PROFESSIONAL SERVICES AGREEMENT

EMPLOYER SPONSORED HEALTH INSURANCE BENEFITS

BETWEEN

COOK COUNTY GOVERNMENT

COOK COUNTY OFFICE OF RISK MANAGEMENT

AND

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

CONTRACT NO. 2205-08290A
PURCHASE ORDER NO. 70000300571

PROFESSIONAL SERVICES AGREEMENT

TABLE OF CONTENTS

TERMS AND CONDITIONS 1
ARTICLE 1) INCORPORATION OF BACKGROUND 1
ARTICLE 2) DEFINITIONS 1
a) Definitions 1
b) Interpretation 2
c) Incorporation of Exhibits 3
d) Order of Precedence 3
ARTICLE 3) DUTIES AND RESPONSIBILITIES OF CONSULTANT 3
a) Scope of Services 3
b) Deliverables 4
c) Standard of Performance 4
d) Personnel 5
e) Minority and Women Owned Business Enterprises Commitment 6
f) Insurance …… 6
g) Indemnification 9
h) Confidentiality and Ownership of Documents 9
i) Patents, Copyrights and Licenses 10
j) Examination of Records and Audits 11
k) Subcontracting or Assignment of Contract or Contract Funds 12
ARTICLE 4) TERM OF PERFORMANCE 13
a) Term of Performance 13
b) Timeliness of Performance 13
c) Agreement Extension Option 14
ARTICLE 5) COMPENSATION 14
a) Basis of Payment 14
b) Method of Payment 14
c) Funding 15
d) Non-Appropriation 15
e) Taxes 15
f) Price Reduction 16
g) Consultant Credits 16
ARTICLE 6) DISPUTES 16
ARTICLE 7) COOPERATION WITH INSPECTOR GENERAL AND COMPLIANCE 16
WITH ALL LAWS 16
ARTICLE 8) SPECIAL CONDITIONS 17
a) Warranties and Representations 17
b) Ethics 18
c) Joint and Several Liability 18
d) Business Documents 18
e) Conflicts of Interest 18
f) Non-Liability of Public Officials 19

ARTICLE 9) EVENTS OF DEFAULT, REMEDIES, TERMINATION, SUSPENSION 20
AND RIGHT TO OFFSET 20
a) Events of Default Defined 20
b) Remedies....21
c) Early Termination....23
d) Suspension 24
e) Right to Offset....24
f) Delays 24
g) Prepaid Fees 24
ARTICLE 10) GENERAL CONDITIONS....25
a) Entire Agreement 25
b) Counterparts....26
c) Contract Amendments 26
d) Governing Law and Jurisdiction 26
e) Severability 27
f) Assigns 27
g) Cooperation....27
h) Waiver 27
i) Independent Consultant 28
j) Governmental Joint Purchasing Agreement 28
ARTICLE 11) NOTICES 29
ARTICLE 12) AUTHORITY....30

List of Exhibits

Exhibit 1 Scope of Work
Exhibit 2 Schedule of Compensation
Exhibit 3 Minority and Women Owned Business Enterprise Commitment
Exhibit 4 Evidence of Insurance
Exhibit 5 PPO Administrative Services Agreement
Exhibit 6 HMO Cost Plus Group Administration Document
Exhibit 7 Board Authorization
Exhibit 8 Identification of Subcontractor/Supplier/Subconsultant Form
Exhibit 9 Economic Disclosure Statement

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 "Consultant", pursuant to authorization by the Cook County Board of Commissioners on October 19, 2023, as evidenced by Board Authorization letter attached hereto as EXHIBIT "7".

BACKGROUND

The County of Cook issued a Request for Proposals "RFP"* for *Employer Sponsored Health Insurance Benefits*. *Proposals were evaluated in accordance with the evaluation criteria published in the RFP. The Consultant was selected based on the proposal submitted and evaluated by the County representatives.

WHEREAS, Consultant 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.

NOW, THEREFORE, the County and Consultant 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 here.

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, and all services reasonably necessary to complete the Additional Services to the standards of performance required by this Agreement. Any Additional Services requested by the Using Agency require the approval of the Chief Procurement Officer in a written amendment to this Agreement before Consultant 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.

"**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 claim determinations, network management, utilization reviews, payment integrity, appeal determinations, and customer service involving any direct contact with Covered Persons. "Core Services" does not include 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 Covered Persons. "Customer service" means a call center staffed to answer claims, benefit and network questions received from covered persons."

"**Services**" means, collectively, the services, duties and responsibilities described in Article 3 of this Agreement and any and all work necessary to complete them or carry them out fully and to the standard of performance required in this Agreement.

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

"Using Agency" shall mean the department of agency within Cook County including elected officials.

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 Scope of Work
Exhibit 2 Schedule of Compensation
Exhibit 3 Minority and Women Owned Business Enterprise Commitment
Exhibit 4 Evidence of Insurance
Exhibit 5 PPO Administrative Services Agreement
Exhibit 6 HMO Cost Plus Group Administration Document
Exhibit 7 Board Authorization
Exhibit 8 Identification of Subcontractor/Supplier/Subconsultant Form
Exhibit 9 Economic Disclosure Statement

d) Order of Precedence

In the event there is a conflict between or among any of the documents specified in subsection (c) Incorporation of Exhibits, the terms of the Professional Services Agreement shall control. This Contract shall be interpreted and construed based upon the following Order of Precedence. Such order of precedence shall govern to resolve all cases of conflict, ambiguity or inconsistency between Exhibits:

Exhibit 1 Scope of Work
Exhibit 2 Schedule of Compensation
Exhibit 5 PPO Administrative Services Agreement
Exhibit 6 HMO Cost Plus Group Administration Document
Exhibit 3 Minority and Women Owned Business Enterprise Commitment
Exhibit 4 Evidence of Insurance
Exhibit 7 Board Authorization
Exhibit 8 Identification of Subcontractor/Supplier/Subconsultant Form
Exhibit 9 Economic Disclosure Statement

ARTICLE 3) DUTIES AND RESPONSIBILITIES OF CONSULTANT

a) Scope of Services

This description of Services is intended to state the scope and nature of the Services Consultant is to provide under this Agreement. Any additional mutually acceptable terms that may further define the Services are subject to the amendment provision in Article 10 herein. Consultant must provide the Services in accordance with the standards of

performance set forth in Section 3c. The Services that Consultant must provide include, but are not limited to, those described in Exhibit 1, Scope of Work in accordance with the terms of this Agreement and Exhibits 5 and 6 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, Consultant must prepare or provide to the County various Deliverables. "**Deliverables**" include work product, such as written reviews, recommendations, reports and analyses, produced by Consultant for the County.

The County may reject Deliverables that it reasonably determines 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 determines that Consultant has failed to comply with the foregoing standards, it has 30 days from the discovery to notify Consultant of its failure. If Consultant does not correct the failure, if it is commercially reasonable to do so, within 30 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 Consultant of its commitments under this Agreement.

c) Standard of Performance

Consultant must perform all Services required of it under this Agreement with that degree of skill, care and diligence normally shown by a consultant performing services of a scope and purpose and magnitude comparable with the nature of the Services to be provided under this Agreement. Consultant acknowledges that it is entrusted with or has access to valuable and confidential information and records of the County and with respect to that information, Consultant agrees to be held to the standard of care of a fiduciary.

Consultant must assure that all Services that require the exercise of professional skills or judgment are accomplished by professionals qualified and competent in the applicable discipline and appropriately licensed, if required by law. Consultant must provide copies of any such licenses. Consultant remains responsible for the professional and technical accuracy of all Services or Deliverables furnished, whether by Consultant or its Subconsultants or others on its behalf. All Deliverables must be prepared in a form and content satisfactory to the Using Agency and delivered in a timely manner consistent with the requirements of this Agreement.

If Consultant fails to comply with the foregoing standards, Consultant 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 Consultant 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 Consultant either under this Agreement, at law or in equity.

d) Personnel

i) **Adequate Staffing**

Consultant 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 appropriate, available as needed, qualified and assigned to perform the Services. Consultant 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 and with written consent of the County, which consent the County will not withhold unreasonably. 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**

Consultant 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 Consultant that the County will no longer accept performance of Services under this Agreement by one or more Key Personnel listed. Upon that notice Consultant must immediately suspend the services of the key person or persons and must replace him or them in accordance with the terms of this Agreement. A list of Key Personnel is found in Exhibit 1, Scope of Work.

iii) **Salaries and Wages**

Consultant and Subconsultants 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 Consultant underpays any such salaries or wages, the Comptroller for the County may withhold, out of payments due to Consultant, 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 Consultant 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 Owned Business Enterprises Commitment

In the performance of this Agreement, including the procurement and lease of materials or equipment, Consultant 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 3. Consultant'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. Consultant must utilize minority and women's business enterprises at the greater of the amounts committed to by the Consultant for this Agreement in accordance with Form 1 of the MBE/WBE Utilization Plan.

f) Insurance

The Consultant, at its cost, shall secure and maintain at all times, unless specified otherwise, until completion of the term of this Contract the insurance specified below.

Nothing contained in these insurance requirements is to be construed as limiting the extent of the Consultant's responsibility for payment of damages resulting from its operations under this Contract.

The Cook County Department of Risk Management maintains the right to modify, delete, alter, or change these requirements. Any agreed to changes will be added to this agreement via signed addendum.

i) **Insurance To Be Provided**

(1) Workers Compensation and Employers Liability

Workers' Compensation shall be in accordance with the laws of the State of Illinois or any other applicable jurisdiction.

The Workers Compensation policy shall also include the following provisions:

Employers' Liability coverage with a limit of
$1,000,000 each Accident
$1,000,000 each Employee
$1,000,000 Policy Limit for Disease

(2) Commercial General Liability (Primary and Umbrella)

The Commercial General Liability shall be on an occurrence form basis (ISO Form or equivalent) to cover bodily injury, personal injury and property damage.

Each Occurrence	$1,000,000
General Aggregate	$2,000,000
Completed Operations Aggregate	$2,000,000

The General Liability policy shall include the following coverages:

a) Premises and operations;
b) Contractual Liability;
c) Products/Completed Operations;
d) Severability of interest/separation of insureds clause

(3) Automobile Liability (Primary and Umbrella)

When any vehicles are used in the performance of this contract, Consultant shall secure Automobile Liability Insurance for bodily injury and property damage arising from the Ownership, maintenance or use of owned, hired, and non-owned vehicles with a limit no less than $1,000,000 per accident.

(4) Excess/Umbrella Liability

Such policy shall be excess over Commercial General Liability, Automobile Liability, and Employer's Liability with limits not less than the following amounts:

Each Occurrence: $1,000,000

(5) Professional Liability

The Consultant shall secure insurance appropriate to the Consultant's profession for claims arising out of the performance or nonperformance of professional services. This insurance shall remain in force for the life of the Consultant's obligations under this Contract and shall have a limit of liability of not less than $3,000,000 per claim.

If any such policy is written on a claims-made form:

a) The retroactive coverage date shall be no later than the effective date of this contract.
b) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or before this contract effective date, the Consultant must maintain "extended reporting" coverage for a minimum of three (3) year after completion of services.

(6) Network Security & Privacy Liability (Cyber)

The Consultant shall secure coverage for first and third-party claims with limits not less than $1,000,000 per occurrence or claim, $1,000,000 aggregate.

If any such policy is written on a claims-made form:

a) The retroactive coverage date shall be no later than the effective date of this contract.
b) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date on or before this contract effective date, the Consultant must maintain "extended reporting" coverage for a minimum of three (3) year after completion of services.

ii) **Additional Requirements**

1) Additional Insured

a) Commercial general liability and auto liability shall include Cook County, its officials, employees, and agents as additional insureds with respect to operations performed. Commercial general liability shall be on a primary and non-contributory basis. Any insurance or self-insurance maintained by Cook County shall be excess of the Consultant's insurance and shall not contribute with it.

b) Insurance companies providing coverage shall be licensed or approved by the Department of Insurance, State of Illinois, and shall have a financial rating no lower than (A-) VII as listed in A.M. Best's Key Rating Guide, current edition, or interim report. Companies with ratings lower than (A-) VII will be acceptable only upon consent of the Cook County Department of Risk Management. The insurance limits required herein may be satisfied by a combination of primary, umbrella and/or excess liability insurance policies.

2) Insurance Notices

a) The Consultant shall provide the Office of the Chief Procurement Officer with thirty (30) days advance written notice in the event any required insurance will be cancelled, materially reduced or non-renewed and not replaced. The Consultant shall secure replacement coverage to comply with the stated insurance requirements and provide new certificates of insurance to the Office of the Chief Procurement Officer.

b) Prior to the date on which the Consultant commences performance of its part of the work, the Consultant shall furnish to the Office of the Chief Procurement Officer certificates of insurance maintained by Consultant.

The receipt of any certificate of insurance does not constitute Contract by the County that the insurance requirements have been fully met or that the insurance policies indicated on the certificate of insurance are in compliance with insurance required above.

c) In no event shall any failure of the County to receive certificates of insurance required hereof or to demand receipt of such Certificates of Insurance be construed as a waiver of the Consultant's obligations to obtain insurance pursuant to these insurance requirements.

3) Waiver of Subrogation

a) Commercial general liability, auto liability and workers compensation policies shall contain a Waiver of Subrogation Endorsement in favor of Cook County.

g) Indemnification

(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) as mutually agreed to in writing by the parties; or (ii) to the extent determined by a court of competent jurisdiction. BCBSIL expressly understands and agrees that any 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 Obligation to Indemnify.** The County agrees to indemnify BCBSIL for costs, expenses, reasonable attorney's fees and costs, losses, damages and liabilities incurred or suffered directly from any claims arising out of a breach of this Agreement by County, a failure by County to perform its obligations under this Agreement, or any wrongful 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 (i) as mutually agreed to in writing by the parties; or (ii) or to the extent determined by a court of competent jurisdiction.

h) Confidentiality and Ownership of Documents

Consultant acknowledges and agrees that information provided to Consultant by the County regarding this Contract is confidential and shall not be disclosed, or used by Consultant in any way, whether during the term of this Contract or at any time thereafter, except solely as required in the course of Consultant's performance hereunder, or as may be necessary in

connection with Consultant's compliance and reporting obligations or as authorized in this Agreement or other agreements executed between the County and Consultant. Consultant shall comply with the applicable privacy laws and regulations affecting County. 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), Consultant retains its ownership of such Business Proprietary Information. Consultant shall not have the right to compile and distribute statistical analyses and reports utilizing data derived from information or data obtained from County without the prior written approval of County. In the event such approval is given, any such reports published and distributed by Consultant shall be furnished to County without charge.

All documents, data, studies, reports, work product or product created as a result of the performance of the Contract (the "Documents") shall be included in the Deliverables and shall be the property of the County of Cook except to the extent such materials are the Confidential Information of Consultant, which shall remain the property of Consultant at all times and shall not be disclosed without the approval of Consultant. It shall be a breach of this Contract for the Consultant to reproduce or use any documents, data, studies, reports, work product or product obtained from the County of Cook or any Documents created hereby, whether such reproduction or use is for Consultant's own purposes or for those of any third party. During the performance of the Contract Consultant shall be responsible of any loss or damage to the Documents while they are in Consultant's possession, and any such loss or damage shall be restored at the expense of the Consultant. The County and its designees shall be afforded full access to the Documents and the work at all times.

i) Patents, Copyrights and Licenses

If applicable, Consultant shall furnish the Chief Procurement Officer with all licenses required for the County to utilize any software, including firmware or middleware, provided by Consultant as part of the Deliverables. Such licenses shall be clearly marked with a reference to the number of this County Contract. Consultant shall also furnish a copy of such licenses to the Chief Procurement Officer. Unless otherwise stated in these Contract documents, such licenses shall be effective for the term of this Agreement and shall not limit the number of persons who may utilize the software on behalf of the County.

Consultant agrees to hold harmless and indemnify the County, its officers, agents, 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 Consultant's services constitutes an infringement of any patent, copyright or license or any other property right.

In the event the use of any equipment, hardware or software or any part thereof is enjoined, Consultant with all reasonable speed and due diligence shall provide or otherwise secure for County, at the Consultant'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 Contract; or Consultant 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 Contract.

j) Examination of Records and Audits

The Consultant agrees that the Cook County Auditor the County's duly authorized third-party auditor (collectively, the "Auditor") shall, upon ninety (90) days prior written notice during the terms 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 the Consultant related to the Services performed under this Agreement, or to Consultant's compliance with any term, condition or provision thereof, unless such access is limited or prohibited by applicable law or contract. Consultant will provide a reasonable alternative in the event access to certain records is limited by a contract. The Consultant 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 Consultant and the County. The County will be responsible for its own costs and the cost of the Auditor. 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 the Consultant will agree not to disclose any proprietary or confidential information. The County agrees to require any third-party auditor to hold harmless and indemnify the Consultant in writing of any liability from disclosure of such information prior to engaging in any audit. The County will also provide the Consultant 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.

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

In addition to the Consultant audit rights contained in the Exhibits, during the term of this Agreement and within one hundred eighty (180) days after its termination, Consultant 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 the Consultant receives payment under this Agreement, reimbursement for which is later disallowed by the County, the Consultant shall promptly 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 Consultant under any contract with the County. Consultant 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, Consultant shall identify claims with similar errors and Consultant agrees to correct such claims with similar errors. Further, Consultant has the right to implement reasonable administrative practices in the administration of Claims.

If Consultant carries out any of its duties under the Agreement through a subcontract with a related organization involving a value of cost of $10,000.00 or more over a 12 month period and specifically for the County, Consultant shall be responsible for ensuring that, until the expiration of four years after the furnishing of any service pursuant to said subcontract, the related organization will make available upon request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of said subcontract and any books, documents, records and other data of said related organization that are necessary to certify the nature and extent of such costs. This paragraph relating to the retention and production of documents is included because of possible application of Section 1861(v)(1)(I) of the Social Security Act to this Agreement; if this Section should be found to be inapplicable, then this paragraph shall be deemed inoperative and without force and effect.

k) Subcontracting or Assignment of Contract or Contract Funds

Once awarded, except as otherwise provided in this Agreement, this Agreement shall not be subcontracted to a Subcontractor or assigned, in whole or in part, without the advance written approval of the Chief Procurement Officer, whose approval shall not be unreasonably withheld. In no case, however, shall such approval relieve the Consultant from its obligations or change the terms of this Agreement. The Consultant 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 the Consultant shall have no effect on the County and are null and void.

Prior to the commencement of the Contract, the Consultant shall identify in writing to the Chief Procurement Officer the names of any and all Subcontractors it intends to use in the performance of the Contract by completing the Identification of Subcontractor/Supplier/ Subconsultant Form (“ISF”). The Chief Procurement Officer shall have the right to disapprove any Subcontractor. All Subcontractors shall be subject to the terms of this Contract. Consultant shall be responsible for the performance of any subcontractors and that

such subcontractors will perform consistent with the provisions of the Contract which affect such subcontract. Copies of subcontracts shall be provided to the Chief Procurement Officer upon request.

The Consultant must disclose the name and business address of each Subcontractor, attorney, lobbyist, accountant, consultant and any other person or entity whom the Consultant has retained or expects to retain in connection with the Matter, as well as the nature of the relationship, and the total amount of the fees paid or estimated to be paid. The Consultant is not required to disclose employees who are paid or estimated to be paid. The Consultant is not required to disclose employees who are paid solely through the Consultant'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 the Consultant is uncertain whether a disclosure is required under this Section, the Consultant 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. All Consultants and Subcontractor of the Consultant shall be accountable to the Chief Procurement Officer or his designee while on any County property and shall abide by all rules and regulations imposed by the County.

l) 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, 2023 ("**Effective Date**") and continue until November 30, 2026 or until this Agreement is terminated in accordance with its terms, whichever occurs first.

b) Timeliness of Performance

i) Consultant must provide the Services and Deliverables within the term and within the time limits required under this Agreement, pursuant to the provisions of Section 4(a) and Exhibit 1. Further, Consultant acknowledges that TIME IS OF THE ESSENCE and that the failure of Consultant to comply with the time limits described in this Section 4(b) may result in economic or other losses to the County.

ii) Neither Consultant nor Consultant'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 Consultant by reason of delays or hindrances in the performance of the Services, whether or not caused by the County.

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 will pay Consultant according to the Schedule of Compensation in the attached Exhibit 2 for the successful completion of services.

b) Method of Payment

All invoices submitted by the Consultant shall be in accordance with the cost provisions contained in the Agreement and shall contain a detailed description of the Deliverables, including the quantity of the Deliverables, for which payment is requested. All invoices for services shall include itemized entries indicating the date or time period in which the services were provided, the amount of time spent performing the services, and a detailed description of the services provided during the period of the invoice. All Contracts for services that are procured as Sole Source must also contain a provision requiring the Contractor to submit itemized records indicating the dates that services were provided, a detailed description of the work performed on each such date, and the amount of time spent performing work on each such date. All invoices shall reflect the amounts invoiced by and the amounts paid to the Consultant as of the date of the invoice. Invoices for new charges shall not include "past due" amounts, if any, which amounts must be set forth on a separate invoice. Consultant shall not be entitled to invoice the County for any late fees or other penalties.

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 Contract price, a sum equal to any fines and penalties, including interest, for any tax or fee delinquency and any debt or obligation owed by the Consultant to the County.

The Consultant acknowledges its duty to ensure the accuracy of all invoices submitted to the County for payment. By submitting the invoices, the Consultant certifies that all itemized entries set forth in the invoices are true and correct. The Consultant acknowledges that by submitting the invoices, it certifies that it has delivered the Deliverables, i.e., the goods,

supplies, services or equipment set forth in the Agreement to the Using Agency, or that it has properly performed the services set forth in the Agreement. The invoice must, if applicable, also reflect the dates and amount of time expended in the provision of services under the Agreement. The Consultant acknowledges that any inaccurate statements or negligent or intentional misrepresentations in the invoices shall result in the County exercising all remedies available to it in law and equity including, but not limited to, a delay in payment or non-payment to the Consultant, and reporting the matter to the Cook County Office of the Independent Inspector General.

When a Consultant receives any payment from the County for any supplies, equipment, goods, or services, it has provided to the County pursuant to its Agreement, the Consultant must make payment to its Subcontractors within 15 days after receipt of payment from the County, provided that such Subcontractor has satisfactorily provided the supplies, equipment, goods or services in accordance with the Contract and provided the Consultant with all of the documents and information required of the Consultant. The Consultant may delay or postpone payment to a Subcontractor when the Subcontractor's supplies, equipment, goods, or services do not comply with the requirements of the Contract, the Consultant is acting in good faith, and not in retaliation for a Subcontractor exercising legal or contractual rights.

c) Funding

The source of funds for payments under this Agreement is identified in Exhibit 2, Schedule of Compensation. Payments under this Agreement must not exceed the dollar amount shown in Exhibit 2 without a written amendment in accordance with Section 10(c).

d) 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 Consultant in writing of that occurrence, and this Agreement will 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 there are insufficient funds, the County shall make payments for Services completed and claims costs incurred up to the date of termination specified in the non-appropriation notice. No other payments will be made or due to Consultant and under this Agreement beyond those amounts appropriated and budgeted by the County to fund payments under this Agreement.

e) Taxes

Federal Excise Tax does not apply to materials purchased by the County by virtue of Exemption Certificate No. 36-75-0038K. 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 Contract. The County's State of Illinois Sales Tax Exemption Identification No. is E-9998-2013-07.

f) Price Reduction

[Intentionally Omitted]

g) Consultant Credits

To the extent the Consultant gives credits toward future purchases of goods or services, financial incentives, discounts, value points or other benefits based on the purchase of the materials or services provided for under this Contract, such credits belong to the County and not any specific Using Agency. Consultant shall reflect any such credits on its invoices and in the amounts it invoices the County.

ARTICLE 6) DISPUTES

In the case of disputes arising under this Agreement, the complaining party shall submit a written statement detailing the dispute and specifying the specific relevant Contract 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 his decision to writing and mail or otherwise furnish a copy thereof to the Consultant within thirty (30) days of receipt of the complaining party's written statement unless a notice is issued by the Chief Procurement Officer indicating that additional time is required to review the dispute. This decision will be the County's final position as to the dispute. The decision of the Chief Procurement Officer shall be a condition precedent to an action at law or in equity provided, however, that the parties may commence an action at law or in equity, within the applicable statute of limitations after the Chief Procurement Officer issues his decision or, in the absence of a decision by the Chief Procurement Officer, sixty (60) days after the submission of a complaint from either party to the Chief Procurement Officer. No inference shall be drawn from the absence of a decision by the Chief Procurement Officer. All deliberations concerning dispute resolution are confidential, except to the extent disclosure is required by law, and shall be treated as compromise negotiations for purposes of applicable rules of evidence.

Notwithstanding a dispute, Consultant shall continue to discharge all its obligation, duties and responsibilities set forth in the Contract during any dispute resolution proceeding unless agreed to by the County in writing.

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

The Consultant, 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 Consultant shall observe and comply with the laws, ordinances, regulations and codes of the Federal, State, County and other local government agencies which may in any manner affect the performance of the Contract 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 the Consultant's employees, agents or Subcontractor shall be the responsibility of the Consultant.

The Consultant shall secure and pay for all federal, state and local licenses, permits and fees required for it to provide its Services hereunder.

ARTICLE 8) SPECIAL CONDITIONS

a) Warranties and Representations

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

i) warrants that Consultant 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 Consultant is not appropriately licensed;

ii) warrants it is financially solvent; it and each of its employees, agents and Subcontractors of any tier are competent to perform the Services required under this Agreement; and Consultant is legally authorized to execute and perform or cause to be performed this Agreement under the terms and conditions stated in this Agreement;

iii) warrants 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;

iv) warrants that Consultant and 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, and Consultant warrants it can and will perform, or cause to be performed, the Services in accordance with the provisions and requirements of this Agreement;

vi) represents that Consultant and, based on its knowledge, obtained through commercially reasonable efforts to evaluate such matters, 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 warranties and representations, Consultant warrants:

(1) No officer, agent or employee of the County is employed by Consultant 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 the prime Consultant 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 Consultant, 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 Consultant 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 and subject to applicable confidentiality provisions of any agreements between County and Consultant, Consultant 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) 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. 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) Consultant covenants that it, and to the best of its knowledge, 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 would conflict in any manner or degree with the performance of its Services under this Agreement.

iii) Consultant covenants that to the best of its knowledge, and after reasonable investigation, this Agreement does not present a conflict for Cook County. If Consultant becomes aware of a conflict, it will notify Cook County and take reasonable steps to resolve such conflict.

iv) Without limiting the foregoing, if the Consulting Parties assist the County in determining the advisability or feasibility of a project or in recommending, researching, preparing, drafting or issuing a request for proposals or bid specifications for a project, the Consulting Parties must not participate, directly or indirectly, as a prime, Subcontractor or joint venturer in that project or in the preparation of a proposal or bid for that project during the term of this Agreement or afterwards. The Consulting Parties may, however, assist the County in reviewing the proposals or bids for the project if none of the Consulting Parties have a relationship with the persons or entities that submitted the proposals or bids for that project.

v) The Consultant further covenants that, in the performance of this Agreement, no person having any conflicting interest will be assigned to perform any Services or have access to any confidential information, as defined in Section 3(h) of this Agreement. If the County, by the Chief Procurement Officer in his reasonable judgment, determines that any of Consultant's Services for others conflict with the Services Consultant is to render for the County under this Agreement, Consultant must terminate such other services immediately upon request of the County.

vi) Furthermore, if any federal funds are to be used to compensate or reimburse Consultant under this Agreement, Consultant 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, Consultant 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

Consultant and any assignee or Subcontractor of Consultant 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 the Consultant:

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

ii) Consultant's material failure to perform any of its obligations under this Agreement including the following:

(a) Failure due to a reason or circumstances within Consultant'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 commercially acceptable manner or inability to perform the Services satisfactorily as a result of insolvency, filing for bankruptcy or assignment for the benefit of creditors;

(c) Failure to promptly re-perform within a reasonable time Services that were rejected as erroneous or unsatisfactory;

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

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

iii) Any change in ownership or control of Consultant without the prior written approval of the Chief Procurement Officer, which approval the Chief Procurement Officer will not unreasonably withhold.

iv) Consultant's default under any other agreement it may presently have or may enter into with the County during the life of this Agreement. Consultant 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 the Agreement.

vi) Consultant's repeated or continued violations of County ordinances unrelated to performance under the 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 Consultant;
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), not settled pursuant to the pre-litigation Dispute Resolution process in Article 6, permits the County, at the County's sole option, to declare Consultant in default. The Chief Procurement Officer may in his sole discretion give Consultant an opportunity to cure the default within a certain period of time, which period of time must not exceed sixty (30) days, unless extended by the Chief Procurement Officer. Whether to declare Consultant in default is within the sole discretion of the Chief Procurement Officer and neither that decision nor the factual basis for it is subject for review or challenge under the Article 6 Disputes provision of this Agreement. Nothing in this provision shall impair the ability or rights of Consultant to dispute that decision to declare default or seek damages arising from a default declaration that is wrongful in a court of competent jurisdiction.

2. The Chief Procurement Officer will give Consultant written notice of the default, either in the form of a cure notice ("**Cure Notice**"), or, if no opportunity to cure will be granted, 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 Consultant 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, Consultant must discontinue any Services, unless otherwise directed in the notice, and deliver all materials accumulated in the performance of this Agreement, whether completed or in the process, to the County. After giving a Default Notice, the County may invoke any or all of the following remedies:

i) The right to take over and complete the Services, or any part of them;

ii) 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 County;

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

iv) The right to money damages;

v) The right to withhold Consultant's compensation under this Agreement relating to default;

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

If the Chief Procurement Officer considers it to be in the County's best interests, he may elect not to declare default or to terminate this Agreement. The parties acknowledge that this provision is solely for the benefit of the County and that if the County permits Consultant to continue to provide the Services despite one or more events of default, Consultant 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.

3. **Notices by Consultant.** The occurrence of any event of default set forth under Section 9(a)(2), not settled pursuant to the pre-litigation Dispute Resolution process in Article 6 permits Consultant, 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 Consultant 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 of termination 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 thirty (30) days to cure a default (the "Cure Period"). If the grounds for alleged default are set forth in Article 9(a)(2)(i), Consultant may, after the Cure Period, include in its invoices to County an assessment of interest on those amounts overdue, beginning to accrue upon expiration of the Cure Period, at a rate of.0329% per day (which equates to an amount of twelve percent (12%) per annum).

Whether to declare County in default is within the sole discretion of the Consultant and neither that decision nor the factual basis for it is subject for review or challenge under the Article 6 Disputes provision of this Agreement. Nothing in this provision shall impair the ability or rights of the County to dispute that decision to declare default or seek damages arising from a default declaration that is wrongful in a court of competent jurisdiction.

4. **Exercise of Remedies.** If, after giving a Default Notice, County fails to cure during the specified cure period in accordance with Sections 9(b)(3) above, Consultant 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;

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

remedy;

iii) The right to compensatory damages for amounts due and owing under this Agreement.

5. The remedies under the terms of this Agreement 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, the County may terminate this Agreement, or all or any portion of the Services to be performed under it, at any time by a notice in writing from the County to Consultant. The County will give notice to Consultant in accordance with the provisions of Article 11. The effective date of termination will be the date the notice is received by Consultant or the date stated in the notice, whichever is later. If the County elects to terminate this Agreement in full, all Services to be provided under it must cease and all materials that may have been accumulated in performing this Agreement, whether completed or in the process, must be delivered to the County effective 60 days after the date the notice is considered received as provided under Article 11 of this Agreement (if no date is given) or upon the effective date stated in the notice.

After the notice is received, Consultant 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. 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, but if any compensation is described or provided for on the basis of a period longer than 60 days, then the compensation must be prorated accordingly. No amount of compensation, however, is permitted for anticipated profits on unperformed Services. The County and Consultant must attempt to agree on the amount of compensation to be paid to Consultant, but if not agreed on, the dispute must be settled in accordance with Article 6 of this Agreement. The payment so made to Consultant is in full settlement for all Services satisfactorily performed under this Agreement.

Consultant must include in its contracts with Subcontractors an early termination provision in form and substance equivalent to this early termination provision to prevent claims against the County arising from termination of subcontracts after the early termination. Consultant will not be entitled to make any early termination claims against the County resulting from any Subcontractor's claims against Consultant or the County to the extent inconsistent with this provision.

If the County's election to terminate this Agreement for default under Sections 9(a) and 9(b) is determined in a court of competent jurisdiction to have been wrongful, then in that case the termination is to be considered to be an early termination under this Section 9(c).

d) Suspension

[Intentionally Omitted]

e) Right to Offset

In connection with performance under this Agreement, the County may offset any excess costs incurred:

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

ii) if the County exercises any of its remedies under Section 9(b) of this Agreement; or

iii) if the County has any credits due or has made any overpayments under this Agreement.

The County may offset these excess costs by use of any payment due for Services completed before the County terminated this Agreement or before the County exercised any remedies. If the amount offset is insufficient to cover those excess costs, Consultant is liable for and must promptly remit to the County 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 County.

f) Delays

Consultant agrees that no charges or claims for damages shall be made by Consultant for any delays or hindrances from any cause whatsoever during the progress of any portion of this Contract.

g) Prepaid Fees

In the event this Contract is terminated by either party, for cause or otherwise, and the County has prepaid for any Deliverables, Consultant 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.

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

Each party acknowledges that, except only for those representations, statements or promises expressly contained in this Agreement and any 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 other party, its officials, agents or employees, has induced the party to enter into this Agreement or has been relied upon by it, 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 the Agreement but only as provided in this section. Such amendments shall only be made by mutual agreement in writing.

The Chief Procurement Officer and Consultant may mutually agree 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 $150,000.00. 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 $150,000.00, 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.

Consultant 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 agree that 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, shall be litigated only in state or federal courts within Cook County, State of Illinois and the parties hereby consent and submit to the jurisdiction thereof. In accordance with these provisions, each party waives 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

Consultant must at all times cooperate fully with the County and act in the County's best interests. If this Agreement is terminated for any reason, or if it is to expire on its own terms, Consultant must make every effort to assure 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 Using Agency 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 the County by a proper authority waives Consultant's performance in any respect or waives a requirement or condition to either the County's or Consultant'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 the County may have waived the performance, requirement or condition. Such waivers must be provided to Consultant in writing.

i) Independent Consultant

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 Consultant and the County. The rights and the obligations of the parties are only those expressly set forth in this Agreement. Consultant must perform under this Agreement as an independent Consultant and not as a representative, employee, agent, or partner of the County.

This Agreement is between the County and an independent Consultant and, if Consultant is an individual, nothing provided for under this Agreement constitutes or implies an employer-employee relationship such that:

i) The County will not be liable under or by reason of this Agreement for the payment of any compensation award or damages in connection with the Consultant performing the Services required under this Agreement.

ii) Consultant is not entitled to membership in the County Pension Fund, Group Medical Insurance Program, Group Dental Program, Group Vision Care, Group Life Insurance Program, Deferred Income Program, vacation, sick leave, extended sick leave, or any other benefits ordinarily provided to individuals employed and paid through the regular payrolls of the County.

iv) The County is not required to deduct or withhold any taxes, FICA or other deductions from any compensation provided to the Consultant.

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 under this contract.

In the event that other agencies participate in a joint procurement, the County reserves the right to renegotiate the price to accommodate the larger volume.

k) Comparable Government Procurement

As permitted by the County of Cook, other government entities, if authorized by law, may wish to purchase the goods, supplies, services or equipment under the same terms and conditions contained in this Contract (i.e., comparable government procurement). Each entity wishing to reference this Contract must have prior written authorization from the County of Cook and the Consultant. If such participation is authorized, all purchase orders will be issued directly from and shipped directly to the entity requiring the goods, supplies, equipment or services supplies/services. The County shall not be held responsible for any orders placed, deliveries made or payment for the goods, supplies, equipment or services

supplies/services ordered by these entities. Each entity reserves the right to determine the amount of goods, supplies, equipment or services it wishes to purchase under this Contract.

l) Force Majeure

Neither Consultant nor County shall be liable for failing to fulfill any obligation under this Contract 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 include and not be limited to acts of God, acts of war, terrorism, cybercrime, nature, fires, lightning, floods, epidemics, or riots.

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 County 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 Consultant: Robert Miller
Vice President Blue Cross and Blue
Shield of Illinois 300 E. Randolph
Street, 8th Floor
Chicago, Illinois 60601-5099

and 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

Execution of this Agreement by Consultant is authorized by a resolution of its Board of Directors, if a corporation, or similar governing document, and the signature(s) of each person signing on behalf of Consultant have been made with complete and full authority to commit Consultant 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 in it.

EXHIBIT 1

Scope of Work

Blue Cross Blue Shield of Illinois (BCBSIL)

SCOPE OF SERVICES

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 comprehensive and cost-effective manner. BCBSIL was selected based on a combination of competitive fees, comprehensive provider networks, quality program offerings and member and client service.

The County requires BCBSIL match the County's current plan designs including as Attachment A to this document. Benefit plan designs are subject to the collective bargaining process and may require implementation within the contract term. All such benefit design changes and funding type elections are governed by the terms and conditions of the annual Benefit Program Agreements (BPA)s and Stop Loss Agreements, executed at the authority of Cook County's Director of Risk Management.

BCBSIL agrees to the following service requirements:

1. General Requirements
2. Contract Requirements
3. Ownership and Maintenance of Records
4. Eligibility
5. Plan Administration / Claims Processing
6. Systems Support / Technology
7. Compliance
8. Banking & Invoicing
9. Account Management
10. Reporting
11. Member Services
12. Network Management
13. Clinical and Utilization Management Services
14. Implementation & Termination Service Requirements
15. Stop Loss
16. Employee Assistance Program
17. Performance Guarantees
18. Audit

1. General Requirements

a. BCBSIL will undertake all necessary tasks to properly administer the medical benefits, claim adjudication, provider networks, member services, reporting, integration with the Pharmacy Benefit Manager, clinical services, regulatory and compliance programs, and all other services defined in this Scope of Services.

b. BCBSIL will undertake all other necessary tasks to properly administer the services for the members, including but not limited to, determining member eligibility in accordance with Cook County provided eligibility information at the point of sale; sending communication materials on an as needed basis; responding to telephone and written or electronically submitted inquiries; instructing members on the appropriate and cost-effective use of medical benefits and services.

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 will provide insurance covering all operations of BCBSIL and/or its subcontractors [redacted] to Cook County.

e. BCBSIL will provide written representation and warranty that BCBSIL's own professional staff have met applicable credentialing criteria, licensing and/or certification and insurance requirements.

f. BCBSIL will provide specified services without regard to any waiting period.

g. BCBSIL will provide specified services without regard to any pre-existing condition limitations unless such limitations exist in the applicable Benefit Plan.

h. BCBSIL will administer the plan designs as determined by Cook County. To the extent that BCBSIL fails to administer the plan(s) in accordance with their terms, BCBSIL agrees to reimburse any amounts charged to Cook County or to the member in error.

i. BCBSIL will perform any and all functions necessary to ensure financial control and accuracy of services provided to members. If Cook County determines that services have been provided to an individual or individuals ineligible for services, or that a prescription has been filled for a drug or supply which is excluded from coverage, BCBSIL must reimburse Cook County for claims paid in error.

j. BCBSIL will implement best practices related to medical benefit management and as well as administrative systems and processes.

k. BCBSIL will promptly rectify errors and resolve disputes as mutually agreed or as determined by Article 6 of the Agreement.

l. BCBSIL will participate in a data exchange with Pharmacy Benefit Managers or other vendors selected by Cook County for purposes of plan administration and analysis.

m. BCBSIL will agree to comply with all applicable regulatory requirements that apply to BCBSIL's services, including but not limited to the Affordable Care Act, Consolidated Appropriations Act, the Inflation Reduction Act, and Mental Health Parity, and assist Cook County in its efforts to comply with such regulatory requirements.

2. Contract Requirements

i. BCBSIL will negotiate terms and conditions of a Contract with Cook County on a timely basis.

ii. BCBSIL will execute a contract with Cook County before the effective date of the contract.

iii. BCBSIL will provide that Cook County may renew its Contract for up to two additional two-year periods beyond the original term.

iv. BCBSIL will provide all renewal information to Cook County at least 120 days prior to the expiration date of any Contract period, in form and content acceptable to the County.

v. BCBSIL will complete a Business Associate Agreement (BAA) with Cook County and other service providers as may be required.

vi. BCBSIL will complete the Contractor's Disclosure Forms or Affidavits as may be required by Cook County as set forth in the RFP.

vii. BCBSIL will offer such services in conformance with applicable federal and or state laws and regulations, Cook County's ordinances, personnel policies, procedures, rules and the terms of the applicable Benefit Plans.

viii. BCBSIL will comply with the Women's Business Enterprise (WBE) and Minority Business Enterprise (MBE) and with all other Cook County specific requirements.

ix. BCBSIL will ensure that services are offered by persons and firms authorized and duly licensed as required by federal, state and/or local laws or regulations. BCBSIL must provide evidence of a license to do business in the State of Illinois, and all other licenses and certifications as may be necessary to provide the services requested.

x. BCBSIL will agree that the Contract may be terminated at any time without cause by the relevant Agency or for cause as set forth in the Contract with the Agency.

3. Ownership and Maintenance of Records

a. All data and records derived from services provided as the BCBSIL remain the property of Cook County, except with respect to the Confidential Business Information of BCBSIL, which shall remain the property of BCBSIL at all times.

b. Cook County has the right to review, abstract, audit and copy all data and records of BCBSIL directly or indirectly related to any contracts, provided however, Cook County shall not disclose any of BCBSIL's Confidential Business Information without the express approval of BCBSIL or as permitted by the Agreement.

c. Confidential information must not be used by BCBSIL for other than the purposes specified in any Contracts between Cook County and BCBSIL.

d. Any data provided by Cook County to BCBSIL may not be sold, marketed, furnished, or otherwise made available to any person or entity for any purpose without the prior approval of Cook County.

e. Upon termination of the agreement for any reason, BCBSIL shall return or destroy all PHI created or received by BCBSIL as a business associate in connection with the agreement.

f. BCBSIL will retain all records directly or indirectly, related to its performance of Services during the term of any Contracts and for a period of [redacted] after termination or expiration of any Contract or until all pending disputes are resolved.

g. After being stored online, all historical claims data are stored on tape in a secured climate-controlled facility as required by law. Historical claims data can be retrieved and restored for internal purposes. [redacted]

4. Eligibility

a. BCBSIL will update its eligibility system within [redacted] business days of receiving valid and complete enrollment data from the County via an electronic data interface EDI (Electronic Data Interface) file. Open enrollment files are excluded.

b. BCBSIL will perform data quality checks to assess whether the data is complete. All errors will be reported to the County for verification within [redacted] of receipt of the County's enrollment file. The County will subsequently advise the BCBSIL of what actions to take to resolve each of the discrepancies.

c. BCBSIL will transfer eligibility data to the County's PBM as well as other vendors as designated by the County and manage the resolution of any errors or discrepancies [redacted] and on a

reasonable timeframe. BCBSIL will allow [redacted] standard file lay-outs with a preferred vendor for eligibility and claims for fully insured and ASO funding.

d. To provide members and Cook County with prompt, accurate and courteous service the BCBSIL agrees to make accurate and timely determinations of eligibility for services in accordance with eligibility information provided by Cook County. Timely service specifically includes prompt issuance of identification cards as required by Cook County; prompt recording of overrides authorized by Cook County; and immediate eligibility update requests.

e. No member (subscriber or dependent) may change enrollment information on the BCBSIL systems; eligibility changes can only be processed via Cook County data file or entered online via an administrative portal.

5. Plan Administration / Claims Processing

i. BCBSIL will check all claims for eligibility, benefit design, cost share requirements, and exclusions to determine which claims are successfully processed, pended for prior authorization, or rejected for ineligibility or other factors in the specifications of the Cook County plan.

ii. BCBSIL will maintain a claims-paying unit assigned to the County.

iii. BCBSIL will maintain separate subgroup files in HMO and PPO plans for the various subgroups of members as defined on an annual basis by the County so as to aid in the administration and reporting for such subgroups.

iv. BCBSIL will make health benefit claims determination decisions under a consistent methodology and standards for approval or denial that it applies in doing claims administration across its commercial clients.

v. BCBSIL will not grant exceptions or make modifications to the County's plan.

vi. BCBSIL will notify, in writing, the affected member whenever it denies payment of all or a portion of any claim for benefits under the Summary of Benefits. Each written notice of denial must comply with applicable laws, regulations and regulatory guidance.

i. BCBSIL will conduct reviews of all appeals from such denied claims and will notify the affected member in writing of the member's right to seek external review.

ii. BCBSIL will notify the County in writing [redacted] of receipt of a member's request for an external review of an adverse determination.

vii. BCBSIL will monitor claims during processing for the purpose of identifying instances of claim fraud. BCBSIL will use its best efforts to prevent and identify claim fraud through systems, monitoring, and programmatic reviews.

viii. BCBSIL will perform activities necessary to administer the County plan subrogation provisions as described in the Summary of Benefits.

6. Systems Support / Technology

i. BCBSIL's data center is staffed 24 hours a day, seven days a week, 365 days a year.

ii. BCBSIL will implement and maintain data security procedures to prevent unauthorized access of Cook County data.

iii. BCBSIL will maintain appropriate procedures to prevent and comply with applicable laws to prevent, identify, detect and report a breach of protected health information (PHI).

iv. BCBSIL will use standardized data file formats and data transmission methods as may be required for the administration of the Services, subject to Cook County's approval.

7. Compliance

a. BCBSIL will provide all required information and/or assistance to the County to comply with the obligations of the Patient Protection and Affordable Care Act, Consolidated Appropriations Act, Transparency in Coverage, and Mental Health Parity regulations as set forth in Section 4 of Exhibit 5 of the Agreement or as mutually agreed.

b. BCBSIL will to the extent mutually agreed or required by Applicable Law, require participating providers and facilities to ask whether an individual is covered by a group health plan. If so, to the extent required by Applicable Law in effect at the time, require the participating provider to furnish the BCBSIL with a good faith estimate that meets the requirements of the CAA of the expected charges for the items/services, along with the expected billing and diagnostic codes. BCBSIL must, upon receipt of that estimate, provide in a manner that fulfills County's obligations under Applicable Law the individual with a clear and understandable advanced EOB.

c. BCBSIL will furnish the County in a timely manner with an annual SOC 1 and SOC 2 Audit Report under the Statement on Standards for Attestation Engagements or a substantially similar audit agreeable to the County, issued by the independent auditors of the BCBSIL.

d. BCBSIL will communicate any legislative or regulatory changes related to plan operations to the County within [redacted] of any applicable law going into effect or regulation adopted. BCBSIL will update plan booklets [redacted] to the County.

8. Banking & Invoicing

a. Reserved

9. Account Management

a. BCBSIL shall provide a designated account manager and supporting account team of sufficient size and responsibility to handle all needs, 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.

c. BCBSIL will provide emergency contact information for key managers responsible for Cook County's account. Such key managers must include both operational and account management staff who are of sufficient authority within the organization as to be capable of and in a position to resolve emergency situations.

d. BCBSIL will meet with Cook County representatives whenever necessary to promptly resolve any problems which occur related to the administration of the services.

e. BCBSIL will provide communication pieces for the County.

f. BCBSIL will produce plan booklets at the request of the County. Plan booklets and other contractual documents may be customized by working with the County's account team.

g. BCBSIL will, upon request, provide member communication material as requested regarding the HMO and PPO network providers.

h. BCBSIL will provide co-branding of existing written and electronic communications or other minor modifications [redacted].

i. BCBSIL will participate in Open Enrollment meetings and Health/Wellness Fairs on an as requested basis in both virtual and in-person formats.

j. BCBSIL will staff various work locations with company representatives to meet with Cook County employees on an as needed basis.

k. BCBSIL will provide professional consulting services to Cook County about medical benefits on an on-going basis to ensure compliance with all laws and provide advice regarding benefit design and communication to members.

l. BCBSIL will consult collaboratively with Cook County staff to identify cost savings, efficiencies, and performance improvements during the life of the collective bargaining agreements and extensions thereto.

m. BCBSIL will record 100% of member calls to customer service.

n. BCBSIL will grant access to call transcripts to authorized County representatives if requested to resolve member concerns.

o. BCBSIL will provide a senior communication consultant and/or vendor to meet with the County's benefits communication team and develop a 12-month employee wellness and communication campaign based on both communication objectives and health care management goals.

   i. 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.

p. BCBSIL offer virtual and on-site wellness events and will work with the County to incorporate offerings into an annual plan. Wellness activities may be provided subject to Wellness Credits as outlined in the Schedule of Compensation. A wellness coordinator may be provided to coordinate client wellness activities and build health promotion activities.

   i. Health Fairs - The County may 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.

   ii. Health Education Classes - The County may 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.

10. Reporting

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

b. BCBSIL will offer the County access to its Web-based reporting application. Key analyses within the reporting application include utilization trend, financial analysis, provider, and plan analysis. Features of this reporting application include:

   i. Billed charges

ii. Not Covered Charges
iii. Covered Charges
iv. Allowed Charges
v. Deductible
vi. Coinsurance amounts
vii. Copayment amounts
viii. Subrogation amounts
ix. COB amounts
x. Other adjustment amounts
xi. Net paid amounts
xii. Customized reports to include logos
xiii. Standard executive summary reports
xiv. 24/7 online access
xv. Drill-down and reach through functionality
xvi. Benchmarking data against the Plan's book of business
xvii. Multiple security levels
xviii. Monthly data loads with rolling 38 months of data

c. The reporting portal will be available to the County's designated account manager and other designated staff to complete any ad hoc reporting needs. [redacted]

d. 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. [redacted]

e. BCBSIL will provide a designated client consultant to support the County's reporting needs. Report analytics and outcomes will be discussed on a [redacted] basis. [redacted]

11. Member Services

a. BCBSIL will work cooperatively and in good faith with Cook County to assure that all services are rendered in a prompt and accurate manner to all members.

b. Customer service team members will be trained in Cook County's policies and procedures.

c. Customer service team members can access claims history/status, SPDs/plan documents and the history and status of member questions/complaints, when available, to respond to member inquiries.

d. 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.

e. All BCBSIL customer service team members have been trained in claims processing and have the authority to authorize adjudication of claims, with varying degrees of authority.

f. BCBSIL customer service team members will provide direct referrals to the program for PPO members, answer members' initial questions, and assist members in accessing disease and care management contacts.

g. BCBSIL will accept warm transfers from and provide a warm transfer to the County's other vendors mutually agreed to by the parties.

h. BCBSIL will audit [redacted] of member service calls each year for accuracy and service delivery.

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

j. BCBSIL shall provide toll-free telephone, TDD access and IVR for member service. The current hours of operation are Monday through Friday, from 8:00 a.m. to 6:00 p.m., Central Time.

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

l. BCBSIL shall maintain a website for the County's members and plan administrators as well as a [redacted] iPhone and Android app.

m. Website and mobile member tools will have the following capabilities:

   i. Access provider directories or check whether providers are in the network. This should include hospitals, physicians, and urgent care centers.
   ii. Change a PCP
   iii. Access provider quality information
   iv. Access benefit plan summaries
   v. Check eligibility
   vi. Order replacement ID cards
   vii. View and print ID cards from the website
   viii. "Talk" to a nurse (i.e., "Ask-the-Physician")
   ix. File a claim
   x. Review a history of medical claims
   xi. Download printable versions of claim forms
   xii. Check claim status
   xiii. Submit appeals
   xiv. Access cost estimators
   xv. Submit inquiries to member service via email
   xvi. Access and complete satisfaction surveys
   xvii. Research symptoms, medical conditions, or wellness information

n. BCBSIL will provide price comparison guidance online or by telephone in a manner that fulfills the County's obligations under Applicable Law.

o. BCBSIL will provide health management tools so that members can use to learn about and manage their condition.

p. BCBSIL will provide ID cards within [redacted] following the receipt of all necessary information from the County and submission to BCBSIL.

q. BCBSIL will provide reasonable customization of the ID card [redacted]. The card will include the County's logo and custom message based on the benefit programs offered, to the extent permitted by ID Card rules.

12. Network Management

a. BCBSIL will, in good faith, establish and maintain the HMO and PPO Provider Network that will consist of primary care providers, pediatricians, physician specialists, non-physician specialists,

hospitals, outpatient clinics, urgent care centers, mental health and chemical dependency care providers home health care providers, durable medical equipment suppliers, and such other providers available directly to the members or by referral as may be required by the terms of the Summary of Benefits.

b. BCBSIL will establish and maintain HMO and PPO provider networks through which members may directly or through referral seek services for ob/gyn care, pediatric care, annual routine vision exams and medically necessary vision services for illness or injury, chiropractic care, mental health and chemical dependency care.

c. Medical Health Plan Administrator will make its best effort to ensure that the HMO and PPO primary care provider network, specialist physician care network, chiropractic care network and the mental health and chemical dependency services network size meets the minimum access standards set by the State of Illinois. BCBSIL will include Cook County Health and Hospital providers in the PPO network offered to members. BCBSIL will make a commercially reasonable effort to include Cook County Health facilities and physician groups within the HMO.

d. BCBSIL will include Cook County Health and Hospital providers as the lowest cost share tier (Tier 1) in the PPO network, with in-network providers as Tier 2, and out-of-network providers as Tier 3.

e. While the HMO and PPO network may change due to the addition or withdrawal of specific providers, as well as due to any disciplinary action taken against providers by professional review boards, BCBSIL will work to ensure consistency in the network.

f. To the extent that any participating provider ceases to participate in the HMO and PPO network, BCBSIL will continue to make such participating provider available to members through the end of the contract year [redacted] to the County or members.

g. In developing or maintaining the HMO network, and in evaluating potential network changes or development of new networks, BCBSIL will review primary and specialist physicians and facilities using information on provider performance and quality available through national, state, and independent reporting and analytical organizations.

h. BCBSIL is willing to recruit "must have" providers in the HMO and PPO networks.

i. BCBSIL will provide access to Centers of Excellence program for identified conditions for members.

j. BCBSIL will negotiate the provider reimbursement terms of all HMO and PPO network participation agreements. BCBSIL represents and warrants that with the exception of reimbursement terms for BCBSIL's narrow-networks or ACO products with specific benefit designs, each provider's reimbursement terms will be equal to or more favorable than all other network participation agreements between BCBSIL and those providers with respect to commercial network participation agreements.

k. BCBSIL upon the request of the County will provide provider-specific cost or data relating to providers, the plan sponsor, participants, or beneficiaries (or individuals who are eligible for coverage under the County's plan) in a mutually agreeable format.

13. Clinical and Utilization Management Services

a. BCBSIL will use its best efforts to develop, maintain and refine programs concerning health risk management, disease management, health promotion, health education, self-care, and other efforts

toward improving the health of members, reducing health care costs, and educating members to be informed consumers of health care.

b. 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.

c. BCBSIL will offer a 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.

d. BCBSIL will provide a Diabetes care program that includes:

   i. Identifying members with diabetes through analytics on pharmacy claims, medical claims, and lab results
   ii. Providing glucose monitors to members and monitoring blood glucose for participants that choose to participate with connected monitors
   iii. Offer guideline driven screenings
   iv. Providing clinical case management and support to participating members with the support of clinicians certified in Diabetes care
   v. Monitoring adherence to medications related to the treatment of Diabetes
   vi. Providing digital tools through a mobile or online application

e. 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.

   i. Case managers will coordinate and promote transition of care by providing members with information about available resources that promote quality and cost-effective outcomes.

   ii. Case managers will 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.

   iii. [redacted] a Case Manager, who has experience in case management, will contact the member and may contact the provider on an as needed basis.

   iv. Case management will be assessed on the following criteria:
      i. Coordination and access to required services
      ii. maximize appropriate, efficient, and cost-effective utilization of resources
      iii. Promote continuity of care across the health care continuum
      iv. Reduce unnecessary ambulatory sensitive inpatient admissions and readmissions
      v. Reduce unnecessary emergency room (ER) encounters
      vi. Increase member self-care and management of diagnosed diseases and conditions when appropriate
      vii. Increase use of appropriate alternative settings

f. BCBSIL will provide HMO case management services collaboratively between BCBSIL and the network providers or IPAs.

i. 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.

ii. HMO care management will include providing a range of disease management and quality improvement programs, embedded [redacted] in the HMO product.

iii. These programs offer incentive compensation to contracting IPAs based on improved outcomes.

iv. BCBSIL will offer a wellness program and preventive care and condition - specific programs for HMO members.

g. BCBSIL will offer, at a minimum, the following disease/condition management program, care plan, or intervention for high risk, high need members identified through health management:

i. Arthritis
ii. Asthma
iii. Cancer
iv. Cerebrovascular Disease
v. CHF
vi. COPD
vii. Coronary Artery Disease
viii. Depression
ix. Diabetes
x. GERD
xi. High Risk Pregnancy
xii. HIV/Aids
xiii. Hypercholesterolemia
xiv. Joint Disorders
xv. Low Back Pain
xvi. Pain Management
xvii. Renal Failure
xviii. Smoking Cessation
xix. Weight Management

h. BCBSIL will provide members with a Lifestyle Management Program on health issues including tobacco cessation, weight management, weight loss, and metabolic syndrome, as well as via its wellness portal, on issues including tobacco cessation, weight management, stress management, nutrition, physical activity, blood pressure, and cholesterol programs. Based on member need, severity, or request, the member will be contacted with 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. BCBSIL will provide wellness coaching, online tools and resources, fitness programs, wellness coordinating services, premium communication packages, and onsite health events and screenings.

j. For all clinical or UM programs, BCBSIL will make multiple outreach attempts to a high-risk, high need members in accordance with BCBSIL's standard processes and members' needs and preferences.

k. 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.

l. BCBSIL will offer telehealth that includes telephonic or video virtual visits. Telehealth must be accessible by mobile app or web-based platform.

14. Implementation & Termination Service Requirements

a. BCBSIL will cooperate fully and take all actions necessary to efficiently transfer this function.

b. BCBSIL will provide an implementation calendar and workplan for successful transition of the medical benefits immediately upon award of the contract.

c. BCBSIL will provide an experienced implementation team to manage the implementation process.

d. BCBSIL will provide a pre-enrollment website and phone number for members prior to the start of Open Enrollment.

e. BCBSIL will program and test the Cook County benefits in advance of the effective date and provide testing result summaries to Cook County.

f. BCBSIL will test, accept and load transition files and applicable data from the incumbent including prior authorization files, case management and large case management files, and other transition of care files.

g. BCBSIL will implement a communication plan to notify all Cook County members impacted by network or other transition changes as well as remedies for the member.

h. BCBSIL will provide claim processing reporting upon the effective date that summarizes claim rejections and the reasons for the rejections.

i. In the event that another company is selected to provide these services to Cook County following the expiration or termination of the contract, BCBSIL will cooperate fully and take all actions necessary to efficiently transfer this function.

j. BCBSIL will provide, [redacted] prior authorization files, case management and large case management files, and other transition of care files.

15. Stop Loss

a. BCBSIL will provide stop loss coverage and is effective as of December 1, 2023.

b. BCBSIL shall reimburse Cook County when the total amount of Paid Claims pertaining to Subscribers or Members exceeds the Specific Stop Loss Limit.

c. BCBSIL reimbursement shall begin no later than the month following the date on which the Specific Stop Loss Limit is exceeded.

d. Health Plan Administrator will provide a standard reporting package to Cook County.

16. Employee Assistance Program

a. EAP provider will offer a broad network of licensed clinicians.

b. EAP provider will maintain sufficient capacity of providers that are accepting new patients.

c. EAP provider will ensure timely access to providers with minimal wait time for routine appointments, urgent appointments, and crisis appointments.

d. EAP provider will maintain capacity to provide on-site critical incidence support.

e. EAP provider will provide 24-hour crisis counseling, emergency triage and appointment scheduling.

f. EAP provider will offer a base package of services including Critical Incidence Support, Management Support, Unlimited Wellness Coaching (phone and video), and a Bank of Work-Life Training Hours (150 hours).

g. EAP provider will make available a minimum of five (5) counseling sessions annually. Assistance is be provided through a range of methods including digital, phone, video, and face-to-face.

h. EAP provider will refer concerns that cannot be adequately addressed through the EAP to appropriate health plan, private or community resources.

i. EAP provider will provide a member portal which is user-friendly and thorough. The portal is to be available on all devices, offer online customer service chat, and provide access to tools, resources, and apps.

j. EAP provider will offer additional resources for digital self-care, financial counseling, and work-life services, among others.

k. EAP provider will provide periodic utilization reporting.

l. EAP provider will provide robust employee engagement materials in print and electronic formats.

m. EAP provider will conduct member surveys to assess program effectiveness.

17. Performance Guarantees

a. Performance Guarantees are included in the Schedule of Compensation.

18. Audit

a. The County will have the right to audit such documents and records of BCBSIL as it determines to be appropriate in order to test or verify the validity of any report, record or claim.

b. Cook County, or a mutually acceptable independent third party, may conduct an annual claims audit for the prior contract year to help ensure accuracy by BCBSIL in processing claims, compliance with financial obligations, performance guarantees, business operations, and other contractual obligations.

c. A full claims audit may be conducted upon sixty (60) days advance written notice by the County.

d. BCBSIL will assign sufficient staff capable of assisting the County in the performance of any audit.

e. Any amounts recovered for overpayments discovered during such audit will accrue to the benefit of the County.

EXHIBIT 2

Schedule of Compensation

		12/2023 - 11/2024		12/2023 Estimate			12/2024 Estimate			12/2025 Estimate			Total 3-Year		
		HMO	PPO	HMO	PPO	Total	HMO	PPO	Total	HMO	PPO	Total	HMO	PPO	Total
	Lives as of 08/16/2023			9,431	8,468	17,899	9,431	8,468	17,899	9,431	8,468	17,899	28,293	25,404	53,697
	Claims [1]														
1	[redacted]														
2															
3															
4	Subtotal														
	Administration	PEPM	PEPM												
5	[redacted]														
6															
7															
8															
9															
10															
11	Subtotal														
13	Grand Total														
14	Margin														
15	Grand Total Not to Exceed														
	Other Credits applicable to services														
16	[redacted]														

Footnotes:

[redacted]

[redacted]

EXHIBIT-PG HMO

POLICYHOLDER NAME: COOK COUNTY
POLICYHOLDER ACCOUNT NUMBER: 289800
POLICYHOLDER GROUP NUMBERS: B50001, B03351
Effective for the Settlement Period beginning December 1, 2023, and ending November 30, 2024
Effective for the Settlement Period beginning December 1, 2024, and ending November 30, 2025
Effective for the Settlement Period beginning December 1, 2025, and ending November 30, 2026
Effective for the Settlement Period beginning December 1, 2026, and ending November 30, 2027
Effective for the Settlement Period beginning December 1, 2027, and ending November 30, 2028

Performance guarantees are contingent upon adherence to the terms and conditions of the HMO Performance Guarantee Agreement to which this Exhibit-PG HMO is attached and maintaining an enrollment in the Plan of not less than **8,902** Covered Employees, based on a total of **9,891** contracts. Performance measurement will begin **December 1, 2023**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
ID Cards - Ongoing	**Ongoing ID Cards –** [redacted]	[redacted]	[redacted]
Account Management	**Account Management** [redacted]	[redacted]	[redacted]
	Open Enrollment and Benefit Fair Support - [redacted]	[redacted]	[redacted]
	Consolidated Appropriations Act Support - [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
Claim System Availability	**Claim System Availability -** [redacted]	[redacted]	[redacted]
Claims Processing Turnaround Time – Process-Ready Claims	**Claims Processing Turnaround Time** [redacted]	[redacted]	[redacted]
Claims Processing Turnaround Time – All Claims	**Claims Processing Turnaround Time** [redacted]	[redacted]	[redacted]
Claim Processing Accuracy	**Claim Processing Accuracy** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
	[redacted]		
Claim Financial Accuracy	**Claim Financial Accuracy** [redacted]	[redacted]	[redacted]
Customer Service	**Inquiry Resolution** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the HMO Administrative Fee[1]
	Average Speed of Answer of Telephone Calls, [redacted]	[redacted]	[redacted]
	Abandoned Calls [redacted]	[redacted]	[redacted]
Monthly Reports	**Monthly Reports -** [redacted]	[redacted]	[redacted]
Customer Satisfaction	**Customer Satisfaction** [redacted]	[redacted]	[redacted]
Total Medical			[redacted]

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

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

Performance Guarantee Further Terms and Conditions

1. Performance guarantees will be measured and settled on an annual calendar year basis.
2. Adverse performance shall be excused to the extent it is directly attributable to any disaster or epidemic outside of Contractor's control which substantially disrupts its normal business operation.
3. These Performance Guarantees may be amended prospectively by written agreement of both parties and shall terminate upon termination of this Agreement. [redacted]
4. [redacted]
5. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Contractor, the Contractor reserves the right to re-evaluate and renegotiate the level of performance and/or the administrative fees at risk.
6. [redacted]

FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Network Discount Savings 12/1/2023-11/30/2024	**Network Discount Savings** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

BlueCross BlueShield of Illinois

Cook County Actives

December 1, 2023 - November 30, 2024

HMO Network Discount Guarantee

Medical Claims Only

Guaranteed Discount Percentage: [redacted]



Administration Fee At Risk: [redacted]

Conditions/Caveats

[redacted]

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

Proprietary Information

Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

IN WITNESS WHEREOF, the parties have executed this Exhibit-PG to remain in effect for the indicated period of time.

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**COOK COUNTY**
By: Kathy M. Selck	By:
Kathy Selck Please Print Name	Please Print Name
Title: Vice President & Chief Underwriter	Title:
Date: July 5, 2023	Date:

Proprietary Information
Not for use or disclosure outside the Plan, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

EXHIBIT-PG
EMPLOYER NAME: COOK COUNTY
Employer Account Number: 289800
Employer Group Numbers: 289803, 289804, 291116
Effective for the Settlement Period beginning December 1, 2023, and ending November 30, 2024
Effective for the Settlement Period beginning December 1, 2024, and ending November 30, 2025
Effective for the Settlement Period beginning December 1, 2025, and ending November 30, 2026
Effective for the Settlement Period beginning December 1, 2026, and ending November 30, 2027
Effective for the Settlement Period beginning December 1, 2027, and ending November 30, 2028

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 **7,246** Covered Employees, based on a total of **8,051** contracts. Performance measurement will begin **December 1, 2023**. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
ID Cards - Ongoing	**Ongoing ID Cards –** [redacted]	[redacted]	[redacted]
Account Management	**Account Management** [redacted]	[redacted]	[redacted]
	[redacted]		
	Open Enrollment and Benefit Fair Support - [redacted]	[redacted]	[redacted]
	Consolidated Appropriations Act Support - [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Claim System Availability	**Claim System Availability -** [redacted]	[redacted]	[redacted]
PPO Claims Processing Turnaround Time – Process-ready PPO Claims	**PPO Claims Processing Turnaround Time** [redacted]	[redacted]	[redacted]
PPO Claims Processing Turnaround Time – All PPO Claims	**PPO Claims Processing Turnaround Time** [redacted]	[redacted]	[redacted]
PPO Claim Processing Accuracy	**PPO Claim Processing Accuracy** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	[redacted]		
PPO Claim Financial Accuracy	**PPO Claim Financial Accuracy** [redacted]	[redacted]	[redacted]
Customer Service	**Inquiry Resolution** [redacted] **Average Speed of Answer of Telephone Calls,** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	[redacted] **Abandoned Calls** [redacted]	[redacted]	[redacted]
Eligibility	**Eligibility Processing** [redacted]	[redacted]	[redacted]
Monthly Reports	**Monthly Reports -** [redacted]	[redacted]	[redacted]
Customer Satisfaction	**Customer Satisfaction** [redacted]	[redacted]	[redacted]
Total Medical			[redacted]

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

Performance Guarantee Further Terms and Conditions

1. Performance guarantees will be measured and settled on an annual calendar year basis.
2. Adverse performance shall be excused to the extent it is directly attributable to any disaster or epidemic outside of Contractor's control which substantially disrupts its normal business operation.
3. These Performance Guarantees may be amended prospectively by written agreement of both parties and shall terminate upon termination of this Agreement.
4. [redacted]
5. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Contractor, the Contractor reserves the right to re-evaluate and renegotiate the level of performance and/or the administrative fees at risk.
6. [redacted]

FINANCIAL	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Network Discount Savings 12/1/2023-11/30/2024	**Network Discount Savings** [redacted]	[redacted]	[redacted]
Trend / Claim Cost 12/1/2023-11/30/2024	**Trend / Claim Cost** [redacted]	[redacted]	[redacted]

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

BlueCross BlueShield of Illinois

Cook County Actives

December 1, 2023 - November 30, 2024
PPO Network Discount Guarantee

Medical Claims Only

Guaranteed Discount Percentage: [redacted]



BCBS does not exclude any large claims from the guarantee.

Administration Fee At Risk: [redacted]

Conditions/Caveats

[redacted]

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

Blue Cross and Blue Shield of IL, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

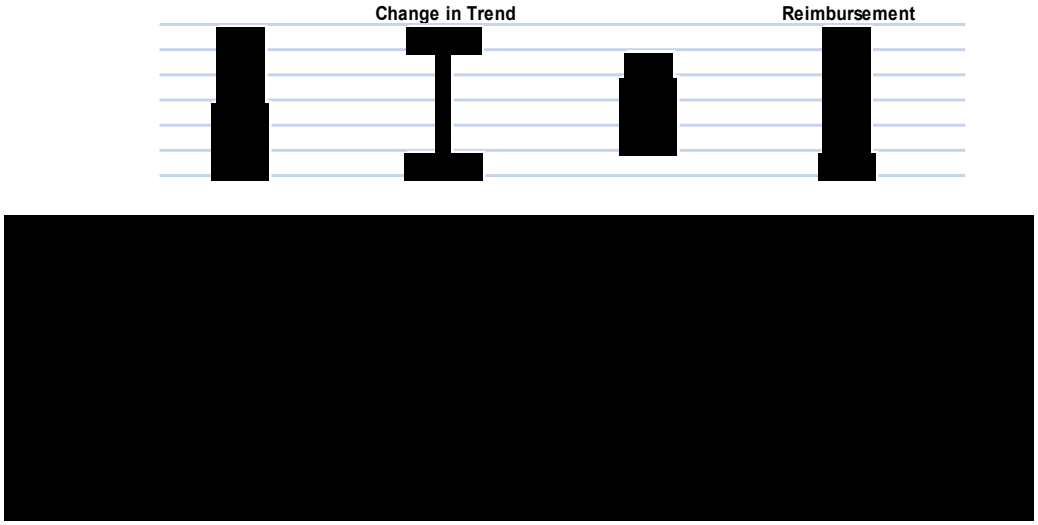
Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

companies and third-party representatives, except with written permission of BCBSIL.

Cook County Actives

December 1, 2023 - November 30, 2024
Trend / Cost of Care Guarantee

PPO Medical only
Claims Incurred 12/01/2023 through 11/30/2024, Paid 12/01/2023 through 02/28/2025



* Baseline claims = Plan paid medical claims incurred from 12/01/2022 through 11/30/2023 and paid from 12/01/2022 through 02/28/2024.

Conditions / Caveats

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.



Blue Cross and Blue Shield of IL, a Division of Health Care Service Corporation, a Mutual
Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

IN WITNESS WHEREOF, the parties have executed this Exhibit-PG to remain in effect for the indicated period of time.

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**COOK COUNTY**
By: Kathy M. Selck	By:
Kathy Selck Please Print Name	Please Print Name
Title: Vice President & Chief Underwriter	Title:
Date: July 6, 2023	Date:

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except under written agreement.

EXHIBIT 3

Minority and Women Owned Business Enterprise Commitment

OFFICE OF CONTRACT COMPLIANCE
NICOLE N. MANDEVILLE
DIRECTOR, CONTRACT COMPLIANCE
161 N. Clark – 23rd Floor ● Chicago, Illinois 60601 ● (312) 603-5502

TONI PRECKWINKLE
PRESIDENT
Cook County Board of Commissioners

TARA STAMPS
1st District

DENNIS DEER
2nd District

BILL LOWRY
3rd District

STANLEY MOORE
4th District

MONICA GORDON
5th District

DONNA MILLER
6th District

ALMA E. ANAYA
7th District

ANTHONY QUEZADA
8th District

MAGGIE TREVOR
9th District

BRIDGET GAINER
10th District

JOHN P. DALEY
11th District

BRIDGET DEGNEN
12th District

JOSINA MORITA
13th District

SCOTT R. BRITTON
14th District

KEVIN B. MORRISON
15th District

FRANK AGUILAR
16th District

SEAN M. MORRISON
17th District

August 30, 2023

Mr. Raffi Sarrafian
Chief Procurement Officer
161 N. Clark, Suite 2300
Chicago, IL 60601

Re: Contract No. 2205-08290A
Employer Sponsored Medical Benefits
Department of Risk Management

Dear Mr. Sarrafian:

The following bid for the above-referenced contract has been reviewed for compliance with the Minority- and Women- owned Business Enterprises (MBE/WBE) Ordinance and have been found to be responsive to the ordinance.

Bidder: Blue Cross Blue Shield of Illinois
Contract Amount: [redacted]
Contract Goal: [redacted]

MBE/WBE	Status	Certifying Agency	Commitment (Direct)*	Commitment (Indirect)*
[redacted]	MBE (HA)	Cook County	[redacted]	
	MBE (HA)	City of Chicago		
	MBE (AA)	City of Chicago		
	MBE (AAPI)	City of Chicago		
	MBE (AA)	City of Chicago		
	MBE (AAPI)	City of Chicago		
		Total		

The Office of Contract Compliance has been advised by the Requesting Department that no other bidders are being recommended for award. Original MBE/WBE forms were used in the determination of the responsiveness of this contract.

***Commitment percentages are based on the Administrative Services fees amount of** [redacted]

Sincerely,

Jeanetta Cardine

Jeanetta Cardine
Contract Compliance Director

JC/vl

cc: CoMakiya Baskin-Smith, OCPO
Jacqueline Hrabak, RM

EXHIBIT 3
Minority and Women Owned Business Enterprise Commitment

I. 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 [thirty-five percent (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
69 West Washington Street, Suite 3000
Chicago, Illinois 60602
(312) 603-5502

EXHIBIT 4

Evidence of Insurance

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/22/2023

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 have ADDITIONAL INSURED provisions or 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 LLC. 540 W. MADISON CHICAGO, IL 60661 Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212-948-1307 CN101825276-PL.-PL-23-24	**CONTACT NAME:** Healthcare Team **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:** Healthcare.AccountsCSS@marsh.com
INSURED HEALTH CARE SERVICE CORPORATION A MUTUAL LEGAL RESERVE COMPANY AND ITS SUBSIDIARIES 300 EAST RANDOLPH CHICAGO, IL 60601	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** Homesite Insurance Company / 17221 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CHI-008415642-20 **REVISION NUMBER:** 2

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)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	PROFESSIONAL LIABILITY/E&O			MPO-140076294-01	12/01/2023	12/01/2024	LIMIT OF LIABILITY	[redacted]

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 LLC

Ali Lenti

EXHIBIT 5

PPO Administrative Services Agreement



BlueCross BlueShield of Illinois

EXHIBIT 5

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.

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.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

TABLE OF CONTENTS

ADMINISTRATIVE SERVICES AGREEMENT 1
SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES 3
SECTION 2: EMPLOYER RESPONSIBILITIES 4
SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS 6
SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS AND DISPUTE RESOLUTION 7
SECTION 5: NON-ERISA GOVERNMENT REGULATIONS 12
SECTION 6: OTHER PROVISIONS 13
SECTION 7: DEFINITIONS 14
EXHIBIT 5-A CLAIM ADMINISTRATOR SERVICES 21
EXHIBIT 5-B FEE SCHEDULE AND FINANCIAL TERMS 24
SECTION 1: FEE SCHEDULE 24
SECTION 2: EXHIBIT DEFINITIONS 24
SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR 25
SECTION 4: CLAIM PAYMENTS 26
SECTION 5: EMPLOYER PAYMENT 26
SECTION 6: CLAIM SETTLEMENTS 27
SECTION 7: LATE PAYMENTS AND REMEDIES 27
SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION 28
EXHIBIT 5-C NOTICES/REQUIRED DISCLOSURES 29
SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS 29
SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP 29
SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS 29
SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS 30
SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS 31
SECTION 6: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES 32
SECTION 7: MEDICARE SECONDARY PAYER INFORMATION REPORTING 32
SECTION 8: REIMBURSEMENT PROVISION 33
SECTION 9: MEMBER DATA SHARING 33
EXHIBIT 5-D BLUE CROSS BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS 34
SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS 34
SECTION 2: ADMINISTRATIVE SERVICES ONLY, NETWORK ONLY 35
SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS 35
SECTION 4: INTER-PLAN ARRANGEMENTS 36
EXHIBIT 5-E RECOVERY LITIGATION AUTHORIZATION 43

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

This Agreement made as of the Effective Date, by and between **Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and Employer, for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a Plan as defined herein; and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA; and

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

WHEREAS, the Parties agree that it is desirable to set forth more fully the obligations, duties, rights and liabilities of Claim Administrator and Employer;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter, and subject to the terms of Cook County Professional Services Agreement Contract No. 2205-08290A ("PSA") set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services set forth in Exhibit 5-A in connection with the administration of the Plan ("Services") through the date of Contract expiration or, if the Contract is terminated prior to the expiration date, until the date of termination per a termination notice. Employer agrees that it will not perform or engage any other party to perform the Services with respect to any Covered Persons prior to the termination of this Contract. Nothing in his provision shall preclude the County from soliciting claim administration services from another third party for commencement after the termination of the Agreement.

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state or local laws that may apply to Claim Administrator's performance of its Services except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. 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 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 that 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.

1.3 **Claim Appeals.** After exhaustion of all internal claim review remedies and exhaustion of an Independent External Review, if applicable, offered by Claim Administrator, a Covered Person may appeal all adverse benefit determinations to Employer. Claim Administrator will cooperate in providing Claim information pursuant to this Agreement.

1.4 **External Review Coordination**. If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 5-A and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

1.5 **Claim Administrator Review of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days prior

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
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written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the Services, Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities, and shall effectuate notice to Employer per the terms of the PSA.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement, or in the PSA.

The Parties acknowledge and agree Claim Administrator does not underwrite or assume any financial risk with respect to claims liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

2.2 **Employer's Direction as to Benefit Design.** Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in an automated benefit summary and similar documentation (collectively, "ABS"), and the ASO BPA. Employer agrees that Claim Administrator shall process claims in accordance with the ABS and the ASO BPA. Employer agrees Claim Administrator may rely on the most current version of the ABS and the ASO BPA as the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

2.3 **Eligibility.** Employer shall determine eligibility for coverage under the Plan. Employer is responsible for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination. Any clerical errors with respect to eligibility will not invalidate coverage that would otherwise be validly in force or continue coverage that would otherwise validly terminate. Such errors will be corrected according to Claim Administrator's reasonable administrative practices including, but not limited to, those related to Timely notification of a change in a Covered Person's status.

2.4 **Notices to Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 6, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 5-C to Covered Persons.

2.5 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform 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 Claim Administrator with respect to any Covered Persons.

Employer shall Timely notify Claim Administrator in a mutually agreeable format of any change in a Covered Person's status under this Agreement. Employer shall obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.6 **Grandfathered Health Plans (If Applicable).** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes that would cause any benefit package of its Plan(s) to lose its status as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide notice thereof as required) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any

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legal, tax or other ramifications related to any plan's grandfathered health plan status 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 into and become part of this Agreement, and Employer represents and warrants that the information it submits on such Form is true, complete and accurate.

2.7 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Non-federal Governmental Plans (If Applicable).** If Claim Administrator provides Services for any retiree only plans, excepted benefits and/or self-insured non-federal governmental plans (with an exemption election), then Employer 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 Claim Administrator to the terms and conditions of this Agreement. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.

2.8 **Summary of Benefits and Coverage ("SBC").** Unless otherwise provided in the applicable ASO BPA, Employer acknowledges and agrees that Employer will be 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 Claim Administrator have any responsibility or obligation with respect to the SBC and Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

2.9 **Massachusetts Health Care Reform Act.** If elected on the applicable ASO BPA, Claim Administrator will provide in accordance with the Massachusetts Health Care Reform Act required written statements of creditable coverage to individuals residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

2.10 **Employer Audits Claim Administrator.** Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments and Net Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments and Net Claim Payments. Employer will be responsible for its own costs and the cost of the auditor. Employer will reimburse Claim Administrator for all reasonable expenditures necessary to support audits conducted after termination of this Agreement. 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. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any proprietary information. Employer and its agent shall execute an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
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SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 **Use and Disclosure of Covered Persons' Information.** The Parties acknowledge and agree that they have entered into a Business Associate Agreement ("BAA") as required by HIPAA. Although the BAA was executed to comply with HIPAA, the Parties agree the BAA will govern any personally identifiable information ("PII"), including Protected Health Information ("PHI"), Claim Administrator may collect or receive. While Claim Administrator does not anticipate receiving or collecting PII about Covered Persons that is not PHI, Claim Administrator agrees to protect and secure any PII of Covered Persons according to the terms and requirements of the BAA, except as otherwise provided in this Agreement.

3.2 **Electronic Exchange of Information.** If Employer and Claim Administrator exchange data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the Parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data and other information to Employer in the electronic format mutually agreed to by the Parties.

3.3 **Providing Data to Employer's Vendor(s).** If Employer directs Claim Administrator to provide data directly to Employer's third-party consultant and/or vendor ("Employer's Vendor"), and Claim Administrator agrees in its sole discretion, then Employer acknowledges and agrees that it shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator. Employer hereby acknowledges and agrees and Employer's Vendor shall acknowledge and agree:

- **a.** That the requested documents, records and other information (for purposes of this Section 3, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.
- **b**. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 3, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.
- **c.** To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed and consistent with the Inter-Plan provisions of this Agreement.
- **d.** To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.
- **e.** To use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
- **f.** To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.
- **g.** To not sell, re-sell or lease the Information.
- **h.** To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter.

Employer shall provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose or exchange data and provide written authorization and specific directions with respect to such release, disclosure, or exchange. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of PHI as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 **Business Confidential Information and Proprietary Marks.** The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information. Employer shall not use or disclose such Business Confidential Information, including those portions of the Agreement that

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

are exempt from disclosure under the Illinois Freedom of Information Act, to any third party without prior written consent of Claim Administrator. Employer agrees to provide written notice to Claim Administrator if Employer believes it is required by law to disclose BCI, including but not limited to this Agreement, to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has the opportunity to object and ensure appropriate confidentiality protections are in place. Employer will at all times remain liable for maintaining the confidentiality of this Agreement and shall ensure that any affiliated entities or third-party representatives to whom the Agreement is disclosed are bound in writing not to further disclose this Agreement without the prior written consent of Claim Administrator.

Neither Party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other Party or the other Party's respective clients in advertising or promotional materials without prior written consent of the other Party; provided, however, that Claim Administrator may include Employer in its list of clients.

3.5 **Claim Administrator/Association Ownership.** Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association. Employer agrees not to contest (i) the Blue Cross and Blue Shield Association's ownership of, or the license granted by the Blue Cross and Blue Shield Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or Business Confidential Information.

3.6 **Infringement.** Claim Administrator agrees not to infringe upon, dilute or harm Employer's rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Blue Cross and Blue Shield Association and utilized by Claim Administrator under a license with the Blue Cross and Blue Shield Association.

3.7 **Records.** For a period of [redacted] following termination of this Agreement, Claim Administrator shall, upon the request of the Employer, provide to Employer, a copy of all Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors, in the possession of Claim Administrator. Such copy shall be transmitted in a form as agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by Employer. Claim Administrator shall retain all such Claim records for the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator, but shall be no less than [redacted] and in compliance with all relevant regulatory requirements.

3.8 **Industry Improvement, Research and Safety.**

[Intentionally omitted.]

SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS AND DISPUTE RESOLUTION

4.1 **Litigation.** [redacted] Notwithstanding the foregoing, Claim Administrator shall have the option, at its sole discretion, to select and employ attorneys to defend any such action, in which event the fees and costs of those attorneys shall be the responsibility of Claim Administrator. For such actions, each Party shall reasonably cooperate with the other Party's defense, unless a conflict of interest exists. Some defense support by Claim Administrator, such as external claim review, may require an additional fee, [redacted]

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator is authorized to follow its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). 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

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An Independent Licensee of the Blue Cross and Blue Shield Association

Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Sections a. – e. below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

a. **Reductions from Future Payments to Contracted Providers.** Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) if the Provider is a Contracted Provider, from Other Plans, up to an amount equal to the Overpayment (collectively, "Offset").

b. **Cross-Plan Offsets for Contracted Providers.** Claim Administrator has the right to reduce Another Plan's payment to a Contracted Provider by the amount necessary to recover the Plan's Overpayment to the same Contracted Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Contracted Provider by the amount necessary to recover Another Plan's Overpayment to the same Contracted Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

c. **Division of Recovery for Multiple Plans.** If Claim Administrator has made Overpayments to a Contracted Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively, against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 4.

d. **Employer Authorization for Offsets and Cross-Plan Offsets.** Employer authorizes and directs Claim Administrator to perform Offsets and Cross-Plan Offsets. Cross-Plan Offsets will be carried out consistent with the terms of the Provider contract. Notwithstanding the foregoing, Employer acknowledges and agrees that claims processed through Inter-Plan arrangements with other Blue Cross and/or Blue Shield licensees operate under rules and procedures issued by the Association, and the recovery policies and procedures of each Blue Cross and/or Blue Shield independent licensee may apply.

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator will recover Overpayments in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan.

4.3 **Third-Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, 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 Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of Providers' Claim coding or billing to identify discrepancies prior to Claim Payments. Third parties' fees associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

4.4 **Assignment.** Except as otherwise permitted by Section 1 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both Parties. Any such attempted assignment in the absence of the prior written consent of the Parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates or successors to the Parties.

4.5 **Applicable Law.** This Agreement shall be governed by and construed under the laws of the state of Illinois without regard to any state choice–of–law statutes. All disputes between Employer and Claim Administrator arising out of or related to this Agreement will be resolved in Chicago, Illinois. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

4.6 **Limitations; Limitation of Liability.** No action or dispute shall be brought to recover under this Agreement after the expiration of [redacted] from the date the cause of action accrued. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any arbitration expenses incurred), [redacted]

4.7 **Services Related to Federal Regulatory Requirements.**, Claim Administrator agrees to provide Employer the services and processes described in this section in connection with requirements imposed on group benefit plans by federal laws and regulations, including the Consolidated Appropriations Act of 2020 ("CAA") and the No Surprises Act ("NSA").

a. **Transparency Requirements under the Consolidated Appropriations Act.** Services that Claim Administrator will provide to Employer related to certain Transparency Requirements under the CAA are:

i. ***Contracted Provider Data Verification***. Claim Administrator will maintain a central database of Contracted Providers' demographic information, which shall include name, address, phone number, specialty, and web address ("Data Elements"). Claim Administrator will implement commercially reasonable procedures to track data updates for Contracted Providers or confirm Provider data accuracy related to the Data Elements. Claim Administrator will initiate an outreach to Contracted Providers to verify the accuracy of the Data Elements up to ninety (90) days following the last recorded update or verification. Claim Administrator will implement commercially reasonable procedures to track the receipt of updated data from a Contracted Provider and update the central database within appropriate timeframes.

ii. ***Directory of Verified Contracted Providers***. Claim Administrator will provide an online Provider directory representing the Contracted Providers who render services which may be billed to plans and policies administered by Claim Administrator. This directory shall include Providers contracted with Claim Administrator as well as Providers contracted with any Blue Cross and Blue Shield Plan as well as Claim Administrator and another entity performing services on behalf of Claim Administrator. The directory shall not reflect services administered by external claims administrators or other Providers not directly contracted through Claim Administrator.

Providers who fail to confirm the accuracy of the Data Elements may be subject to removal from the Provider directory until they confirm the accuracy of their information.

To the extent information for the Provider directory is provided by a third-party, Claim Administrator shall not be responsible for delays in updates to Provider data directories, or misinformation due to such delays in receiving information from third parties.

iii. ***Provider Network Status Verification***. Covered Persons in plans or policies administered by Claim Administrator may seek clarification of a Provider's Network status through Claim Administrator. Notwithstanding any terms in this Agreement, Employer authorizes Claim Administrator to communicate with Covered Persons as reasonably necessary to provide information to or responses in connection with this section. When this clarification is sought via phone, Claim Administrator will use commercially reasonable efforts to provide an electronic confirmation of the Provider's Network status in writing within twenty-four (24)

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

hours of the call. This verification shall be based on the information available to Claim Administrator at the time of the request and does not represent future guarantee of Network status.

Employer acknowledges that Claim Administrator will not issue a written confirmation of Provider Network status when request is sought through a third-party service center.

iv. ***ID Cards***. Claim Administrator will include up to four (4) tiers of deductible limits and out-of-pocket maximum limits for major medical coverage on the member ID card. The limits will reflect both family and individual limits when applicable to policy, together with in- and out-of-network limits.

For policies that include prescription drug coverage through Prime with an independent out-of-pocket or Copayment/Deductible, up to two (2) tiers of coverage limits will be included on the ID card.

Claim Administrator will include a phone number and a website URL for consumer assistance information on ID cards issued by Claim Administrator.

Claim Administrator will issue physical ID cards in accordance with its standard processes and will not re-issue physical ID cards unless requested by Employer, in which case additional charges may apply. All newly issued physical ID cards will contain the information reflected in this section.

v. ***Machine Readable Files***. Claim Administrator will publish and host machine readable files populated with the negotiated rates with providers, and an aggregated out-of-network allowable amount file, as contemplated by CMS standards, for services administered by Claim Administrator on behalf of the Plan. The files will be updated monthly and hosted on a publicly available website. The Plan may choose to download and/or link to the files from their own website. Claim Administrator will supply an implementation guide that provides additional information on how to obtain a link to the website that will contain the machine-readable files. To the extent Employer or the Plan engages a third-party Vendor to administer or host the Machine Readable Files, Employer hereby acknowledges and agrees that neither Claim Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the performance, acts or omissions of any of Employer's Vendors.

vi. ***Cost Sharing Estimator Tool***. Claim Administrator will make available a Cost Sharing Estimator Tool (CSET) to enable Plans to provide enrollees personalized cost-sharing estimates for items covered by the Plan administered by Claim Administrator. The CSET will be made available through a secure member portal and via a mobile application, for active policies, and include services in accordance with the following schedule:

Effective with the plan year beginning on or after January 1, 2023, enrollees will be able to search for the cost of five hundred (500) services, as defined by CMS, covered by the Plan administered by Claim Administrator, to identify the estimated cost for the procedure, illustrate how the member's benefits will apply to the procedure, and disclose if there may be any prerequisites to care, such as requiring a prior authorization for a service or procedure.

For each plan year beginning on or after January 1, 2024, the services that can be estimated through the CSET will be expanded to support all services and procedures covered by the Plans that are administered by Claim Administrator.

To the extent Employer or the Plan engages a third-party Vendor to administer a substantially similar CSET for the same or similar services, Employer hereby acknowledges and agrees that neither Claims Administrator nor any of Claim Administrator's affiliates, delegates, subcontractors or assigns shall have any responsibility for any act, error, or omission of such Vendor or with respect to the performance of such Vendor. Employer shall remain fully responsible and liable for the acts or omissions of any of Employer's Vendors.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

vii. ***Drug Cost Reporting***. Claim Administrator will provide on behalf of Employer, based on the type of pharmacy coverage and data Claim Administrator administers and maintains for Employer, drug cost reporting to the extent within the possession of Claim Administrator as contemplated by Section 204 of the CAA according to Claim Administrator's standard processes and procedures, unless otherwise mutually agreed.

b. Surprise Billing Requirements of the No Surprises Act.

i. ***Qualifying Payment Amount***. As it pertains to Employer's self-funded plans, Employer acknowledges that NSA requires, among other things, that member cost-share for certain items and services the Plan covers are calculated based on the lesser of the Provider's billed charge or the NSA's "Qualifying Payment Amount" ("QPA"). With respect to the calculation of QPA, Employer elects to use and adopts the QPA calculated by Claim Administrator based on Claim Administrator's self-funded business and not a QPA customized for Employer's Plan(s).

ii. ***Negotiation and Independent Resolution Process***. Employer acknowledges that Claim Administrator will make on the Plan's behalf an initial payment amount on Claims consistent with Employer's direction as established by Employer's Plan and this Agreement. For non-participating Claims subject to the NSA, a Provider may seek additional payment through a dispute process the NSA and related regulations establish. This process may include informal negotiations with the Provider and an independent dispute resolution ("IDR") process as described in the NSA.

Employer authorizes Claim Administrator, or for Claims for service rendered outside of Claim Administrator's service area another Blue Cross and Blue Shield licensee, to represent the Plan with respect to any Claim with services for which a Provider seeks to negotiate as provided by the NSA, or for which a Provider institutes IDR.

With respect to any negotiations where Claim Administrator represents the Plan to resolve any disputed Claim, Employer expressly authorizes Claim Administrator in such negotiations to resolve any disputed Claim for an amount which Claim Administrator determines is reasonable under the circumstances but in no event will a disputed claim be resolved for more than QPA plus ten percent (10%) of the QPA, without approval of Employer.

Claim Administrator will maintain a summary description of its currently applicable approach to negotiation of services or Claims subject to the dispute resolution process of the NSA. The approach will be generally the same or similar for Claims under Employer's Plan as for similarly-situated Claims under Claim Administrator's fully insured health insurance policies.

The negotiation approach is subject to change from time to time by Claim Administrator. Information about the approach then in effect will be made available to Employer upon reasonable request. Employer acknowledges and agrees that Claim Administrator shall follow its then-current negotiation approach, such negotiations may not be successful, and may result in institution of IDR without exhaustion of the full settlement authority Employer granted to Claim Administrator, which in turn will result in additional administrative fees, as well as IDR entity fees in the event of settlement after institution of an IDR or an IDR loss. Notwithstanding the additional administrative fee and other possible expenses, Employer expressly authorizes Claim Administrator not to exhaust its settlement authority (up to QPA plus ten percent (10%) of the QPA) if Provider's last offer is outside the parameters of the then-effective negotiation approach. Employer acknowledges that settling these Claims within the settlement authority range stated here and the scope of Claim Administrator's then current negotiation approach is in the Plan's interest.

Negotiation services Claim Administrator provides shall include communicating with Provider, supplying requested documentation as appropriate, and proposing and documenting resolution of disputed Claims. Services in connection with an IDR shall also include handling interactions with the IDR entity and Provider, supplying requested information in connection with the IDR, and analyzing circumstances of disputed Claims to

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determine position on disputed Claims. On a quarterly basis, Claim Administrator shall provide Employer with information regarding the status of negotiations and IDR decisions.

Employer acknowledges that Claim Administrator undertakes negotiations at the direction of the Employer, undertakes such negotiations because they are necessary to the operation of the Plan, that the compensation to be paid to Claim Administrator for such negotiations is reasonable, and that, notwithstanding any other section of this Agreement, Claim Administrator does not act as a fiduciary, including under ERISA in connection with the negotiation or IDR of any disputed Claim. Employer is solely responsible for payment of any amounts determined to be payable as a result of such negotiations or awards entered through IDR on NSA-eligible items and services. Employer indemnifies and will hold Claim Administrator harmless with respect to any award entered in IDR and any subsequent payment made thereon and/or any judgment entered thereon. Employer acknowledges that other terms, conditions, or fees may apply with respect to any negotiations or IDR processes performed by another Blue Cross and Blue Shield licensee.

c. **Effect of Future Changes In Law And Regulations.** The laws and regulations that are the subject of this Section 4.12 are subject to additional rulemaking and interpretation. The terms and conditions stated herein, including any associated costs/fees, may change as additional requirements and regulatory guidance are released or as additional information becomes known. In the event of a change because additional requirements and regulatory guidance are released or as additional information becomes known, Claim Administrator shall provide notice to Employer and such change shall be effective ninety (90) days after such notice.

Employer acknowledges that Employer, and not Claim Administrator, shall be responsible for making the necessary adjustments to its ERISA Plan Document(s) and Summary Plan Description(s) to be consistent with Employer's election, including any amendments to governing Plan documents.

SECTION 5: NON-ERISA GOVERNMENT REGULATIONS

5.1 **In Relation to the Plan.** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee benefit plan document of Employer, Employer agrees that Claim Administrator does not and will not accept any allocation or delegation of any responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator or of the Plan.

5.3 **Claim Administrator's Limited Fiduciary Responsibility.** Although Employer is exempt from ERISA, Employer hereby delegates to Claim Administrator the discretionary authority to administer claims in accordance with the terms of Employer's self-funded health care benefit plan and to make initial claim determinations concerning the availability of Plan benefits and final internal review and benefit determinations for appealed Claims. Claim Administrator hereby acknowledges and agrees that it shall act as a limited fiduciary to the Plan solely with respect to its performance of such claims processing and payment services and Employer acknowledges and agrees that Claim Administrator shall not have any other fiduciary duties or responsibilities under the Plan. In particular, but not in limitation of the foregoing, Employer acknowledges and agrees that Claim Administrator shall have no discretionary authority under its agreement with Employer except as otherwise set forth in this Agreement, and no fiduciary duty to the Plan, with respect to services performed by Employer, Employer's other vendors, vendors, independent contractors and subcontractors of any type. Employer further agrees and acknowledges that Claim Administrator shall have no authority or obligation to act on behalf of the Plan or Plan participants or

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

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 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.

SECTION 6: OTHER PROVISIONS

6.1 **Term and Termination.** This Agreement will continue in full force and effect from the effective date of the PSA to the end of the term provided therein. This Agreement may be terminated as follows:

- **a.** By both Parties on any date mutually agreed to in writing;
- **b.** By either Party, after the Article 9 provisions of Events of Default, Remedies, Termination, Suspension, and Right to Offset) of the PSA have been satisfied;
- **c.** By Claim Administrator, if Employer fails to pay Timely 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, upon Employer's failure to cure the non-payment within [redacted] days of written notice of the non-payment to Employer as provided in Section 7.1 of Exhibit 5-B of this Agreement; or
- **d.** By Employer evoking rights of Early Termination pursuant to Article 9(c) of the PSA.

6.2 **Relationship of the Parties and Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. Nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of Employer and their dependents.

6.3 **Entire Agreement.** This Agreement, including all Exhibits and Addenda, and the Professional Services Agreement to which this Agreement is attached, represents the entire agreement and understandings of the Parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. In the event there is a conflict between or among any of the documents specified, the terms of the Professional Services Agreement shall control the engagement between the Parties. The provisions of this Agreement shall prevail in the event of a conflict with any of the following components.

The Exhibits of this Exhibit 5 to the Professional Services Agreement are:

- **a.** Exhibit 5-A - Claim Administrator Services
- **b.** Exhibit 5-B - Fee Schedule and Financial Terms
- **c.** Exhibit 5-C - Notices/Required Disclosures
- **d.** Exhibit 5-D – Blue Cross Blue Shield Association Disclosures and Provisions
- **e.** Exhibit 5-E – Recovery Litigation Authorization

6.4 **Amending.** This Agreement may be amended only by mutual written agreement of the Parties. Notwithstanding the foregoing, any amendments required by law, regulation or order ("Law") or by Claim Administrator or the Blue Cross and Blue Shield Association may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within thirty (30) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. If the Parties cannot

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to dispute resolution, as set forth in Section 4.

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

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

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

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 1 "Claim Administrator Responsibilities"; Section 2 "Employer Responsibilities"; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 5-B); and Section 8 of Exhibit 5-B "Financial Obligations Upon Agreement Termination."

6.6 **Notice of Annual Meeting.** 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, consistent with HCSC bylaws. The annual meeting is scheduled to be 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 Section, the term "member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

SECTION 7: DEFINITIONS

Capitalized terms used in this Agreement shall have the meanings set forth in this Section 7, unless otherwise provided in the Agreement.

7.1 **"Administrative Charge"** means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

7.2 **"Ambulance Transportation"** means local transportation in a specially equipped vehicle for certified ground and air transportation options from Covered Persons' home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing facility or from a Skilled Nursing facility or Hospital to a Covered Persons' home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of the Covered Person, the Covered Person's family/caregivers or Physician, or the transferring facility, is not considered medically necessary.

7.3 **"Average Discount Percentage" ("ADP")** [redacted]

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

[redacted]

7.4 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, trademarks, service marks, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and Blue Shield licensees through Inter-Plan arrangements, that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence.

7.5 **"Claim"** means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, 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 (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

7.6 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, [redacted]

7.7 **"Claim Payment"** [redacted]

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

7.9 **"Contracted Provider"** means a Participating Provider and a Participating Professional Provider, collectively.

7.10 **"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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

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 physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

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

7.12 **"Covered Employee"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.13 **"Covered Person"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.14 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

7.15 **"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 (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

7.16 **"Dental Maximum Allowance"** [redacted]

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7.17 **"Eligible Charge"** [redacted]

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

7.19 **"Fee Schedule"** means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. The Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with Exhibit 5-B.

7.20 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

7.21 **"HIPAA"** means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services (all the foregoing, collectively "HIPAA").

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

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

7.24 **"Maximum Allowance"** [redacted]

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

[redacted]

7.25 **"Net Claim Payment"** [redacted]

7.26 **"Network"** means identified Providers, including Physicians, other professional health care Providers, Hospitals, ancillary Providers, and other health care facilities, that have entered into agreements with 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.

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

7.28 **"Overpayment"** means a payment to a Provider or a Covered Person that was more than it should have been, or a payment that was made in error.

7.29 **"Physician"** means a physician duly licensed to practice medicine in any of its branches recognized by applicable state law.

7.30 **"Plan"** means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

7.31 **"Prescription Drug Program Eligible Charge"** [redacted]

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

7.32 **"Primary Care Physician"** means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in one of the recognized areas of pediatrics, obstetrics and gynecology (if applicable), internal medicine and family practice.

7.33 **"Private Duty Nursing Service"** means (T1000) 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 Service 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.

7.34 **"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.

7.35 **"Reminder Notice"** means a notice sent when claims have not been paid within ten (10) days.

7.36 **"Skilled Nursing Service"** means (T1000, S9123, S9124) 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.

7.37 **"Supplemental Charge"** [redacted]

7.38 **"Surcharges"** means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor Fees [redacted] paid by 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. [redacted]

7.39 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within forty-eight (48) business hours of notification to Employer by Claim Administrator, monthly fees (e.g. Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

b. With respect to all information due Claim Administrator by 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 Claim Administrator by Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

EXHIBIT 5-A
CLAIM ADMINISTRATOR SERVICES

- **ALTERNATIVE PROVIDER COMPENSATION ARRANGEMENTS**

  Employer agrees to participate in Alternative Provider Compensation Arrangements as applicable based on Covered Person criteria established by Claim Administrator.

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions on applicable benefit plan terms and design, including determination of pre-service or prior authorization of services. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS ("EOB")**

  Prepare and transmit EOBs to Covered Persons.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to inquiries — written, phone or in–person – related to membership, benefits, and Claim Payment, Net Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

  Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, when scheduled in advance based on staffing availability, 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.

- **DISABLED DEPENDENT VERIFICATION**

  Determine the disabled status of any dependent children of Covered Persons, for purposes of administering the Group's age limit for eligibility. Determination will be made based on Claim Administrator's review of clinical information received by Claim Administrator from the Covered Person or the dependent's medical provider(s).

- **CLIENT SERVICES AND MATERIALS**

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

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

  b. ***Standard Identification Cards.*** Prepare 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 a toll–free customer service telephone number.

  e. ***Medical Prior-Authorization Service Telephone Number.*** For those services determined by Employer and provided in writing to Claim Administrator that require prior authorization, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical prior-authorization service telephone number for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

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- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlements (as outlined in Exhibit 5-B, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting processes [redacted]. 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 (or proposed to be 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 under the Plan for those services.

- **ACTUARIAL AND UNDERWRITING**

  Provide Claims projections and pricing of administrative services and stop–loss coverage.

- **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 applying Claim Administrator's standard processes; address any related recovery litigation as set forth in Exhibit 5-E.

- **EMPLOYER PORTAL (currently called "BLUE ACCESS® FOR EMPLOYERS")**

  Provide Employer with an on-line resource that allows employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called "BLUE ACCESS® FOR MEMBERS")**

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying the status of finalized claims, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes 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.

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 5-C, Section 7 entitled "Medicare Secondary Payer 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 FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible funds will escheat to state of payee's last known address on behalf of Employer in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

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- **ADDITIONAL SERVICES NOT SPECIFIED**

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

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations such as support functions.

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **EXTERNAL REVIEW COORDINATION**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator's coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan's determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **BLUE CARE CONNECTION® PROGRAM**

  Provide 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 Employer and agreed to by Claim Administrator.

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator.

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

  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 subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING ("RBP")**

  Assist Employer with establishing a maximum coverage amount for specified imaging, inpatient, and outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via (i) interactive audio communication (via telephone or similar technology) and/or (ii) interactive audio/video examination and communication (via online portal, mobile app or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE ("SBC")**

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator.

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EXHIBIT 5-B
FEE SCHEDULE AND FINANCIAL TERMS

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current ASO BPA and the PBM Exhibit, if applicable. 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 and the PBM Exhibit, if applicable; (ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA or PBM Exhibit, if applicable; or (iii) the date the Agreement is terminated (or, if applicable, in the case of the PBM Exhibit, the date such Exhibit is terminated).

Inter-Plan Arrangement Fees:

1.1 **BlueCard® Program/Network Access Fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable;

1.2 **Negotiated 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);

1.3 **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).

**If applicable, 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: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

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

2.2 **"Employer Payment Method"** means the method elected in the Fee Schedule specifications of the most current ASO BPA 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.

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 Exhibit 5-C Section 7 titled "Medicare Secondary Payer Information Reporting.")

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

2.6 **"Run–Off Period"** means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which 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 that is required by Claim Administrator upon termination of the

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Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of Service Charges.*** Employer will pay service charges to Claim Administrator in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, if applicable, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining Service Charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, if applicable, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing Service Charges.*** Such service charges shall be subject to change by 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, provided that sixty (60) days prior written notice is given by Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by 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 +/- [redacted] from Claim Administrator's projections;
- **e.** The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, producer/broker fees, etc.) becomes outdated or inaccurate; or
- **f.** On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service Charges upon Termination.*** In the event the Agreement is terminated in accordance with the "Term and Termination" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA. Termination Administrative Charges assume the continuation of the Plan benefit program(s) and the administrative services in effect prior to termination. Should such Plan benefit program(s) and/or administrative services change, or in the event the average Plan enrollment during the three (3) months immediately preceding termination varies [redacted] from the enrollment used to determine the service charges in effect at the time of termination, Claim Administrator reserves the right to adjust the fees for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge. In the event of a termination by Employer of more than [redacted] of Claim Administrator's projections of Covered Employees, Employer will pay the Termination Administrative Charge as specified in the current ASO BPA for such terminated Covered Employees.

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, Claim Administrator may charge Employer for:

- **a.** Any applicable Supplemental Charge(s);
- **b.** Reasonable fees for the reproduction or return of Claim records requested by 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 Employer, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or
- **d.** Any other fees for services mutually agreed upon by the Parties in writing.

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3.6 ***Effect of Plan Enrollment.*** Administrative Charges will be paid based upon information 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 Claim Administrator under the Agreement are contingent upon the payment of any amount owed Claim Administrator by Employer before the end of the applicable cure period.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's Payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid before the end of the applicable cure period.

4.2 ***Employer's Liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Net Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Net Claim Payment pursuant to Section 6 below titled "Claim Settlements." 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 ("Extended Benefits"). Employer shall be liable for all Claim Payments, Net Claim Payments and the applicable service charges for such Extended Benefits.

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

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay before the end of the applicable cure period any amount owed Claim Administrator, 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 Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall Timely pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period. [redacted]

5.2 ***Confirmation or Notification of Amount Due and Payment Due Date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

a. ***If Employer Payment Method is by Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.

b. ***If Employer Payment Method is other than Check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the Parties, of the amount due. Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by 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.

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5.3 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no circumstances will Claim Administrator be responsible for payment of Reinsurance Contributions.

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

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. The Claim settlement shall reflect the sum of the following:

a. All Net Claim Payments calculated on the basis of Claim Payments paid by Claim Administrator in the particular Claim settlement period.

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

c. The Administrative Charges and credits, Surcharges, 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 Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within [redacted] from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer. [redacted]

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

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer Fails to Pay.*** [redacted] If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent according to its procedures. If defaults are not cured following written notice to Employer, Claim Administrator may, at its option:

a. Suspend Claim Payments; or

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

7.2 ***When Claim Administrator Fails to Timely Notify.*** Pursuant to Section 6.5 "Severability; Enforcement; Force Majeure; Survival" of the Agreement, Claim Administrator's failure to provide 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 Employer.

7.4 ***Insolvency.*** In addition, if 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 Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the

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payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, or on the date of a termination by Employer of more than [redacted] of Claim Administrator's projections of Covered Employees, 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 Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). 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 Claim Administrator, as of the date of termination or termination, including, but not limited to, Claim Payments and/or Net Claim Payment 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 and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of termination of covered Employees but not the Agreement.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by 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 Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for Overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments.

8.4 ***Uncashed Funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old) will be escheated to the state of payee's last known address by Claim Administrator, on Employer's behalf in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

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EXHIBIT 5-C
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **Claim Payment.** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

1.2 **Claim Dispute.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request 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, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

1.3 **Invalidity of Assignments.** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and 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. If 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 Claim Administrator will have no obligation to pursue recovery of such payment; however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 "Claim Overpayments."

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship to a Provider.** The choice of a Provider is solely the choice of the Covered Person, and Claim Administrator will not interfere with the Covered Person's relationship with any Provider. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. 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 that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

[redacted]

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[redacted]

SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

[redacted]

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[redacted]

SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

[redacted]

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[redacted]

SECTION 6: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES

[redacted]

SECTION 7: MEDICARE SECONDARY PAYER INFORMATION REPORTING

7.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

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

7.3 **Disclosure Statement:** Employer acknowledges that 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 8: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current ASO Benefit Program Application ("ASO BPA")

8.1 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. Claim Administrator on behalf of Employer has the right to reimbursement for all benefits 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 or guardians 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 Claim Administrator has provided benefits to the Covered Person, reduced by any ADP applicable to the Covered Person's Claim or Claims.

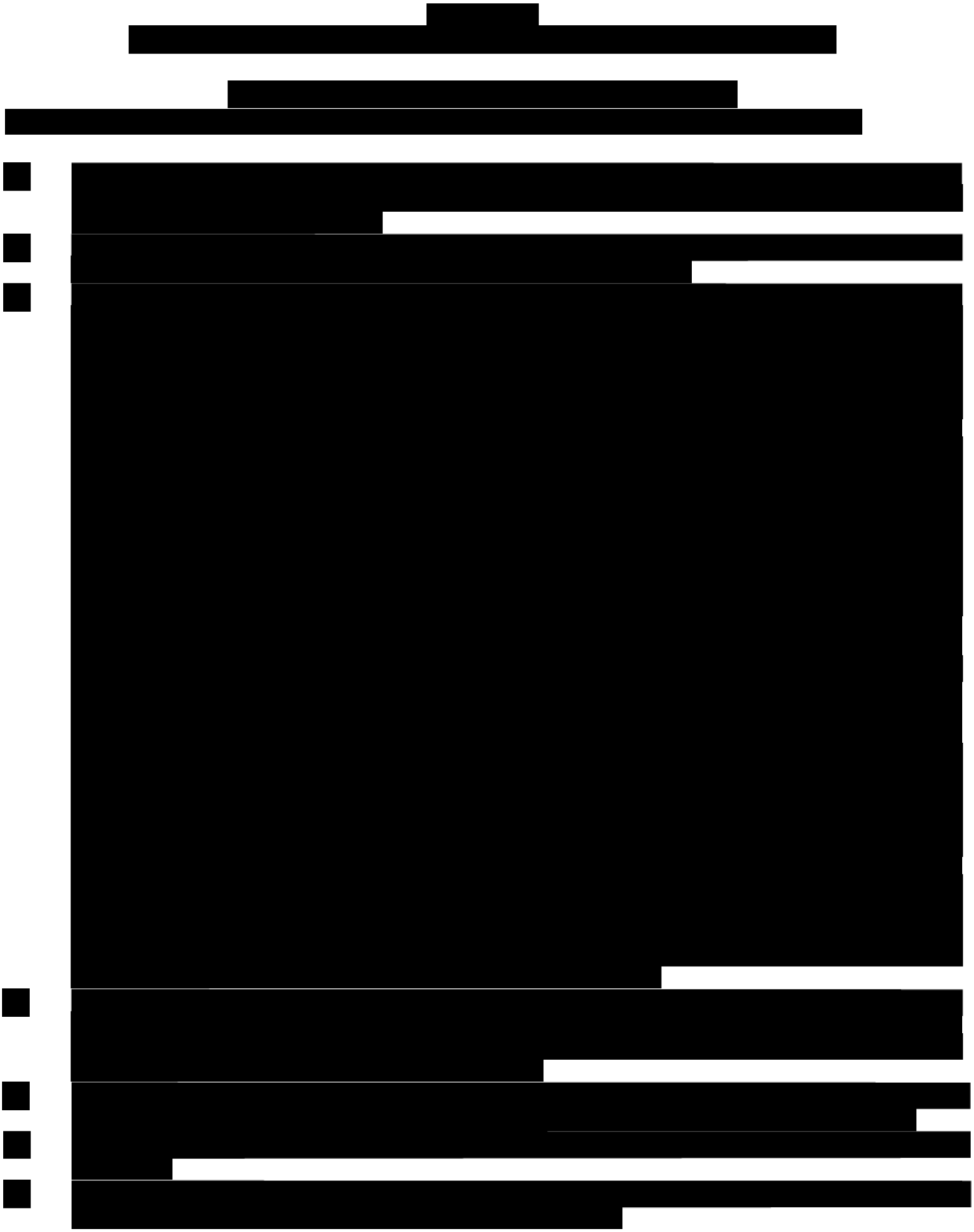
b. Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

8.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to exercise for the same expenses for which 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 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 9: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's 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 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), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator 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, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 9.

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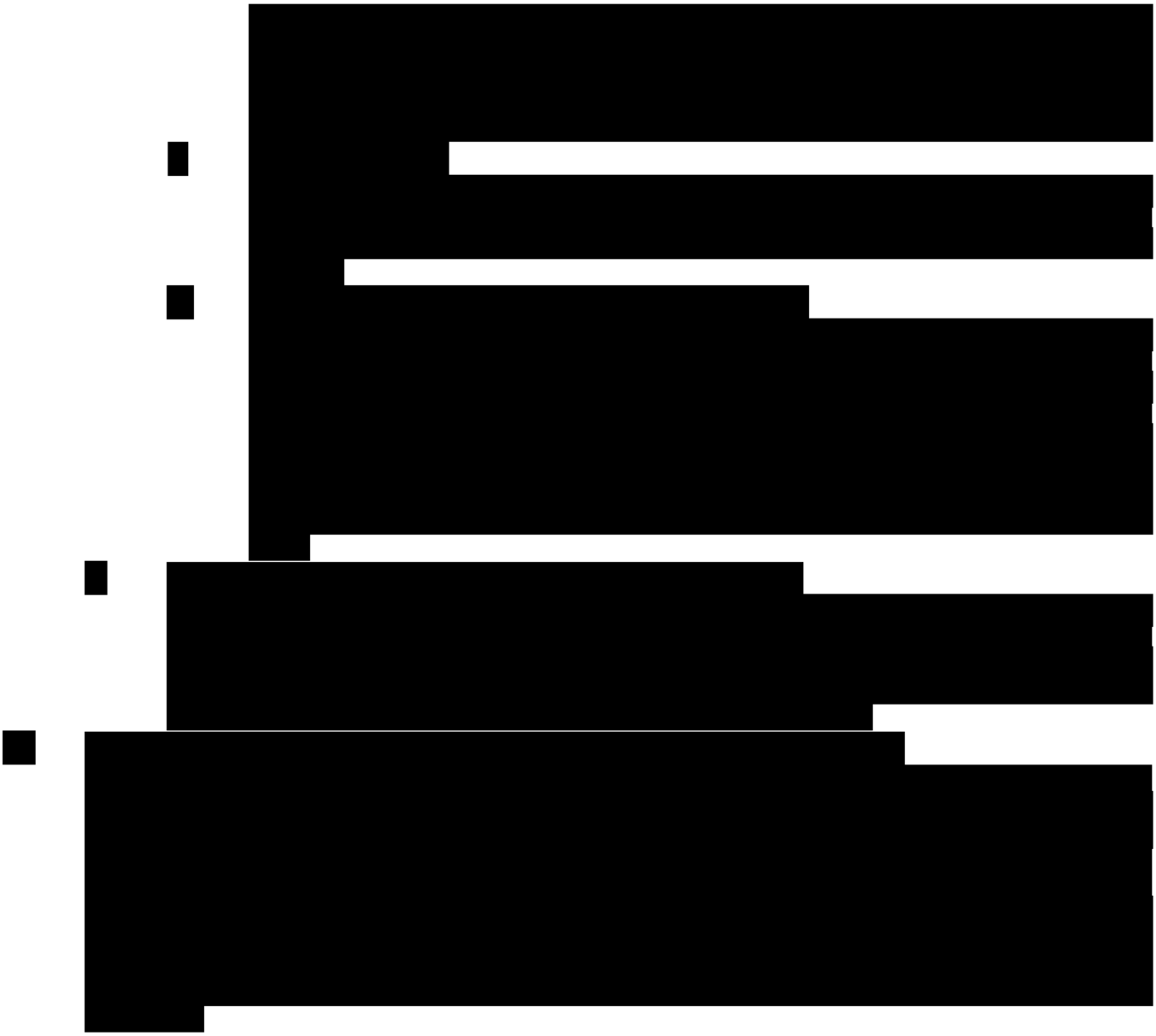
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EXHIBIT 6

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 Group Administration Document supersedes all previous contracts 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 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 [redacted] after the Plan furnishes notice of a Claim Settlement to the Policyholder. [redacted]

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]

   [Intentionally Omitted]
2. 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.
3. 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 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 prior to the last day of coverage.
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 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 [redacted] after the Policyholder's receipt of the Plan's invoice for such payment. [redacted]

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 [redacted] after the Policyholder's receipt of the Plan's invoice for such payment. [redacted]

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 Policy 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.
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 may use a formula based in part on a health insurer's net premiums from the preceding calendar year. In addition, ACA and/or other applicable laws or regulatory guidance may provide for the establishment of temporary transitional reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the "Reinsurance Fees" or "Amounts") from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how the Reinsurance Fees or Amounts are calculated. The premium may be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees or Amounts, if any.

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 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 in excess of the ADP.

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

1. In the case of Covered Services received from a Participating Prescription Drug Provider (as defined below) under the prescription drug benefit, the Policyholder's experience account under the Policy, if any, shall be calculated based on the cost mutually agreed upon by Policyholder and the Plan set forth in the PBM Fee Schedule Addendum to the BPA. Covered Persons' required Coinsurance and Deductibles for Covered Services received from Participating Prescription Drug Providers under the prescription drug benefit will be calculated based on the Eligible Charge.

   In the case of Covered Services received from a Non-Participating Prescription Drug Provider (as defined below) under the prescription drug benefit, (a) the Policyholder's experience account under the Policy, if any, and (b) the Covered Persons' required Deductible and Coinsurance shall be calculated based on the Eligible Charge.

   For purposes of this Agreement, the term "Non-Participating Prescription Drug Provider" means a Provider that does not have a written agreement with the Plan, a Blue Cross and/or Blue Shield Plan or the entity chosen by the Plan to provide the prescription drug program, to provide prescription drug services to a Covered Person at the time Covered Services under the prescription drug benefit are rendered.

   If covered under the Plan, notwithstanding anything to the contrary in this Agreement, Policyholder will reimburse the Plan for Covered Prescription Drug Products and Services designated as Specialty Drugs under the Specialty Drug program, at the lesser of (i) the pricing set forth in the BPA Addendum or (ii) the U&C price on the date the prescription transaction is processed, subject to the Copayment/Deductible and Coinsurance in the applicable Benefit Plan. Specialty Drugs may be provided by Prime, an affiliate of Prime, or other specialty pharmacy that has a written arrangement with Prime or Claim Administrator. Pricing for Specialty Drug Claims are not included in the retail and mail pharmacy pricing described above. Members will pay the lesser of the contracted rate, U&C, or Member Copayment/Deductible or Coinsurance.

   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 and/or other appropriate document; a benefit program and premium notification letter, if any; or applicable rate summary(ies).

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" or "PBM"), 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 and the Plan have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, mail service and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC.

   In negotiating the Policy, Policyholder acknowledges that it has taken into consideration that the Plan and/or the PBM will keep a portion of the discounts and/or other allowances that the Plan or the PBM has negotiated with Participating Prescription Drug Providers. The Service Charges that the Policyholder pays to the Plan for Covered Services provided by Participating Prescription Drug Providers are calculated based on the fixed pricing terms set forth in this PBM Fee Schedule Addendum to the BPA which shall be guaranteed for the term of such Addendum. Such pricing may or may not equal the amounts actually paid to the Participating Prescription Drugs Providers or received from drug manufacturers (e.g., rebates), or the amounts paid or received between the Plan and the PBM. As a result, the PBM or the Plan may realize positive margin on prescriptions filled at retail or mail order pharmacies, or prescription drug rebates. The Policyholder acknowledges that it has negotiated for the specific guaranteed fixed pricing terms set forth in the Addendum and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by the Plan or the PBM and consents to the Plan and the PBM's retention of all such amounts.

   The PBM negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to the Plan under the PBM's agreement with the Plan. This negotiation is conducted by the PBM for the benefit of the Plan and not for the benefit of the Policyholder or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to the Plan (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). The PBM has advised the Plan that the rebate arrangements are based on volume purchase discounts or other similar arrangements with the pharmaceutical manufacturers. Each year, the Plan will calculate a projection of the amount of rebates it expects to receive from the PBM. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on several factors and projections for the Fee Schedule Period, which may include Policyholder-specific demographics, retail, mail order pharmacy and specialty pharmacy utilization, cost of prescription drugs, the Policyholder's benefit design, and rebate arrangements entered by the PBM, none of which the Plan directly controls. The Plan's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Group Administration Document. Rebates, like all the Plan's assets and revenue sources, are utilized by the Plan in various ways to enable the Plan to provide cost-effective products

   and services. Additional information about rebates, the PBM and the Rebate Credit will be available upon request. The Plan may provide the Policyholder with a Rebate Credit, the amount of which is set forth in the BPA. The Rebate Credit provided to the Policyholder will be provided from the Plan's own assets and may or may not equal the entire amount of the rebates provided to the Plan by the PBM. The Policyholder acknowledges that it has negotiated for the specific Rebate Credit included as part of this Group Administration Document and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM to the Plan and consents to the Plan's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

If after the Effective Date: (I) changes to the formula, methodology, or way AWP is calculated or reported by Media-Span take effect or (ii) Media-Span ceases to publish AWP for the covered prescription drug services under this Policy, then the financial terms of this Policy shall be automatically adjusted at the time of such change to return the parties to their respective economic positions as they existed under the Policy immediately prior to such change. If the event described in item (ii) above occurs, the AWP pricing under this Policy shall immediately and automatically be converted to an alternative pricing benchmark determined by the PBM and Policyholder. In the event the Policyholder wishes to implement benefit plan design changes including, but not limited to, implementation of Coinsurance or increase of Copayment/Deductible, the pricing in the PBM Fee Schedule Addendum to the BPA will no longer be applicable and a new PBM Fee Schedule Addendum to the BPA pricing will need to be negotiated.

The Policyholder further understands and agrees that fees and compensation that the PBM receives related to the pharmacy benefit management program and/or the provision of pharmaceutical products and services by pharmacies may be revised. Some of these fees and compensation may be charged each time a Claim is processed (or requested to be processed) through the PBM and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by the PBM to the Plan, administrative fees charged by the PBM to pharmacies, and administrative fees charged by the PBM to pharmaceutical manufacturers. Currently, none of these fees are passed on to the Policyholder as expenses or accrue to the benefit of the Policyholder, unless otherwise specifically set forth in the Policy.

In addition, the PBM has advised the Plan that the PBM receives fees from pharmaceutical manufacturers as compensation for bona fide administrative services performed by the PBM for such manufacturer. The PBM may retain these manufacturers administrative fees or pass them along, in whole or in part, to the Plan in accordance with the PBM's agreement with the Plan. As of the Effective Date, the maximum that the PBM will receive from any such manufacturer for such administrative fees is five and one half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of the Plan; provided, however, the Plan will advise the Policyholder if such maximum has changed.

C. Inter-Plan Arrangements

1. Out-of Area Services

The Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." Whenever 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 ("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 Providers in the Host Blue geographic area that do not have a contractual agreement ("Nonparticipating Providers") with the Host Blue. The Plan remains responsible for fulfilling the contractual obligations to Covered Persons. 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 and Urgent Care obtained outside the geographic area the Plan serves. Follow-up care following an emergency is also available, provided the services are pre-authorized by the Plan. 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 Host Blue will be responsible for contracting and handling all interactions with its participating providers.

The financial terms of the BlueCard Program are described generally below.

a. Liability Calculation Method

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 Provider's billed covered charges 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 be represented by 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 price, estimated price 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. The method of claims payment by Host Blues is taken into account by the Plan in determining your premiums.

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 the Policyholder's premium.

b. Return of Overpayments

Recoveries of overpayments from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, Provider/hospital bill audits, credit balance audits, utilization review refunds, and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied in general on a claim-by- claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to 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.

c. 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.

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. Blue Cross Blue Shield Global Core

General Information

If Covered Persons are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Covered Persons with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Covered Persons receive care from Providers outside the 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.

Emergency Care Services

This Policy covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Medical Care and Urgent Care obtained outside of the United States. Follow-up care following an emergency is also available. Any other services will not be eligible for benefits unless authorized by the Plan.

Inpatient Services

In most cases, if Covered Persons contact the 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 Blue Cross Blue Shield Global Core Contracting hospital will submit Covered Persons claims to the 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

Benefits for outpatient services are only available for Emergency Care. Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Covered Persons to pay in full at the time of service. Covered Persons must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Persons pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Persons should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the Provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If Covered Person needs assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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. It is also Policyholder's obligation to obtain the required consent(s) from Covered Persons the Plan to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. 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. All such data is the sole property of, and owned by, the Plan.

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

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

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 the member being automatically enrolled in another IPA.

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, 60601-5099 on or before December 31st of the calendar year following the year in which Covered Services were rendered. For purposes of this paragraph, Covered Services furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.
2. Upon 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, applicable diagnoses (including appropriate codes), a specific itemized statement of the services rendered or furnished (including appropriate codes), 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 payments by the Plan for the benefit of any Covered Persons may be made directly to any Provider furnishing the Covered Services for which such payment is due, and the Plan is authorized by such Covered Person to make such payments directly to such Providers. However, the Plan reserves the right to pay any benefits that are payable under the terms of this Policy directly to the Covered Person, unless reasonable evidence of a properly executed and enforceable assignment of benefit payment has been received by the Plan sufficiently in advance of the Plan's benefit payment. The Plan reserves the right to require submission of a copy of the assignment of benefit payment.
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 by Covered Person or his agent will be given effect. Furthermore, the Plan will have no liability to the Covered Person or any other

person because of its rejection of such request.

3. Except for the assignment of benefit payment described above, neither coverage under this policy nor a Covered Person's Claims or rights under the Policy, including but not limited to claims for payment of benefits are not assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under this Policy is expressly non-assignable and 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 Policy. However, if the Plan makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and the Plan will have no obligation to pursue such payment.

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 which can only be legally performed by a Provider are not provided by the Plan. Any contractual relationship between a Provider and the Plan shall not be construed to mean that the Plan is providing professional service.
3. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's Health Benefit Program.

L. Agency Relationships

1. 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.
2. Providers are not employees, agents or other legal representatives of Blue Cross and Blue Shield of Illinois.

M. Medicare Secondary Payer ("MSP") Provisions

The Policyholder has certain obligations under the Medicare Secondary Payer ("MSP") statute.

1. For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), The Plan shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and the Plan can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs the Plan to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan. So that the Plan may make accurate primary/secondary MSP determinations. Employer agrees to timely and accurately respond to the Plan's requests for information.
2. It shall be Employer's responsibility to notify the Plan promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by 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 Employer that place it in, or take it out of, the scope of the MSP statute.
3. **Disclosure Statement**
   The Policyholder acknowledges that the Plan has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare as Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administer Medicare.

N. ERISA

This Section (N.) applies to any 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 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 Policyholder (or any Policyholder member, if the Policyholder is an association), the Policyholder agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Policyholder (or any Policyholder member, if the Policyholder is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in 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 Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Policy. The Plan will not be required to examine the provisions of a Policyholder's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.
2. 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 anywaiting 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. If a person is added to the Policy and it is later determined that the Policyholder reported a Coverage Date earlier than what would apply, based on the waiting period and eligibility conditions the Policyholder provided to the Plan, the Plan reserves the right to retroactively adjust the Coverage Date for such person.

P. Service Mark

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, an association of independent Blue Cross and Blue Shield Plans (“Association”). 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 heldaccountable 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 obligations 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. Reimbursement Provision

If an Insured or an Insured's covered dependent incursexpenses 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 the Plan shall have the right to first reimbursement for all benefits the Plan paid for from any and all damages collected from the negligent 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. Covered Persons are required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to exercise the Plan’s rights under this provision. This provision applies whether or not the third party admits liability.

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 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.

See provisions of this Group Administration Document regarding Average Discount Percentage (ADP) in the section entitled the “PLAN’S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS.”

The Plan shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which the Plan has provided benefits as a result of that sickness or injury.

The Covered Person is required to furnish any information or assistance or provide any documents that the Plan may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

T. 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.

U. 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.

1.

V. Information and Medical Records

1. All Claim information, including, but not limited to, medical records, received by the Plan in the performance of its duties hereunder will be kept confidential by the Plan and except for 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.

W. Overpayments

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

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

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

(b) any future benefit payment made to any person or entity under another Plan-administered ASO benefit program and/or Plan-administered insured benefit program or policy; or,

(c) any future benefit payment made to any person or entity under another Plan-insured group benefit plan or individual policy, or

(d) any future benefit payment, other payment, made to any person or entity; or,

(e) any future payment owed to one or more Providers; or,

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

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

BB. 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 (BB). in a time, form and manner specified by the Plan.

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

The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of the Policyholder and any Insured or former Insured (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws and regulations. The Policyholder shall assure appropriate notification to federal and state tax agencies and that any payment to the Insureds and former Insureds (if applicable) will be accompanied by appropriate federal and state documentation, e.g., Form 1099 or W-2. The Policyholder agrees to indemnify and hold the Plan harmless against any and all claims, demands, costs, fines, losses, interest, settlements, judgments, damages, penalties, taxes, expenses (including reasonable attorneys' fees) or other liabilities resulting from the Policyholder's failure to carry out its responsibilities or obligations as set forth in this Policy.

CC. Dispute Resolution.

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

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

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

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

2. Arbitration shall be held in Chicago, Illinois.
3. Arbitration proceedings will be governed by the AAA Commercial Rules.
4. The arbitrator shall be required to issue a written opinion resolving all disputes in any matter in which the controversy exceeds $10,000 and designating one party as the prevailing party.
5. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction over the dispute.
6. The arbitrator's fees and any costs imposed by the arbitrator will be shared equally by the parties. All costs and expenses, including but not limited to reasonable attorney and witness fees shall be borne by the non-prevailing party or as apportioned by the arbitrator.
7. This provision precludes the Policyholder from filing an action at law or in equity and from having any dispute covered by this Policy heard by a judge or jury.
8. Except as may be required by law, neither a party nor an arbitrator may disclose the existence, content, or results of any arbitration pursuant to this Section without the prior written consent of both parties.

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

V. TERM AND 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 applicable laws, as described in Section VIII. 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 (or such other notice, if any, required by applicable law or regulatory guidance) 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.

G. When otherwise permitted by applicable law or regulatory guidance.

VII. DISCONTINUANCE OF COVERAGE

A. Discontinuance of a Particular Product

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

1. Provides ninety (90) days advance notice to the Policyholder and Covered Persons (or such other notice, if any, required by applicable law or regulatory guidance);
2. Offers the Policyholder the option to purchase all or any other health insurance coverage currently offered by the Plan to other employers of similar circumstance, including, but not limited to, employer size; and
3. Acts uniformly without regard to the claims experience of the Policyholder or the health status of any existing, new or potentially new Covered Persons.

B. Discontinuance of All Coverage

The Plan may discontinue all coverage in the large group market, or both, in a state in accordance with applicable law or regulatory guidance and provided that the Plan:

1. Provides one-hundred eighty (180) days advance notice to the Policyholder and Covered Persons (or such other notice, if any, required by applicable law or regulatory guidance); and
2. Discontinues and does not renew all health insurance coverage issued or delivered for issuance in the state in such market(s).

C. Other Discontinuance of Coverage

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

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 applicable law and effective uniformly among group health plans with that product.

IX. POLICYHOLDER NOTIFICATION TO COVERED PERSONS

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

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

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 or the Plan’s posting of such documents on the intranet and/or internet, the Policyholder acknowledges and agrees that such electronic file is not intended to meet the Policyholder's requirements for compliance under ERISA.

The Policyholder further acknowledges and agrees that it is solely responsible for providing employees access, via the intranet, internet, paper copy or otherwise, to the most current version of any electronic file provided to the Policyholder by the Plan. In addition, in all instances, the electronic file of the most current document issued to the Policyholder by the Plan for use by the Policyholder is the legal document used to administer 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.

"Average Discount Percentage ("ADP")" means a percentage discount calculated 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, which is 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.

"Average Wholesale Price ("AWP")" means the average wholesale price of a prescription drug as set forth in the Prime price file at the time a Claim is processed. The price file will be updated no less frequently than weekly through the Pricing Source. The applicable AWP used for retail and mail will be based on the NDC-11 of the package size submitted.

"Benefit Program Application (BPA)" means the document, including any addenda attached thereto, 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.

"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 a properly completed notification in a form acceptable to the Plan, including but not limited to, form and content required by applicable law, that service 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 (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes) and the Claim Charge, and any other information which the Plan may request in connection 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 Copayment that is a percentage of an eligible expense that a Covered Person is required to pay towards a Covered Service.

"Copayment" means a specified dollar amount or Coinsurance 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.

"Effective Date of Policy" means the date specified by the Policyholder in the Benefit Program Application or other appropriate document.

"Eligible Charge" means: (i) For Covered Services under the medical benefit, the Eligible Charge shall have the meaning set forth in the Certificate Booklet in the definitions section.

(ii) For Covered Services under the prescription drug program, the Eligible Charge shall have the meaning set forth in the Certificate Booklet in the Outpatient Prescription Drug Program Benefit section.

"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.

"Independent Physician 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 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. 1395y(b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

"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.

"Pricing Source" means Medi-Span, or other such national drug database or alternate pricing benchmark as Prime and the Plan may designate, which established and provides updates to Prime no less frequently than weekly or as otherwise required by law, regarding AWP or other alternative pricing benchmark for covered prescription drug products and services. The Plan will only use a single nationally recognized pricing source at any given time.

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

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

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

"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.

"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 (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**.**

"Usual and Customary ("U&C")" means the price, including any dispensing fee, that a network participant would charge a particular customer if such customer were paying cash for the identical prescription drug service on the date dispensed. This includes any applicable discounts including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to attract customers.

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 scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois 60601-5099 each year on the last Tuesday in October at 12:30 p.m.

The Plan pays indemnification or advances expenses to a director, officer, employee, or agent consistent with the Plan's bylaws then in force and as otherwise required by applicable law.

For purposes of the aforementioned paragraph the term "member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Insureds or Covered Persons under 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)."

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

Plan President

EXHIBIT 7

Board Authorization

Board of Commissioners of Cook County

Master

118 North Clark Street
Chicago, IL

File Number: 23-4569

File ID:	23-4569	**Type:**	Contract	**Status:**	Approved
Version:	1	**Presenters :**		**Agency:**	Board of Commissioners
				File Created:	08/23/2023
File Name:	New Contract Health Care Service Corp DBA BCBSIL (Medical) 2205-08290A			**Final Action:**	10/19/2023

genda Item: PROPOSED CONTRACT

Department(s): Risk Management

Vendor: Blue Cross and Blue Shield Of Illinois, A Division Of Health Care Service Corporation, A Mutual Legal Reserve Company, Chicago Illinois

Request: Authorization for the Chief Procurement Officer to enter into and execute

Good(s) or Service(s): Employer-Sponsored Medical Benefits

Contract Value: $982,888,049.00

Contract period: 12/1/2023 - 11/30/2026, with (2) two (2) two-year renewal options

Potential Fiscal Year Budget Impact: FY 2024 $312,621,753.00, FY 2025 $327,266,140.00, FY 2026 $343,000,156.00

Accounts: 11250.1021.10155.501610

Contract Number(s): 2205-08290A

Concurrences:
The vendor has met the Minority- and Women-owned Business Enterprise Ordinance via Direct Participation.

The Chief Procurement Officer concurs.

Summary: This contract will allow Cook County Department of Risk Management to provide Employer-Sponsored Medical Benefits for all eligible employees.

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) to provide Employer-Sponsored Medical Benefits. Cook County offers HMO and PPO health plan options for all eligible employees. The premium and 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 annual Benefit Program Applications, Stop Loss Agreements, and HIPAA Plan Sponsor Authorization requests to support the selected HMO and PPO plans. Employees contribute to the plan's cost through payroll deductions, with the balance of the cost covered through annual appropriations.

This contract is awarded through a publicly advertised Request for Proposals (RFP) in accordance with Cook County Procurement Code. Blue Cross and Blue Shield of Illinois, A

Division Of Health Care Service Corporation, A Mutual Legal Reserve Company, Chicago Illinois was selected based on established evaluation criteria.

Notes:

Sponsors:

Enactment Date:

Attachments: 23-4569 - New Contract Health Care Service Corp DBA BCBSIL (Medical) 2205-08290A

Enactment Number:

Contact:

Hearing Date:

Drafter: Jacqueline.Hrabak@cookcountyil.gov

Effective Date:

History of Legislative File

Ver-sion:	Acting Body:	Date:	Action:	Sent To:	Due Date:	Return Date:	Result:
1	Board of Commissioners	09/21/2023	withdraw				
1	Board of Commissioners	10/19/2023	approve				Pass

Text of Legislative File 23-4569

EXHIBIT 8

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.: 2205-08290	Date: 12/15/2022
Total Bid or Proposal Amount [redacted]	Contract Title: Employer Sponsored Medical/Prescription Drug Benefits & Management Services
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: [redacted]
Authorized Contact for Contractor: Katina Neal-Turner	Authorized Contact for Subcontractor/Supplier/ Subconsultant: [redacted]
Email Address (Contractor): katina_neal-turner@bcbsil.com	Email Address (Subcontractor [redacted]
Company Address (Contractor): 300 East Randolph Street	Company Addres (Subcontractor): [redacted]
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): [redacted]
Telephone and Fax (Contractor) 312-653-6144 / 312-228-540-8741	Telephone and Fax (Subcontractor) [redacted]
Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2026	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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	[redacted]

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
Katina Neal-Turner, Manager Supplier Diversity

Title

12/15/2022

Prime Contractor Signature Date

CONTRACT NO.

Cook County
Office of the Chief Procurement Officer
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◯ Check Complete

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Authorized Contact for Contractor: Katina Neal-Turner	Authorized Contact for Subcontractor/Supplie Subconsultant: [redacted]
Email Address (Contractor): katina_neal-turner@bcbsil.com	Email Address (Subcontractor [redacted]
Company Address (Contractor): 300 East Randolph	Company Address (Subcontractor): [redacted]
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): [redacted]
Telephone and Fax (Contractor) 312-653-6144 / 312-540-8764	Telephone and Fax (Subcontractor) [redacted]
Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2026	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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 Wellness Program Promotion with Cook County.	[redacted]

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
Katina Neal-Turner, Manager, Supplier Diversity

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12/15/2022

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Total Bid or Proposal Amount: [redacted]	Contract Title: Employer Sponsored Medical/Prescription Drug Benefits & Management Services
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier Subconsultant to be added or substitute: [redacted]
Authorized Contact for Contractor: Katina Neal-Turner	Authorized Contact for Subcontractor/Supplier/ Subconsultant: [redacted]
Email Address (Contractor): katina_neal-turner@bcbsil.com	Email Address (Subcontractor) [redacted]
Company Address (Contractor): 300 East Randolph	Company Addres (Subcontractor): [redacted]
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): [redacted]
Telephone and Fax (Contractor) 312-653-6144 / 312-540-8762	Telephone and Fa (Subcontractor) [redacted]
Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2026	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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	[redacted]

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
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Katina Neal Turner, Manager Supplier Diversity

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Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2023	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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	[redacted]

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
Katina Neal-Turner Manager Supplier Diversity

Title

12/15/22

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Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: [redacted]
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Telephone and Fax (Contractor) 312-653-8291 / 312-540-8764	Telephone and Fax (Subcontractor) [redacted]
Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2026	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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**
DATA PROCESSING, COMPUTER, PROGRAMMING, AND SOFTWARE SERVICES Computer Aided Design Services IT Consulting	[redacted]

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
Katina Neal-Turner, Manager Supplier Diversity

Title

12/15/2022

Prime Contractor Signature Date

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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.: 2205-08290	Date: 12/15/2022
Total Bid or Proposal Amount [redacted]	Contract Title: Employer Sponsored Medical/Prescription Drug Benefits & Management Services
Contractor: Health Care Service Corporation, a Mutual Legal Reserve Company	Subcontractor/Supplier/ Subconsultant to be added or substitute: [redacted]
Authorized Contact for Contractor: Katina Neal-Turner	Authorized Contact for Subcontractor/Supplier/ Subconsultant: [redacted]
Email Address (Contractor): katina_neal-turner@bcbsil.com	Email Address (Subcontractor): [redacted]
Company Address (Contractor): 300 East Randolph	Company Address (Subcontractor): [redacted]
City, State and Zip (Contractor): Chicago, IL 60601-5099	City, State and Zip (Subcontractor): [redacted]
Telephone and Fax (Contractor) 312-653-8291 / 312-540-8764	Telephone and Fax (Subcontractor) [redacted]
Estimated Start and Completion Dates (Contractor) 12/1/2023 - 11/30/2026	Estimated Start and Completion Dates (Subcontractor) 12/1/2023 - 11/30/2026

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**
Staffing	[redacted]

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
Katina Neal-Turner, Manager Supplier Diversity

Title

12/15/2022

Prime Contractor Signature Date

EXHIBIT 9

Economic Disclosure Statement

COOK COUNTY
ECONOMIC DISCLOSURE STATEMENT
AND EXECUTION DOCUMENT
INDEX

Section	Description	Pages
1	Instructions for Completion of EDS	EDS i - ii
2	Certifications	EDS 1– 2
3	Economic and Other Disclosures, Affidavit of Child Support Obligations, Disclosure of Ownership Interest and Familial Relationship Disclosure Form	EDS 3 – 12
4	Cook County Affidavit for Wage Theft Ordinance	EDS 13-14
5	Contract and EDS Execution Page	EDS 15
6	Cook County Signature Page	EDS 16

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.

Effective October 1, 2016 all foreign corporations and LLCs must be registered with the Illinois Secretary of State's Office unless a statutory exemption applies to the applicant. Applicants who are exempt from registering must provide a written statement explaining why they are exempt from registering as a foreign entity with the Illinois Secretary of State's Office.

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, 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.

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

N/A

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:

Health Care Service Corporation, a Mutual Legal Reserve Company, is headquartered at:

300 East Randolph Street, Chicago, Illinois 60601

c) Does Applicant employ the majority of its regular full-time workforce within Cook County?

Yes: ☐ No: ☒

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 East Randolph Street, Chicago, Illinois 60601

(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.

2205-08290

Declaration of Child Support Obligations

This form must be completed by all Applicants seeking issuance or renewal of a County Privilege.

Applicable law provides that 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.

- **Applicant:** any person or business entity, including all Substantial Owners, seeking issuance of a County Privilege or renewal of an existing County Privilege from the County. This term shall not include any political subdivision of the federal or state government, including units of local government, and not-for-profit organizations.

- **County Privilege:** any business license, including but not limited to liquor dealer's licenses, packaged goods licenses, tavern licenses, restaurant licenses, and gun licenses; real property licenses or lease; permit, including but not limited to building permits, zoning permits or approvals; environmental certificate; County HOME Loan; and contracts exceeding the value of $10,000.

- **Substantial Owner:** 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 Applicants are required to complete this declaration and comply with the Child Support Enforcement Ordinance. An Applicant's signature on this form constitutes a certification that the information provided below is correct and complete, and that the individual signing this form has personal knowledge of such information.

Section A: Applicant Information:

If Applicant is a business entity with no Substantial Owners, check Box D in Section B.
If Applicant is a business entity with Substantial Owners as defined above, each Substantial Owner must complete and submit this declaration.

Business Name: Health Care Service Corporation, a Mutual Legal Reserve Company

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security Number (last four digits): ☐☐☐☐

Section B: Child Support Obligation Information:

The undersigned Applicant, being duly sworn on oath or affirmation hereby states that, "To the best of my knowledge": (click check box left of questions "A", "B", "C", or "D" as is appropriate)

☐ **A.** I do not have judicially or administratively ordered child support obligations.

☐ **B.** I have an outstanding judicially or administratively ordered obligation, but is paying it in accordance with the terms of the order.

☐ **C.** I am delinquent in paying judicially or administratively ordered child support obligations.

☒ **D.** I am an authorized representative of the applicant. The applicant does not have any Substantial Owners as described above.

The undersigned Applicant understands that failure to disclose any judicially or administratively ordered child support debt will be grounds for denying, suspending, or revoking County Privilege(s); and, declares under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Applicant Signature: _____

For Internal Office Use Only:

Contract/Permit/Application Number: _____

Department Name: _____

Date Received: _____

Date: 5/7/24

Contact Name:

Contact Email:

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. **County reserves the right to request additional information to verify veracity of information contained in this statement.**

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: N/A FEIN # Only: 36-1236610

Street Address: 300 E. Randolph Street

City: Chicago State: Illinois Zip Code: 60601-5099

Phone No.: (312) 653-8069 Fax Number: (312) 819-9474 Email:

Cook County Business Registration Number: N/A
(Sole Proprietor, Joint Venture Partnership)

Corporate File Number (if applicable): N/A

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

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
N/A		

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
N/A		

3. Is the Applicant constructively controlled by another person or Legal Entity? [ ] Yes [X] 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
N/A			

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.

COOK COUNTY DISCLOSURE OF OWNERSHIP INTEREST STATEMENT SIGNATURE PAGE

Robert Miller
Name of Authorized Applicant/Holder Representative (please print or type)

Vice President of Sales
Title

Signature

5/7/24
Date

Robert_Miller@bcbsil.com
E-mail address

312-653-8069
Phone Number

Subscribed to and sworn before me
this 7th day of May, 2024

My commission expires: 01/18/2028

x
Notary Public Signature

Notary Seal

OFFICIAL SEAL
YESICA GUZMAN RUIZ
Notary Public, State of Illinois
Commission No. 828450
My Commission Expires January 18, 2028

HEALTH CARE SERVICE CORPORATION (HCSC)
As of 05/01/2024

HCSC Board of Directors	
Name	**Title**
Milton Carroll	Executive Chair
Sidney Dillard	Director
Clyde Drexler	Director
Wayne R. Ebersberger	Director
Dennis J. Gannon	Director
Dianne B. Gasbarra, M.D.	Director
Thaddeus J. Malik	Director
Veronica Hinojosa Segura	Director
Maurice S. Smith	Vice Chair
Phillip R. Smith	Director
HCSC Corporate Officers	
Name	**Title**
Milton Carroll	Executive Chair
Maurice S. Smith	President, CEO and Vice Chair
Catherine B. Nelson	EVP, Secretary and Chief Legal Officer
HCSC Elected Officers	
Name	**Title**
Monica E. Berner, M.D.	SVP Chief Clinical Officer & Markets Shared Services
Tom Boras	SVP Finance
Gregory E. Brown	SVP Chief Customer Service Officer
Kevin M. Cassidy	President HCSC National Accounts
Opella Ernest, M.D.	President HCSC Markets
Michael E. Frank	EVP Chief Operating Officer
Stephania Grober	President Oklahoma Division & Western Markets
Stephen D. Harris	SVP IL Plan President & HCSC Markets
Lisa D. Kelley	President Montana Division
Scott M. Morgan	SVP Chief Information Officer
Arun Prasad	EVP Chief Strategy Officer & President Diversified Businesses
Sarah W. Soong	VP and Treasurer*
James G. Springfield	SVP TX Plan President & HCSC Markets
Lillian M. Sutton	Treasurer (acting)*
Janice M. Torrez	President New Mexico Division
Manika M. Turnbull	SVP Chief Human Resources Officer
James E. Walsh	EVP and Chief Financial Officer
Jill A. Wolowitz	EVP, Chief Administrative Officer & Chief Compliance and Privacy Officer

*The current HCSC By-Laws require the Board to elect the Treasurer annually, regardless of officer title. Effective August 25, 2023, Lillian M. Sutton was appointed by the Board as Treasurer in an acting capacity for HCSC.

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
- ☐ Child
- ☐ Brother
- ☐ Sister
- ☐ Aunt
- ☐ Uncle
- ☐ Niece
- ☐ Nephew
- ☐

- ☐ Grandparent
- ☐ Grandchild
- ☐ Father-in-law
- ☐ Mother-in-law
- ☐ Son-in-law
- ☐ Daughter-in-law
- ☐ Brother-in-law
- ☐ Sister-in-law
- ☐

- ☐ Stepfather
- ☐ Stepmother
- ☐ Stepson
- ☐ Stepdaughter
- ☐ Stepbrother
- ☐ Stepsister
- ☐ Half-brother
- ☐ Half-sister
- ☐

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: Health Care Service Corporation, a Mutual Legal Reserve Company

Address of Person Doing Business with the County: 300 E. Randolph Street, Chicago, Illinois 60601

Phone number of Person Doing Business with the County: Contact : Robert Miller- 312-653-8069

Email address of Person Doing Business with the County: Contact : Robert Miller- Robert_Miller@bcbsil.com

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:
Contact : Robert Miller, Vice President of Sales - 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: 1953-17933

The aggregate dollar value of the business you are doing or seeking to do with the County: $ 882,697,214

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:

CoMakiya Baskin-Smith, Sr. Contract Negotiator, Office of the Chief Procurement Officer, (312) 603-6707

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: Deanna Zalas, Deputy Chief Procurement Officer, Cook County Department of Risk Management (312) 603-4481

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.

□ [X] 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.

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*
N/A			

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*
N/A			

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*

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.

Ruth White — Signature of Recipient

5/7/24 — Date

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.

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. **County reserves the right to request additional information to verify veracity of information contained in this Affidavit.**

I. Contract Information:

Contract Number: CBO-2019-01

County Using Agency (requesting Procurement): Chicago Benefits Office of the City of Chicago's Department of Finance

II. Person/Substantial Owner Information:

Person (Corporate Entity Name): Health Care Service Corporation, a Mutual Legal Reserve Company

Substantial Owner Complete Name: N/A

FEIN# 36-1236610

Date of Birth: E-mail address: Robert_Miller@bcbsil.com

Street Address: 300 East Randolph Street

City: Chicago State: Illinois Zip: 60601

Home Phone: ( ) -

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:

No *Illinois Wage Payment and Collection Act, 820 ILCS 115/1 et seq.,* ***YES or NO***

No *Illinois Minimum Wage Act, 820 ILCS 105/1 et seq.,* ***YES or NO***

No *Illinois Worker Adjustment and Retraining Notification Act, 820 ILCS 65/1 et seq.,* ***YES or NO***

No *Employee Classification Act, 820 ILCS 185/1 et seq.,* **YES or NO**

No *Fair Labor Standards Act of 1938, 29 U.S.C. 201, et seq.,* ***YES or NO***

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:

No There has been a bona fide change in ownership or Control of the ineligible Person or Substantial Owner. YES or NO

No Disciplinary action has been taken against the individual(s) responsible for the acts giving rise to the violation. YES or NO

No Remedial action has been taken to prevent a recurrence of the acts giving rise to the disqualification or default. YES or NO

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: Robert Miller Date: 5/7/24

Name of Person signing (Print): Robert Miller Title: Vice President of Sales

Subscribed and sworn to before me this 7th day of May, 2024

X Yesica Guzman Ruiz
Notary Public Signature

Notary Seal

OFFICIAL SEAL
YESICA GUZMAN RUIZ
Notary Public, State of Illinois
Commission No. 828450
My Commission Expires January 18, 2028

Note: The above information is subject to verification prior to the award of the Contract.

SECTION 15

CONTRACT AND EDS EXECUTION PAGE

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	Stephen Harris, SVP, IL Plan President & HCSC Markets
Corporation's Name	President's Printed Name and Signature
Robert Miller, Vice President of Sales: 312-653-8069	Robert Miller, Vice President of Sales: Robert_Miller@bcbsil.com
Telephone	Email
Secretary Signature	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 Signature	Assumed Name (if applicable)
Date	Telephone and Email

Subscribed and sworn to before me this 7th day of May, 2024.

My commission expires:

OFFICIAL SEAL
YESICA GUZMAN RUIZ
Notary Public, State of Illinois
Commission No. 828450
My Commission Expires January 10, 2026

Notary Public Signature

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.

SECTION 16
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

Date

APPROVED AS TO FORM:

Assistant State's Attorney
(Required on contracts over $1,000,000

Date

CONTRACT TERM & AMOUNT

Contract #

Original Contract Term

Renewal Options (If Applicable)

Contract Amount

Cook County Board Approval Date (If Applicable)