda attached hereto, the Certificate Booklet, the Benefit Program Application or other appropriate document; the benefit program and premium notification letter, if any; Change

Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Enrollees, and the Individual Applications, if any, of the Enrollees.

"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 or other appropriate document for the 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.

(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.

(c) **"Medicare Participating Provider"** means a Provider which has been certified by the Department of Health and Human Services for participation in the Medicare Program.

"Service Charges" means fees paid by the Policyholder to the Plan for the processing of Claims and administrative and other services provided to the Policyholder. However, the term "Service Charges" shall also mean prescription drug rebate credits applicable under the Policy.

"Service Mark" means the names BLUE CROSS and/or 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, including, but not limited to amounts due in connection with the Health Insurer Fee and the Reinsurance Fee (defined above), paid by the Plan which are imposed upon or resulting from the Policy, or are otherwise payable by the Plan. Surcharges may or may not be related to a particular claim for benefits.

XIII. 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 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 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 the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to ``premium(s)'' shall mean "charge(s)."

EXHIBIT 7

HMO 151-Plus Grandfathered Group Administration Document

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BlueCross BlueShield of Illinois

EXHIBIT 7

HMO 151-PLUS GRANDFATHERED GROUP ADMINISTRATION DOCUMENT

(This Exhibit is applicable when the County elects HMO fully insured funding for its benefit plan(s) as described in the Professional Service Agreement, to which this GAD is attached.)

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 Effective Date of the Policy; 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 eligible Covered Persons;

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

I. ENTIRE POLICY AND CHANGES TO THE POLICY

This Group Administration Document, including the addenda, if any, attached hereto; the Professional Service Agreement, the Certificate Booklet; the Benefit Program Application; the benefit program and premium notification letter, if any; the Benefit Program Application Change Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Covered Persons constitute the entire contract of insurance. 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 the Policy, unless it is contained in a written application. No change in the 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 the Policy or to waive any of its provisions.

The issuance of this Group Administration Document supersedes all previous HMO 151-Plus Grandfathered contracts or policies between the Policyholder and the Plan which are in force on the Effective Date of this Group Administration Document.

II. CERTIFICATE BOOKLETS

The Plan will issue a Certificate Booklet directly to each Enrollee; such Certificate Booklet will state the benefits, limitations, exclusions and requirements of the Policy. A Certificate Booklet also will be included as part of the Policy issued to the Policyholder.

III. PREMIUM PROVISIONS

A. Premium Rates

1. On the Effective Date of Policy, the Individual Coverage Premium (Enrollee only) and, when applicable, the Family Coverage Premium (Enrollee and one or more dependents) shall be the amounts specified in the Benefit Program Application; 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 Group Administration Document. Subsequent changes to the Individual and/or Family Coverage Premiums shall be specified in the Benefit Program Application; 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 the Policy.
2. If Enrollee 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 Enrollee 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, if any, specified on the Benefit Program Application.

B. Payment of Premiums

The first premium payment is due on the Effective Date of the Policy. 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.

C. Premium Computation

1. The premium payment due for the Policy on any premium due date is the aggregate amount composed of the Individual and Family Coverage premiums for all Enrollees covered for the benefits provided under the Policy, as specified in the Benefit Program Application; 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 the 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, provided that the Plan notifies the Policyholder of such new premium at least thirty (30) days prior to such date;
b. Any premium due date, provided the Plan notifies the Policyholder of such new premium at least thirty (30) days in advance of such premium due date;
c. Whenever the benefits under the Policy are changed;
d. Whenever a class of persons is made eligible or is eliminated from eligibility;
e. Whenever the Plan is obligated to pay any new taxes, Surcharges or other fees imposed upon or resulting from the Policy including, but not limited to, premium taxes or taxes on the Plan's benefits or services provided under the Policy; and
f. Whenever there is a legislative or regulatory mandate or requirement for a change in benefits which would require additional premium.

3. If the age of a Covered Person under the 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 Plan Year, 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 amounts.

   Policyholder is hereby notified that beginning in 2014, the Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding calendar year. In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run from 2014 through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how the Reinsurance Fee is calculated. Beginning with your bill for January 1, 2014 coverage, your premium will be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

D. Grace Period and Termination for Non-Payment

1. A grace period of two (2) months will be allowed for payment of any premium after the first payment. During such grace period the 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 the Policy is to be terminated as of such premium due date.

2. If the Policyholder does not pay the premium during the grace period, the Policy may be terminated, at the Plan's option, and the Policyholder will be liable to the Plan for the payment of all premiums then due, including those for the grace period. The foregoing notwithstanding, the County will have ten (10) days from the date of the Plan's written notice of default of payment to cure.

E. Experience Rating Refunds - Applicable to Premium Retrospective Funding Arrangements Only

1. The Policyholder may be eligible for experience refunds as ascertained and apportioned by the Plan at each Policy anniversary date, provided the Policy has been continued in force by payment of all premiums to the anniversary date. The Plan will reasonably determine the distribution of the experience refunds unless otherwise agreed upon between the Plan and the Policyholder. However, the Plan will have no liability to the Policyholder, or any of the Covered Persons under the Policy, or any other person or entity for any alleged or actual improper use or application of such experience refunds.
2. If at any time the aggregate of any individual contributions made under the Policy exceeds the aggregate of premiums paid under the Policy (after giving effect to any experience reduction), such excess will be applied by the Policyholder for the sole benefit of Enrollees, but the Plan will have no liability for any alleged or actual misapplication of such excess.

IV. GENERAL PROVISIONS

A. The Plan's Separate Financial Arrangements with Providers

The Policyholder's experience account under the Policy, if any, shall be calculated on the basis of the Provider's Charge 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 that it has contracts with certain Providers (``Plan Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates and group policies and contracts to which the Plan is a party, including the Covered Persons under the 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 the Plan Provider, or the Plan may pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or may receive from Plan Providers other substantial allowances under the Plan's contracts with them. The Policyholder understands that the Plan may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances as part of any experience rating refund, if applicable to the Policy, or otherwise. The existence or anticipation of

such discounts or allowances are factored into the premiums, which are given to the Policyholder in advance. Any copayments and/or deductibles payable by a Covered Person are pre-determined fixed amounts, based upon the selected benefit plan, which are not impacted by any discounts or contractual allowances which the Plan may receive from a Provider.

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 the Policy, if any, and all required Copayment and Coinsurance amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost 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, 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 Plan is a party, including the Covered Persons under the Policy, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for prescription drugs dispensed to Covered Persons under the Policy.

   The Policyholder understands that the Plan may receive such discounts during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the premium specified on the Benefit Program Application; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, as 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 and that the Plan has entered into one or more agreements with Prime Therapeutics LLC 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 the 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.

   The Policyholder understands that the Plan may receive such rebates during the term of the 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; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, as part of any experience rating refund, if applicable to this policy, or otherwise.

C. INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation (herein called "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 available to Covered Persons under this contract 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 (i.e., are "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 non-participating healthcare Providers. The Plan's payment practices in both instances are described below.

The Plan covers only limited healthcare services received outside of the Plan's service area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care, Urgent Care, follow-up care obtained outside the geographic area the Plan serves. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Covered Person's Primary Care Physician ("PCP"). Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by the Covered Person's Primary Care Physician ("PCP") or Women's Principal Health Care Provider ("WPHCP").

2. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Covered Persons access Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, the Plan will remain responsible to the Policyholder for fulfilling the Plan's contractual obligations. 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.

a. Emergency Care Services:

If Covered Persons experience a Medical Emergency while traveling outside the Blue Cross and Blue Shield of Illinois service area, go to the nearest Emergency, Urgent Care facility, or other licensed Provider.

b. Liability Calculation Method Per Claim

Unless subject to a fixed dollar copayment, the calculation of the Covered Person's liability on claims for Out-of-Area Covered Healthcare Services processed through the BlueCard Program will be based on the lower of the healthcare 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 healthcare Provider contracts. The negotiated price made available to the Plan by the Host Blue may represent one of the following::

(1) an actual price. An actual price is a negotiated rate of payment in effect at the time the claim is processed without any other increases or decreases, or

(2) an estimated price. An estimated price is a negotiated rate of payment in effect at the time the 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

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

Host Blues determine whether or not they will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Policyholder pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

c. Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and nonparticipating healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in these ways will generally require correction on a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue

to the Plan, they will be credited to Policyholder account.

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 Policyholder as a percentage of the recovery.

The Plan hereby informs the Policyholder, and the Policyholder acknowledges, that the Plan's and the Host Blue's Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing ITS software used to process Claims for services rendered by the Plan's and the Host Blue's Providers may result in minor deviations in Claim processing and/or pricing of claims for the same services.

3. Non-Participating Healthcare Providers Outside the Plan's Service Area

For non-participating healthcare Providers outside the Plan's service area, please refer to the corresponding section in the benefit booklet issued to Covered Persons under this Certificate.

4. BlueCard Worldwide® Program

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"), they may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, the Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Covered Persons contact the BlueCard Worldwide Service Center for assistance, hospitals will not require Covered Persons to pay for covered inpatient hospital services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the BlueCard Worldwide Program contracting hospital will submit Covered Persons claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a claim to obtain reimbursement for Covered 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.

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"), they may be able to take advantage of the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although the BlueCard Worldwide Program 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 United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, the Covered Persons will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Covered Persons contact the BlueCard Worldwide Service Center for assistance, hospitals will not require Covered Persons to pay for covered inpatient hospital services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the BlueCard Worldwide Program contracting hospital will submit Covered Persons claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the Covered Person paid in full at the time of service, the Covered Person must submit a claim to obtain reimbursement for Covered 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 BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide Service Center (the address is on the form) to initiate claims processing. The claim form is available from the Plan, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If Covered Persons need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

D. Records of Covered Person Eligibility and Adjustments

1. 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 the Policy. Such data may include, without limitation, a list of Covered Persons who are to be

covered under the Policy and completed application cards of the Enrollees and information required by the Plan to identify dual coverage situations which are subject to Medicare Secondary Payer ("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 the 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. Minor clerical errors in keeping or reporting data relative to coverage under the 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 which may materially affect an individual's coverage under the 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 the 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.

2. No waiting period may exceed ninety (90) days unless permitted by applicable law. If the Plan's records show that Policyholder has a waiting period that exceeds the time period permitted by applicable law, 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.
3. During the term of the Policy and within one hundred eighty (180) days after the termination of the 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.
4. The Policyholder shall be liable to 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 to the Plan or data furnished by the Policyholder to the Plan in a format not approved by the Plan.

E. New Enrollees

There shall be added from time to time to the group or class originally covered under the Policy, all new employees of the employer, 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 the Policy.

F. Termination of a Covered Person's Coverage

1. If an Enrollee, with or without cause, ceases to be an Eligible Person, such Enrollee'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.
2. 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.

3. A Covered Person's coverage under the 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 the Policy for Medicare-eligible Covered Persons and coverage required in accordance with MSP laws.
4. Termination of the 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 the Policy, but all coverages will automatically terminate as of the effective date of termination of the Policy regardless of whether such notice is given.
5. 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 the Policy except as otherwise specifically provided in Benefit Sections of the Certificate Booklet.
6. If a Covered Person whose insurance terminates is entitled to exercise the conversion privilege specified in the Conversion Privilege section of the Certificate Booklet, it is the Policyholder's responsibility to present written notice of the existence of the conversion privilege to the Enrollee or to mail such notice to the Enrollee's last known address.

G. Disenrollment from a Participating IPA

A Participating IPA may request that an Enrollee be removed from the rolls of that Participating IPA. Such request must be made to the Plan, in writing, and specify the reasons for the request. In no case will the health status of a Covered Person or the type, amount or cost of services required be accepted by the Plan as sufficient cause for such removal. When other reasons for removal are presented and substantiated by the Participating IPA, the Enrollee will be offered, within thirty (30) days of Plan acceptance of the request for removal, enrollment in any other Participating IPA (with capacity to receive such enrollment) or enrollment in any other health care coverage then being provided by the Policyholder, subject to the terms and conditions of such other coverage. Should such Enrollee decide to enroll in another Participating IPA, written notice of that decision must be received by the Plan within thirty (30) days of the Enrollee's having received the offer. Failure to respond to the Plan within thirty (30) days will result in termination of the Enrollee's coverage under the Policy.

H. Failure of a Participating IPA to Perform Under Its Contract

In the event that a Participating IPA should fail to perform under the terms of its contract with the Plan, as determined by the Plan, or fail to renew its contract with the Plan, the benefits of the Policy will be provided to the Covered Persons enrolled with that Participating IPA for Covered Services received from other Providers limited to Covered Services received during a thirty (30) day period beginning on

the date of the Participating IPA's failure to perform or failure to renew its contract with the Plan. During this thirty (30) day period, the Enrollees of that Participating IPA will be given the option of (i) enrolling with any other Participating IPA which then has the capacity for such enrollment, or (ii) transferring to any other health care coverage then being offered by the Policyholder, subject to the terms and conditions of such other coverage. Such transferred enrollment or coverage will be effective thirty-one (31) days from the date the Participating IPA failed to perform or failed to renew its contract with the Plan.

I. Notice and Proof of Claim

1. The Plan will not be liable under the Policy unless a Claim for benefits on account of the rendering of Covered Services is furnished to the Plan at its office at 300 East Randolph Street, Chicago, Illinois, 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 written request to the Plan, the Enrollee will be provided with the forms necessary for filing Claims under the Policy. If such forms are not furnished within fifteen (15) days of the Plan's receipt of such request, the Enrollee shall be deemed, with respect to the particular Claim, to have complied with the requirements of the 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, the diagnosis or diagnoses, a specific itemized statement of the services rendered, including all dates of service, and the Claim Charge. 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.

J. Payment of Claims and Assignment of Benefits

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by each 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 will be given effect. In addition, 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, neither this policy nor a Covered Person's Claim for payment of benefits under this policy is assignable in whole or in part to any person or entity at any time, and 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 aid or attempt to aid any other person in fraudulently obtaining coverage.

K. 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 provide health care services, but solely to arrange for the provision of health care services and make payments to Providers 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 are not provided by the Plan and can only be legally performed by a Provider. Any contractual relationship between a Provider and the Plan shall not be construed to mean that the Plan is providing professional service.
3. Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's ERISA Health Benefit Program.

L. Agency Relationships

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

M. Medicare Secondary Payer ("MSP") Provisions

1. **The MSP Law**

   The Policyholder has certain obligations under the Medicare Secondary Payer ("MSP") statute.

   a. Scope of the Statute:

      The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

      i. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This

is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

ii. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

iii. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the MSP statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on "current employment status," as defined in the MSP statute and regulations.

b. The Non-Discrimination Provisions: Age and Disability:
The MSP statute prohibits GHPs from "taking into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy), or which supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, "Medigap" and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status," and thus the MSP provisions do not apply.

c. ESRD:
The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled

to Medicare based on ESRD and ends 30 months later. During this period, the GHP must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., "carve-out") or "Medigap" coverage in this context.**

d. Policyholder Obligations:
It is the obligation of the Policyholder to ensure that Covered Persons covered by the MSP statute are not improperly enrolled in "carve-out" or "Medigap" coverage under this Policy.

2. **The New Information System**

Improved Information Gathering:

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain Blue Cross and Blue Shield Plans together with the Centers for Medicare and Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, are developing or have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a timely and current fashion, information necessary for the Plan to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular claim.

Under the system, the Plan will provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that CMS can better detect dual coverage situations.

The Policyholder understands that the Plan may provide CMS periodically the information identified below pertaining to Medicare-eligible Covered Persons under the Policy. The Policyholder further agrees to cooperate and to require and facilitate its employees' cooperation in supplying the Plan the following information.

Information on Medicare-Eligible Covered Persons

- Beneficiary Name
- Date of Birth
- Sex
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Insured (e.g., Insured, spouse of Insured, child of Insured, other relationship to Insured)
- Reason for Medicare Entitlement (e.g., age, disability or ESRD)

Information on Insured

- Insured Name
- Social Security Number
- Individual Certificate Number of Insured
- Current Employment/Retirement Status
- Coverage Effective Date
- Coverage Termination Date

- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only)
- Coverage (e.g., individual, family, family but not spouse)

Information on the Policyholder/Employer

- Name and address of employer that pays the bill for coverage

The Policyholder agrees that the Plan's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Plan's files concerning Covered Persons. The Policyholder agrees to use best efforts in responding promptly and accurately to the Plan's requests for information and to require and facilitate its employees' cooperation in responding promptly and accurately to such requests.

Further, to assure the continuing accuracy of the Plan's files, the Policyholder agrees that it is the Policyholder's responsibility to notify the Plan promptly of any change in the size of the Policyholder's work force or status of its employees that might effect the order of payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Policyholder's work force that place it in, or take it out of, the scope of the MSP statute. If the Plan does not receive such information from the Policyholder, the Plan will assume that all relevant factors remain unchanged and will process claims accordingly. The Policyholder acknowledges and agrees that the Plan will be using the information provided by the Policyholder and Covered Persons to update the Plan'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.

The Plan may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in this Policy shall be construed as obligating the Plan to continue its participation in the Data Match system.

3. **Disclosure Statement**

   The Policyholder acknowledges that the Plan 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 administer Medicare.

N. ERISA

This Section (N) applies to any Group Policy 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 Group Policy) has established and as sponsor maintains pursuant to other written documents a health benefit program (``Policyholder's ERISA Health Benefit Program") through the purchase of insurance for the benefit of its eligible employees or eligible members and their dependents, 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 Group (or any Group member, if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in the 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 Group Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Group 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. The Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Policy is an asset of the Policyholder. No assets of the Plan or amounts which have been paid to the Plan under the Policy are assets of or under Policyholder's ERISA Health Benefit Program.

O. INITIAL PLAN PARTICIPATION REQUIREMENTS; Benefit Plan Status; Plan Documents; Retaliation

It is the Policyholder's responsibility, prior to the Effective Date of the Policy (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 the Policy. In addition, Policyholder (iv) is responsible for establishing and/or amending its own plan documents as necessary; and (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. In no event will the Plan have responsibility for such initial plan participation or plan status determinations or for Policyholder's plan documents or its actual or alleged retaliation. Upon request, Policyholder will provide the Plan with information to substantiate such determinations and responsibilities. Policyholder shall be liable to 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 the 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.

P. Incontestability

After the Policy has been in force two (2) years from the date of its issue, no statement of the Policyholder shall be used to void the Policy; and no statement by any Enrollee 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 the Policy or any individual certificate pursuant to the Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of the 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 the Policy shall in any way extend this ``Limitation of Actions" Provision.

R. Physical Examinations and Autopsy

The Plan at its own expense shall have the right and opportunity to examine the person of a Covered Person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

S. Right To Recover Overpayments

If the Plan has made any overpayment of benefits under this Policy, including but not limited to duplicate payments or payments made for services or supplies that fall within the Exclusions sections of the Certificate Booklet or are not Covered Services under the Certificate Booklet, the Plan shall have the right to recover the amount of such overpayment from you or anyone to whom such overpayment was made on your behalf.

You are required to furnish any information or assistance and to provide any documents that the Plan may request in order to recover overpayments under this provision

T. Right to Recovery

The Plan is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Plan for that sickness or Injury. You are 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.

U. 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 reasonable 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 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 the 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 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.

V. 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 the 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 (AA) 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 shall be liable to 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.

VI. TERMINATION OF THE POLICY

A. The Policyholder may cancel the Policy on the first Policy anniversary or on any premium due date after the first Policy anniversary by giving written notice to the Plan at least thirty (30) days in advance.

B. The Policy will be terminated, at the Plan's option, for the Policyholder's non-payment of the appropriate premium when due.

VII. RENEWABILITY OF THE POLICY

The Policy shall be renewable with respect to all Covered Persons except in the following instances:

A. Non-payment of required premiums;

B. A fraudulent act or practice or intentional misrepresentation by the Policyholder;

C. Noncompliance with the Plan's minimum participation requirements;

D. Noncompliance with the Plan's employer contribution requirements;

E. Termination of the benefit plan in accordance with Section VIII., below;

F. Covered Persons' movement outside the Plan's service area; or

G. 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.

VIII. DISCONTINUANCE OF COVERAGE

A. Discontinuance of a Particular Product

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

1. Provides ninety (90) days advance notice to the Policyholder and Covered Persons;
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.

B. Discontinuance of All Coverage

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

1. Provides one-hundred eighty (180) days advance notice to the Policyholder and Covered Persons; and
2. Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the state in such market(s).

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. ELECTRONIC DATA AND DOCUMENTS

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 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.

In the event the Plan provides to the Policyholder an electronic file of any document describing the benefits under, or the administration of, the Policy for the Policyholder's use, including, but not limited to, the Policyholder'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 the 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 shall be liable to 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 or pursuant to Section IV. F. of this Group Administration Document, 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.

XI. INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Policy, the Plan may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Policy 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 Policyholder de-identification (unless the work is being done in connection with the Policyholder's Policy). Solely for the Permitted Purposes, the Plan 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 (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to the Plan-assigned Policyholder Group and Identification numbers.

XII. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

Additional definitions applicable to the Policy are contained in the Certificate Booklet.

"Benefit Program Application (BPA)" means the document through which the Policyholder has applied for health care insurance from the Plan. The Benefit Program Application shall also be the document by which the Policyholder effects renewals, rate and/or Policy changes, subject to the approval of the Plan. The BPA may also include a benefit program and premium notification letter, applicable rate summary(ies) and a Benefit Program Application Change Form.

"Certificate Booklet" means the document, including any addenda or riders attached thereto, issued to the Policyholder and its Enrollees by the Plan. The Certificate Booklet describes the health care benefit program purchased by the Policyholder and being administered by the Plan.

"Claim" means notification in a form acceptable to the Plan 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 and the Claim Charge for such service.

"Claim Charge" means the amount which appears on a Claim as the Provider's 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 Group Administration Document regarding *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 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 Group Administration Document regarding *The Plan's Separate Financial Arrangements with Providers.*)

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

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

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

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

(a) The Enrollee's legal spouse.

(b) The unmarried children of the Enrollee or the Enrollee's legal spouse, including newborn children, children who are under the Enrollee's legal guardianship, children who are in the custody of the Enrollee pursuant to an interim court order of adoption or placement of adoption, whichever comes first, vesting temporary care of the children in the Enrollee, and legally adopted children, who are under the Limiting Age specified in the Benefit Program Application.

(c) Children, as specified in (b) above, who have attained such Limiting Age but are incapable of self-sustaining employment by reason of mental retardation or physical handicap and are dependent upon the Enrollee 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.

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

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

"Eligible Charge" means (1) in the case of a Provider which has a written agreement with the Plan to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (2) in the case of a Provider which does not have a written agreement with the Plan to provide care to a Covered Person at the time Covered Services are rendered, either of the following charges for Covered Services as determined at the discretion of the Plan:

(a) the charge which the particular Participating Prescription Drug Provider or facility usually charges a Covered Person for Covered Services, or
(b) the agreed upon cost between the Participating Prescription Drug Provider and the Plan for a prescription drug, whichever is lower.

"Eligible Person" means an employee of the Policyholder as defined in the Benefit Program Application.

"Eligibility Date" means the date, as determined in the Benefit Program Application, on which an Enrollee becomes eligible for coverage under the Policy.

"Enrollee" means an Eligible Person who has applied for coverage under the Policy and to whom the Plan has directly or indirectly issued an identification card bearing the group number of the Policyholder.

"Family Coverage" means coverage for an Enrollee and one or more other Covered Persons under the Policy.

"Individual Coverage" means coverage under the Policy for the Enrollee only.

"Individual Practice Association (IPA)" means a partnership, association, corporation or other legal entity which delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish such health care services.

"Insured" means the Enrollee.

"Limiting Age" means the age specified in the Benefit Program Application at which coverage is automatically terminated for covered unmarried children.

"Medicare" means the programs established by Title XVIII of the Social Security Act (42 U.S.C. w1395 et seq.).

"Medicare Secondary Payer" or "MSP" means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 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.

``**Participating IPA"** means any IPA which has in force a contract or agreement with the Plan to provide professional and ancillary services to Covered Persons enrolled under the Policy.

"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; the benefit program and premium notification letter, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Enrollees.

"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 for the 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.

(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.
(c) **"Medicare Participating Provider"** means a Provider which has been certified by the Department of Health and Human Services for participation in the Medicare Program.

"Service Mark" means the names BLUE CROSS and/or 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 state or federal taxes, surcharges or other fees paid by the Plan which are imposed upon or resulting from this Group Administration Document.

XII. 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 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 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 the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)."

EXHIBIT 8

PPO Group Administration Document

BlueCross BlueShield of Illinois

EXHIBIT 8
PPO GROUP ADMINISTRATION DOCUMENT

(This Exhibit is applicable when the County elects fully insured funding for its PPO benefit plan(s) as described in the Professional Services Agreement, to which this GAD is attached).

(Applicable to 151-Plus Non-Grandfathered Insured Group 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 Effective Date of the Policy, 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 eligible Covered Persons;
NOW, THEREFORE, the following provisions shall govern the relationship between the Plan and the Policyholder:

I. ENTIRE POLICY AND CHANGES TO THE POLICY

The entire Policy and changes to the Policy are comprised of:

- This Group Administration Document;
- The Professional Services Agreement;
- The Certificate Booklet(s);
- The Benefit Program Application;
- The Benefit Program Application Change Form, if any;
- 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 the Policy, unless it is contained in a written application. No change in the 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 the Policy or to waive any of its provisions.

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

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 the Policy.

III. PREMIUM PROVISIONS

A. Premium Rates

1. On the Effective Date of Policy, 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 the 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 the 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.

B. Payment of Premiums

The first premium payment is due on the Effective Date of Policy. 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 the 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 the 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 the 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, provided that the Plan notifies the Policyholder of such new premium at least thirty (30) days prior to such date;
   b. Any premium due date, provided the Plan notifies the Policyholder of such new premium at least thirty (30) days in advance of such premium due date;
   c. Whenever the benefits under the 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 the Policy including, but not limited to, premium taxes or taxes on the Plan's benefits or services provided under the Policy; and

g. Whenever there is a legislative or regulatory mandate or requirement for a change in benefits 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 the 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 Plan Year, 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 amounts.

   Policyholder is hereby notified that beginning in 2014, the Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding calendar year. In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run from 2014 through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how the Reinsurance Fee is calculated. Beginning with your bill for January 1, 2014 coverage, your premium will be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

D. Grace Period and Termination for Non-Payment

1. A grace period of two (2) months will be allowed for payment of any premium after the first payment. During such grace period the 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 the Policy is to be terminated as of such premium due date. If the Policyholder fails to pay the amounts owed to the Plan during the grace period, the Policyholder will have ten (10) days from the date of the Plan's written notice of payment default to cure
2. Subject to the requirements set forth in the Agreement under Article 9 (Events of Default, Remedies, Termination, Suspension, and Right to Offset), if the Policyholder does not pay the premium during the grace period, the Policy may 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, including those for the grace period. The foregoing notwithstanding, the County will have ten (10) days from the date of the Plan's written notice of default of payment to cure.

E. Experience Refunds (Applicable to Premium Retrospective Funding Arrangements Only)

1. The Policyholder may be eligible for experience refunds as ascertained and apportioned by the Plan at each Policy anniversary date, provided the Policy has been continued in force by payment of all premiums to the anniversary date. The Plan will reasonably determine the distribution of the experience refunds unless otherwise agreed upon between the Plan and the Policyholder. However, the Plan will have no liability to the

Policyholder, or any of the Covered Persons under the Policy, or any other person or entity for any alleged or actual improper use or application of such experience refunds.

2. If at any time the aggregate of any individual contributions made under the Policy exceeds the aggregate of premiums paid under the Policy (after giving effect to any experience reduction), such excess will be applied by the Policyholder for the sole benefit of Insureds, but the Plan will have no liability for any alleged or actual misapplication of such excess.

IV. GENERAL PROVISIONS

A. The Plan's Separate Financial Arrangements with Providers

The Policyholder's experience account under the 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 Average Discount Percentage ("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 that it has contracts with certain Providers ("Plan Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates and group policies and contracts to which the Plan is a party, including the Covered Persons under the Policy, and that 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 the Plan Provider, or the Plan may pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or may receive from Plan Providers other substantial allowances under the Plan's contracts with them. The Policyholder understands that the Plan may receive such payments, discounts and/or other allowances during the term of the 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 the Policy, if any, the maximum amount of benefits payable by the Plan and all required Copayment, deductible and Coinsurance amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost 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 there are arrangements 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 the Policy, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for prescription drugs dispensed to Covered Persons under the Policy.

   The Policyholder understands that the Plan may receive such discounts during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such discounts 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, as 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 and that the Plan has entered into one or more agreements with Prime Therapeutics LLC 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 the 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.
The Policyholder understands that the Plan may receive such rebates during the term of the 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, as part of any experience rating refund, if applicable to this policy, or otherwise.

C. Inter-Plan Arrangements

1. **Out-of Area Services**
Blue Cross and Blue Shield of Illinois, a division of Health Care Service Corporation, (herein called "the Plan") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." 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 (i.e., are "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 non-participating healthcare Providers. 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 Plan will remain responsible to you for fulfilling the Plan's contractual obligations. 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.

   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 healthcare Provider's billed covered 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 healthcare Provider contracts. The negotiated price made available to the Plan by the Host Blue may represent one of the following:

(1) an actual price. An actual price is a negotiated rate payment in effect at the time the claim is processed without any other increases or decreases, or

(2) an estimated price. An estimated price is a negotiated rate of payment in effect at the time the 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

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

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 your premiums.

b. Return of Overpayments

Recoveries from a Host Blue or its participating and nonparticipating healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in these ways will generally require correction on a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Plan, they will be credited to Policyholder's account.

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 employer as a percentage of the recovery.

3. **Negotiated National Account Arrangements**

Instead of using the BlueCard Program, the Plan may process your covered person claims for Covered Services through a negotiated arrangement.

If the Plan has arranged for (a) Host Blue(s) to make available (a) custom healthcare Provider network(s) in connection with this contract, then the terms and conditions set forth in the Plan's negotiated National Accounts arrangement(s) with such Host Blue(s) shall apply.

Covered person liability calculation will be based on the lower of either billed covered charges for Covered Services or negotiated price (Refer to the description of negotiated price under subsection 2., BlueCard Program) made available to the Plan by the Host Blue that allows your covered persons access to negotiated

participation agreement networks of specified participating healthcare Providers outside of the Plan's service area.

4. **Non-Participating Healthcare Providers Outside the Plan's Service Area**
   a. **Liability Calculation**
      (1) In General
      When Covered Services are provided outside of the Plan'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 contract for non-participating Providers located inside our service area. Covered persons may be responsible for the difference between the amount that the non-participating healthcare 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.
      (2) Exceptions
      In some exception cases, the Plan 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.

5. **Value-Based Programs BlueCard Program**
   The Plan has included a factor for bulk distributions from Host Blues in employer's premium for Value-Based Programs when applicable under this contract.

   a. Negotiated Arrangements

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

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 employer's premium.

7. BlueCard Worldwide® Program

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"), they may be able to take advantage of the BlueCard Worldwide Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program 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.

Inpatient Services

In most cases, if covered persons contact the BlueCard Worldwide Service Center for assistance, hospitals will not require covered persons to pay for covered inpatient

services, except for their cost-share amounts/deductibles, coinsurance, etc.. In such cases, the hospital will submit covered persons claims to the BlueCard Worldwide Service Center to initiate claims processing. However, if the covered person paid in full at the time of service, the covered person must submit a claim to obtain reimbursement for Covered Services.

Covered persons must contact the Plan to obtain preauthorization for non-emergency inpatient services.

Submitting a BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form with the provider's itemized bill(s) to the BlueCard Worldwide Service Center address on the form to initiate claims processing. The claim form is available from the Plan, the BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If a covered person need assistance with their claim submissions, they should call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 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 the 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 the Policy, completed application cards of the Insureds and information required by the Plan to identify dual coverage situations which are subject to Medicare Secondary Payer ("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 the 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. Minor clerical errors in keeping or reporting data relative to coverage under the 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 the 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 the 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.

No waiting period may exceed ninety (90) days unless permitted by applicable law. If the Plan's records show that Policyholder has a waiting period that exceeds the time period permitted by applicable law, 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 the Policy and within one hundred eighty (180) days after the termination of the 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 shall be liable to 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. 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 the 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 the Policy for Medicare eligible Covered Persons and coverage in accordance with MSP laws.
5. Termination of the 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 the Policy, but all coverages will automatically terminate as of the effective date of termination of the 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 the Policy, except as otherwise specifically provided in Benefit Sections of the Certificate Booklet.
7. If a Covered Person whose insurance terminates is entitled to exercise the conversion privilege specified in the Conversion Privilege section of the Certificate Booklet, it is the Policyholder's responsibility to present written notice of the existence of the conversion privilege to the Insured or to mail such notice to the Insured's last known address.

F. Notice and Proof of Claim

1. The Plan will not be liable under the Policy unless a Claim for benefits is furnished to the Plan at its office at 300 East Randolph Street, Chicago, Illinois, 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 written request to the Plan, the Insured will be provided with the forms necessary for filing Claims under the 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 the 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, the diagnosis or diagnoses, a specific itemized statement of the services rendered,

including all dates of service, and the Claim Charge. 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.

G. Payment of Claims and Assignment of Benefits

All benefit payments may be made by the Plan directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by each 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 will be given effect. In addition, 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, this policy is not assignable to any person or entity at any time, and 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 aid or attempt to aid any other person in fraudulently obtaining coverage.

H. 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 or medical service, but 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 are not provided by the Plan and can only be legally performed by a Provider. Any contractual relationship between a Physician and a Plan Provider 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 deal with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's ERISA Health Benefit Program.

I. Agency Relationships

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

J. Medicare Secondary Payer ("MSP") Provisions

1. The MSP Law

The Policyholder has certain obligations under the Medicare Secondary Payer ("MSP") statute.

a. Scope of the Statute:

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

i. GHPs that cover individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

ii. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

iii. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the MSP statute and regulations must be consulted. Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on "current employment status," as defined in the MSP statute and regulations.

b. The Non-Discrimination Provisions: Age and Disability:

The MSP statute prohibits GHPs from "take[ing] into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy), or which supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, "Medigap" and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status," and thus the MSP provisions do not apply.

c. ESRD:

The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period

specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPS are prohibited from offering secondary (i.e., "carve-out") or "Medigap" coverage in this context.**

d. Policyholder Obligations:
It is the obligation of the Policyholder to ensure that Covered Persons covered by the MSP statute are not improperly enrolled in "carve-out" or "Medigap" coverage under this Policy.

2. The New Information System

Improved Information Gathering:

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain BlueCross and BlueShield Plans together with the Centers for Medicare and Medicaid Services ("CMS") formerly known as Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, are developing or have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a timely and current fashion, information necessary for the Plan to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular claim.

Under the system, the Plan will provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that CMS can better detect dual coverage situations.

The Policyholder understands that the Plan may provide CMS periodically the information identified below pertaining to Medicare-eligible Covered Persons under the Policy. The Policyholder further agrees to cooperate and to require and facilitate its employees' cooperation in supplying the Plan the following information.

Information on Medicare-Eligible Covered Persons

- Beneficiary Name
- Date of Birth
- Sex
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Insured (e.g., Insured, spouse of Insured, child of Insured, other relationship to Insured)
- Reason for Medicare Entitlement (e.g., age, disability or ESRD)

Information on Insured

- Insured Name
- Social Security Number
- Individual Certificate Number of Insured
- Current Employment/Retirement Status
- Medicare Coverage Effective Date
- Medicare Coverage Termination Date
- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only)
- Coverage (e.g., individual, family, family but not spouse)

Information on the Policyholder/Employer

- Name and address of employer that pays the bill for coverage

The Policyholder agrees that the Plan's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Plan's files concerning Covered Persons. The Policyholder agrees to use best efforts in responding promptly and accurately to the Plan's requests for information and to require and facilitate its employees' cooperation in responding promptly and accurately to such requests.

Further, to assure the continuing accuracy of the Plan's files, the Policyholder agrees that it is the Policyholder's responsibility to notify the Plan promptly of any change in the size of the Policyholder's work force or status of its employees that might effect the order of payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Policyholder's work force that place it in, or take it out of, the scope of the MSP statute. If the Plan does not receive such information from the Policyholder, the Plan will assume that all relevant factors remain unchanged and will process claims accordingly. The Policyholder acknowledges and agrees that the Plan will be using the information provided by the Policyholder and Covered Persons to update the Plan'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.

The Plan may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in this Policy shall be construed as obligating the Plan to continue its participation in the Data Match system.

3. **Disclosure Statement**

The Policyholder acknowledges that the Plan 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 BlueCross and BlueShield Association and reviewed by CMS, which administers Medicare.

K. ERISA

This Section (M) applies to any Group Policy 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 Group Policy) has established and as sponsor maintains pursuant to other written documents a health benefit program ("Policyholder's ERISA Health Benefit Program") through the purchase of insurance for the benefit of its eligible employees or eligible members and their dependents, 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 Group (or any Group member, if the Group is an association), the Group agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in the 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 Group Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Group 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. The Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Policy is an asset of the Policyholder. No assets of the Plan or amounts which have been paid to the Plan under the Policy are assets of or under Policyholder's ERISA Health Benefit Program.

L. INITIAL PLAN PARTICIPATION REQUIREMENTS; Benefit Plan Status; Plan Documents; Retaliation

It is the Policyholder's responsibility, prior to the Effective Date of the Policy (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 the Policy. In addition, Policyholder (iv) is responsible for establishing and/or amending its own plan documents as necessary; and (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. In no event will the Plan have responsibility for such initial plan participation or plan status determinations or for Policyholder's plan documents or its actual or alleged retaliation. Upon request, Policyholder will provide the Plan with information to substantiate such determinations and responsibilities. Policyholder shall be liable to 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 the 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.

M. Incontestability

After the Policy has been in force two (2) years from the date of its issue, no statement of the Policyholder, except fraud or intentional misstatements of material fact, shall be used to void the 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.

N. Limitations of Actions

No civil action shall be brought to recover under the Policy or any individual Certificate pursuant to the Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of the 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 the Policy shall in any way extend this "Limitation of Actions" Provision.

O. New Insureds

There shall be added from time to time to the group or class originally insured under the 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 the Policy.

P. Physical Examinations and Autopsy

The Plan at its own expense shall have the right and opportunity to examine the person of a Covered Person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Q. 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 Average Discount Percentage ("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.

R. 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 reasonable 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 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 the 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 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.

S. 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 the 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 (Y). 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 shall be liable to 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.

V. RENEWABILITY OF THE POLICY

The 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 large group market and acts in accordance with state 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 large group market, the Plan would deny enrollment with respect to such plan, and ninety (90) days advance notice 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.

VI. DISCONTINUANCE OF COVERAGE

A. Discontinuance of a Particular Product

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

1. Provides ninety (90) days advance notice to the Policyholder and Covered Persons;
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.

B. Discontinuance of All Coverage

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

1. Provides one-hundred eighty (180) days advance notice to the Policyholder and Covered Persons; and
2. Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the state in such market(s).

VII. UNIFORM MODIFICATION

The Plan may modify health insurance coverage for a product offered to a group health plan in the large group market.

VIII. 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.

IX. TERMINATION OF THE POLICY

A. The Policyholder may terminate this Group Administration Document and/or the entire Policy on the first Policy anniversary or on any premium due date after the first Policy anniversary by giving written notice to the Plan at least thirty (30) days in advance.

B. After the provisions of Article 9 (Events of Default, Remedies, Termination, Suspension, and Right to Offset) of the Agreement have been satisfied, the Policy will be terminated, at the Plan's option for the Policyholder's non-payment of the appropriate premium when due.

C. After the provisions of Article 9 (Events of Default, Remedies, Termination, Suspension, and Right to Offset) of the Agreement have been satisfied, the Policy may be terminated, at the

Plan's option, for the Policyholder's noncompliance with the Plan's employer participation and/or contribution requirements, if any.

X. ELECTRONIC DATA AND DOCUMENTS

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 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.

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, the Policy for the Policyholder's use, including, but not limited to, the Policyholder'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 the 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 shall be liable to 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 Group Administration Document, 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.

XVI. INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Policy, the Plan may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Policy 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 Policyholder de-identification (unless the work is being done in connection with the Policyholder's Policy). Solely for the Permitted Purposes, the Plan 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 (other than with respect to limited data sets). The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to the Plan-assigned Policyholder Group and Identification numbers.

XVII. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

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

"Average Discount Percentage ("ADP")" means a percentage discount 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 15% of such estimate, to reflect related costs. (See provisions of this Group Administration Document regarding 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 a Benefit Program Application and/or other appropriate Change, 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, if applicable, as specified on the BPA, for delivery to each Insured. The Certificate Booklet describes the health care benefit program purchased by the Policyholder and being administered by the Plan pursuant to the Policy.

"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 notification in a form acceptable to the Plan 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 and the Claim Charge for such service.

"Claim Charge" means the amount which appears on a Claim as the Provider's 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 Group Administration Document regarding *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 Group Administration Document regarding *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 the 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 mental retardation or physical handicap 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.

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

"Domestic Partner" means a person with whom you have entered into a Domestic Partnership.

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

(i) You and your Domestic Partner have lived together for at least six (6) months;

(ii) Neither you nor your Domestic Partner is married to anyone else or has another domestic partner;

(iii) Your Domestic Partner is at least eighteen (18) years of age and mentally competent to consent to contract;

(iv) Your Domestic Partner resides with you and intends to do so indefinitely;
(v) You and your Domestic Partner have an exclusive mutual commitment similar to marriage; and
(vi) You and your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

"Effective Date of Policy" means the date specified by the Policyholder in the Benefit Program Application and/or other appropriate document.

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

"Eligibility Date" means the date on which an Insured becomes eligible for coverage under the Policy.

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

"Insured" means the person employed by the Policyholder to whom coverage under the Policy has been extended by the Policyholder and to whom the Plan has issued an identification card bearing the group number of the Policyholder. For purposes of providing benefits under the 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.

"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. w1395 et seq.).

"Medicare Secondary Payer" ("MSP") means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 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.

"**Negotiated National Account Arrangement**" means an agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

"Net Claim Payment" means the net 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 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 Plan and the particular Provider. (See Section IV. A. of this Group Administration Document regarding the *Plan's Separate Financial Arrangements with Providers.*)

"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 Benefit Program Application and/or other appropriate document Change Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Insureds.

"Policyholder" means the: (1) employing entity, corporation, partnership, sole proprietor or other employer, or (2) association, or (3) trust which has executed the Benefit Program Application and/or other appropriate document for the 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.

(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.

(c) **"Medicare Participating Provider"** means a Provider which has been certified by the Department of Health and Human Services for participation in the Medicare Program.

"Service Mark" means the names BLUE CROSS and/or 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, including, but not limited to amounts due in connection with the Health Insurer Fee and the Reinsurance Fee (defined above), paid by the Plan which are imposed upon or resulting from the 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 an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

XVII. 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 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 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 the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)."

EXHIBIT 9

PPO Administrative Services Agreement

BlueCross BlueShield
of Illinois

EXHIBIT 9

ADMINISTRATIVE SERVICES AGREEMENT ("ASA")

(This Exhibit is applicable when the County elects self-funding for its PPO benefit plan(s) as described in the Professional Service Agreement, to which this ASA is attached. This Exhibit is subject to HCSC's pending 2016 ASA updates)

The Effective Date of this Agreement is the date agreed to by the parties in the BPA.

For Employer Group Number(s): as noted in the most current ASO BPA.

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This Exhibit 9 is made as of the Effective Date of the Agreement, by and between **Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (for purposes of this Exhibit 9 the "Claim Administrator"), and the Cook County Government, (for purposes of this Exhibit 9 the "Employer"), for the Employer Group Number(s) as specified on the most current ASO BPA.

RECITALS

WHEREAS, the Employer on behalf of the Plan (as defined below) has executed an ASO Benefit Program Application ("ASO BPA") and the Claim Administrator has accepted such ASO BPA; and

WHEREAS, the Employer has established and adopted the Plan; and

WHEREAS, the Employer on behalf of the 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 Employer, as sponsor of the 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 Employer 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 "Accountable Care Organization" means a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

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

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

If the actual amount of such Payment is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer prospectively for expected Payments to Network Providers ("the Expected Payments"). Such Expected Payments will be calculated for each specific Alternative Compensation Arrangement on a per member per month ("PMPM") basis. The calculation will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Alternative Compensation Arrangement Payments for all such members. Expected Payment may vary from member to member.

Employer will be billed for its pro rata share of the Expected Payment. Any difference (surplus or deficit) between the Expected Payments that Employer has made to Claim Administrator and actual Alternative Compensation Arrangement Payments will be factored into Claim Administrator's calculation of future Expected Payments. Claim Administrator may retain interest earned, if any, on funds held that are associated with these Arrangements. Claim Administrator may recalculate the PMPM charge from time to time.

2.4 "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 fifteen percent (15%) of such estimate, to reflect related costs. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Appendix 2 of this Exhibit 9.) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into 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.

2.5 "Care Coordination" means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

2.6 "Care Coordinator" means an individual within a Provider organization who facilitates Care Coordination for patients.

2.7 "Care Coordinator Fee" means a fixed amount paid by a BlueCross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

2.8 "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.

2.9 "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 Appendix 2 of this Exhibit.)

2.10 "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, Outpatient Prescription Drug Program Eligible Charge and/or Dental Maximum Allowance, in accordance with the benefit coverage(s) elected on the most current 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 Appendix 2 of this Exhibit.) Claim Payment also includes Employer's pro rata share of Alternative Compensation Arrangement Payments.

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

2.12 "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, a 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.).

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

2.14 "Covered Employee" shall have the same meaning as defined in the Employer's Plan.

2.15 "Covered Person" shall have the same meaning as defined in the Employer's Plan.

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

2.17 "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.

2.18 "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 - 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 Employer:

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.

2.19 "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 100% 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 50% 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 50% 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.

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

2.21 "Fee Schedule" means the specifications setting out certain particulars of this Agreement as set forth in 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 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 Appendix 2's "COMPENSATION TO CLAIM ADMINISTRATOR" provisions.

2.22 "Fee Schedule Period" means the period of time indicated in the Fee Schedule specifications of the most current ASO BPA of this Agreement.

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

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

2.25 "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.

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

2.27 "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 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.

2.28 "Negotiated National Account 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.

2.29 "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 Appendix 2 of this Exhibit.)

2.30 "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.

2.31 "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.

2.32 "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/or 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/or 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/or Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program.

2.33 "Patient-Centered Medical Home" means a model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

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

2.35 "Plan" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996.

2.36 "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.

2.37 "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.

2.38 "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.

2.39 "Provider Incentive" means an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of Covered Persons.

2.40 "Shared Savings" means a payment mechanism in which the provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

2.41 "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.

2.42 "Supplemental Charge" means a charge for costs due and payable to the Claim Administrator by the Employer that is separate and apart from the service charges detailed in the Fee Schedule specifications of the most current 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 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.

2.43 "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, Employer 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.

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

- **a.** With respect to all payments due the Claim Administrator by the Employer under this Exhibit, within one (1) month of notification of the Employer by the Claim Administrator; or
- **b.** With respect to all information due the Claim Administrator by the Employer 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 Employer, upon the effective date of this Exhibit and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

2.45 "Value-Based Program" means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

2.46 "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 ***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 Employer. Any reference in this Exhibit 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 EMPLOYER AND THE CLAIM ADMINISTRATOR

4.1 ***Employer Responsibility.*** The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer 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 Employer 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 Employer 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 Employer 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 Employer 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 Employer 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 Employer'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 Employer 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 Exhibit 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 Employer is liable for any benefits paid for a terminated Covered Person until the Employer 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 Employer and the Claim Administrator exchange various data and information electronically, the Employer 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 Employer 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 Employer authorizes the Claim Administrator to submit reports, data and other information to the Employer in the electronic format mutually agreed to by the parties. In the event the Employer 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: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

This Section 5 will only apply if the Employer does not elect Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA. As provided in this Exhibit, 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 Employer for review and final decision. Such referral shall be at the sole discretion of the Claim Administrator.

SECTION 6: CLAIM DISPUTE RESOLUTION

This Section 6 will only apply if the Employer does not elect Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA.

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

6.2 ***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 7: FINAL DETERMINATION OF CLAIMS/INQUIRIES

This Section 7 will only apply if the Employer does not elect Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA.

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

7.2 ***Referrals to Employer.*** Certain claims and/or inquiries will be referred to the Employer 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 Employer after exhaustion of all remedies offered by the Claim Administrator.

SECTION 8: CLAIMS/INQUIRIES

This Section 8 will only apply if the Employer elects Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA.

8.1 ***Claim Administrator's responsibilities.*** As provided in this Agreement, the Claim Administrator will receive eligibility information, review and process Claims, respond to customer inquiries and conduct Claim reviews and appeals; 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.

8.2 ***Claim reviews and final determinations.*** 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. Claims or inquiries where there is a question of eligibility will be referred to the Employer for review and final determination.

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 Exhibit.

SECTION 10: INDEMNIFICATION

10.1 [Intentionally left blank]

10.2 ***Employer Responsibilities.*** The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan governed by this Exhibit 9 or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Exhibit by the Claim Administrator.

10.3 ***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 responsibility with respect to such examples, which shall be determined in accordance with the Agreement and Section 10.1 or 10.2, 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 Employer.

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

d. Any claim arising from the Employer's use or posting of electronic files on the intranet and/or internet pursuant to Section 15 below.

e. Any claim that may arise from or in connection with the Claim Administrator's suspension of Claim Payments due to the Employer'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 12.2 below.

f. Any claim arising from the Employer's directive to the Claim Administrator to print Employer–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 Employer's directive to the Claim Administrator to include mutually agreed upon Employer 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 based upon Medicare Secondary Payer ("MSP") laws or regulations including, but not limited to, the untimely and/or inaccurate provision by the Employer to the Claim Administrator of Employer Acknowledgement Forms ("EAFs") as and when requested by the Claim Administrator.

j. 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 ASO BPA, based upon untimely and/or inaccurate data or certification provided by the Employer to the Claim Administrator with respect to Covered Persons under the Agreement subject to the Massachusetts Health Care Reform Act.

SECTION 11: TERMINATION OF AGREEMENT

11.1 ***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 ASO BPA upon two hundred seventy (270) days prior written notice to the other party; or

b. By both parties on any date mutually agreed to in writing; or

c. By either party, after the provisions of Article 9 (Events of Default, Remedies, Termination, Suspension, and Right to Offset) of the Agreement have been satisfied, 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 17 below; or

d. By the Claim Administrator, upon the Employer'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 ASO BPA.

11.2 ***Notice of termination to Covered Employees.*** If this Agreement is terminated pursuant to this Section 10, the Employer agrees to notify all Covered Employees. The parties agree that the Employer will give such notice because the Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 12: RELATIONSHIP OF PARTIES

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

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

12.3 ***Assignment.*** Except as otherwise permitted by Section 3 of this Exhibit, no part of this ASA, 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 13: ERISA

13.1 ***In relation to the Plan.*** The Employer 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 Employer, the Employer 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 Employer is effective with respect to or accepted by the Claim Administrator.

13.2 ***In relation to the Plan Administrator/Named Fiduciary(ies).*** The Claim Administrator is not the plan administrator of the Employer's separate employee welfare benefit plan as defined under ERISA. It is understood and agreed that (i) the Employer 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 Employer, the Plan Administrator or of the Plan.

13.3 This Section 13.3 will only apply if the Employer does not elect Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA

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 Employer's plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer's ERISA employee welfare benefit plan. The Employer 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 Employer's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

13.4 This Section 13.4 will only apply if the Employer elects Claim Administrator to be the County's limited claims and appeals fiduciary on the most recent ASO BPA.

Claim Administrator's limited fiduciary responsibility. The Employer hereby delegates to the Claim Administrator the discretionary authority to administer claims in accordance with the terms of the Employer's separate ERISA welfare benefit plan (the "Plan") and to make initial claim determinations concerning the availability of Plan benefits and final review and benefit determinations for appealed Claims. The Claim Administrator hereby acknowledges and agrees that it shall act as an ERISA fiduciary to the Plan solely with respect to its performance of such claims processing and payment services and the Employer acknowledges and agrees that the Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, the Employer acknowledges and agrees that the Claim Administrator shall have no discretionary authority under its agreement with the Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by the Employer, the Employer's other vendors and the Claim Administrator's separate financial arrangements with providers, pharmacy benefit managers, vendors, independent contracts and subcontractors of any type. The Employer further agrees and acknowledges that the Claims Administrator shall have no authority or obligation to act on behalf of the Plan or Plan participants or beneficiaries as a fiduciary or otherwise with respect to any litigation, including litigation by participants or beneficiaries for benefits under the Plan, except as may be required under the Claim Administrator's indemnification obligations under this Agreement or its obligations to act as a fiduciary in its claims processing and payment services function as herein set forth or as may specifically be provided for elsewhere in this Agreement

13.5 The Employer has advised Claim Administrator that its benefit plan is not currently regulated by ERISA, so certain provisions in this Section may not be applicable to the Employer at this time.

SECTION 14: PROPRIETARY MATERIALS

14.1 ***Disclosures in Account Contracts***. The Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between the Employer and the Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Shield 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 Employer 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 Employer for any of the Claim Administrator's obligations to the Employer created under this Exhibit. 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 Exhibit.

14.2 ***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 Employer, the Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and Explanation of Benefits documentation.

SECTION 15: ELECTRONIC DOCUMENTS

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

15.2 ***Employer acknowledgement/responsibilities.*** The Employer 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 Employer by the Claim Administrator at the Employer's request. In addition, in all instances, the electronic file of the most current document issued to the Employer by the

Claim Administrator for use by the Employer is the legal document used to administer the Employer's Plan and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Employer 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 16: 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 Employer 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 Employer. All such Claim records shall be retained by the Claim Administrator until the Claim Administrator receives a request from the Employer for transmittal or for a period of ten (10) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 17: ENTIRE AGREEMENT

17.1 ***Definition.*** This ASA, including all Appendices, Exhibits and Addenda, and the Professional Services Agreement to which this Agreement is attached, 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 Employer pursuant to the Agreement, are and have been merged herein to the extent applicable. In the event of a conflict, the provisions of this ASA and the Appendices and Addenda of this ASA shall prevail.

17.2 ***Components.*** The Exhibits, Appendices and Addenda of this Exhibit 9 Administrative Services Agreement as of the ASA's effective date are:

- **a.** Appendix 1 - Claim Administrator Services
- **b.** Appendix 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
- **c.** Appendix 3 - Recovery Litigation Authorization
- **d.** Exhibit 2 - ASO Benefit Program Application ("ASO BPA")

SECTION 18: 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 19: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Exhibit, the Employer and the Claim Administrator agree to give one another written notice (pursuant to Section 11 of the Agreement) of any complaint or concern the other party may have about the performance of obligations under this Exhibit 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 20: 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 Exhibit, or in the performance of any duty or responsibility contemplated by this Exhibit, shall be limited to the maximum benefits which should have been paid under this Exhibit 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 Exhibit by the Claim Administrator.

SECTION 21: OBLIGATION TO CONTINUE PERFORMANCE

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

SECTION 22: INDUSTRY IMPROVEMENT, RESEARCH AND SAFETY

Notwithstanding any other provision of this Exhibit, the Claim Administrator may use and or disclose a limited data set or de-identified data for purposes of providing the services under this Exhibit 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 Employer de-identification (unless the work is being done in connection with the Employer'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 (other than with respect to limited data sets). 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 23: 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' audit fees associated with such audits and the Claim Administrator's fee for its related administrative expenses to support such third party audits will be paid by the Employer.

SECTION 24: NOTICE OF ANNUAL MEETING

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

APPENDIX 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 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.

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in other performance based reimbursement and alternative provider compensation arrangements as applicable based on Covered Person criteria established by Claim Administrator. Employer agrees that certain benefits will be covered at 100% 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 Employer request, assist Employer, 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 Employer to health care providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

  Provision of those items as elected by Employer 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 determined by Employer 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 ASO BPA, processing of contract conversions, subject to conversion fee set forth therein.

- **OTHER MEMBERSHIP SERVICES**

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

- **STANDARD REPORTS**

  Make available Claim data, Claim Settlement statements (as outlined in Appendix 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 Employer 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 Employer 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 Employer of findings and proof of fraud; address any related recovery litigation as set forth in Appendix 3 of this Exhibit.

- **BLUE ACCESS FOR EMPLOYERS**

  Provides Employer 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.

- **BLUE CARE CONNECTION® PROGRAM (*If elected on the most current 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 Employer.

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

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

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**
  (If elected on the most current ASO BPA)

  At the written direction of Employer, 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 Appendix 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 Employer or escheat amounts pursuant to such checks to Employer, as elected by the Employer, 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 Exhibit; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge.

APPENDIX 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to this Exhibit are set forth in the Fee Schedule section of the most current 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 Exhibit 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 $2,000 per Claim.

SECTION 2: APPENDIX DEFINITIONS

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

2.1 "Employer Payment" means the amount owed or payable to the Claim Administrator by the Employer for a given Employer Payment Period in accordance with Section 5 of this Appendix 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 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 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 Appendix titled "MEDICARE SECONDARY PAYER ("MSP") INFORMATION REPORTING.")

2.5 "Run–Off Claim" means a Claim incurred prior to the termination of Exhibit 9 that is submitted for payment during the Run–Off Period.

2.6 "Run–Off Period" means the time period immediately following termination of Exhibit 9, indicated in the Fee Schedule specifications of the most current 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 ASO BPA of the Agreement that is required by the Claim Administrator upon termination of the Exhibit 9, 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 Employer will pay service charges to the Claim Administrator, in accordance with the Fee Schedule specifications of the most current ASO BPA of the Agreement, as compensation for the processing of Claims and administrative and other services provided to the Employer.

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 ASO BPA of the Agreement, have been determined in accordance with the Claim Administrator's current regulatory status and the Employer'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 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 +/- 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 Employer.

3.4 ***Service charges upon termination.*** [Intentionally Omitted]

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 ASO BPA of the Agreement, the Claim Administrator may charge the Employer for:

- **a.** Any applicable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by the Employer, a governmental agency or pursuant to a court order; and/or
- **c.** Any other fees that may be assessed by third parties for services rendered to the Employer 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.*** Any sums due the Claim Administrator under this Agreement will be paid Timely by the Employer. Performance of all duties and obligations of the Claim Administrator under Exhibit 9 are contingent upon the payment of any amount owed the Claim Administrator by the Employer before the end of the applicable cure period.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's payment.*** Upon receipt of a Claim, the Claim Administrator will make a Claim Payment provided that all payments due the Claim Administrator under the terms of Exhibit 9 are paid before the end of the applicable cure period.

4.2 ***Employer's liability.*** Any reasonable determination by the Claim Administrator in adjudicating a Claim under Exhibit 9 that a Covered Person is entitled to a Net Claim Payment is conclusive evidence of the liability of the Employer 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 Exhibit 9 the Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If the Employer has failed to pay before the end of the applicable cure period 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 Exhibit 9 and at the end of each Employer Payment Period, the Employer shall Timely 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. Claim Administrator is willing to extend a grace period of two (2) months beyond the due date. If Employer fails to pay the amounts owed to the Claim Administrator during the grace period, Claim Administrator will have ten (10) days from the date of Claim Administrator's written notice of payment default to cure.

5.2 ***Confirmation or notification of amount due and payment due date.*** The Employer shall confirm with the Claim Administrator or the Claim Administrator shall notify the Employer'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 BPA of the Agreement and the following:

a. ***If the Employer Payment Method is by check,*** the Claim Administrator shall issue the Employer 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 Employer shall confirm on-line the amount due by accessing the Claim Administrator's "Blue Access for Employers" (as provided in Appendix 1 of Exhibit 9); or the Claim Administrator shall advise the Employer by email or facsimile (at an email address or facsimile number to be furnished by the Employer 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 Employer or the Employer'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.

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

5.3 ***Federal Regulation of Employer.*** Beginning in 2014 (or such other date required by law), Employer 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, Employer 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).

SECTION 6: CLAIM SETTLEMENTS

6.1 ***Determining What Employer Owes.*** A Claim Settlement shall be determined for each Claim Settlement Period indicated in the Fee Schedule specifications of the most current 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 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 ***Employer underpayment.*** If, within the Claim Settlement Period, the Claim Settlement Total exceeds the Employer Payments, the Employer 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 Employer in writing of the results of the Claim Settlement. Any sums due the Claim Administrator will be paid Timely by the Employer. Claim Administrator is willing to extend a grace period of two (2) months beyond the Claim Settlement due date. If Employer fails to pay the amounts owed to the Claim Administrator during the grace period, Claim Administrator will have ten (10) days from the date of Claim Administrator's written notice of payment default to cure.

6.3 ***Employer 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 Employer, apply the difference against amounts then owed the Claim Administrator by the Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due the Claim Administrator from the Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer fails to Pay.*** If the Employer fails to pay when due any amount required to be paid to the Claim Administrator under Exhibit 9, and such default is not cured within ten (10) days of written notice to the Employer, the Claim Administrator may, at its option:

- **a.** Suspend Claim Payments; or
- **b.** Terminate Exhibit 9 as of the effective date specified in such notice.

7.2 ***When Claim Administrator fails to timely notify.*** The Claim Administrator's failure to provide the Employer 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 Employer.

7.3 ***Late charge.*** If the Employer fails to make any payment required by Exhibit 9 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 Employer. 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 .0329% per day which equates to an amount of twelve percent (12%) per annum; or
- **b.** The maximum rate permitted by state law.

7.4 ***Insolvency.*** In addition, if the Employer 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 Employer (including any and all contractual obligations of the Claim Administrator to the Employer) may be offset and/or recouped and applied toward the payment of the Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–off Claims.*** The Employer hereby acknowledges that on the date of termination of the Agreement or Exhibit 9 in accordance with the provisions of either Section 7 of this Appendix or Section 10 of the Exhibit, 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 Employer 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 ASO BPA of the Agreement and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the termination date of the Agreement or Exhibit 9. 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 Employer 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 Appendix for Run–Off Claims, the Employer 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 Appendix. 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 Employer after applying the difference against amounts, if any, then owed to the Claim Administrator by the Employer.

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 Employer'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 Employer represents that it acknowledges and has communicated the provisions stated in each of the following sections of this Appendix 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 Exhibit 9, 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 Employer (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 ASO BPA of the Agreement. The Employer 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 Employer for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and Exhibit 9 and all required deductible and Coinsurance amounts under Exhibit 9 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 Employer, for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Administrator Provider or the Employer and the Claim Administrator.

13.2 The Employer 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 Exhibit 9, 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 Employer acknowledges that in negotiating the service charges set forth in Exhibit 9, it has taken into consideration that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of Exhibit 9 and that the service charges specified in Exhibit 9 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 Employer 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 Exhibit 9.

13.3 The Claim Administrator's compensation for its services under Exhibit 9 shall include the difference between the Net Claim Payments reimbursed to the Claim Administrator by the Employer under Exhibit 10 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 Employer for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of Exhibit 9 and all required Copayment, deductible and Coinsurance amounts under Exhibit 9 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 Employer 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 Employer 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 Employer understands that the Claim Administrator may receive such discounts during the term Exhibit 9. Neither the Employer 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 Employer 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 Employer 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 Employer. 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 Employer'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 Employer 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 Exhibit 9. 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 Employer-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 Employer 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 Employer 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 Employer'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 Employer terminates.

15.3 The Employer understands that the Claim Administrator may receive such rebates during the term Exhibit 9. Neither the Employer 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 Exhibit 9.

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 Exhibit 10 are described generally below. Claim Administrator's services under Exhibit 9 are governed by and subject to the Inter-Plan Programs policies in effect during the term of Exhibit 9.

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 Employer 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 Employer'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 Employer 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 Employer 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 Employer. 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 Employer'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 Employer. 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***

Employer 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 Employer. 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 Employer's benefit period under Exhibit 9.

Claim Administrator will charge these fees as follows:

It is expected that, unless the number of Employer'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 Fee Schedule.

In the event that the number of Employer's Blue enrolled contracts falls below 50,000, 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 $2,000 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 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 Employer

When Claim Administrator is charged a BlueCard Program access fee, Claim Administrator may pass the charge along to Employer as a Claim expense or as a separate amount. The access fee will not exceed $2,000 for any Claim. If Claim Administrator receives an access fee credit, Claim Administrator will give Employer 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 Employer as stated above even though Employer paid little or had no Claim liability.

16.3 ***Negotiated National Account Arrangements***

As an alternative to the BlueCard Program, some of Employer'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 Employer 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 Employer receiving Covered Services in the state and/or service area of such Host Blue.

If Claim Administrator and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with Exhibit 9, 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 Fee Schedule. In negotiating such arrangement(s), Claim Administrator is not acting

on behalf of or as an agent for Employer, Employer's Group Health Plan or Employer's Covered Persons.

a. *Covered Person and Employer 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 Employer's Covered Persons access to negotiated participation agreement networks of specified participating healthcare providers outside of Claim Administrator's service area.

Employer's liability calculation will be based on the negotiated price (refer to the description of negotiated price under 16.2.a, BlueCard Program).

Employer 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, Employer 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 Employer acknowledges that, in negotiating the Administrative Charge set forth in the 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 Employer 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*

Employer 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 Employer. 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 Employer's benefit period under this Exhibit 9.

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 Employer 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 Fee Schedule

Employer 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 Exhibit 9.

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 Fee Schedule.

The Claim Administrator hereby informs the Employer, and the Employer 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***

Employer 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 Employer. 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 Employer's benefit period under this Exhibit 9.

In addition, Claim Administrator must pay an administrative fee to the Host Blue, and Employer 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 Fee Schedule.

16.5 ***Value-Based Programs BlueCard Program***

Value-Based Programs Overview

In some cases, Covered Persons may access Covered Services from certain Host Blue participating healthcare providers that have entered into specific, Value-Based Programs with a Host Blue. These Value-Based Programs consist of Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, pay for performance, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in

the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts. The Host Blue may pass these provider payments to the Claim Administrator, which the Claim Administrator will pass on to the Employer in the form of either an amount included in the price of the claim or an amount charged separately in addition to the claim.

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

a. ***Claim Based - Actual Pricing:*** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed via an enhanced fee schedule.

b. ***Claim Based - Estimated Pricing/Average Pricing:*** The charge to accounts for Value-Based Programs incentives/Shared-Savings settlements is included in the claim as an amount based on a supplemental factor. In such cases, the Claim Administrator will pass any supplemental amounts on to the Employer as part of the Employer's billing.

When such amounts are billed in addition to the claim, they may be billed as Per Member Per Month ("PMPM") billings for incentives/Shared-Savings settlements to accounts that are outside of the claim system. The Claim Administrator will pass these Host Blue charges through to the Employer as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors or PMPM billings are estimates. This means that Host Blues cannot determine final amounts for these arrangements at the time when Covered Persons incur claims for Covered Services. Consequently, Host Blues may hold some portion of the amounts the Employer pays under such arrangements until the end of the applicable Value-Based Program payment and/or reconciliation measurement period.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

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

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

The measurement period for determining these surpluses or deficits may differ from the term of Exhibit 9. Such surpluses or deficits may be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. *Some Host Blues may retain interest earned as part of their negotiated compensation with their providers, if any, on funds held that are associated with these Programs.*

Note: Covered Persons will not bear any portion of the cost of Value-Based Programs except when Host Blues use either average pricing or actual pricing to pay providers under Value-Based Programs

Care Coordinator Fees

For certain Value-Based Programs, Host Blues may also bill the Claim Administrator for Care Coordinator Fees which the Claim Administrator will pass on to the Employer. Based on the methods that Host Blues use to pass these fees on to the Claim Administrator, the Claim Administrator will bill the Employer through:

a. PMPM billings

or

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

As part of Exhibit 9, the Claim Administrator and the Employer will not impose Covered Person cost sharing for Care Coordinator Fees.

16.6 *Value-Based Programs Negotiated National Account Arrangements*

If the Claim Administrator has entered into a Negotiated National Account Arrangement with a Host Blue to provide Value-Based Programs to Employer's Covered Persons, the Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in section 16.5 Value Based Programs BlueCard Program.

16.7 ***Value-Based Programs Return of Overpayments***

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, the Claim Administrator may request the Host Blue to provide full refunds from participating healthcare providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with Value-Based Programs, the Claim Administrator may request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of Exhibit 9.

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 Employer 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 Employer 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 Employer. The Employer 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 Employer 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 Employer agrees that it is the Employer'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 Employer 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 Employer that place it in, or take it out of, the scope of the MSP statute. The Employer acknowledges and agrees that the Claim Administrator will be using the information provided by the Employer 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 Employer 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 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 Employer 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 Employer 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 Employer 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 Employer 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 Employer 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.

APPENDIX 3
RECOVERY LITIGATION AUTHORIZATION

The Employer hereby acknowledges and agrees that the Claim Administrator may, at its election, pursue claims of the Employer 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 Employer and possibly other parties. Notwithstanding the foregoing, the Claims Administrator or its designee shall not file an appearance on behalf of the County of Cook, without the prior approval and appointment of a Special Assistant State's Attorney by the Cook County State's Attorney's Office. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Employer and/or the Plan without the Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Employer and/or the Plan with attorneys identified as counsel for the Employer or in the name of two or more parties, including the Employer and the Claim Administrator, with attorneys identified as counsel for the Employer, 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 Appendix, including providing appropriate authority to communicate with the Employer concerning issues pertaining to any class actions and pursuant to which the Employer 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 Employer shall not waive the attorney–client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Appendix or cooperative efforts pursuant to the provisions of this Appendix 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 Appendix.
9. Nothing in the provisions of this Appendix shall require the Claim Administrator to assert any claims on behalf of the Employer and/or the Plan.
10. Nothing in the provisions of this Appendix 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 Employer 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 Exhibit 9; however, nothing herein shall require the Claim Administrator to assert any claims on the Employer's and/or the Plan's behalf following the termination of Exhibit 9. If the Exhibit 9 is terminated after the Claim Administrator has asserted a claim on behalf of the Employer and/or the Plan but before any recovery, the Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.
12. If the Employer should desire to participate in a class or multi–district settlement rather than defer to the Claim Administrator, the Employer 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 Article 11 NOTICES of the Agreement.
13. The Employer further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Article 11 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Employer 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 Appendix effective immediately;
    b. Opt out of any class action settlement or keep the Employer 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 Employer 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 sole 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 Employer 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 Appendix, the provisions of this Appendix shall prevail.

EXHIBIT 10

Business Associate Agreement and HIPAA Insured Certifications

BUSINESS ASSOCIATE AGREEMENT

This Agreement is made effective the October 7, 2015 by and between the County of Cook , hereinafter referred to as "Covered Entity", and Blue Cross Blue Shield of Illinois, a division of Health Care Service Corporation, a Mutual Legal Reserve Company hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

Business Associate may have access to Protected Health Information ("PHI") from or on behalf of Covered Entity. To the extent applicable, the Parties desire to meet their respective obligations under the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"). The HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules codified in the Code of Federal Regulations ("C.F.R.") at 45 C.F.R. parts 160 and 164, Pub. Law No. 104-191 (collectively, "HIPAA") and the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No. 111-5 and its implementing regulations (collectively, "HITECH").

Business Associate agrees that as of the effective date this Agreement it shall abide by the provisions of this Agreement with respect to any Protected Health Information or Electronic Protected Health Information (as defined below).

1. **DEFINITIONS**

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule.

(a). Breach. "Breach" shall mean the unauthorized acquisition, access, use, or disclosure of Protected Health Information which compromises the security or privacy of such information subject to the exceptions set forth in 45 C.F.R. 164.402.

(b). Business Associate. "Business Associate" shall generally have the same meaning as the term "Business Associate" at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean the entity named above.

(c). Covered Entity. "Covered Entity" shall generally have the same meaning as the term "Covered Entity" at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean Cook County.

(d). Electronic Protected Health Information. "Electronic Protected Health Information" or "EPHI" shall have the same meaning as the term "Electronic Protected Health Information" in 45 C.F.R. 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

(e). Individual. "Individual" shall have the same meaning as the term "Individual" in 45 C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. 164.502(g).

(f). Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164.

(g). Protected Health Information. "Protected Health Information" or PHI shall have the same meaning as the term "Protected Health Information" in 45 C.F.R. 106.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

(h). Required By Law. "Required By Law" shall have the same meaning as the term "Required By Law" in 45 C.F.R. 164.103.

(i). Secretary. "Secretary" shall mean the Secretary of the U.S Department of Health and Human Services or his designee.

(j). Security Rule. "Security Rule" shall mean the Security Standards at 45 C.F.R. parts 160, and 164.

(k). Unsecured Protected Health Information. "Unsecured Protected Health Information" shall mean Protected Health Information is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary.

2. **OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE**

(a). For purposes of this Part 2, Business Associate shall ensure that any obligations set forth herein shall apply to any of its employees, agents, consultants, contractors or subcontractors or assigns who creates, receives, maintains or transmits Covered Entity's Protected Health Information.

(b). Business Associate shall not use or disclose Protected Health Information other than as permitted or required by this Agreement or as Required By Law.

(c). Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Business Associate creates, receives, maintains, or transmits on behalf of Covered Entity as required by the Privacy Rule, Security Rule, and the HITECH Act.

(d). Business Associate shall report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

(e). Business Associate must, following the discovery of any appearance of a Breach, non-permitted use or disclosure, security incident, or other incident affecting unsecured Protected Health Information of members associated with the Cook County group heatlh plan, notify the Cook County Department of Risk Management and the Office of the Chief Procurement Officer without unreasonable delay, and no later than 10 business days from the date that the Business Associate discovers such Breach, non-permitted use or disclosure, security incident, or other incident. To avoid unnecessary burden on either Party, Business Associate will only be required to report, upon Covered Entity's request, attempted incidents of which Business Associate becomes aware. These attempted incidents are defined as incidents that do not result in the unauthorized use, access or disclosure of Protected Health Information. Business Associate shall provide any reports or notices required by HIPAA as a result of Business Associate's discovery. On behalf of Cook County, Business Associate will provide such reports or notices to any party or entity (including but not limited to media, Secretary, and individuals affected by the Breach) entitled by law to receive the reports or notices as directed by the County. Business Associate agrees to pay the costs associated with notifying individuals affected by the Breach, which may include, but are not limited to, paper, printing, and mailing costs. In the event of a disagreement, final determination of a

Breach will be made by the Director of Risk Management or her designee..

Covered Entity shall check "YES", below, if Covered Entity is electing to delegate to Business Associate the provision of the Breach services described in Attachment 1 of this Agreement ("Attachment 1"), Covered Entity shall check "NO", below, if Covered Entity is electing to retain the provision of the Breach services described in Attachment 1. If Covered Entity does not check "YES" or "NO" below, Business Associate will NOT provide the Breach services described in Attachment 1 and these services will become the responsibility of Covered Entity.

☒ Yes ☐ No

(f). If applicable, Business Associate shall provide access, at the request of Covered Entity, and in a reasonable time and manner, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual or an individual's designee in order to meet the requirements under 45 C.F.R. 164.524. Upon termination of this Agreement, Business Associate will respond to an Individual's request during such time that the Business Associate maintains the data.

(g). Business Associate shall, when directed by Covered Entity, make amendment(s) to Protected Health Information in a Designated Record Set in a reasonable time and manner, or take other measures as necessary, as required by 45 C.F.R. 164.526. During such time that Business Associate maintains the data. Upon termination of this Agreement, Business Associate will respond to an Individual's request. In the event the Agreement is terminated prior to a six-year retention period of the County, the parties shall exercise the rights under section 5(c) of this Agreement.

(h). Business Associate shall make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary, in a reasonable time and manner or as designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with HIPAA and the HITECH Act.

(i). Business Associate will comply with the request for restriction as described in Section 4.C.

(j). Business Associate shall provide to Covered Entity when requested for a specific individual, in a reasonable time and manner, an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528. During the term of the Agreement or any extension of the term of the Agreement, Business Associate will respond to an Individual's request for an Accounting of Disclosures of PHI for a period of up to six years. In the event the Agreement is terminated prior to a six-year retention period of the County, the parties shall exercise the rights under section 5(c) of this Agreement.

(k). To the extent Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.

3. **PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE**

3.1 For purposes of this Part 3, Business Associate shall ensure that any of its employees, agents, consultants, contractors or subcontractors or assigns who creates, receives, maintains or transmits

Covered Entity's Protected Health Information shall comply with the provisions set for herein.

(a). Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as set forth in this Agreement.

(b). Business Associate may use or disclose Protected Health Information as Required by Law.

(c). Business Associate agrees to make uses and disclosures and requests for Protected Health Information consistent with Covered Entity's minimum necessary policies and procedures.

(d). Business Associate may not use or disclose Protected Health Information in a manner that would violate the Privacy Rule if done by Covered Entity, except for the specific uses and disclosures set forth below in Section 3.2.

(e). Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

(f). Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(g). Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(h). Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

3.2 **Data Ownership**

Business Associate acknowledges and agrees that Covered Entity owns all right, title, and interest in and to all Protected Health Information of Covered Entity that Business Associate creates, receives, maintains or transmits and that such all such right, title, and interest is vested in Covered Entity; nor shall Business Associate nor any of its employees, agents, consultants or assigns have any right, title or interest to any of the Protected Health Information. Business Associate shall not use the Protected Health Information in any form including, but not limited to, stripped, de-identified, or aggregated information, or statistical information derived from or in connection with the Protected Health Information, except as expressly set forth in this Agreement.. Business Associate represents, warrants, and covenants that it will not compile and/or distribute analyses to third parties using any Protected Health Information without Covered Entity's express written

consent. Notwithstanding the foregoing, the Business Associate may use and/or disclose a limited data set or de-identified data as required or permitted by applicable law as set forth in Section 22, Industry Improvement, Research, and Safety, of the Administrative Services Agreement.

4. **OBLIGATIONS OF COVERED ENTITY**

4.1 **Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions**

(a). Covered Entity shall notify Business Associate itself of any limitation(s) in the Notice of Privacy Practices of Covered Entity on Attachment 2 in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b). Covered Entity shall notify Business Associate itself of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c). Business Associate shall restrict disclosure of an Individual's Protected Health Information as directed by Covered Entity., Covered Entity shall notify Business Associate itself of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to as provided in 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information. Additionally, prior to responding to such a request, Covered Entity shall notify the Business Associate so that the Business Associate can accommodate the request. If Business Associate is unable to accommodate the request as presented by Covered Entity, Covered Entity and Business Associate shall work together in good faith to accommodate the request.

(d). Covered Entity or Business Associate receives a request from an Individual for confidential communication of PHI by alternative means or at alternative locations in accordance with 45 CFR 164.522(b), Covered Entity, prior to responding to such a request, Covered Entity shall promptly notify Business Associate of its decision on the request for confidential communication of PHI.

(e). Covered Entity shall obtain any consent, authorization or permission that may be required by the Privacy Rule or applicable state law and/or regulations prior to furnishing Business Associate Protected Health Information.

(f). Covered Entity shall provide Business Associate the necessary information to fulfill Business Associate's obligations under this Agreement, including but not limited to, a written statement of the restrictions for the Disclosure of PHI by Business Associate to the Covered Entity. Covered Entity represents and warrants that the benefit Plan Documents have been amended in compliance with 45 CFR 164.314(b) and 45 CFR 164.504(f) and that information from the applicable amendments shall be provided to Business Associate, as applicable.

(g). Covered Entity shall identify its Business Associates and Covered Entity employees on Attachment 2 to whom Business Associate is permitted to directly Disclose PHI. Covered

Entity shall provide information on any limitations or restrictions on Business Associate's Disclosure to a specific Business Associate or Covered Entity employee.

4.2 **Permissible Requests by Covered Entity**

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity except for uses and disclosures under Section 3.2.

5. **TERMINATION**

(a). Term. This Agreement shall be effective as of the Effective Date, and shall either terminate when Covered Entity provides written notice to Business Associate or as provided in 5(b), Termination for Cause, below.

(b). Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement;
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

(c). Effect of Termination.

1. Except as provided in paragraph (2) of this Section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, received, or maintained by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of consultants, contractors, subcontractors, employees or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make returning or destroying it infeasible. If Covered Entity agrees that such return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

3. The provisions of this Section 5(c), Effect of Termination, shall survive the termination of this Agreement.

6. **MITIGATION**

(a). Mitigation. To the extent known or reasonably foreseeable, Business Associate agrees to use commercially reasonable efforts to mitigate, to the extent practicable, any harmful effect resulting from a use or disclosure of Protected Health Information by Business Associate or its agents in violation of the terms of this Agreement.

7. **MISCELLANEOUS**

(a). Regulatory References. A reference in this Agreement to a Section in HIPAA or the HITECH Act means the Section as in effect or as amended.

(b). Amendment. The Parties agree to meet and confer regarding amendment of this Agreement from time to time as is necessary for either Party or both Parties to comply with the requirements of HIPAA and the HITECH Act. Any amendment, however, must be mutually agreed upon by the Parties in writing. In the event the Parties are, for any reason, unable to agree on an acceptable amendment, either Party may terminate this Agreement on written notice to the other Party.

(c). Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Parties to comply with the HIPAA and the HITECH Act as may be amended from time to time.

(d). Construction of Terms. The terms of this Agreement shall be construed in light of any applicable interpretation or guidance on HIPAA and/or the HITECH Act issued by HHS or the Office for Civil Rights ("OCR") from time to time.

(e). No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

SIGNATURE PAGE FOLLOWS

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

BUSINESS ASSOCIATE		COVERED ENTITY	
TYPE OR PRINT YOUR NAME		TYPE OR PRINT YOUR NAME	
TITLE		TITLE	
SIGNATURE	DATE	SIGNATURE	DATE

Attachments:
ATTACHMENT 1 - DELEGATION of HITECH BREACH NOTIFICATION
ATTACHMENT 2 - ADDITIONAL INFORMATION FORM

ATTACHMENT 1 – DELEGATION OF BREACH NOTIFICATION
Business Associate Agreement

The following Breach services will be provided as indicated by Covered Entity on the Business Associate Business Associate Agreement, as allowed by HIPAA:

- Investigate any unauthorized access, use, or disclosure of Covered Entity member PHI.
- Determine whether there is a low probability that the PHI has been compromised based on a risk assessment as provided for in HIPAA.
- Determine whether the incident falls under any of the HIPAA Breach notification exceptions.
- Document and retain each Breach risk assessment and exception analyses, and make this information available to Covered Entity members upon request.
- Provide Covered Entity with written notification that describes the Breach incident in detail including a list of the impacted members and/or a copy of a member notification.
- Notify each Covered Entity member impacted by the Breach by first class mail within the applicable statutory notification period, and provide toll-free numbers to the impacted members in order to handle any member questions regarding the incident. The notification will include the following:
    - A brief description of the incident, including the date of the Breach and the date it was discovered;
    - A description of the types of PHI involved in the Breach (i.e., name, birth date, home address, account number, Social Security Number, etc.);
    - The steps that individuals might take to protect themselves from potential harm; and
    - A brief description of what the Business Associate is doing to mitigate the harm and to avoid further incidents.
- Provide a substitute notice, as described in HIPAA, to impacted members if there is insufficient mailing address information.

- Maintain a log and submit to DHHS an annual report of Breaches that impact fewer than 500 members.
- Notify DHHS immediately in the event the Breach involved 500 or more individuals.
- Notify media in the event the Breach involves more than 500 residents of a state or jurisdiction and alert Covered Entity if any such notifications are needed.

NOTE: If Covered Entity does not designate on the Business Associate Agreement which Party will provide the Breach services listed above, these services will NOT be provided by Business Associate and will be the responsibility of the Covered Entity.

The above listed Breach services may be changed from time to time by Business Associate as necessary, and as required by HIPAA and DHHS guidance.

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM
Self Funded Accounts
(Please Print or Type this form)

This document replaces any previous Attachment 2 – Business Associate Agreement Additional Information Documents.

Employer or Plan Sponsor:
BCBSIL Account number:
BCBSIL group number(s):

Business Associate's Privacy Officer: Thomas C. Lubben
Address: HCSC Privacy Office; PO Box 804836; 300 E. Randolph St., Chicago, IL 60680-4110

Primary Privacy Officer Contact	Alternate Privacy Officer Contact
Name:	Name:
Title:	Title:
Phone #:	Phone #:
FAX #:	FAX #:
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
e-Mail Address:	e-Mail Address:

Authorized Signatory (Form should only be signed by authorized employee of the account.)

Name of individual completing this form:
Title of individual completing this form:

Signature: _____ Date: ____

Limitations

Please identify any limitations in any of the following documents that may affect Business Associate's use or disclosure of PHI in the Covered Entity's:

(List the limitation or indicate "none")

a. Notice of Privacy Practices (NoPP) _____
b. Covered Entity Plan Document _____
c. Other:_____

HIPAA Individual Rights Requests

Employer or Plan Sponsor:

BCBSIL Account number:

BCBSIL group number(s):

Upon receiving a request from a member to exercise one of the following HIPAA Individual Rights requests, should Business Associate respond directly to the member or direct the member back to the Employer/ Covered Entity?

Please select Employer/COVERED ENTITY **OR** Business Associate (not Both).

1) Request to Access PHI: ☐ - Employer/ Covered Entity
   ☐ - Business Associate
2) Request for Disclosure Accounting: ☐ - Employer/ Covered Entity
   ☐ - Business Associate
3) Request to Amend PHI: ☐ - Employer/ Covered Entity
   ☐ - Business Associate

Group Health Plan Authorizations

Please identify employees within your organization with whom BCBSIL is authorized to release PHI for Plan Administration functions. Please list by name or job title and indicate any limitations or restrictions on Business Associate's disclosure of PHI to such employee.

Please list: **JOB TITLE**, **NAME** (optional), **RESTRICTIONS**

enter each position or person on a different line

Business Associate Authorizations

Please identify your Business Associates and employees within that organization with whom Business Associate is authorized to release PHI for HIPAA purposes. Please list company name, employee name or title, and indicate any limitations or restrictions on Business Associate's disclosure of PHI to such Business Associate.

Please list: **COMPANY NAME, JOB TITLE**, **NAME** (optional), **RESTRICTIONS**

enter each position or person on a different line

Employer or Plan Sponsor: BCBSIL Account number: BCBSIL group number(s):

Note: It is the Employer's/Covered Entity's responsibility to notify Business Associate of any updates to the information provided in this document.

Exhibit 10 (continued)
HIPAA Insured Certications
COOK COUNTY

BCBS Group Number(s): H89805,B50000,B50001,289801

BCBS Account Number: 289800

September 24,2015

BLUE CROSS AND BLUE SHIELD OF ILLINOIS
300 East Randolph
Chicago, Illinois 60601

Re: HIPAA Plan Sponsor Certification of Group Health Plan Document Amendment ("Certification")

Dear Blue Cross and Blue Shield of Illinois:

COOK COUNTY ("Plan Sponsor") is the sponsor of **Blue Cross Blue Shield of Illinois** ("Group Health Plan"). Plan Sponsor performs plan administration functions for Group Health Plan and needs access to the Group Health Plan participants' protected health information (PHI) to carry out those plan administration functions. Accordingly, Plan Sponsor represents and warrants that Group Health Plan is a "covered entity" as that term is defined by the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations (HIPAA) and that Plan Sponsor is responsible for Group Health Plan's compliance with HIPAA.

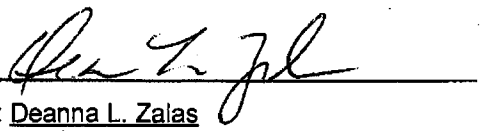
Plan Sponsor hereby certifies that it has complied with the HIPAA Privacy protections and requirements of 45 Code of Federal Regulations § 164.504(f). Plan Sponsor further represents that it has reviewed the contents of the HIPAA Certification Process Notice in Attachment 1 of this document incorporated herein by reference.

Plan Sponsor shall identify employees of the Plan Sponsor that are authorized to receive PHI and any limitations or restrictions to that authorization on Attachment 2 of this document incorporated herein by reference. On behalf of Group Health Plan, Plan Sponsor shall also identify Group Health Plan's designated Business Associates. Plan Sponsor hereby authorizes Blue Cross and Blue Shield of Illinois to disclose Group Health Plan PHI to its Authorized Employees and Business Associates as identified on Attachment 2.

Plan Sponsor may amend this Certification to change which Authorized Employees or Business Associates may receive PHI on its behalf by completing a new Attachment 2. Plan Sponsor is responsible for providing timely updates to Blue Cross and Blue Shield of Illinois to successfully implement such change.

Sincerely,

COOK COUNTY

Signature: 

Printed Name: Deanna L. Zalas

Title: Director, Risk Management

Date: September 25, 2015

Attachments 1 & 2

ATTACHMENT 1 - Insured Group Certification

Blue Cross and Blue Shield of Illinois - Fully Insured Accounts

HIPAA Plan Sponsor Certification Process Notice

The Health Insurance Portability and Accountability Act, as amended, and its implementing regulations (HIPAA) permits a group health plan (and its insurer or HMO) to disclose protected health information (PHI) to a plan sponsor/employer for "plan administration functions," but only if the plan document is amended as required by HIPAA, a firewall (adequate separation) is in place between the plan sponsor's employees who have access to PHI and those who do not, and the plan sponsor certifies to the insurer, in writing, that the plan has been amended in accordance with the HIPAA requirements and that the plan sponsor agrees to the restrictions contained in the amendment. The plan's HIPAA Notice of Privacy Practices must also state that the plan, or a health insurance issuer or HMO with respect to the plan, may disclose PHI to the plan sponsor for plan administration purposes.

These HIPAA Plan Sponsor Certification documents were developed for use by our Insured Group clients who request PHI to perform plan administration functions. The documents include a statement of certification that the Group Health Plan documents have been amended to comply with the requirements of 45 Code of Federal Regulations § 164.504(f)(2). Attachment 2 also gives you, the Plan Sponsor, the opportunity to list individuals within your organization who are authorized to have access to PHI or to designate Business Associates of your Group Health Plan to whom you are authorizing Blue Cross and Blue Shield of Illinois (BCBSIL) to release PHI.

Please take this time to review the HIPAA Plan Sponsor Certification documents. After completing and signing both the Insured Group Certification and the Attachment 2 documents, make a copy for your files, and return the originals to BCBSIL as soon as possible. Plan Sponsor is responsible for the Group Health Plan's compliance with the requirements of HIPAA set forth in 45 CFR §164.504(f) and other applicable requirements of HIPAA.

A Group Health Plan that receives PHI has additional responsibilities under HIPAA than a Group Health Plan that does **not** receive PHI. Some of the requirements that apply to a Group Health Plan that receives PHI include:

- Create and distribute a "Notice of Privacy Practices" setting forth the plan's use and disclosure of PHI and individual rights with respect to PHI.
- Designate a privacy official responsible for developing policies and procedures and designate a contact person or office for receiving complaints and providing information about the group health plan's privacy practices to individuals.
- Provide training for all members of its workforce regarding its privacy policies and procedures and sanction workforce members who violate the policies and procedures.
- Implement administrative, technical and physical safeguards to protect the privacy of PHI.
- Mitigate any harmful effects caused by a use or disclosure of PHI in violation of its policies and procedures, or the HIPAA Privacy Rules, by itself or its Business Associates.
- Not to intimidate, threaten, coerce, discriminate against or take other retaliatory action against individuals and others for asserting their rights under HIPAA.
- Not to require an individual to waive their privacy rights as a condition of treatment, payment, enrollment or eligibility.
- To have and implement written privacy policies and procedures for PHI that are consistent with HIPAA.
- To provide breach notification to individuals, the media and the Secretary of HHS of its breaches of PHI and the breaches of Business Associates.

The HIPAA Privacy Rules do not preempt state law that provides greater rights to individuals or that does not conflict with the Privacy Rules. A Group Health Plan that receives PHI should consider all applicable law when devising its policies and procedures.

Of course, the information above is intended for general informational purposes only. The information should not be construed as legal advice or as legal opinion on any specific facts or circumstances and is not intended to replace independent legal counsel. You are urged to consult a lawyer concerning your own situation or any specific legal questions you have.

ATTACHMENT 2 – Insured Group HIPAA Certification

Blue Cross and Blue Shield of Illinois Fully Insured Accounts

(Please Print or Type this form)

☐ New Account ☐ Add to Existing Account Data ☐ Standard Agreement

☒ Replace ALL on Existing Account Data ☐ Nonstandard Agreement

Employer or Plan Sponsor:	**COOK COUNTY**
BCBSIL Account Number:	**289800**
BCBSIL Group Number(s):	**H89805, B50000, B50001, 289801**

Authorized Signatory (Form should only be signed by authorized employee of the account)

Name of individual completing this form: **Deanna Zalas**

Title of individual completing this form: **Director, Risk Managment**

Signature: _____ Date: **September 25, 2015**

Limitations

Please identify any limitations in any of the following documents that may affect BCBSIL's use or disclosure of protected health information (PHI) in the Group Health Plan's:

(List the limitation or indicate "none")

a. **Notice of Privacy Practices (NOPP)** none

b. **GHP Plan Document** none

c. **Other:** none

Group Health Plan/Employer Authorizations

Please identify employees within your organization with whom BCBSIL is authorized to release PHI for Plan Administration functions. Please list by name or job title and indicate any limitations or restrictions on BCBSIL's disclosure of PHI for HIPAA purposes to such employee.

Please list: JOB TITLE, NAME **(optional)**, RESTRICTIONS

enter each position or person on a different line

Director, Risk Management, None
Employee Benefits Manager, None
Employee Benefits Representative, None
Employee Benefits Administrator, None
Employee Benefits Coordinator, None
Employee Benefits & Wellness Coordinator, None
Employee Benefits Assistant, None
Deputy Director, Risk Management, None
Risk Management Analyst

Business Associate Authorizations
Please identify your Business Associates and employees within that organization with whom BCBSIL is authorized to release PHI for HIPAA purposes. Please list company name, employee name or title, and indicate any limitations or restrictions on BCBSIL's disclosure of PHI for HIPAA purposes to such Business Associate. **Please list:** COMPANY NAME, JOB TITLE, NAME **(optional)**, RESTRICTIONS **enter each position or person on a different line**
Price Waterhouse Coopers, Actuary, None
Price Waterhouse Coopers, Consultant, None
CVS/Caremark, None

Note: It is the Employer's/GHP's responsibility to notify BCBSIL of any updates to the information provided in this document.

EXHIBIT 11

Board Authorization

Board of Commissioners of Cook County

118 North Clark Street
Chicago, IL

Legislation Details (With Text)

File #:	15-4297	**Version:** 1	**Name:**	Employer-Sponsored Health Insurance Benefits Contract - Blue Cross and Blue Shield of Illinois, Chicago, Illinois
Type:	Contract		**Status:**	Approved
File created:	6/30/2015		**In control:**	Finance Committee
On agenda:	10/7/2015		**Final action:**	10/28/2015
Title:	PROPOSED CONTRACT			

Department(s): Risk Management

Vendor: Health Care Service Corporation DBA Blue Cross and Blue Shield of Illinois, Chicago, Illinois

Request: Authorization for the Chief Procurement Officer to enter into and execute

Good(s) or Service(s): Employer Sponsored Health Insurance Benefits

Contract Value: $884,195,500.00

Contract period: 12/1/2015 - 11/30/2018, with (2) two (1) one year options for renewal.

Potential Fiscal Year Budget Impact: FY 2016 $294,731,833.33 FY 2017 $294,731,833.33, FY 2018 $294,731,833.34

Accounts: 490-176 (899-176, 499-176)

Contract Number(s): 1518-14008

Concurrences:
The vendor has met the Minority and Women Owned Business Enterprise Ordinance.

The Chief Procurement Officer concurs.

Summary: The Department of Risk Management respectfully submits this item requesting authorization for the Chief Procurement Officer to award a contract to Blue Cross Blue Shield of Illinois (BCBSIL). Request for Proposals (RFP) procedures were followed in accordance with the Cook County Procurement Code. BCBSIL was recommended based on established evaluation criteria to provide employer sponsored health insurance benefits for Cook County Employees.

Cook County offers both HMO and PPO health plan options for all eligible employees. The premium and/or premium equivalent rates for each health plan offered to County employees are subject to annual review and negotiation based on enrollment and utilization. The Director of Risk Management is authorized to execute Benefit Program Applications to support the selected HMO and PPO plans. Employees contribute to the cost of the plan through payroll deductions with the balance of the cost covered through annual appropriations.

BCBSIL offers a wide provider network with no disruption by definition as the incumbent, as well as substantial provider discounts and excellent member and client service.

Sponsors:

Indexes: DEANNA ZALAS, Director, Department of Risk Management

Code sections:

Attachments: 1. Legislative Affairs Form E - Employer Sponsored Health Insurance Benefits - October 2015

Date	Ver.	Action By	Action	Result
10/28/2015	1	Finance Committee		
10/28/2015	1	Board of Commissioners	approved	Pass
10/7/2015	1	Board of Commissioners	referred	Pass

PROPOSED CONTRACT

Department(s): Risk Management

Vendor: Health Care Service Corporation DBA Blue Cross and Blue Shield of Illinois, Chicago, Illinois

Request: Authorization for the Chief Procurement Officer to enter into and execute

Good(s) or Service(s): Employer Sponsored Health Insurance Benefits

Contract Value: $884,195,500.00

Contract period: 12/1/2015 - 11/30/2018, with (2) two (1) one year options for renewal.

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BCBSIL offers a wide provider network with no disruption by definition as the incumbent, as well as substantial provider discounts and excellent member and client service.

EXHIBIT 12

Identification of Subcontractor/Supplier/Subconsultant Form

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract**. In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: October 1, 2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Tele Tech Services Corporation *
Authorized Contact for Contractor: Robert Miller	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Confidential
Email Address (Contractor): Robert.Miller@bcbsil.com	Email Address (Subcontractor): Confidential
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): Parque Industrial Tecnologico II, Anillo Periferico Sur No. 7980 Col. Santa Maria Tequepexpan, 45600 Tlaquepaque,
City, State and Zip (Contractor): Chicago, Illinois 60601-5099	City, State and Zip (Subcontractor): Guadalajara, Jalisco, Mexico Edificio 1 Int A
Telephone and Fax (Contractor) (312) 653- 8069 / Fax: (312) 228-7914	Telephone and Fax (Subcontractor) Confidential
Estimated Start and Completion Dates (Contractor) Contact date: 12/1/2015- 11/30/2018	Estimated Start and Completion Dates (Subcontractor) September 2015- May 2016

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Spanish Speaking only Customer Service)	Confidential

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor Health Care Service Corporation, a Mutual Legal Reserve Company

Maurice Smith
Name

President, Illinois Division
Title

Prime Contractor Signature

October 1, 2015
Date

* there were no subcontractors/suppliers/vendors hired specifically for the contract. All entities were hired in the ordinary course of business for all customers. Teletech is identified as a core subcontractor under the contract so information is being provided for County's convenience.

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract**. In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Action Bag Company
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Nancy Cwynar
Email Address (Contractor): Latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): nc@actionbag.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 1001 Entry Drive
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Bensenville, IL 60106-3314
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) (800) 824-2247, (630) 766-2063
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Marketing and Promotional Materials	TBD preliminary amount $400,286

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/2015
Date

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract.** In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Innovative System Group, Inc
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Gerry Schoenneman
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): GerryS@innovativesys.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 799 Roosevelt Road, Bldg 4-109
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Glen Ellyn, IL 60137
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) 630-858-8500 / 630-858-8532
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Provide information technology resources as needed on a temporary basis	TBD preliminary amount $1,600,144

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

CONTRACT NO.

OCPO ONLY:
○ Disqualification
○ Check Complete

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract.** In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Instant Technology, LLC
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Rona Borre
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): rborre@instanttechnology.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 200 W. Adams Street, Suite 1440
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Chicago, IL 60606-5224
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) (312) 582-2600, (312) 582-2699
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Computer systems design consulting services	TBD preliminary amount $1,401,001

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
Latonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract**. In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Kairos Consulting Worldwide, LLC
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Lynn Sutton
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): lynn.sutton@kairosworldwide.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 1 South Dearborn Street, Suite 2100
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Chicago, IL 60603
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) 312-7575-5197 312-757-5492
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Develop and implement a comprehensive communication plan that will enhance the Health and Wellness Program Promotion with Cook County	TBD preliminary amount $600,429

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles/ Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

CONTRACT NO.

OCPO ONLY:
○ Disqualification
○ Check Complete

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract.** In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: Montenegro Paper Ltd
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Irma Bates
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): Irma.Bates@montenegropaper.com
Company Address (Contractor): 300 East Randolph	Company Address (Subcontractor): 400 West Lake Street, Suite 214
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Roselle, IL 60172
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) 630-894-0350 / 630-894-0095
Estimated Start and Completion Dates (Contractor) 12/1/2015-11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015-11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Commercial printing paper, envelopes and packing materials	TBD preliminary amount $400,286

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

CONTRACT NO.

OCPO ONLY:
○ Disqualification
○ Check Complete

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract.** In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 15-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TBD	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: My Wellness Community
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Charles Smith
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): csmith@mywellnesscommunity.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 542 S. Dearborn Street 8th Floor
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Chicago, IL 60605
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) (312) 724-8358, (312) 566-0965
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2018	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2018

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Provide Health and Wellness Program promotion, which includes Tobacco Cessation, Health Coaching, and Preventative Wellness	TBD preliminary amount $800,572

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
Identification of Subcontractor/Supplier/Subconsultant Form

OCPO ONLY:
○ Disqualification
○ Check Complete

The Bidder/Proposer/Respondent ("the Contractor") will fully complete and execute and submit an Identification of Subcontractor/Supplier/Subconsultant Form ("ISF") with each Bid, Request for Proposal, and Request for Qualification. **The Contractor must complete the ISF for each Subcontractor, Supplier or Subconsultant which shall be used on the Contract.** In the event that there are any changes in the utilization of Subcontractors, Suppliers or Subconsultants, the Contractor must file an updated ISF.

Bid/RFP/RFQ No.: 12-18-14008	Date: 10/2/2015
Total Bid or Proposal Amount: TDB	Contract Title: Employer Sponsored Health Insurance Benefits
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: VIVA USA, Inc.
Authorized Contact for Contractor: LaTonya Fourte-Lyles	Authorized Contact for Subcontractor/Supplier/ Subconsultant: Vasanthi Ilangovan
Email Address (Contractor): latonya_fourte-lyles@bcbsil.com	Email Address (Subcontractor): vilangovan@viva-it.com
Company Address (Contractor): 300 East Randolph Street	Company Address (Subcontractor): 3601 Algonquin Road Suite 425
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): Rolling Meadows, IL 60008
Telephone and Fax (Contractor) 312-653-8291 / 312-228-7841	Telephone and Fax (Subcontractor) (847) 368-0860, (847) 368-0864
Estimated Start and Completion Dates (Contractor) 12/1/2015 - 11/30/2015	Estimated Start and Completion Dates (Subcontractor) 12/1/2015 - 11/30/2015

Note: Upon request, a copy of all written subcontractor agreements must be provided to the OCPO.

Description of Services or Supplies	**Total Price of Subcontract for Services or Supplies**
Computer systems design consulting services	TBD preliminary amount $1,800,287

The subcontract documents will incorporate all requirements of the Contract awarded to the Contractor as applicable. The subcontract will in no way hinder the Subcontractor/Supplier/Subconsultant from maintaining its progress on any other contract on which it is either a Subcontractor/Supplier/Subconsultant or principal contractor. This disclosure is made with the understanding that the Contractor is not under any circumstances relieved of its abilities and obligations, and is responsible for the organization, performance, and quality of work. **This form does not approve any proposed changes, revisions or modifications to the contract approved MBE/WBE Utilization Plan. Any changes to the contract's approved MBE/WBE/Utilization Plan must be submitted to the Office of the Contract Compliance.**

Contractor
Health Care Service Corporation, a Mutual Legal Reserve Company

Name
LaTonya Fourte-Lyles, Manager Supplier Diversity

Title

Prime Contractor Signature

10/5/15
Date

EXHIBIT 13

Economic Disclosure Statement

CONTRACT NO.

COOK COUNTY
ECONOMIC DISCLOSURE STATEMENT
AND EXECUTION DOCUMENT
INDEX

SECTION 1
INSTRUCTIONS FOR COMPLETION OF
ECONOMIC DISCLOSURE STATEMENT AND EXECUTION DOCUMENT

This Economic Disclosure Statement and Execution Document ("EDS") is to be completed and executed by every Bidder on a County contract, every Proposer responding to a Request for Proposals, and every Respondent responding to a Request for Qualifications, and others as required by the Chief Procurement Officer. The execution of the EDS shall serve as the execution of a contract awarded by the County. The Chief Procurement Officer reserves the right to request that the Bidder or Proposer, or Respondent provide an updated EDS on an annual basis.

Definitions. Terms used in this EDS and not otherwise defined herein shall have the meanings given to such terms in the Instructions to Bidders, General Conditions, Request for Proposals, Request for Qualifications, as applicable.

Affiliate means a person that directly or indirectly through one or more intermediaries, Controls is Controlled by, or is under common Control with the Person specified.

Applicant means a person who executes this EDS.

Bidder means any person who submits a Bid.

Code means the Code of Ordinances, Cook County, Illinois available on municode.com.

Contract shall include any written document to make Procurements by or on behalf of Cook County.

Contractor or *Contracting Party* means a person that enters into a Contract with the County.

Control means the unfettered authority to directly or indirectly manage governance, administration, work, and all other aspects of a business.

EDS means this complete Economic Disclosure Statement and Execution Document, including all sections listed in the Index and any attachments.

Joint Venture means an association of two or more Persons proposing to perform a for-profit business enterprise. Joint Ventures must have an agreement in writing specifying the terms and conditions of the relationship between the partners and their relationship and respective responsibility for the Contract

Lobby or lobbying means to, for compensation, attempt to influence a County official or County employee with respect to any County matter.

Lobbyist means any person who lobbies.

Person or *Persons* means any individual, corporation, partnership, Joint Venture, trust, association, Limited Liability Company, sole proprietorship or other legal entity.

Prohibited Acts means any of the actions or occurrences which form the basis for disqualification under the Code, or under the Certifications hereinafter set forth.

Proposal means a response to an RFP.

Proposer means a person submitting a Proposal.

Response means response to an RFQ.

Respondent means a person responding to an RFQ.

RFP means a Request for Proposals issued pursuant to this Procurement Code.

RFQ means a Request for Qualifications issued to obtain the qualifications of interested parties.

INSTRUCTIONS FOR COMPLETION OF ECONOMIC DISCLOSURE STATEMENT AND EXECUTION DOCUMENT

Section 1: Instructions. Section 1 sets forth the instructions for completing and executing this EDS.

Section 2: Certifications. Section 2 sets forth certifications that are required for contracting parties under the Code and other applicable laws. Execution of this EDS constitutes a warranty that all the statements and certifications contained, and all the facts stated, in the Certifications are true, correct and complete as of the date of execution.

Section 3: Economic and Other Disclosures Statement. Section 3 is the County's required Economic and Other Disclosures Statement form. Execution of this EDS constitutes a warranty that all the information provided in the EDS is true, correct and complete as of the date of execution, and binds the Applicant to the warranties, representations, agreements and acknowledgements contained therein.

Required Updates. The Applicant is required to keep all information provided in this EDS current and accurate. In the event of any change in the information provided, including but not limited to any change which would render inaccurate or incomplete any certification or statement made in this EDS, the Applicant shall supplement this EDS up to the time the County takes action, by filing an amended EDS or such other documentation as is required.

Additional Information. The County's Governmental Ethics and Campaign Financing Ordinances impose certain duties and obligations on persons or entities seeking County contracts, work, business, or transactions, and the Applicant is expected to comply fully with these ordinances. For further information please contact the Director of Ethics at (312) 603-4304 (69 W. Washington St. Suite 3040, Chicago, IL 60602) or visit the web-site at cookcountyil.gov/ethics-board-of.

Authorized Signers of Contract and EDS Execution Page. If the Applicant is a corporation, the President and Secretary must execute the EDS. In the event that this EDS is executed by someone other than the President, attach hereto a certified copy of that section of the Corporate By-Laws or other authorization by the Corporation, satisfactory to the County that permits the person to execute EDS for said corporation. If the corporation is not registered in the State of Illinois, a copy of the Certificate of Good Standing from the state of incorporation must be submitted with this Signature Page.

If the Applicant is a partnership or joint venture, all partners or joint venturers must execute the EDS, unless one partner or joint venture has been authorized to sign for the partnership or joint venture, in which case, the partnership agreement, resolution or evidence of such authority satisfactory to the Office of the Chief Procurement Officer must be submitted with this Signature Page.

If the Applicant is a member-managed LLC all members must execute the EDS, unless otherwise provided in the operating agreement, resolution or other corporate documents. If the Applicant is a manager-managed LLC, the manager(s) must execute the EDS. The Applicant must attach either a certified copy of the operating agreement, resolution or other authorization, satisfactory to the County, demonstrating such person has the authority to execute the EDS on behalf of the LLC. If the LLC is not registered in the State of Illinois, a copy of a current Certificate of Good Standing from the state of incorporation must be submitted with this Signature Page.

If the Applicant is a Sole Proprietorship, the sole proprietor must execute the EDS.

A "Partnership" "Joint Venture" or "Sole Proprietorship" operating under an Assumed Name must be registered with the Illinois county in which it is located, as provided in 805 ILCS 405 (2012), and documentation evidencing registration must be submitted with the EDS.

CONTRACT NO.:

SECTION 2

CERTIFICATIONS

THE FOLLOWING CERTIFICATIONS ARE MADE PURSUANT TO STATE LAW AND THE CODE. THE APPLICANT IS CAUTIONED TO CAREFULLY READ THESE CERTIFICATIONS PRIOR TO SIGNING THE SIGNATURE PAGE. SIGNING THE SIGNATURE PAGE SHALL CONSTITUTE A WARRANTY BY THE APPLICANT THAT ALL THE STATEMENTS, CERTIFICATIONS AND INFORMATION SET FORTH WITHIN THESE CERTIFICATIONS ARE TRUE, COMPLETE AND CORRECT AS OF THE DATE THE SIGNATURE PAGE IS SIGNED. THE APPLICANT IS NOTIFIED THAT IF THE COUNTY LEARNS THAT ANY OF THE FOLLOWING CERTIFICATIONS WERE FALSELY MADE, THAT ANY CONTRACT ENTERED INTO WITH THE APPLICANT SHALL BE SUBJECT TO TERMINATION.

A. PERSONS AND ENTITIES SUBJECT TO DISQUALIFICATION

No person or business entity shall be awarded a contract or sub-contract, for a period of five (5) years from the date of conviction or entry of a plea or admission of guilt, civil or criminal, if that person or business entity:

1) Has been convicted of an act committed, within the State of Illinois, of bribery or attempting to bribe an officer or employee of a unit of state, federal or local government or school district in the State of Illinois in that officer's or employee's official capacity;

2) Has been convicted by federal, state or local government of an act of bid-rigging or attempting to rig bids as defined in the Sherman Anti-Trust Act and Clayton Act. Act. 15 U.S.C. Section 1 *et seq.;*

3) Has been convicted of bid-rigging or attempting to rig bids under the laws of federal, state or local government;

4) Has been convicted of an act committed, within the State, of price-fixing or attempting to fix prices as defined by the Sherman Anti-Trust Act and the Clayton Act. 15 U.S.C. Section 1, *et seq.;*

5) Has been convicted of price-fixing or attempting to fix prices under the laws the State;

6) Has been convicted of defrauding or attempting to defraud any unit of state or local government or school district within the State of Illinois;

7) Has made an admission of guilt of such conduct as set forth in subsections (1) through (6) above which admission is a matter of record, whether or not such person or business entity was subject to prosecution for the offense or offenses admitted to; or

8) Has entered a plea of *nolo contendere* to charge of bribery, price-fixing, bid-rigging, or fraud, as set forth in sub-paragraphs (1) through (6) above.

In the case of bribery or attempting to bribe, a business entity may not be awarded a contract if an official, agent or employee of such business entity committed the Prohibited Act on behalf of the business entity and pursuant to the direction or authorization of an officer, director or other responsible official of the business entity, and such Prohibited Act occurred within three years prior to the award of the contract. In addition, a business entity shall be disqualified if an owner, partner or shareholder controlling, directly or indirectly, 20% or more of the business entity, or an officer of the business entity has performed any Prohibited Act within five years prior to the award of the Contract.

THE APPLICANT HEREBY CERTIFIES THAT: The Applicant has read the provisions of Section A, Persons and Entities Subject to Disqualification, that the Applicant has not committed any Prohibited Act set forth in Section A, and that award of the Contract to the Applicant would not violate the provisions of such Section or of the Code.

B. BID-RIGGING OR BID ROTATING

THE APPLICANT HEREBY CERTIFIES THAT: *In accordance with 720 ILCS 5/33 E-11, neither the Applicant nor any Affiliated Entity is barred from award of this Contract as a result of a conviction for the violation of State laws prohibiting bid-rigging or bid rotating.*

C. DRUG FREE WORKPLACE ACT

THE APPLICANT HEREBY CERTIFIES THAT: The Applicant will provide a drug free workplace, as required by (30 ILCS 580/3).

D. DELINQUENCY IN PAYMENT OF TAXES

THE APPLICANT HEREBY CERTIFIES THAT*: The Applicant is not an owner or a party responsible for the payment of any tax or fee administered by Cook County, by a local municipality, or by the Illinois Department of Revenue, which such tax or fee is delinquent, such as bar award of a contract or subcontract pursuant to the Code, Chapter 34, Section 34-171.*

E. HUMAN RIGHTS ORDINANCE

No person who is a party to a contract with Cook County ("County") shall engage in unlawful discrimination or sexual harassment against any individual in the terms or conditions of employment, credit, public accommodations, housing, or provision of County facilities, services or programs (Code Chapter 42, Section 42-30 *et seq.*).

F. ILLINOIS HUMAN RIGHTS ACT

THE APPLICANT HEREBY CERTIFIES THAT: *It is in compliance with the Illinois Human Rights Act (775 ILCS 5/2-105), and agrees to abide by the requirements of the Act as part of its contractual obligations.*

G. INSPECTOR GENERAL (COOK COUNTY CODE, CHAPTER 34, SECTION 34-174 and Section 34-250)

The Applicant has not willfully failed to cooperate in an investigation by the Cook County Independent Inspector General or to report to the Independent Inspector General any and all information concerning conduct which they know to involve corruption, or other criminal activity, by another county employee or official, which concerns his or her office of employment or County related transaction.

The Applicant has reported directly and without any undue delay any suspected or known fraudulent activity in the County's Procurement process to the Office of the Cook County Inspector General.

H. CAMPAIGN CONTRIBUTIONS (COOK COUNTY CODE, CHAPTER 2, SECTION 2-585)

THE APPLICANT CERTIFIES THAT: It has read and shall comply with the Cook County's Ordinance concerning campaign contributions, which is codified at Chapter 2, Division 2, Subdivision II, Section 585, and can be read in its entirety at www.municode.com.

I. GIFT BAN, (COOK COUNTY CODE, CHAPTER 2, SECTION 2-574)

THE APPLICANT CERTIFIES THAT: It has read and shall comply with the Cook County's Ordinance concerning receiving and soliciting gifts and favors, which is codified at Chapter 2, Division 2, Subdivision II, Section 574, and can be read in its entirety at www.municode.com.

J. LIVING WAGE ORDINANCE PREFERENCE (COOK COUNTY CODE, CHAPTER 34, SECTION 34-160;

Unless expressly waived by the Cook County Board of Commissioners, the Code requires that a living wage must be paid to individuals employed by a Contractor which has a County Contract and by all subcontractors of such Contractor under a County Contract, throughout the duration of such County Contract. The amount of such living wage is annually by the Chief Financial Officer of the County, and shall be posted on the Chief Procurement Officer's website.

The term "Contract" as used in Section 4, I, of this EDS, specifically excludes contracts with the following:

1) Not-For Profit Organizations (defined as a corporation having tax exempt status under Section 501(C)(3) of the United State Internal Revenue Code and recognized under the Illinois State not-for -profit law);

2) Community Development Block Grants;

3) Cook County Works Department;

4) Sheriff's Work Alternative Program; and

5) Department of Correction inmates.

CONTRACT NO.

SECTION 3

REQUIRED DISCLOSURES

1. DISCLOSURE OF LOBBYIST CONTACTS

List all persons that have made lobbying contacts on your behalf with respect to this contract:

Name Address

NA

2. LOCAL BUSINESS PREFERENCE STATEMENT (CODE, CHAPTER 34, SECTION 34-230)

Local business means a Person, including a foreign corporation authorized to transact business in Illinois, having a bona fide establishment located within the County at which it is transacting business on the date when a Bid is submitted to the County, and which employs the majority of its regular, full-time work force within the County. A Joint Venture shall constitute a Local Business if one or more Persons that qualify as a "Local Business" hold interests totaling over 50 percent in the Joint Venture, even if the Joint Venture does not, at the time of the Bid submittal, have such a bona fide establishment within the County.

a) Is Applicant a "Local Business" as defined above?

Yes: X No: _____

b) If yes, list business addresses within Cook County:
300 E. Randolph Street, Chicago, Illinois 60601-5099

c) Does Applicant employ the majority of its regular full-time workforce within Cook County?

Yes: _____ No: X

3. THE CHILD SUPPORT ENFORCEMENT ORDINANCE (CODE, CHAPTER 34, SECTION 34-172)

Every Applicant for a County Privilege shall be in full compliance with any child support order before such Applicant is entitled to receive or renew a County Privilege. When delinquent child support exists, the County shall not issue or renew any County Privilege, and may revoke any County Privilege.

All Applicants are required to review the Cook County Affidavit of Child Support Obligations attached to this EDS (EDS-5) and complete the Affidavit, based on the instructions in the Affidavit.

4. REAL ESTATE OWNERSHIP DISCLOSURES.

The Applicant must indicate by checking the appropriate provision below and providing all required information that either:

a) The following is a complete list of all real estate owned by the Applicant in Cook County:

PERMANENT INDEX NUMBER(S): 17-10-318-034-0000

300 E. Randolph Street, Chicago, Illinois 60601-5099

(ATTACH SHEET IF NECESSARY TO LIST ADDITIONAL INDEX NUMBERS)

OR:

b) _____The Applicant owns no real estate in Cook County.

5. EXCEPTIONS TO CERTIFICATIONS OR DISCLOSURES.

If the Applicant is unable to certify to any of the Certifications or any other statements contained in this EDS and not explained elsewhere in this EDS, the Applicant must explain below:

N/A

If the letters, "NA", the word "None" or "No Response" appears above, or if the space is left blank, it will be conclusively presumed that the Applicant certified to all Certifications and other statements contained in this EDS.

CONTRACT NO.

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT

The Cook County Code of Ordinances (§2-610 *et seq.*) requires that any Applicant for any County Action must disclose information concerning ownership interests in the Applicant. This Disclosure of Ownership Interest Statement must be completed with all information current as of the date this Statement is signed. Furthermore, this Statement must be kept current, by filing an amended Statement, until such time as the County Board or County Agency shall take action on the application. The information contained in this Statement will be maintained in a database and made available for public viewing.

If you are asked to list names, but there are no applicable names to list, you must state NONE. An incomplete Statement will be returned and any action regarding this contract will be delayed. A failure to fully comply with the ordinance may result in the action taken by the County Board or County Agency being voided.

"*Applicant*" means any Entity or person making an application to the County for any County Action.

"County Action" means any action by a County Agency, a County Department, or the County Board regarding an ordinance or ordinance amendment, a County Board approval, or other County agency approval, with respect to contracts, leases, or sale or purchase of real estate.

"Person" "Entity" or *"Legal Entity"* means a sole proprietorship, corporation, partnership, association, business trust, estate, two or more persons having a joint or common interest, trustee of a land trust, other commercial or legal entity or any beneficiary or beneficiaries thereof.

This Disclosure of Ownership Interest Statement must be submitted by :

1. An Applicant for County Action and

2. A Person that holds stock or a beneficial interest in the Applicant and is listed on the Applicant's Statement (a "Holder") must file a Statement and complete #1 only under **Ownership Interest Declaration**.

Please print or type responses clearly and legibly. Add additional pages if needed, being careful to identify each portion of the form to which each additional page refers.

This Statement is being made by the [X] Applicant or [ ] Stock/Beneficial Interest Holder

This Statement is an: [X] Original Statement or [ ] Amended Statement

Identifying Information:

Name Health Care Service Corporation, a Mutual Legal Reserve Company

D/B/A: _____ FEIN NO.: 36-1236610

Street Address: 300 E. Randolph Street

City: Chicago State: Illinois Zip Code: 60601-5099

Phone No.: 312-653-8069 (Robert Miller) Fax Number: 312-228-7914 Email: Robert_Miller@bcbsil.com

Cook County Business Registration Number: NA
(Sole Proprietor, Joint Venture Partnership)

Corporate File Number (if applicable): NA

Form of Legal Entity:

[ ] Sole Proprietor [ ] Partnership [ ] Corporation [ ] Trustee of Land Trust

[ ] Business Trust [ ] Estate [ ] Association [ ] Joint Venture

[X] Other (describe) a Mutual Legal Reserve Company

CONTRACT NO.

Ownership Interest Declaration:

1. List the name(s), address, and percent ownership of each Person having a legal or beneficial interest (including ownership) of more than five percent (5%) in the Applicant/Holder.

Name	Address	Percentage Interest in Applicant/Holder
NA		

2. If the interest of any Person listed in (1) above is held as an agent or agents, or a nominee or nominees, list the name and address of the principal on whose behalf the interest is held.

Name of Agent/Nominee	Name of Principal	Principal's Address
NA		

3. Is the Applicant constructively controlled by another person or Legal Entity? [ ] Yes [ ] No

If yes, state the name, address and percentage of beneficial interest of such person, and the relationship under which such control is being or may be exercised.

Name	Address	Percentage of Beneficial Interest	Relationship
NA			

Corporate Officers, Members and Partners Information:

For all corporations, list the names, addresses, and terms for all corporate officers. For all limited liability companies, list the names, addresses for all members. For all partnerships and joint ventures, list the names, addresses, for each partner or joint venture.

Name	Address	Title (specify title of Office, or whether manager or partner/joint venture)	Term of Office
Please see the attached list of HCSC officers and Board of Directors.			

Declaration (check the applicable box):

[X] I state under oath that the Applicant has withheld no disclosure as to ownership interest in the Applicant nor reserved any information, data or plan as to the intended use or purpose for which the Applicant seeks County Board or other County Agency action.

[ ] I state under oath that the Holder has withheld no disclosure as to ownership interest nor reserved any information required to be disclosed.

CONTRACT NO.

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT SIGNATURE PAGE

Maurice Smith
Name of Authorized Applicant/Holder Representative (please print or type)

President, Illinois Division
Title

Signature

October 1, 2015
Date

SmithM@bcbsil.com
E-mail address

(312) 653-4729
Phone Number

Subscribed to and sworn before me
this 2 day of October, 2015

My commission expires:

OFFICIAL SEAL
LINDA WATSON-VASSAR
Notary Public - State of Illinois
My Commission Expires Nov 21, 2016

X
Notary Public Signature

Notary Seal

CONTRACT NO.

COOK COUNTY BOARD OF ETHICS
69 W. WASHINGTON STREET, SUITE 3040
CHICAGO, ILLINOIS 60602
312/603-4304 Office 312/603-9988 Fax

FAMILIAL RELATIONSHIP DISCLOSURE PROVISION

Nepotism Disclosure Requirement:

Doing a significant amount of business with the County requires that you disclose to the Board of Ethics the existence of any familial relationships with any County employee or any person holding elective office in the State of Illinois, the County, or in any municipality within the County. The Ethics Ordinance defines a significant amount of business for the purpose of this disclosure requirement as more than $25,000 in aggregate County leases, contracts, purchases or sales in any calendar year.

If you are unsure of whether the business you do with the County or a County agency will cross this threshold, err on the side of caution by completing the attached familial disclosure form because, among other potential penalties, any person found guilty of failing to make a required disclosure or knowingly filing a false, misleading, or incomplete disclosure will be prohibited from doing any business with the County for a period of three years. The required disclosure should be filed with the Board of Ethics by January 1 of each calendar year in which you are doing business with the County and again with each bid/proposal/quotation to do business with Cook County. The Board of Ethics may assess a late filing fee of $100 per day after an initial 30-day grace period.

The person that is doing business with the County must disclose his or her familial relationships. If the person on the County lease or contract or purchasing from or selling to the County is a business entity, then the business entity must disclose the familial relationships of the individuals who are and, during the year prior to doing business with the County, were:

- its board of directors,
- its officers,
- its employees or independent contractors responsible for the general administration of the entity,
- its agents authorized to execute documents on behalf of the entity, and
- its employees who directly engage or engaged in doing work with the County on behalf of the entity.

Do not hesitate to contact the Board of Ethics at (312) 603-4304 for assistance in determining the scope of any required familial relationship disclosure.

Additional Definitions:

"*Familial relationship*" means a person who is a spouse, domestic partner or civil union partner of a County employee or State, County or municipal official, or any person who is related to such an employee or official, whether by blood, marriage or adoption, as a:

☐ Parent	☐ Grandparent	☐ Stepfather
☐ Child	☐ Grandchild	☐ Stepmother
☐ Brother	☐ Father-in-law	☐ Stepson
☐ Sister	☐ Mother-in-law	☐ Stepdaughter
☐ Aunt	☐ Son-in-law	☐ Stepbrother
☐ Uncle	☐ Daughter-in-law	☐ Stepsister
☐ Niece	☐ Brother-in-law	☐ Half-brother
☐ Nephew	☐ Sister-in-law	☐ Half-sister

CONTRACT NO.

COOK COUNTY BOARD OF ETHICS
FAMILIAL RELATIONSHIP DISCLOSURE FORM

A. PERSON DOING OR SEEKING TO DO BUSINESS WITH THE COUNTY

Name of Person Doing Business with the County: _____

Address of Person Doing Business with the County: _____

Phone number of Person Doing Business with the County: _____

Email address of Person Doing Business with the County: _____

If Person Doing Business with the County is a Business Entity, provide the name, title and contact information for the individual completing this disclosure on behalf of the Person Doing Business with the County:
Health Care Service Corporation, a Mutual Legal Reserve Company

300 E. Randolph Street, Chicago, Illinois 60601-5099 Contact : Robert Miller- 312-653-8069 , Robert_Miller@bcbsil.com

B. DESCRIPTION OF BUSINESS WITH THE COUNTY

Append additional pages as needed and for each County lease, contract, purchase or sale sought and/or obtained during the calendar year of this disclosure (or the proceeding calendar year if disclosure is made on January 1), identify:

The lease number, contract number, purchase order number, request for proposal number and/or request for qualification number associated with the business you are doing or seeking to do with the County: 15-18-14008

The aggregate dollar value of the business you are doing or seeking to do with the County: $ Confidential

The name, title and contact information for the County official(s) or employee(s) involved in negotiating the business you are doing or seeking to do with the County: Robert Miller Vice President- Municpal Accounts- 312-653-8069, Robert_Miller@bcbsil.com

The name, title and contact information for the County official(s) or employee(s) involved in managing the business you are doing or seeking to do with the County: Robert Miller Vice President- Municpal Accounts- 312-653-8069, Robert_Miller@bcbsil.com

C. DISCLOSURE OF FAMILIAL RELATIONSHIPS WITH COUNTY EMPLOYEES OR STATE, COUNTY OR MUNICIPAL ELECTED OFFICIALS

Check the box that applies and provide related information where needed

☐ The Person Doing Business with the County **is an individual** and there is **no familial relationship** between this individual and any Cook County employee or any person holding elective office in the State of Illinois, Cook County, or any municipality within Cook County.

☒ The Person Doing Business with the County **is a business entity** and there is **no familial relationship** between any member of this business entity's board of directors, officers, persons responsible for general administration of the business entity, agents authorized to execute documents on behalf of the business entity or employees directly engaged in contractual work with the County on behalf of the business entity, and any Cook County employee or any person holding elective office in the State of Illinois, Cook County, or any municipality within Cook County.

CONTRACT NO.

COOK COUNTY BOARD OF ETHICS
FAMILIAL RELATIONSHIP DISCLOSURE FORM

☐ The Person Doing Business with the County **is an individual** and **there is a familial relationship** between this individual and at least one Cook County employee and/or a person or persons holding elective office in the State of Illinois, Cook County, and/or any municipality within Cook County. **The familial relationships are as follows:**

Name of Individual Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

If more space is needed, attach an additional sheet following the above format.

☐ The Person Doing Business with the County **is a business entity** and **there is a familial relationship** between at least one member of this business entity's board of directors, officers, persons responsible for general administration of the business entity, agents authorized to execute documents on behalf of the business entity and/or employees directly engaged in contractual work with the County on behalf of the business entity, on the one hand, and at least one Cook County employee and/or a person holding elective office in the State of Illinois, Cook County, and/or any municipality within Cook County, on the other. **The familial relationships are as follows**:

Name of Member of Board of Director for Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

Name of Officer for Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

CONTRACT NO.

Name of Person Responsible for the General Administration of the Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

Name of Agent Authorized to Execute Documents for Business Entity Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

Name of Employee of Business Entity Directly Engaged in Doing Business with the County	Name of Related County Employee or State, County or Municipal Elected Official	Title and Position of Related County Employee or State, County or Municipal Elected Official	Nature of Familial Relationship*

If more space is needed, attach an additional sheet following the above format.

VERIFICATION: To the best of my knowledge, the information I have provided on this disclosure form is accurate and complete. I acknowledge that an inaccurate or incomplete disclosure is punishable by law, including but not limited to fines and debarment.

Signature of Recipient

Date 10/2/15

SUBMIT COMPLETED FORM TO: Cook County Board of Ethics
69 West Washington Street, Suite 3040, Chicago, Illinois 60602
Office (312) 603-4304 – Fax (312) 603-9988
CookCounty.Ethics@cookcountyil.gov

* Spouse, domestic partner, civil union partner or parent, child, sibling, aunt, uncle, niece, nephew, grandparent or grandchild by blood, marriage (*i.e.* in laws and step relations) or adoption.

CONTRACT NO.

SECTION 4

COOK COUNTY AFFIDAVIT FOR WAGE THEFT ORDINANCE

Effective May 1, 2015, every Person, ***including Substantial Owners***, seeking a Contract with Cook County must comply with the Cook County Wage Theft Ordinance set forth in Chapter 34, Article IV, Section 179. Any Person/Substantial Owner, who fails to comply with Cook County Wage Theft Ordinance, may request that the Chief Procurement Officer grant a reduction or waiver in accordance with Section 34-179(d).

"*Contract*" means any written document to make Procurements by or on behalf of Cook County.

"*Person*" means any individual, corporation, partnership, Joint Venture, trust, association, limited liability company, sole proprietorship or other legal entity.

"*Procurement*" means obtaining supplies, equipment, goods, or services of any kind.

"*Substantial Owner*" means any person or persons who own or hold a twenty-five percent (25%) or more percentage of interest in any business entity seeking a County Privilege, including those shareholders, general or limited partners, beneficiaries and principals; except where a business entity is an individual or sole proprietorship, Substantial Owner means that individual or sole proprietor.

All Persons/Substantial Owners are required to complete this affidavit and comply with the Cook County Wage Theft Ordinance before any Contract is awarded. Signature of this form constitutes a certification the information provided below is correct and complete, and that the individual(s) signing this form has/have personal knowledge of such information.

I. Contract Information:

Contract Number: 15-18-14008

County Using Agency (requesting Procurement): Cook County Risk Management

II. Person/Substantial Owner Information:

Person (Corporate Entity Name): Health Care Service Corporation, a Mutual Legal Reserve Company

Substantial Owner Complete Name: Not applicable.

FEIN# 36-1236610

Date of Birth: Not applicable. E-mail address: Robert_Miller@bcbsil.com

Street Address: 300 E. Randolph Street

City: Chicago State: Illinois Zip: 60601-5099

Home Phone: (312)653-8069 (Robert Miller Office number) Driver's License No: Not applicable.

III. Compliance with Wage Laws:

Within the past five years has the Person/Substantial Owner, in any judicial or administrative proceeding, been convicted of, entered a plea, made an admission of guilt or liability, or had an administrative finding made for committing a repeated or willful violation of any of the following laws:

Illinois Wage Payment and Collection Act, 820 ILCS 115/1 et seq., **YES or (NO)**

Illinois Minimum Wage Act, 820 ILCS 105/1 et seq., **YES or (NO)**

Illinois Worker Adjustment and Retraining Notification Act, 820 ILCS 65/1 et seq., **YES or (NO)**

Employee Classification Act, 820 ILCS 185/1 et seq., **YES or (NO)**

Fair Labor Standards Act of 1938, 29 U.S.C. 201, et seq., **YES or (NO)**

Any comparable state statute or regulation of any state, which governs the payment of wages **YES or (NO)**

If the Person/Substantial Owner answered **"Yes"** to any of the questions above, it is ineligible to enter into a Contract with Cook County, but can request a reduction or waiver under **Section IV.**

IV. Request for Waiver or Reduction

If Person/Substantial Owner answered **"Yes"** to any of the questions above, it may request a reduction or waiver in accordance with Section 34-179(d), provided that the request for reduction of waiver is made on the basis of one or more of the following actions that have taken place:

There has been a bona fide change in ownership or Control of the ineligible Person or Substantial Owner ***YES or NO***

Disciplinary action has been taken against the individual(s) responsible for the acts giving rise to the violation ***YES or NO***

Remedial action has been taken to prevent a recurrence of the acts giving rise to the disqualification or default ***YES or NO***

Other factors that the Person or Substantial Owner believe are relevant.
YES or NO

The Person/Substantial Owner must submit documentation to support the basis of its request for a reduction or waiver. The Chief Procurement Officer reserves the right to make additional inquiries and request additional documentation.

V. Affirmation

The Person/Substantial Owner affirms that all statements contained in the Affidavit are true, accurate and complete.

Signature: Maurice D. Smith Date: October 1, 2015

Name of Person signing (Print): Maurice Smith Title: President, Illinois Division

Subscribed and sworn to before me this 1 day of October, 2015

X L Vaman
Notary Public Signature

Notary Seal

OFFICIAL SEAL
LINDA WATSON-VASSAR
Notary Public - State of Illinois
My Commission Expires Nov 21, 2016

Note: The above information is subject to verification prior to the award of the Contract.

CONTRACT NO.

SECTION 5

CONTRACT AND EDS EXECUTION PAGE

PLEASE EXECUTE THREE ORIGINAL COPIES

The Applicant hereby certifies and warrants that all of the statements, certifications and representations set forth in this EDS are true, complete and correct; that the Applicant is in full compliance and will continue to be in compliance throughout the term of the Contract or County Privilege issued to the Applicant with all the policies and requirements set forth in this EDS; and that all facts and information provided by the Applicant in this EDS are true, complete and correct. The Applicant agrees to inform the Chief Procurement Officer in writing if any of such statements, certifications, representations, facts or information becomes or is found to be untrue, incomplete or incorrect during the term of the Contract or County Privilege.

Execution by Corporation

Health Care Service Corporation, a Mutual Legal Reserve Company	Maurice Smith, President-Illinois Division
Corporation's Name	President's Printed Name and Signature
(312) 653-4729	SmithM@bcbsil.com
Telephone	Email
Catherine Nelson	October 1, 2015
~~Secretary~~ Signature VP & General Counsel	Date

Execution by LLC

LLC Name	*Member/Manager Printed Name and Signature
Date	Telephone and Email

Execution by Partnership/Joint Venture

Partnership/Joint Venture Name	*Partner/Joint Venturer Printed Name and Signature
Date	Telephone and Email

Execution by Sole Proprietorship

Printed Name and Signature	Date
Telephone	Email

Subscribed and sworn to before me this 1 day of October, 2015.

L. Watson

Notary Public Signature

My commission expires:

OFFICIAL SEAL
LINDA WATSON-VASSAR
Notary Public - State of Illinois
My Commission Expires Nov 21, 2016

Notary Seal

If the operating agreement, partnership agreement or governing documents requiring execution by multiple members, managers, partners, or joint venturers, please complete and execute additional Contract and EDS Execution Pages.

Health Care Service Corporation

Principal Officers	
Title	**Name**
Chairman of the Board	Milton Carroll
CEO	Patricia A. Hemingway Hall
President	Paula A. Steiner
Secretary	Vacant
Treasurer	Gerard T. Mallen
Executive Vice President and President of Plan Operations	Colleen F. Reitan
Executive Vice President	Karen M. Atwood
Executive Vice President	John Cannon III
President, Illinois Division	Maurice S. Smith
President, Montana Division	Michael E. Frank
President, New Mexico Division	Kurt B. Shipley
President, Oklahoma Division	M. Ted Haynes
President, Texas Division	Bert E. Marshall
President, Retail Markets	Jeffrey A. Tikkanen
President, Government Programs	Mark W. Owen
Senior Vice President, CFO	Kenneth S. Avner
Senior Vice President and CIO	Steven Betts
Senior Vice President	Kevin M. Cassidy
Senior Vice President	Carolyn L. Dawson
Senior Vice President	Stephen F. Hamman
Senior Vice President	James L. Kadela
Senior Vice President and Chief Actuary	Janice J. Knight
Senior Vice President	Thomas C. Lubben
Senior Vice President and CMO	Stephen L. Ondra, M.D.
Senior Vice President	Nazneen Razi
Senior Vice President	J. Darren Rodgers

HCSC Board of Directors
Milton Carroll, Chairman
Patricia A. Hemingway Hall, CEO
Timothy L. Burke
Robert T. Clarke
Michelle L. Collins
James R. Corrigan
Tieman H. Dippel, Jr.
Dennis J. Gannon
Dianne B. Gasbarra, M.D.
Chase T. Hibbard
Thomas R. Hix
Elaine M. Mendoza
M. Ray Perryman, Ph.D.
Waneta C. Tuttle, Ph. D.

HCSC senior officers and Board of Directors as of August 15, 2015

CONTRACT NO. 1518-14008

SECTION 6
COOK COUNTY SIGNATURE PAGE

ON BEHALF OF THE COUNTY OF COOK, A BODY POLITIC AND CORPORATE OF THE STATE OF ILLINOIS, THIS CONTRACT IS HEREBY EXECUTED BY:

_____

COOK COUNTY CHIEF PROCUREMENT OFFICER

DATED AT CHICAGO, ILLINOIS THIS 20 DAY OF November ,20 15 .

IN THE CASE OF A BID/ PROPOSAL/RESPONSE, THE COUNTY HEREBY ACCEPTS:

THE FOREGOING BID/PROPOSAL/RESPONSE AS IDENTIFIED IN THE CONTRACT DOCUMENTS FOR CONTRACT NUMBER

1518-14008

OR

ITEM(S), SECTION(S), PART(S): N/A

TOTAL AMOUNT OF CONTRACT: $ 884,195,500.00

(DOLLARS AND CENTS)

FUND CHARGEABLE: _____

APPROVED BY BOARD OF
COOK COUNTY COMMISSIONERS

OCT 28 2015

APPROVED AS TO FORM:

_____

ASSISTANT STATE'S ATTORNEY
(Required on contracts over $1,000,000.00)

_____

Date