ITEM RES 00-04254

VILLAGE OF DOWNERS GROVE
REPORT FOR THE VILLAGE COUNCIL MEETING
SEPTEMBER 14, 2010 AGENDA

SUBJECT:	TYPE:	SUBMITTED BY:
Blue Cross/Blue Shield Medical Claim Administration	✓ Resolution Ordinance Motion Discussion Only	Wesley Morgan, SPHR Director of Human Resources

SYNOPSIS
A resolution has been prepared to authorize approval of a contract with Blue Cross/Blue Shield for medical claim administration at an annual cost of $219,993. The contractual arrangement will establish Blue Cross/Blue Shield as the Village's health insurance carrier, allowing plan participants access to a larger network with greater discounts on medical services and resulting in significant cost savings.

STRATEGIC PLAN ALIGNMENT
The 2010 Strategic Plan identified an *Exceptional Municipal Organization.* A supporting objective of this statement is to provide *Financially Sound and Sustainable Village Government.*

FISCAL IMPACT
Approval of this contract will result in a projected savings of $1.3 million dollars compared with a continuation of the contracts associated with the current providers. The FY11 Proposed Budget includes $219,993 in the Health Insurance Fund for the direct costs associated with this contract.

RECOMMENDATION
Approval on the September 21, 2010 consent agenda.

BACKGROUND
The Village of Downers Grove maintains a partially self-funded medical plan and contracts with an outside vendor to provide claim administration on behalf of the Village. Claim administration includes medical and prescription drug claim adjudication, pre-certification and medical case management services. Staff routinely reviews the claims administration services received from the vendor, along with the relationship the vendor has with preferred provider organizations (PPO) to ensure that the discounts received through the PPO contracts are cost effective.

The current claim administrator for the Village of Downers Grove is Professional Benefit Administrators (PBA). PPO network discounts are received through PBA's relationship with PHCS/Multiplan, as well as an agreement between the Village and Advocate-Good Samaritan Hospital. In the review of services and costs for FY 2011, staff with the assistance with the Village's healthcare consultant, GCG Financial, identified and evaluated three alternative vendors that were able to provide claims administration and offer stronger PPO discounts that the current providers. The three vendors included:

- Blue Cross/Blue Shield of Illinois
- CIGNA HealthCare
- United HealthCare UMR

The following table summarizes the evaluation of the three vendors, as compared with 2011 projections for the current vendor:

	PBA/PHCS (Current)	Blue Cross/Blue Shield	Cigna HealthCare	United HealthCare
2011 Projected Avg. In-network discounts	38.2%	55.0%	55.0%	55.0%
Projected 2011 Claims (w/ discounts applied)	$5,638,000	$4,208,000	$4,208,000	$4,208,000
2011 Claims Administration Costs	$ 121,500	$ 219,993	$ 167,884	$158,775
Total Claims & Administration Costs	$5,759,500	$4,427,993	$4,375,884	$4,366,775
Savings Compared with Current Provider		$1,331,507	$1,383,616	$1,392,725
Other Factors Considered In Evaluating Vendors		• Largest PPO Network in Illinois • Serves 70% of municipalities & school districts in Chicago area • Claim to have greatest discounts among competitors • Downers Grove-based employer	• Concern that certain hospitals are not currently included in PPO network (Rush)	• Limited presence in Illinois, no municipal references in the state

Staff recommends approval of the contract with Blue Cross/Blue Shield for the following reasons:

- Results in projected savings of $1.3 million in the Village's Health Insurance Fund
- Establishes a contractual relationship with an industry leader and strong community partner that already has a presence in Downers Grove
- Allows for significant cost savings with very little impact to health insurance plan design or participant out-of-pocket cost.
- Minimizes risk of failure to perform due to poor customer service or claims disputes

ATTACHMENTS

Resolution
Blue Cross/Blue Shield Sample Agreement
Blue Cross/Blue Shield Interview Presentation Slides

RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF AGREEMENTS BETWEEN THE VILLAGE OF DOWNERS GROVE AND BLUE CROSS/BLUE SHIELD OF ILLINOIS

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Administrative Services and Claim Administrator Business Associate Agreement (the "Agreements"), between the Village of Downers Grove (the "Employer") and Blue Cross/Blue Shield of Illinois (the "Claim Administrator"), for medical claim administration services, as set forth in the form of the Agreements submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreements, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreements.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

_____
Mayor

Passed:
Attest: _____
Village Clerk

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BlueCross BlueShield of Illinois

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Administrative Services Agreement (the "Agreement") is the Effective Date of Coverage specified on the ASO Benefit Program Application ("ASO BPA") incorporated into and made a part of this Agreement.

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

BLUE CROSS AND BLUE SHIELD OF ILLINOIS, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company	**EMPLOYER NAME specified on the most current ASO BPA of this Agreement**
By: Scott Nilg	By: _____
Title: Divisional Vice President	Title: _____
Date: Effective Date of Coverage noted above	Date: _____

Blue Cross and Blue Shield of Illinois is in the process of revising its reimbursement methodology for out-of-network providers; additional information will be provided.

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This Agreement made as of the Effective Date of Coverage specified on the ASO BPA described below, by and between **Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the "Claim Administrator"), and the Employer specified on such ASO BPA, (hereinafter referred to as the "Employer"), for the Employer Group Number(s) set forth on such ASO BPA, WITNESSETH AS FOLLOWS:

RECITALS

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

WHEREAS, the Employer's Group Health Plan has established and adopted an employee welfare benefit plan ("Plan") as described in its plan document, which shall be provided by the Employer to the Claim Administrator; and

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

WHEREAS, it is desirable to set forth more fully the obligations, duties, rights and liabilities of the Claim Administrator and the Employer, as representative of the Group Health Plan, with respect to the Plan;

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

SECTION 1: APPOINTMENT

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

SECTION 2: AGREEMENT DEFINITIONS

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

2.2 **"Average Discount Percentage ("ADP")"** means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to Covered Persons by hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim to Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount, not to exceed fifteen percent (15%) of such estimate, to reflect related costs. (See provisions regarding "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS" in Exhibit 2 of this Agreement.) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among hospitals and other facilities, the Claim Administrator's contracts with hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when the Covered Person's benefits under the Plan are secondary to Medicare and/or coverage under any other group program.

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

2.4 **"Claim"** means notification in a form acceptable to the Claim Administrator that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the

Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection for such service.

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

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

2.7 "Covered Employee" shall have the same meaning as defined in the Employer's Plan.

2.8 "Covered Person" shall have the same meaning as defined in the Employer's Plan.

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

2.10 "Eligible Charge" means (a) in the case of a Provider other than a professional Provider which has a written agreement with the Claim Administrator to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider other than a professional Provider which does not have a written agreement with the Claim Administrator to provide care to a Covered Person at the time Covered Services are rendered, the amount for Covered Services determined by the Claim Administrator based on the following order:

a. The charge which is within the range of charges other similar hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claim Administrator, if available; or

b. The amount that Centers for Medicare & Medicaid Services ("CMS") reimburses hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program; or

c. The charge which the particular hospital or facility usually charges its patients for Covered Services.

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

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

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

2.14 "Group Health Plan" means, as applied to this Agreement, the self-insured employee welfare benefit plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996.

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

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

2.17 "Network" means identified Providers, including physicians, other professional health care providers, hospitals, ancillary providers, and other health care facilities, that have entered into agreements with the Claim Administrator (and, in

some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point-of-service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

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

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

2.20 "Provider's Eligible Charge" means (a) in the case of a Provider which has a written agreement with the Claim Administrator to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Claim Administrator to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services, not to exceed the reasonable charge or, if dental benefits coverage is elected on the most current Exhibit 4 - ASO BPA of this Agreement, the Usual and Customary Fee, therefor as reasonably determined by the Claim Administrator.

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

2.22 "Surcharges" means state or federal taxes, surcharges or other fees, including, but not limited to World Access Fees, paid by the Claim Administrator which are imposed upon or resulting from this Agreement.

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

a. With respect to all payments due the Claim Administrator by the Employer under this Agreement, within ten (10) calendar days of notification of the Employer by the Claim Administrator; or

b. With respect to all information due the Claim Administrator by the Employer concerning Covered Persons, within thirty-one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or

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

2.24 "Usual and Customary Fee" means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the physician, dentist, podiatrist, psychologist, chiropractor or optometrist who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other physicians, dentists, podiatrists, psychologists, chiropractors or optometrists of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if the Claim Administrator reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by the Claim Administrator.

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

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR

3.1 ***Subcontractors.*** During the continuance of this Agreement, the Claim Administrator will perform such services as set forth in Exhibit 1 of this Agreement, attached hereto and made a part hereof. The Claim Administrator, at its sole discre-

tion, may contract with other entities for performance of any of the services to be performed by the Claim Administrator hereunder; provided, however, the Claim Administrator shall remain fully responsible and liable for performance of any such services to be performed by the Claim Administrator but delegated to other entities.

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

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

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

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

4.3 ***Litigation.*** Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. The Employer shall undertake the defense of such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement.

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

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

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

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

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

4.6 ***Plan eligibility errors.*** Clerical errors in keeping or reporting data relative to coverage under this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly termi-

nate. Such errors will be corrected by the Claim Administrator subject to the terms and conditions of this Agreement and the Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. The Employer is liable for any benefits paid for a terminated Covered Person until the Employer has notified the Claim Administrator of such Covered Person's termination.

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

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

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

SECTION 5: THIRD PARTY DATA RELEASE

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

- **a.** The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 5, "Confidential Information").
- **b.** Release of the Confidential Information may also reveal the Claim Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 5, "Proprietary Information").
- **c.** To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 5, collectively, "Information").

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

- **a.** Use the Information only for the purpose of complying with the terms and conditions of its contract with the Employer.
- **b.** Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Employer.
- **c.** Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
- **d.** Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
- **e.** Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.
- **f.** Not use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
- **g.** Execute the Claim Administrator's then-current confidentiality agreement.

5.3 ***Employer obligations.*** The Employer shall:

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

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

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

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

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

SECTION 7: CLAIM DISPUTE RESOLUTION

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

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

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES

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

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

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

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

SECTION 9: COOPERATION OF THE PARTIES

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

SECTION 10: HIPAA/CERTIFICATE OF CREDITABLE COVERAGE

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

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

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

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

SECTION 11: INDEMNIFICATION

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

11.2 ***Employer indemnifies Claim Administrator.*** The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. The Employer agrees to indemnify and hold harmless the Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Claim Administrator in connection with the design or administration of the Plan, unless the liability therefor was the direct consequence of the acts or omissions of the Claim Administrator or its directors, officers or employees and is adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment and/or Net Claim Payment errors by the Claim Administrator.

Examples of such actions brought against the Claim Administrator in connection with the design and administration of the Plan include, but are not limited to, the following:

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

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

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

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

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

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

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

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

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

j. Any claim based upon Medicare Secondary Payer ("MSP") laws or regulations.

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS

12.1 ***Employer audits Claim Administrator.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Employer or an authorized agent of the Employer (as mutually agreed to by the Claim Administrator and the Employer) may, upon at least ninety (90) days prior written notice to the Claim Administrator, conduct reasonable audits of the Claim Administrator's records in regard to Claim Payments and Net Claim Payments calculated on the basis of Claim Payments made under the Agreement. The Employer and such agent that have access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary or confidential information, and to hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information. Audits performed on a contingency fee basis will not be allowed or supported by the Claim Administrator. The Employer will be responsible for all costs associated with the inspection or audit. All such audits shall be subject to the Claim Administrator's external audit policy and procedures, a copy of which shall be furnished to the Employer upon request to the Claim Administrator. The audit period will be limited to the most recent twenty-four (24) months and no more than one (1) audit shall be conducted during a twelve (12) consecutive-month period.

12.2 ***Errors identified.*** The Claim Administrator shall be responsible only for the correction of errors identified in specific Claim Payments and Net Claim Payments subject to the terms and conditions of the Agreement and shall not be responsible for errors calculated to exist in a population of Claim Payments and Net Claim Payments on the basis of a sample drawn from that population. Further, the Claim Administrator has the right to implement reasonable administrative practices in the administration of this Agreement.

12.3 ***Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Claim Administrator may, upon at least thirty (30) days prior written notice to the Employer, conduct reasonable audits of Employer's membership records with respect to eligibility.

SECTION 13: TERM AND TERMINATION OF AGREEMENT

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

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

a. By either party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA upon ninety (90) days prior written notice to the other party; or

b. By both parties on any date mutually agreed to in writing; or

c. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Agreement, upon written notice as provided under Section 22 below.

d. By the Claim Administrator, upon the Employer's failure to pay all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the Fee Schedule of the most current Exhibit 4 - ASO BPA.

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

SECTION 14: RELATIONSHIP OF PARTIES

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

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

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

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

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

SECTION 15: ERISA

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

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

15.3 ***In Relation to Claim Administrator's Responsibilities.*** The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Employer's plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer's ERISA employee welfare benefit plan. The Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

SECTION 16: PROPRIETARY MATERIALS

16.1 ***Types of materials as may be used by the parties.*** The parties acknowledge that each party has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which

are proprietary information ("Business Proprietary Information"). Neither party shall use or disclose to any third party Business Proprietary Information without prior written consent of the other party. Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Claim Administrator may include the Employer in its list of clients.

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

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

SECTION 17: ELECTRONIC DOCUMENTS

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

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

SECTION 18: RECORDS

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

SECTION 19: APPLICABLE LAW

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

SECTION 20: ENTIRE AGREEMENT

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

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

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

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

SECTION 21: LIMITATIONS

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

SECTION 22: NOTICE AND SATISFACTION

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

SECTION 23: LIMITATION OF LIABILITY

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

SECTION 24: DISPUTE RESOLUTION/ARBITRATION

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

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

- **a.** Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;
- **b.** If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of $200, the American Arbitration Association shall recommend an arbitrator; or
- **c.** If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is $200 or less, the Claim Administrator shall select an independent third party to be the arbitrator.

24.3 ***Expectations.*** The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All

other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Arbitration Association then in effect.

SECTION 25: OBLIGATION TO CONTINUE PERFORMANCE

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

SECTION 26: NOTICES

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

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

SECTION 27: SEVERABILITY

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

SECTION 28: ENFORCEMENT

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

SECTION 29: FORCE MAJEURE

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

SECTION 30: NOTICE OF ANNUAL MEETING

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

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

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

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

- **EXPLANATION OF BENEFITS (EOB)**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Handling of inquiries -- written, phone or in-person - related to membership, benefits, and Claim Payment, Net Claim Payment or Claim denial.

- **ENROLLMENT SERVICE**

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

- **CLIENT SERVICES AND MATERIALS**

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

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

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

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

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

  e. ***Medical Pre-notification Helpline.*** For those services determined by Employer and provided in writing to Claim Administrator that require pre-notification, advance Claim Administrator review of medical necessity of such services covered under the Plan; access to toll-free medical pre-notification helpline for Covered Persons and their health care providers to call for assistance.

- **MEMBERSHIP VALIDATION**

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

- **MEMBERSHIP FILE UPDATES**

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

- **OTHER MEMBERSHIP SERVICES**

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

- **STANDARD REPORTS**

  Make available Claim data, Claim Settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy at no additional

charge. Any additional reports required by Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

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

- **REPORTING SERVICES**

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

- **ACTUARIAL AND STATISTICAL**

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

- **FINANCIAL SERVICES**

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

- **FRAUD DETECTION AND PREVENTION**

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

- **BLUE ACCESS FOR EMPLOYERS**

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

- **BLUE ACCESS FOR MEMBERS**

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

- **PROVIDER NETWORK(S)**

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

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

  Issuance of Certificates of Creditable Coverage.

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

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

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

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

- **ADDITIONAL SERVICES NOT SPECIFIED**

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

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

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

SECTION 2: EXHIBIT DEFINITIONS

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

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

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

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

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

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

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

2.7 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children. (See Section 18 of this Exhibit titled "MEDICARE SECONDARY PAYER ("MSP") DATA MATCH.")

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

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

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

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

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

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

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

- **a.** At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement, provided that sixty (60) days prior written notice is given by the Claim Administrator;
- **b.** On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase the Claim Administrator's cost of administration;
- **c.** On any date changes imposed by governmental entities increase expenses incurred by the Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
- **d.** On any date that the number of Covered Employees enrolled in the Plan changes by an amount equal to ten percent (10%) or more of total enrollment over a one (1) month period or twenty-five percent (25%) or more of total enrollment over a three (3) month period; or
- **e.** On any date an affiliate, subsidiary, or other business entity is added or dropped by the 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, the Employer will Timely pay the Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement.

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

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

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

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

SECTION 4: CLAIM PAYMENTS

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

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

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

SECTION 5: EMPLOYER PAYMENT

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

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

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

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

Late payments are subject to the penalties outlined in Section 7.3 of this 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 Exhibit 4 - ASO BPA of the Agreement. The Claim Settlement shall reflect the sum of the following:

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

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

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

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

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

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

SECTION 7: LATE PAYMENTS AND REMEDIES

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

a. Suspend Claim Payments; or

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

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

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

a. The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or

b. The maximum rate permitted by state law.

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

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run-off Claims.*** The Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 13 of the Agreement, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to the Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Claim Administrator ("Run-Off Claims"). The Employer shall be responsible for the reimbursement of all Run-Off Claims, whether or not such Claims have been submitted, or whether or not Net Claim Payments calculated on the basis of Claim Payments for such Claims have been made by the Claim Administrator, as of the date of termination, including, but not limited to, Claim Payments and/or Net Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current Exhibit 4 - ASO BPA of the Agreement and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date. Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a hospital or other facility Provider until the Covered Person is discharged or until the end of the Covered Person's benefit period, whichever occurs first ("Extended Benefits"). The Employer shall be liable to the Claim Administrator for all Claim Payments, Net Claim Payments and the applicable service charges for such Extended Benefits.

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

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

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

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

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

10.1 ***Claim payment assignment.*** All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Claim Administrator

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

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

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

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

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

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

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

a. ***Physician Selection.***

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

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

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

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

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

SECTION 12: LIMITED BENEFITS FOR NON-NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current Exhibit 4 - ASO BPA of the Agreement. The Employer acknowledges that when Covered Persons elect to utilize the services of a

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

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

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

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

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

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

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

14.2 The Claim Administrator hereby informs the Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group

health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement.

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

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

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

15.2 Based upon previous experience with such rebates, the Claim Administrator has estimated that any drug rebate for the Employer would be based on an average dollar amount per prescription ("Expected Rebate"). One-hundred percent (100%) of the Expected Rebate is shared with employers based upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Employer is determined by multiplying the sum of the estimated dollars times the expected number of annual prescriptions dispensed, then divided by the expected number of Covered Employees, then divided by twelve (12) months. The Expected Rebate amount is reflected as a prescription drug rebate credit per Covered Employee per month.

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

SECTION 16: BLUECARD

16.1 Like all Blue Cross and Blue Shield Licensees, the Claim Administrator participates in a program called "BlueCard." Whenever Covered Persons access health care services outside the Claim Administrator's service area, the Claims for those services may be processed through BlueCard and presented to the Claim Administrator for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Covered Persons receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), the Claim Administrator will remain responsible to the Employer for fulfilling the Claim Administrator's contract obligations.

For point-of-service managed care health benefits coverage programs if elected on the most current Exhibit 4 - ASO BPA of the Agreement, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers, handling all interaction with its participating Providers, and providing some managed care services. The financial terms of BlueCard are described generally below.

For health benefits coverage programs other than point-of-service managed care, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

16.2 Liability Calculation Method Per Claim

The calculation of a Covered Person's liability on Claims for Covered Services incurred outside the Claim Administrator's service area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Claim Administrator pays the Host Blue.

The calculation of the Employer's liability on Claims for Covered Services incurred outside the Claim Administrator's service area and processed through BlueCard will be based on the negotiated price the Claim Administrator pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Claim Administrator on a Claim for Covered Services processed through BlueCard may represent:

a. The actual price paid on the Claim by the Host Blue to the health care Provider ("Actual Price"), or

b. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-Claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

c. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-Claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Covered Person and the Employer from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Person and the Employer is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Employer being held in a variance account by the Host Blue, pending settlement with its participating Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Employer and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either a) to use a basis for calculating a Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or b) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Claim Administrator would then calculate the Covered Person's liability and the Employer's liability for any Covered Services consistent with the applicable state statute in effect at the time the Covered Person received those services.

16.3 Negotiated Price Per Covered Employee or Covered Person Per Month (for point-of-service managed care health benefits coverage programs if elected on the most current Exhibit 4 - ASO BPA of the Agreement)

For some Host Blues, the Employer may have liability on a per Covered Employee or Covered Person per month basis for Provider health care services performed outside of the Claim Administrator's service area, such as for capitated service fees, performance incentive fees, adjustments to the Actual Price determined by the Host Blue instead of developing an Estimated Price or Average Price per Claim, or other Provider fees charged on this basis. The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts.

The Employer liability for capitated Provider services will be at the negotiated price the Claim Administrator pays to the Host Blue. The negotiated price paid by the Claim Administrator for per Covered Employee or Covered Person per month capitated services provided through BlueCard represents:

(1) The Provider's actual per Covered Employee or Covered Person per month price paid by the Host Blue to the health care Provider ("Actual PMPM Price"), or

(2) An estimated per Covered Employee or Covered Person per month price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual PMPM Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-Claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated PMPM Price"), or

(3) An average per Covered Employee or Covered Person per month price, determined by the Host Blue in accordance with BlueCard Policies, based on a) a sum of the Actual PMPM Price of each Covered Employee or Covered Person of the Employer, adjusted for expected settlements, withholds, any other contingent payment arrangements and non-Claims transactions, divided by b) the total number of Covered Employees or Covered Persons of the Employer ("Average PMPM Price").

Negotiated prices, other than for capitated services, for Provider fees paid per Covered Employee or Covered Person per month by the Claim Administrator to a Host Blue, such as a performance incentive fee, are based on an estimate of the annualized total of that fee, determined by the Host Blue, in accordance with BlueCard Policies, for all of its health care Providers or for a specified group of Providers.

Host Blues using either the Estimated PMPM Price or Average PMPM Price method will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated PMPM Price or Average PMPM Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Employee or Covered Person and the Employer is a final price and will not be affected by such adjustment. In addition, a liability calculation method of Estimated PMPM Price or Average PMPM Price will result in some portion of the amount paid by the Employer being held in a variance account by the Host Blue, pending settlement with its Providers. Because all amounts paid are final, the funds held in a variance account do not belong to the Employer and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

16.4 Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a Claim-by-Claim or prospective basis.

16.5 BlueCard Fees and Compensation

The Employer understands and agrees a) to pay certain fees and compensation to the Claim Administrator which the Claim Administrator is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors and b) that fees and compensation under BlueCard may be revised from time to time without the Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a Claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these Claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the Employer as an additional Claim liability. Other fees include, but are not limited to, a toll-free phone number fee and a fee for providing certain Provider directories. If you do not have a complete listing, or want an updated listing, of these types of fees or the amount of these fees paid directly by the Employer, you should contact the Claim Administrator's representative.

16.6 Determinations of Covered Health Care Services (for point-of-service managed care health benefits coverage programs if elected on the most current Exhibit 4 - ASO BPA of the Agreement)

If the Claim Administrator or, if applicable, the Employer determines that health care services are covered, or the Employer's medical plan covers the health care services, coverage of those health care services cannot be denied based on the Host Blue's network protocols. However, under BlueCard, the Covered Person cannot be denied coverage of health care services received outside of the Claim Administrator's service area if the health care services a) are covered by the network protocols of the Host Blue; and b) are not specifically limited or excluded by the Employer's plan.

SECTION 17: SERVICING PLAN AGREEMENTS BETWEEN CLAIM ADMINISTRATOR AND OTHER BLUE CROSS AND BLUE SHIELD PLANS

17.1 In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (hereinafter called the "Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments and certain

administrative services for those Covered Persons of the Employer residing in the state and/or service area of the Servicing Plans. Pursuant to the agreement between the Claim Administrator and the Servicing Plans, the Claim Administrator has agreed to reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for those Covered Persons of the Employer residing in the state and/or service area of such Servicing Plan.

17.2 The Claim Administrator hereby informs the Employer, and the Employer shall advise its Covered Persons, that certain Servicing Plans may have contracts with certain Providers ("Servicing Plan Providers") in their service area for the provision of, and payment for, health care services to persons entitled to health care benefits under health policies and contracts to which the Servicing Plan is a party, including the Covered Persons covered under the Agreement, and that pursuant to the Servicing Plan's contracts with its Servicing Plan Providers, under certain circumstances described therein, the Servicing Plan may receive substantial payment from Servicing Plan Providers with respect to services rendered to such persons for which the Servicing Plan was obligated to pay the Servicing Plan Provider, or the Servicing Plan may pay Servicing Plan Providers less than their billed charges for services, by discounts or otherwise, or may receive from Servicing Plan Providers other allowances under the Servicing Plan's contracts with them. The Employer acknowledges that in negotiating the service charges set forth in the Agreement, it has taken into consideration that, among other things, the Servicing Plan may receive such payments, discounts and/or other allowances during the term of its agreement with the Claim Administrator. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges thereon pursuant to the terms of its agreement with the Claim Administrator (and with respect to most Servicing Plans, any required deductible and Coinsurance amounts under the Employer's Plan) shall be calculated on the basis of the Servicing Plan Provider's Claim Charge for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between the Servicing Plan Provider and the Servicing Plan as referred to herein. However, the Employer acknowledges that the Claim Administrator, under its contract with each Servicing Plan, may be required to reimburse the Servicing Plan only for Claim Payments which have been discounted pursuant to an agreement between the particular Servicing Plan and its Servicing Plan Providers including the service charges thereon. In any event the Employer shall reimburse the Claim Administrator the amount paid by the Claim Administrator to the Servicing Plan for Claim Payments plus any service charges payable by the Claim Administrator to the Servicing Plan, in addition to applicable service charges of the Claim Administrator hereunder.

17.3 The Claim Administrator hereby informs the Employer, and the Employer acknowledges, that the Claim Administrator's, the Host Plans' and the Servicing Plans' Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers, Host Plans' Providers and the Servicing Plans' Providers may result in minor deviations in Claim processing and/or pricing of Claims for same services.

SECTION 18: MEDICARE SECONDARY PAYER ("MSP") DATA MATCH

18.1 In an effort to facilitate the processing of Claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain Blue Cross and Blue Shield Plans together with the Centers for Medicare & Medicaid Services ("CMS"), formerly known as Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a Timely and current fashion, information necessary for the Claim Administrator to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular Claim.

18.2 Under the system, the Claim Administrator will provide basic information to CMS about individuals enrolled in Group Health Plans who are also covered by Medicare so that CMS can better detect dual coverage situations.

18.3 The Employer hereby authorizes and directs the Claim Administrator to disclose to CMS periodically, information pertaining to Medicare-eligible Covered Persons under the Plan.

18.4 The Employer agrees that the Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Claim Administrator's files concerning Covered Persons. The Employer agrees to use its best efforts in responding promptly and accurately to the Claim Administrator's requests for information and to require and facilitate its Covered Persons' cooperation in responding promptly and accurately to such requests.

18.5 Further, to assure the continuing accuracy of the Claim Administrator's files, the Employer agrees that it is the Employer's responsibility to notify the Claim Administrator promptly of any change in the size of the Employer's work force 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 size of the Employer's work force that place it in, or take it out of, the scope of the MSP statute. If the Claim Administrator does not receive such information from the Employer, the Claim Administrator will assume that all relevant factors remain unchanged and will process Claims accordingly. The Employer acknowledges and agrees that the Claim Administrator will be using the information provided by the Employer and Covered Persons to update the Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

18.6 The Claim Administrator may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in the Agreement shall be construed as obligating the Claim Administrator to continue its participation in the Data Match system.

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

SECTION 19: REIMBURSEMENT PROVISION

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

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

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

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

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

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

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

1.1 The Claim Administrator shall have the right to select and retain legal counsel.

1.2 Any lawsuit filed or arbitration initiated by the Claim Administrator will be done in the name of the Claim Administrator for its own benefit, as well as on behalf of the Employer and possibly other parties. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Employer and/or the Plan without the Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Employer and/or the Plan with attorneys identified as counsel for the Employer or in the name of two or more parties, including the Employer and the Claim Administrator, with attorneys identified as counsel for the Employer, the Claim Administrator and possibly other parties.

1.3 The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including providing appropriate authority to communicate with the Employer concerning issues pertaining to any class actions and pursuant to which the Employer specifically declines representation by class litigation counsel.

1.4 The Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.

1.5 The Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.

1.6 Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Claim Administrator on any reasonable basis it deems appropriate.

1.7 Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney-client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. The Employer shall not waive the attorney-client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of the Claim Administrator.

1.8 The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.

1.9 Nothing in the provisions of this Exhibit shall require the Claim Administrator to assert any claims on behalf of the Employer and/or the Plan.

1.10 Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, the Employer acknowledges that the efforts of the Claim Administrator may not result in recovery or in full recovery in any particular case.

1.11 The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Claim Administrator to assert any claims on the Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Claim Administrator has asserted a claim on behalf of the Employer and/or the Plan but before any recovery, the Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.

1.12 If the Employer should desire to participate in a class or multi-district settlement rather than defer to the Claim Administrator, the Employer may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 26 NOTICES of the Agreement.

1.13 The Employer further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Section 26 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Employer and/or the Plan, to:

a. Pursue claims that the Claim Administrator pursues on its own behalf in class action litigation, federal multi-district litigation, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;

b. Opt out of any class action settlement or keep the Employer and/or the Plan in the class, if the Claim Administrator believes it is in the best interest of the parties to do so;

c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.

1.14 The Employer further acknowledges and agrees that the Claim Administrator's decision to pursue recovery in connection with particular claims shall be in the Claim Administrator's sole discretion and the Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of the Employer and/or the Plan when, as, and if, the Claim Administrator determines that such claims may be pursued in the common interest of the parties.

1.15 The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail.

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

CLAIM ADMINISTRATOR BUSINESS ASSOCIATE AGREEMENT

This Claim Administrator Business Associate Agreement ("Agreement") 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 insert name of employer ("Employer") and the Employer on behalf of its Group Health Plan ("GHP"), collectively the "Parties," is effective on insert effective date.

The purpose of this Agreement is to set forth the Parties' mutual agreement on the terms for their compliance with the Health Insurance Portability and Accountability Act ("HIPAA" or "Privacy Rule" or "Security Rule" or "Electronic Transactions Rule") and its implementing regulations (45 C.F.R. Parts 160-164) and the requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as incorporated in the American Recovery and Reinvestment Act of 2009 and the implementing regulations, as issued and amended by the Secretary, that are applicable to Business Associates. Capitalized terms used in this Agreement and not otherwise defined herein shall have the meanings set forth in HIPAA and/or HITECH which definitions are hereby incorporated by reference.

The Parties acknowledge and agree that Claim Administrator is a Business Associate and that the Group Health Plan ("GHP") established and maintained by the Employer is a Covered Entity as those terms are defined by HIPAA. Employer acknowledges that its employee welfare benefit plan meets the definition of Health Plan in 45 CFR 160.103.

1. Obligations and Activities of Claim Administrator as Business Associate.

(a) Claim Administrator agrees to use or disclose Protected Health Information (PHI) it creates or receives for or from Employer and GHP only as permitted or required by this Agreement or as Required by Law.

(i) Claim Administrator is permitted to use or disclose PHI to perform the functions, activities and services as the claim administrator for Employer's GHP. In addition, the Parties may enter into other agreements from time to time that include additional functions, activities, and services provided by the Claim Administrator, and to the extent that such agreements include the Use or Disclosure of PHI, the Parties agree that the terms of this Agreement shall also apply.

(ii) Claim Administrator is permitted to use or disclose PHI to perform functions, activities, or services for, or on behalf of, the GHP as Covered Entity, provided that such Use or Disclosure would not violate the Privacy Rule or HITECH if done by Covered Entity, including the minimum necessary and/or Limited Data Set requirements of the Privacy Rule and HITECH.

(iii) Except as otherwise limited in this Agreement, Claim Administrator may use PHI for the proper management and administration of the Agreement or to carry out the legal responsibilities of the Claim Administrator.

(iv) Except as otherwise limited in this Agreement, Claim Administrator may disclose PHI to carry out Claim Administrator's proper management, administration or legal responsibilities, provided that the Disclosures are: Required by Law; or Claim Administrator obtains reasonable assurances from the person/entity to whom the information is disclosed, that it will remain confidential and used or further disclosed only as Required by Law. An executed Business Associate Agreement or other applicable Confidentiality Agreement would be used as evidence to support this. Furthermore, the information disclosed will only be used for its intended purpose and if the confidentiality of the information has been breached, the person/entity will notify the Claim Administrator in all instances.

(v) Except as otherwise limited in this Agreement, Claim Administrator may use PHI to provide Data Aggregation services relating to the Health Care Operations of the GHP and as permitted by 45 CFR 164.504(e)(2)(i)(B).

(vi) Claim Administrator may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1) and HITECH.

(b) Claim Administrator agrees to use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement. Claim Administrator agrees to implement administrative, technical, and physical measures that reasonably and appropriately protect the confidentiality, integrity, and availability of the

Electronic PHI that Claim Administrator creates, receives, maintains, or transmits on Covered Entity's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and/or as required by Section 13401 of HITECH.

(c) Claim Administrator agrees to report to Covered Entity any Use or Disclosure of PHI not provided for by this Agreement of which it becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of such Use or Disclosure not provided for by this Agreement.

(d) Claim Administrator agrees to report to Covered Entity any successful Security Incident of which Claim Administrator becomes aware. Claim Administrator will make such report to Covered Entity's Privacy Office within a reasonable time after Claim Administrator learns of any successful Security Incidents. To avoid unnecessary burden on either Party, Claim Administrator will only be required to report, upon the Covered Entity's request, attempted, but unsuccessful Security Incidents which Claim Administrator becomes aware; provided that the Covered Entity's request shall be made no more often than is reasonably based upon the relevant facts, circumstances and industry practices.

(e) Claim Administrator will report to Covered Entity, as required by law of any "Breach" of "Unsecured Protected Health Information" as these terms are defined by HITECH. Claim Administrator shall cooperate with Covered Entity in investigating the Breach and in meeting the Covered Entity's obligations under HITECH and any other security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Claim Administrator to have been accessed, acquired, or disclosed during such Breach as required by law.

Covered Entity shall check "YES", below, if Covered Entity is electing to delegate to Claim Administrator the provision of the HITECH Act Security Breach services described in Attachment 1 of this Agreement ("Attachment 1"), Covered Entity shall check "NO", below, if Covered Entity is electing to retain the provision of the HITECH Act Security Breach services described in Attachment 1. If Covered Entity does not check "YES" or "NO" below, Claim Administrator will NOT provide the HITECH Act Security Breach services described in Attachment 1 and these services will become the responsibility of the Covered Entity.

☐ Yes ☐ No

(f) Claim Administrator agrees to ensure that any of its agents, including a subcontractor, to whom Claim Administrator provides PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, agree in writing to substantially the same restrictions, conditions, and security measures that apply through this Agreement to Claim Administrator with respect to such information.

(g) Claim Administrator agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the Use and Disclosure of PHI received from, or created or received by Claim Administrator on behalf of Covered Entity, available to the Secretary, in a time and manner as reasonably requested by or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(h) Claim Administrator agrees to document such Disclosures of PHI and information related to such Disclosures as would be required for Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528 and HITECH.

(i) The Party identified on Attachment 2 of this Agreement ("Attachment 2") agrees to provide to an Individual, and in the time and manner mutually agreed by the Parties, information collected in accordance with Section 1(h) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an Accounting of Disclosures of PHI in accordance with 45 CFR 164.528. Upon termination of this Agreement, Claim Administrator will respond to the Individual for a period of up to six years.

(j) The Party identified on Attachment 2 agrees to provide access, at the request of an Individual, and in the time and manner mutually agreed by the Parties, to PHI for an Individual in order to meet the requirements under 45 CFR 164.524 and HITECH. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(k) Prior to responding to an Individual's request for an amendment pursuant to 45 CFR 164.526, Covered Entity shall ask Claim Administrator if Claim Administrator created the PHI maintained in the designated record set. Claim Administrator will notify Covered Entity of its recommendation to deny or grant the individual's request. The Party identified on Attachment 2 will respond to Individual's request for an amendment. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(l) In those instances when Claim Administrator may conduct Standard Transactions on behalf of the Covered Entity, Claim Administrator will comply with the HIPAA requirements for Standard Transactions and Data Code Sets.

2. Obligations of GHP as Covered Entity.

(a) Covered Entity shall notify Claim Administrator of any limitation(s) in the Notice of Privacy Practices of Covered Entity on Attachment 2 in accordance with 45 CFR 164.520, to the extent that such limitation may affect Claim Administrator's Use or Disclosure of PHI. Employer or Covered Entity will notify Claim Administrator of any material change in privacy policies, procedures or practices.

(b) Covered Entity shall notify Claim Administrator of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Claim Administrator's Use or Disclosure of PHI.

(c) Prior to responding to an Individual's restriction request on the Use or Disclosure of PHI in accordance with 45 CFR 164.522, Covered Entity shall ask Claim Administrator if the proposed restriction will affect its functions, activities, or services under the Agreement. If such restriction would affect Claim Administrator's Use or Disclosure of PHI, Covered Entity will deny the Individual's request. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(d) If Covered Entity or Claim Administrator receives a request from an Individual for confidential communication of PHI by alternative means or at alternative locations in accordance with 45 CFR 164.522(b), Covered Entity, prior to responding to such a request, shall ask Claim Administrator for information on the feasibility of implementing or accommodating the request and on whether there may be an additional cost. Covered Entity shall promptly notify Claim Administrator of its decision on the request for confidential communication of PHI. Upon termination of this Agreement, Claim Administrator will respond to an Individual's request during such time that Claim Administrator maintains the data.

(e) Covered Entity shall provide Claim Administrator the necessary information to fulfill Claim Administrator's obligations under this Agreement, including but not limited to, a written statement of the restrictions for the Disclosure of PHI by Claim Administrator to the Employer. Employer certifies that the Employer's benefit Plan Documents have been amended in compliance with 45 CFR 164.314(b) and 45 CFR 164.504(f) and that information from the applicable amendments shall be included in the written statement provided to Claim Administrator.

(f) Covered Entity shall identify its Business Associates and Group Health Plan employees on Attachment 2 to whom Claim Administrator is permitted to directly Disclose PHI. Covered Entity shall provide information on any limitations or restrictions on Claim Administrator's Disclosure to a specific Business Associate or Group Health Plan employees of Covered Entity.

3. Permissible Requests by Covered Entity.

Covered Entity shall not request Claim Administrator to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, unless otherwise noted in this Agreement.

4. Term and Termination.

(a) **Term**. The Term of this Agreement shall be effective on the date stated on the first page of this Agreement and shall terminate without notice upon termination of any agreement or arrangement between the Parties for Claim Administrator to provide administrative services to Employer's self-insured health benefit welfare plan.

(b) **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Claim Administrator, Covered Entity shall either:

(i) Provide an opportunity for Claim Administrator to cure the breach or end the violation and terminate this Agreement if Claim Administrator does not cure the breach or end the violation within the time specified by Covered Entity;

(ii) Immediately terminate this Agreement if Claim Administrator has breached a material term of this Agreement and cure is not possible; or

(iii) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) **Effect of Termination**. The Parties agree that returning or destroying the PHI is not feasible due to: (1) state or federal regulatory requirements applicable to Claim Administrator and Covered Entity, or (2) Claim Administrator's record retention policies. Therefore, Claim Administrator shall extend the protections of this Agreement to such PHI, limiting further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Claim Administrator maintains such PHI.

(d) **Cure of Non-material Breach**. Covered Entity shall provide an opportunity for Claim Administrator to cure a non-material breach within the time specified by Covered Entity.

5. Miscellaneous.

(a) **Regulatory References**. A reference in this Agreement to a section in the HIPAA Rules (45 C.F.R. Parts 160-64) and HITECH means the section as in effect and the implementing regulations, as issued and amended by the Secretary.

(b) **Amendment**. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA and HITECH and as the HIPAA Privacy, Security, and Electronic Transactions Rule may be amended from time to time.

(c) **Survival**. The respective rights and obligations of Covered Entity and Claim Administrator under Section 4(c) of this Agreement shall survive the termination of this Agreement.

(d) **Interpretation.**

(i) Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy, Security, Electronic Transactions Rule and HITECH.

(ii) Any conflict between terms of this Agreement and any other agreement between the Parties concerning the Employer's health welfare benefits plan shall be resolved so that the terms of this Agreement supersede and replace the relevant terms of any such other agreement concerning the confidentiality of GHP data, medical records information, and other records containing PHI.

(e) **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed an original, and all of which shall constitute one binding agreement.

(f) **Severability**. The provisions of this Agreement shall be severable, and if any provision of this Agreement shall be held or declared to be illegal, invalid or unenforceable, the remainder of this Agreement shall continue in full force and effect as though such illegal, invalid or unenforceable provision had not been contained.

(g) **Identifying Information**. Employer's and Claim Administrator's respective Privacy Office information is provided in Attachment 2.

IN WITNESS WHEREOF, the Parties hereto have authorized this Agreement to be executed.

Enter the Name of Employer, Employer [*or Plan Sponsor]* and Employer on behalf of its Group Health Plan, the Covered Entity:	**Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company Claim Administrator:**
Signature: _____	**Signature:** 
Printed Name: _____	**Printed Name: Scott Hilgemann**
Title: _____	**Title: Vice President & Chief Underwriter**
Date: _____	**Date:** _____

Attachments:
ATTACHMENT 1 - DELEGATION of HITECH BREACH NOTIFICATION
ATTACHMENT 2 - ADDITIONAL INFORMATION FORM

ATTACHMENT 1 – DELEGATION OF HITECH BREACH NOTIFICATION
Claim Administrator Business Associate Agreement

The following Health Information Technology for Economic and Clinical Health Act ("HITECH") Security Breach services will be provided as indicated by Covered Entity on the Claim Administrator Business Associate Agreement, as allowed by the HITECH Act and any subsequent regulation or guidance from the United States Department of Health and Human Services (DHHS):

- Investigate any unauthorized access, use, or disclosure of Group Health Plan member protected health information (PHI).
- Determine whether there is a significant risk of financial, reputational or other harm to any Group Health Plan member as provided for in the HITECH Act.
- Determine whether the incident falls under any of the HITECH Act Security Breach notification exceptions.
- Document and retain each HITECH Security Breach risk assessment and exception analyses, and make this information available to Group Health Plan members upon request.
- Provide Group Health Plan with written notification that describes the HITECH Security Breach incident in detail including a list of the impacted members and/or a copy of a member notification.
- Notify each Group Health Plan member impacted by the HITECH Security Breach by first class mail within the applicable statutory notification period, and provide toll-free numbers to the impacted members in order to handle any member questions regarding the incident. The notification will include the following:

    - A brief description of the incident, including the date of the Security Breach and the date it was discovered;
    - A description of the types of PHI involved in the Security Breach (i.e., name, birth date, home address, account number, Social Security Number, etc.);
    - The steps that individuals might take to protect themselves from potential harm; and
    - A brief description of what the Claim Administrator is doing to mitigate the harm and to avoid further incidents.

- Provide a substitute notice, as described in the HITECH Act, to impacted members if there is insufficient mailing address information.
- Maintain a log and submit to DHHS an annual report of Security Breaches that impact fewer than 500 members.
- Notify DHHS immediately, in the event the Security Breach impacts more than 500 individuals.
- Notify media when required under the HITECH Act and alert Group Health Plan if any such notifications are needed.

NOTE: If Covered Entity does not designate on the Business Associate Agreement which Party will provide the Security Breach services listed above, these services will NOT be provided by Claim Administrator and will be the responsibility of the Covered Entity.

The above listed HITECH Act Security Breach services may be changed from time to time by Claim Administrator as necessary, and as required by the HITECH Act, DHHS regulation and DHHS guidance.

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM
Self Funded Accounts

(**Please Print or Type this form**)

This document replaces any previous Attachment 2 – Business Associate Agreement Additional Information Documents.

☐ New Account ☐ Add to existing Account data ☐ Replace all existing Account data

☐ Standard Agreement ☐ Nonstandard Agreement

Employer or Plan Sponsor:

BCBSIL Account number:

BCBSIL group number(s):

Claim Administrator's Privacy Officer: Thomas C. Lubben

Address: HCSC Privacy Office; PO Box 804836; 300 E. Randolph St., Chicago, IL 60680-4110

Primary Privacy Officer Contact	**Alternate Privacy Officer Contact**
Name:	Name:
Title:	Title:
Phone #:	Phone #:
FAX #:	FAX #:
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
e-Mail Address:	e-Mail Address:

Authorized Signatory (Form should only be signed by authorized employee of the account.)

Name of individual completing this form:

Title of individual completing this form:

Signature: _____ Date: _____

Limitations

Please identify any limitations in any of the following documents that may affect BCBSIL's use or disclosure of protected health information (PHI) in the Group Health Plan's:

(List the limitation or indicate "none")

a. Notice of Privacy Practices (NoPP) _____

b. GHP Plan Document _____

c. Other:_____

HIPAA Individual Rights Requests

Upon receiving a request from a member to exercise one of the following HIPAA Individual Rights requests, should BCBSIL respond directly to the member or direct the member back to the Employer/Group Health Plan (GHP)?

Please select Employer/GHP **OR** BCBSIL (not Both).

1) Request to Access PHI: ☐ - Employer/GHP ☐ - BCBSIL
2) Request for Disclosure Accounting: ☐ - Employer/GHP ☐ - BCBSIL
3) Request to Amend PHI: ☐ - Employer/GHP ☐ - BCBSIL

For BCBSIL (HCSC) to directly administer "Requests for Restriction" and "Requests for Confidential Communications" require prior approval of Plan President and HCSC Corporate Privacy Officer and appropriately modified contract language.

☐ New Account ☐ Add to existing Account data ☐ Replace all existing Account data

☐ Standard Agreement ☐ Nonstandard Agreement

Employer or Plan Sponsor:
BCBSIL Account number:
BCBSIL group number(s):

Group Health Plan Authorizations
Please identify employees within your organization with whom BCBSIL is authorized to release PHI for Plan Administration functions. Please list by name or job title and indicate any limitations or restrictions on BCBSIL's disclosure of PHI to such employee. Please list: **JOB TITLE**, **NAME** (optional), **RESTRICTIONS** **enter each position or person on a different line**

Business Associate Authorizations
Please identify your Business Associates and employees within that organization with whom BCBSIL is authorized to release PHI for HIPAA purposes. Please list company name, employee name or title, and indicate any limitations or restrictions on BCBSIL's disclosure of PHI to such Business Associate. Please list: **COMPANY NAME, JOB TITLE**, **NAME** (optional), **RESTRICTIONS** enter each position or person on a different line

Note: It is the Employer's/GHP's responsibility to notify HCSC of any updates to the information provided in this document.

ASO

Benefit Program Application ("ASO BPA")

Applicable to Administrative Services Only (ASO) Group Accounts

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

Employer Account Number (6-digits):

Employer Group Number(s):

Section Number(s):

Employer Name:

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

Address:

City: State: Zip:

Standard Industry Code (SIC): Employer Identification Number (EIN):

Subsidiaries:

Affiliated Companies:

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

Administrative Contact: Phone Number: Fax Number:

Title: Email Address:

Blue Access for Employers (BAE) Contact: Phone Number: Fax Number:

(The BAE Contact is the Employee of the Account authorized by the Employer to access and maintain its account via BAE.) Email Address:

ERISA Plan: ☐ Yes ☐ No If yes, specify ERISA Plan Year:

ERISA Plan Administrator: Plan Administrator's address:

Effective Date of Coverage: Anniversary Date:

SCHEDULE OF ELIGIBILITY

1. Eligible Person means:
   - ☐ A full-time employee of the Employer.
   - ☐ A full-time employee who is a member of:

     (name of union)
   - ☐ Other:
2. Full-Time Employee means:
   - ☐ A person who is regularly scheduled to work a minimum of hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:
3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Domestic Partners covered: ☐ Yes ☐ No

If yes: A Domestic Partner, as defined in the Plan, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those Covered Employees with Domestic Partners.

If yes, are Domestic Partners eligible to continue coverage under COBRA? ☐ Yes ☐ No

If yes, are dependents of Domestic Partners eligible for coverage? ☐ Yes ☐ No

5. Limiting Age for covered unmarried children:

a) Applicable if Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code:

☐ twenty-six (26) years; thirty (30) years if eligible military personnel as described in the Employer's Plan.

☐ years; years if eligible military personnel as described in the Employer's Plan.
(The minimum allowable ages for this option are 26; 30 if eligible military personnel)

☐ years if a full-time student.
(The minimum allowable ages for this option are 26; 30 if eligible military personnel)

b) Applicable to all other Employers:

☐ .

☐ ; if a full-time student.

☐ Other:

Coverage based on the Limiting Age(s) elected above terminates on:

☐ The birthday on which the Limiting Age is reached.

☐ The last day of the calendar month in which the Limiting Age is reached.

However, such coverage shall be extended in accordance with any applicable federal or state law.

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

☐ The date of employment.

☐ The day of employment.

☐ The day of the month following month(s) or days of employment.

☐ The day of the month following the date of employment.

☐ Other:

7. Enrollment:

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

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

Open Enrollment: ☐ Yes ☐ No

An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period.

- Specify Open Enrollment Period:

Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

8. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:

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

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

9. COBRA Auto Cancel? ☐ Yes ☐ No

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

ASO STATUS

1. Group Status: Select from Pull Down
2. If a former HCSC Insured Group is converting to ASO, on what basis?

   Basis: Select from Pull Down

LINES OF BUSINESS

(Check all applicable products)

☐ Participating Provider Option	☐ Outpatient Prescription Drugs:
☐ Point of Service (BlueChoice)	☐ Outpatient Prescription Drug Program
☐ Blue Choice Select	☐ Covered under the medical benefit
☐ Comprehensive Major Medical	☐ Dental
☐ Base Plus	☐ Blue Care Connection®

FEE SCHEDULE

Fee Schedule Period

To begin on Effective Date of Coverage and continue for:

☐ **12 Months** ☐ **Other (please specify):** **Months**

Administrative Charge(s)

% of Claim Payments or $ per Covered Employee per month

☐ Applies to all coverages

☐ Different percentage(s) or amount(s) for the following types of coverages. Please specify:

Subscriber Share Methodology for Illinois Network Provider Claims Applies*:* ☐ Yes ☐ No
(If no, a letter declining Subscriber Share Methodology for Claims processing must be attached to this Benefit Program Application.)

Claim Administrator Provider Access Fee(s)

Group Number(s):

☐ % of ADP Savings: %

☐ $ per Covered Employee per month: $

Complete for Groups with multiple Provider Access Fees by products (i.e., CMM, PPO and/or POS plans):
Group Number(s):

☐ % of ADP Savings: %

☐ $ per Covered Employee per month: $

BlueCard Program/Network access fees: Available upon request.

Other Service and/or Program Fee(s)

Prescription Drug Rebate: $ per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. Rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in the governing Administrative Services Agreement to which this ASO BPA is attached under the section titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

Reimbursement Provision: ☐ Yes ☐ No

If yes*:* It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability claim, the Claim Administrator will retain 25% of any recovered amounts other than recovered amounts received as a result of or associated with any Workers' Compensation Law.

Conversion Privilege: ☐ Yes ☐ No *If yes,* conversion fee: $6,000 per conversion.

Blue Care Connection ("BCC") Program

BCC Package:

Select from Pull Down

Fee: $ per Covered Employee per month for administration of the program package.

BCC Package Upgrade(s):

Description:

Fee: $ per Covered Employee per month for administration of the package upgrade.

Description:

Fee: $ per Covered Employee per month for administration of the package upgrade.

Ancillary Program:

Select from Pull Down

Termination Administrative Charge

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

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

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

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 by ten percent (10%) or more from the enrollment used to determine the service charges in effect at the time of termination, the Claim Administrator reserves the right to adjust the rates for service charges (including, but not limited to, access fees) to be used to compute the Termination Administrative Charge.

Payment Specifications

Employer Payment Method:	☐ **Online Bill Pay**	☐ **Electronic**	☐ **Check**
Employer Payment Period:	☐ **Weekly *(cannot be selected if Check is selected as payment method above)***		
☐ **Twice-Monthly**	☐ **Monthly**	☐ **Other (please specify):**	
Claim Settlement Period:	☐ **Monthly**	☐ **Other (please specify):**	

Run-Off Period

Employer Payments are to be made for months following end of Fee Schedule Period.

Standard is twelve (12) months.

Final Settlement: Final Settlement is to be made within days after end of Run-Off Period.

Standard is sixty (60) days.

Broker/Consultant Compensation

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

HCSC COBRA ADMINISTRATIVE SERVICES

HCSC COBRA Administrative Services Purchased: ☐ Yes ☐ No

If yes, please complete the COBRA sections below. If no, the COBRA sections below do not apply.

☐ **RENEWAL - NO CHANGES COBRA Services**	
COBRA Administrative Billing Services Only:	☐ Yes ☐ No
COBRA Administrative Full Services:	☐ Yes ☐ No
Notification Services included: (Full Services):	☐ Yes ☐ No
Conversion Rights included: (Full Services):	☐ Yes ☐ No
Monthly Reports* included: **Paper reports provided by mail/electronic reports via email*	☐ Yes ☐ No *If Yes,* Email Address:
Effective date(s) of services if different from ASO Effective Date of Coverage:	

COBRA Service Charges	
Billing Services Fee per Participant per month:	$10.00
If Notification Services included (Full Services) Notification Fee (per Participant for each notice):	$10.00
Monthly Administrative Fee:	$75.00
The Employer will pay HCSC a sum of One Hundred Dollars *($100.00)* per hour for any system programming costs associated with non-standard administration services.	$100.00

COBRA Membership	
Number of Active Members*:	
Number of current COBRA participants/members*:	
Number of current COBRA retiree participants/members*:	
**Full Service Unit (FSU) set-up of participants/members in BlueStar required*	
FSU Location:	
FSU Contact:	Phone Number:
Email Address:	Fax Number:
Is all COBRA participant census information attached?	☐ Yes ☐ No
Is all COBRA participant coverage(s) and level elected information attached?	☐ Yes ☐ No
Is all dependent census information attached?	☐ Yes ☐ No

COBRA Coverage	
Are rates (SINGLE/FAMILY or TIERED) for all coverages attached?	☐ Yes ☐ No
Is 2% included in attached rates?	☐ Yes ☐ No
Does Employer have any non-HCSC coverage?	☐ Yes ☐ No
If Yes, Other Carrier(s):	
Name:	
Address:	

City:	State:	Zip:

Administrative Contact:	Phone Number:	Fax Number: Email Address:

Name:	
Address:	

City:	State:	Zip:

Administrative Contact:	Phone Number:	Fax Number: Email Address:

COBRA coverage begins:	☐ On date of Qualifying Event ☐ First of month following date of Qualifying Event
Should 150% of the COBRA premium be charged to participants eligible for disability extension for the remaining 11 months of COBRA? *(Extension is from 18 months to 29 months when deemed disabled by Social Security)*	☐ Yes ☐ No
Is contract provided and signed?	☐ Yes ☐ No
Prior COBRA administrator info:	
Name:	
Address:	

City:	State:	Zip:
Administrative Contact:	Phone Number:	Fax Number: Email Address:

OTHER PROVISIONS

1. Certificate of Creditable Coverage: ☐ Yes ☐ No

   If yes: The Employer directs the Claim Administrator to issue to individuals, whose coverage under the Plan terminates during the term of the Administrative Services Agreement to which this ASO BPA is attached, a Certificate of Creditable Coverage. The Certificate of Creditable Coverage shall be based upon information required for issuance of a Certificate of Creditable Coverage to be provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement.

2. Case Management Program/Medical Services Advisory: ☐ Yes ☐ No

   If yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Administrative Services Agreement to which this ASO BPA is attached and the Employer's plan document.

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

4. The Massachusetts Health Care Reform Act requires employers to provide, or contract with another entity to provide, a written statement to individuals residing in Massachusetts who had "creditable coverage" at any time during the prior calendar year through the employer's group health plan and to file a separate electronic report to the Massachusetts Department of Revenue verifying information in the individual written statements.

   a. The Employer directs Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act. Such written statements and electronic reporting shall be based on information provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement. The Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. The Employer acknowledges that the Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. The Employer or its Covered Employees should seek advice from their legal or tax advisors as necessary.

      ☐ Yes ☐ No

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

5. Stop Loss Coverage purchased: ☐ Yes ☐ No *(If yes, complete a separate Exhibit to the Stop Loss Coverage Policy)*
6. Fort Dearborn Life Insurance purchased: ☐ Yes ☐ No *(If yes, complete separate Life application)*
7. Health Care Account (HCA) Administrative Services purchased: ☐ Yes ☐ No *(If yes, complete separate HCA application)*
8. This ASO Benefit Program Application (ASO BPA) is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

ADDITIONAL PROVISIONS:

Sales Representative

District Phone & FAX Numbers

Producer Representative

Producer Firm

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

Tax I.D. No.

Signature of Authorized Purchaser

Title

Date

PROXY

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

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

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dated this _____ day of _____
Month Year

BLUE CROSS AND BLUE SHIELD OF ILLINOIS (BCBSIL)
MEDICARE SECONDARY PAYER (MSP)
EMPLOYER ACKNOWLEDGEMENT FORM (EAF)

BlueCross BlueShield of Illinois
Experience. Wellness. Everywhere.℠

Under federal law, it is the employer's responsibility to inform its insurer or third-party administrator of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health plan size, is used in determining whether the group health plan or Medicare is the primary payer. Please refer to the enclosed document titled "Instructions – Completing the MSP Employer Acknowledgement Form" for more details. **In the absence of employer-provided employee counts, CMS requires that the employer's group health plan coverage be considered primary to Medicare. Please complete this form, sign, date, and return to BCBSIL as soon as possible.**

Employer Name – Legal Name of Company:	Employer Identification Number (EIN):	
Physical Address (number & street), City, State, ZIP:		
Account Number(s):	Group Number(s):	
⇨ New BCBSIL clients please check the correct box	☐ The client was **not** in business during the preceding calendar year	☐ The client was in business during the preceding calendar year
⇨ Current BCBSIL clients please check the correct box	☐ Submitting this EAF at renewal	☐ Submitting this EAF as an update ☐ Submitting this EAF as an error correction
Do you have any affiliates or subsidiaries? ☐ Yes ☐ No If "yes", list name of each:		

IMPORTANT NOTE: Some of the following responses are based on the current calendar year, while others are based on the preceding year. Unless making an update or error correction, please use the year of your upcoming renewal as 'current year' when answering the following questions. For example, if your upcoming renewal is effective July 1, 2009, base your current year answers on 2009. Or, if your upcoming renewal is effective January 1, 2010, base your current year answers on 2010. Please indicate the current calendar year for which the form is being completed: _____ If there have not yet been 20 weeks in the current calendar year, base your answer on current employee count. Understand that you are obligated to notify BCBSIL if and when your status changes.

1. In the year immediately prior to the current calendar year, did you file a separate federal tax return, that is, not consolidated with another individual or entity? If you are not required to file a federal tax return, please check N/A ☐		☐ Yes	☐ No
2. How many employees did all the entities on the preceding calendar year's tax return have on the payroll (whether full-time, part-time, seasonal, or partners) during the preceding calendar year? Enter number of employees.		_____ (# of employees)	
3. During the current year are you part of a multi-employer group health plan? The term "multi-employer group health plan" means any trust, plan, association or any other arrangement made by one or more employers or by employers and unions to offer, contribute to, sponsor, or directly provide health benefits.		☐ Yes	☐ No
4. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ Check 'Yes' or 'No' for both the current and preceding calendar years ☐ If you checked "Yes" for the current calendar year, and the threshold was met during the current year, please check this box and enter the date the threshold was met in the following space. _____/_____/_____. ☐ If you check "No" for the current year and your answer changes to "Yes" at any time, you must promptly notify BCBSIL by completing a new EAF, checking this box and entering the date the threshold was met in the space above.	Current year (See Important Note above.)	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
5. If you are currently or were during the preceding year part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year? ⇨ If you answered 'Yes' to #3, then check 'Yes' or 'No' for both the current and preceding calendar years ⇨ If you answered 'No' to #3, then check 'Yes' or 'No' for the preceding calendar year only	Current year (See Important Note above.)	☐ Yes	☐ No
	Preceding year	☐ Yes	☐ No
6. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No
7. If you are part of a multi-employer group health plan (as defined in #3), did any one employer that is part of the multi-employer group health plan have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the preceding calendar year?		☐ Yes	☐ No

I understand that BCBSIL is relying on my answers to the above questions to determine whether Medicare will be the primary payer of claims for my Medicare eligible insured(s). I certify that the answers are true to the best of my knowledge and belief. I also understand that I am responsible to promptly notify BCBSIL, as indicated above, if my answers to the above questions change because we have increased the number of employees.

Signature of company officer or authorized representative

Print Name

Title

Date

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Blue Cross and Blue Shield of Illinois

Experience. Wellness. Everywhere.℠

DOWNERS GROVE

August 25, 2010

www.bcbsil.com

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

PPO Network

Experience. Wellness. Everywhere.℠

PPO
Freedom of Choice

BlueCross BlueShield of Illinois

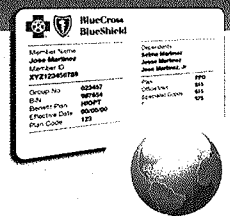
Access to Largest PPO Network in Illinois ▶ Freedom of Choice
Providers in <u>every</u> Illinois county

PPO Network

- Over **92%** of Illinois hospitals
- Over **91%** of Illinois primary care physicians
- Over **87%** of Illinois specialists

Additional Coverage

- **National coverage** available when traveling or living outside home state in the U.S.
- **International coverage** while traveling outside the U.S.



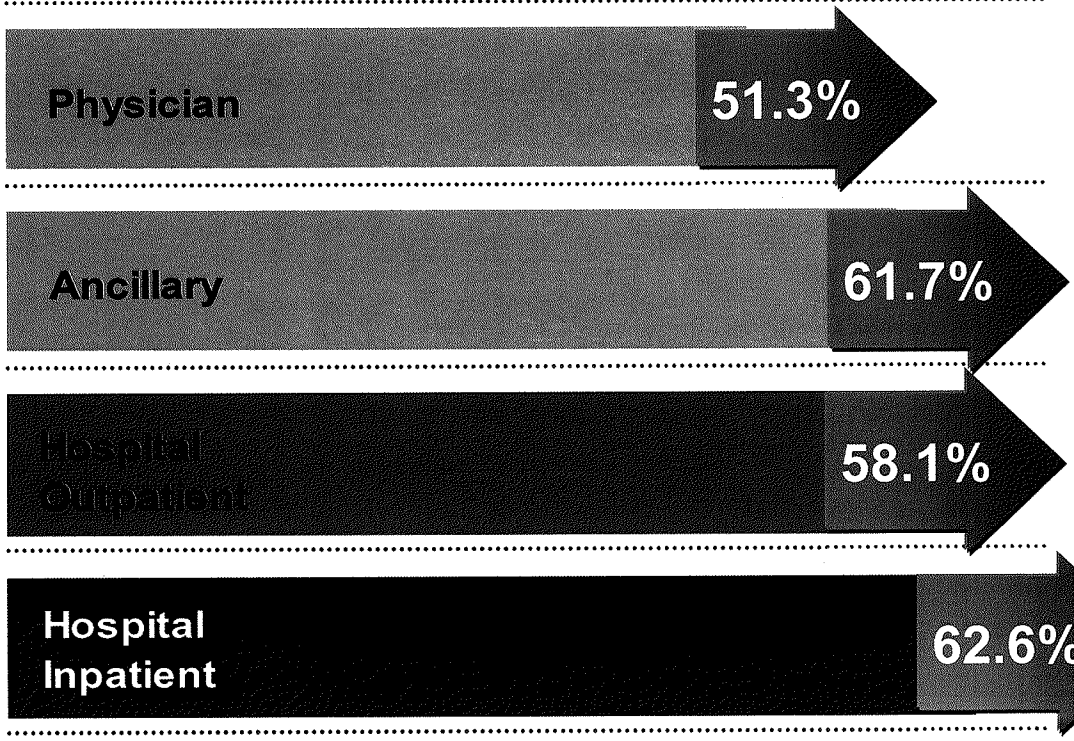
With exclusive BlueCard® Coverage

Immediate Value through Network Discount Advantages

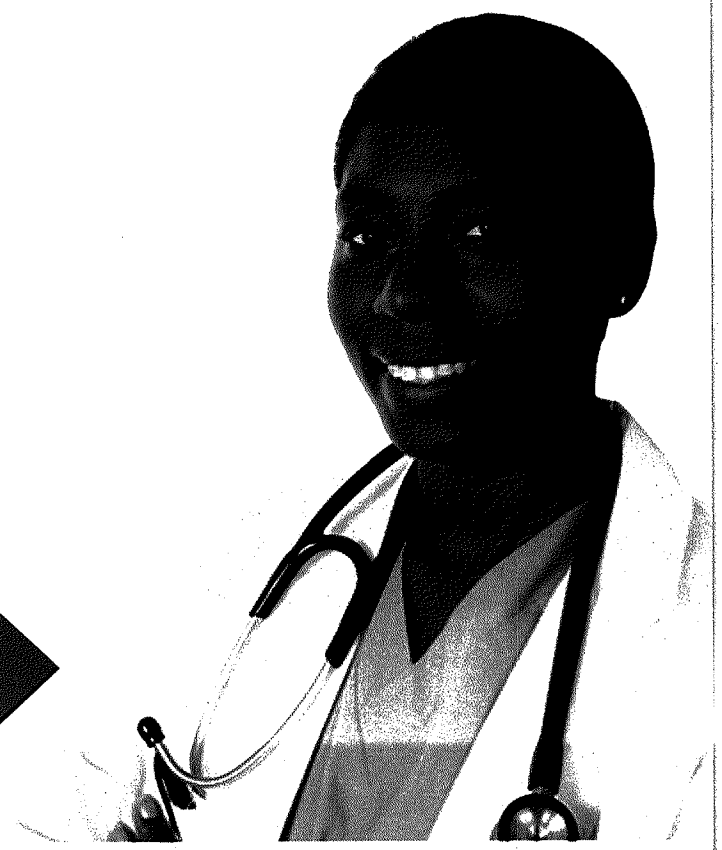
BlueCross BlueShield of Illinois

Our market position allows us to negotiate provider contracting advantages that benefit our customers

For the Chicago Metro Area:



IL Metro ***as of 1/1/2010***



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

Account Support Capabilities

Experience. Wellness. Everywhere.℠

Strategic Account Management

BlueCross BlueShield of Illinois

BCBSIL provide an experienced account management team that delivers:

- A single point of contact for the group administrator
- Strategic account oversight and consultation
- Knowledge of group-specific health care needs and industry trends
- Client advocacy and liaison with internal departments
- Support during the renewal process
- Full client support for employee communications
- Flexibility to receive eligibility in a variety of formats
- Reporting
- Assistance with open enrollment, health fairs, and health education

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.℠

Unrivaled Claims and Customer Service

Experience. ***Support.*** Everywhere.

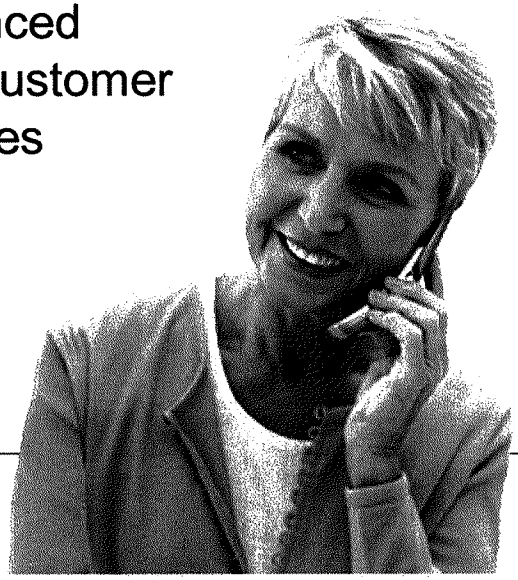
Multi-Channel Customer Service Choices

BlueCross BlueShield of Illinois

Members have multiple service options from which to choose:

Personal Touch

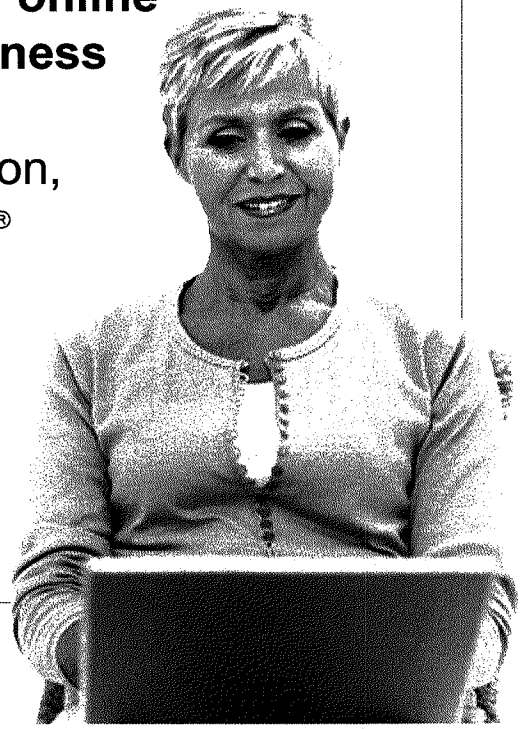
Personalized telephonic customer support from our caring, experienced BCBS Customer Advocates



-and-

Self-Service

Robust suite of online health and wellness tools, claim and benefit information, via Blue Access® Online



No Hassle, Immediate Resolution

BlueCross BlueShield of Illinois

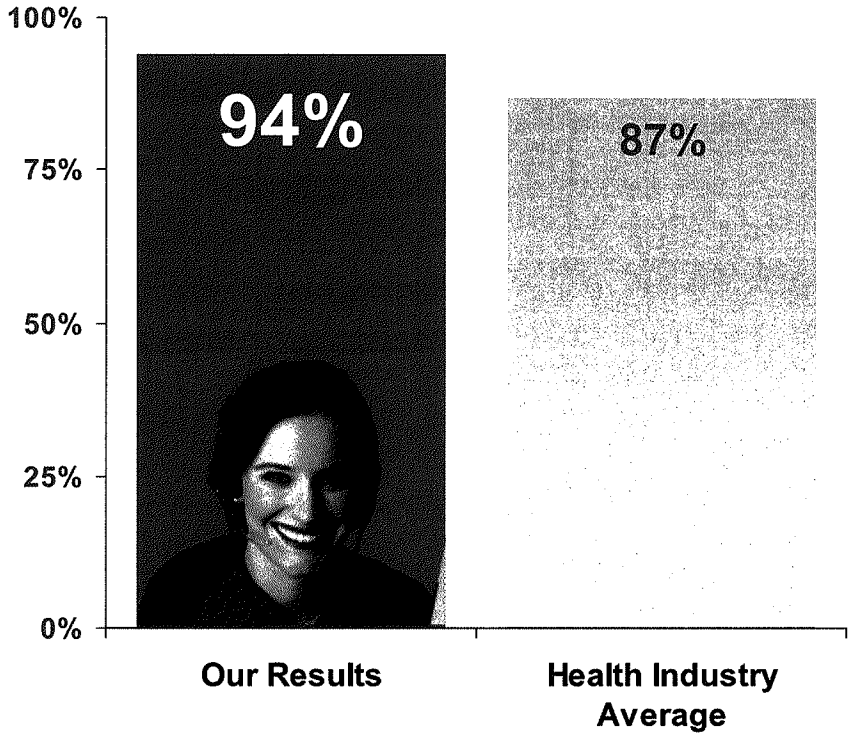
Unique blend of technology and personality:

- State-of-the art technology
- Seamless claims administration for national customers
- Full integration of membership, claims, customer service and medical care management
- Focus on the customer; understanding that technology complements, rather than replaces personal service

First-call resolution is our goal:

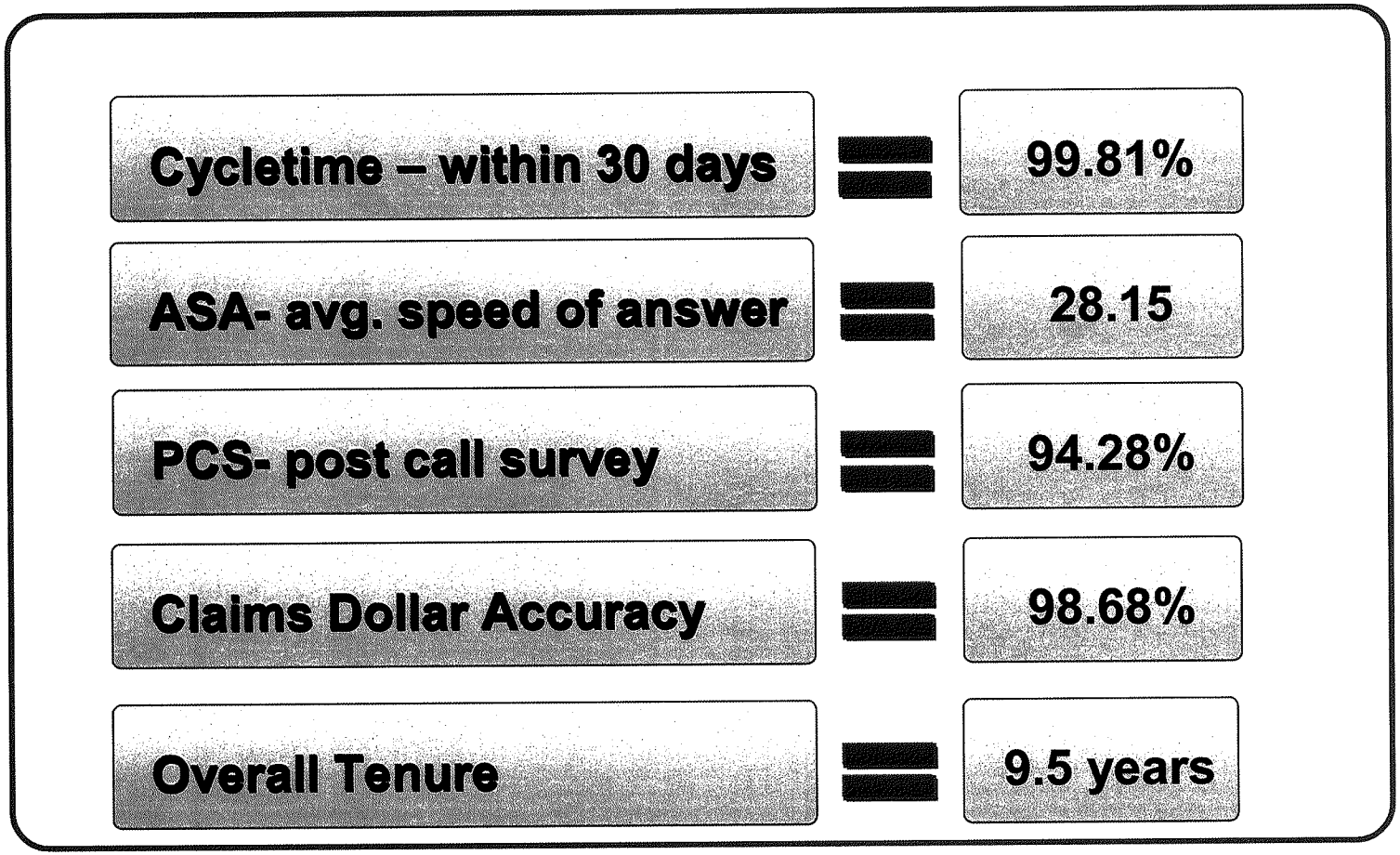
- Adjustments are completed the day of call
- Questions are answered before the call is complete

More than 9 times out of 10,
inquiries are resolved during the first phone call



Quincy Scorecard 2010

BlueCross BlueShield of Illinois



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Implementation

Experience. Wellness. Everywhere.℠

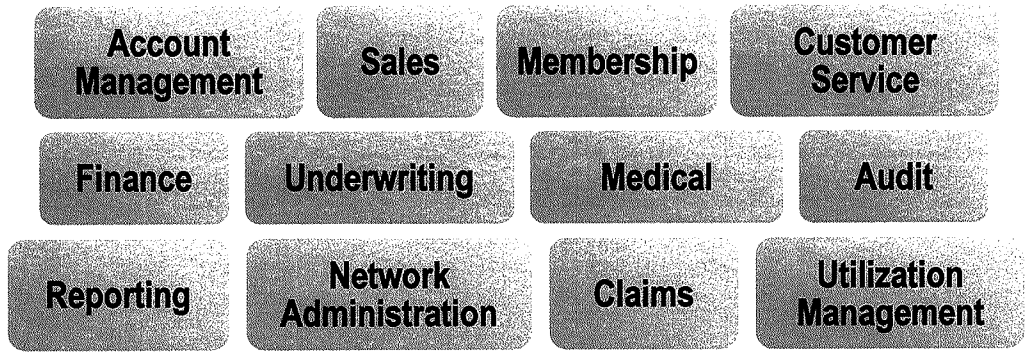
Implementation Support
Providing Seamless Transitions

BlueCross BlueShield of Illinois

- Understand your needs
- Alleviate Open Enrollment stress
- Enhance your Day to Day work
- Providing what the Village wants for their employees

BCBS Implementation Manager

- Single point of contact during the implementation
- Dedicated experienced account project management
- Directs all affected areas of BCBSIL that will be working on the Village of Downers Grove account



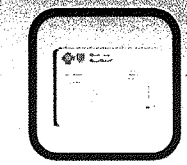
Key Implementation Considerations

BlueCross BlueShield of Illinois

Open Enrollment

- Employee meetings at all locations
- Distribute hardcopy communications
- Webinar with custom presentation

Membership



- Applications
- Design Account Structure
- ID Card Design
- Mailing of ID Cards

Benefits

- Input Summary Plan Descriptions into BCBSIL Benefit Design
- BCBSIL Internal Review
- Document Review
- Code Benefits
- Test Benefits

Future Steps

- Automated Eligibility/ Blue Access for Employers
- In-Depth Blue Insight Training
- Wellness Initiatives
- Communications

Enrollment Options

BlueCross BlueShield of Illinois

Census Import

- Allows eligible members to be entered into our membership system via a spreadsheet import
- Quickest enrollment option

Additional enrollment options

- **On Line Enrollment:** Employees elect or waive coverage on line
- **Automated Eligibility Process (AEP):** Allows for electronic transfer of enrollment and maintenance information
- **Paper Applications**