PREMIUM ACCOUNT AGREEMENT

This Premium Account Agreement (this Agreement) describes the terms of the arrangement between **Blue Cross and Blue Shield of Massachusetts, Inc.** and/or, for HMO Blue plans, **Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.** (together referred to as Blue Cross and Blue Shield) and the **Account** to provide health care benefits for the Account's covered employees and their covered dependents (Members). In this Agreement, the terms *you* and *your* refer to the Account that has entered into this Agreement.

Blue Cross and Blue Shield will provide these health care benefits in accordance with the terms and conditions of this Agreement which incorporates by reference *The Manual of Underwriting Guidelines for Group Business* and the subscriber certificates including riders (together referred to as Subscriber Certificates) describing your benefits plans. Your benefits plans are those plans you select from the proposal or renewal package Blue Cross and Blue Shield sends you and which are identified by the premium charges stated on your monthly invoices during your policy year under this Agreement. Blue Cross and Blue Shield will provide benefits to your Members as long as they meet the eligibility requirements of this Agreement and the Subscriber Certificates describing your benefits plans and as long as the applicable premium charges are paid.

Section 1
Term of This Agreement

This Agreement will be effective for one policy year beginning on your 2021 anniversary/renewal date unless terminated as described in Section 12. You must pay all premium charges that Blue Cross and Blue Shield bills you for coverage through the date of termination. Blue Cross and Blue Shield will automatically renew your coverage with Blue Cross and Blue Shield according to the benefits plans and premium rates you select from your renewal package for the next one-year term and Blue Cross and Blue Shield will issue a new agreement to you, which may differ from this Agreement with respect to terms and conditions. If you do not want to have a new agreement with Blue Cross and Blue Shield for another one-year term, you must give Blue Cross and Blue Shield written notice at least 30 days before this Agreement ends.

Section 2
Acceptance

This Agreement will be considered accepted and binding by both parties when you pay your first month's premium charges.

This Agreement and your renewal package constitute both parties' entire understanding and supersede all prior representations and understandings, whether oral or written, and will be governed by and construed according to the laws of the Commonwealth of Massachusetts.

You, on your own behalf and on behalf of your covered employees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and Blue Cross and Blue Shield of Massachusetts, Inc. and/or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (collectively, Blue Cross and Blue Shield), which are corporations independent of and operating under licenses from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that Blue Cross and Blue Shield is not contracting as the agent of the Association. You, on your own behalf and on behalf of your covered employees, further acknowledge and agree that you have not entered into this Agreement based upon representations by any person other than Blue Cross and Blue Shield and that no person, entity, or organization other than Blue Cross and Blue Shield shall be held

accountable or liable to you for any of Blue Cross and Blue Shield's obligations to you created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield other than those obligations created under other provisions of this Agreement.

Section 3
General Terms of This Agreement

Health Care Benefits

Blue Cross and Blue Shield will provide benefits for Members based upon the coverage that is in effect for the Member at the time the services are furnished and on contractual agreements made with providers. No action may be brought against Blue Cross and Blue Shield for failure to provide benefits unless brought within two years from the date the cause of action arises.

Fiduciary Obligations

You will be solely responsible for complying with all applicable provisions of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This includes the fiduciary responsibilities of administering your benefits plans, maintaining adequate funding to support these plans and providing required notices to Members.

Solely for the benefits plans provided under this Agreement, and not for purposes of the health engagement services and programs described in Attachment 1 or the Account-Based Offerings described in Attachment 2, Blue Cross and Blue Shield is the fiduciary to whom you have granted full discretionary authority to make decisions regarding the amount, form and timing of benefits; to conduct medical necessity review; to apply utilization management; to exercise fair and impartial review of denied claims for services; and to resolve any other matter under the benefits plan which is raised by a Member or identified by Blue Cross and Blue Shield regarding entitlement to benefits as described in the Subscriber Certificates for your benefits plan. All determinations of Blue Cross and Blue Shield with respect to any matter within its assigned responsibility will be conclusive and binding on all persons unless it can be shown that the interpretation or determination was arbitrary and capricious.

Account/Subsidiary Relationship

You agree that all your eligible employees are employed by you or by a subsidiary entirely owned by you. In the event that any such subsidiary is covered by this Agreement, you represent and warrant that you have the authority to enter into this Agreement on behalf of yourself and of every subsidiary that is covered by this Agreement. You, for yourself and for your subsidiaries covered under this Agreement, agree that you and each and every subsidiary are jointly and severally liable for payment of all premium charges owed under this Agreement. In the event that any such subsidiary is sold or is no longer entirely owned by you, you must notify Blue Cross and Blue Shield immediately.

Non-Discrimination as Required Under Massachusetts Law

By accepting this Agreement, you certify that each of the benefit plans provided for under this Agreement for Massachusetts residents will be offered to all of your full-time employees who live in Massachusetts. For purposes of this provision, full-time employees is limited to that employee classification as defined by Massachusetts law or regulations (generally employees working 35 hours or more each week). You also certify that, except as permitted by law, your premium contribution percentage amount for any one full-time employee living in Massachusetts is not less than your premium contribution percentage amount for any other full-time employee living in Massachusetts who is enrolled in the same benefit plan and whose total hourly or annual salary is the same or more. (This non-discrimination provision does not apply for an employer that establishes separate contribution percentages for employees who are covered under collective bargaining agreements.) If Blue Cross

and Blue Shield has a reason to believe that you are not in compliance with this non-discrimination provision, this Agreement may be subject to immediate termination as described in Section 11.1(e).

Federal and State Regulations

In the event that any federal or state laws or regulations mandate a change in the health care benefits or in the eligibility of covered employees and their covered dependents, or in any way affect the amount of your claims, Blue Cross and Blue Shield will implement such mandatory change. Only if necessary, these changes will be made with adjustments to the premium charges indicated on your monthly invoices. If your premium charges are to be increased, Blue Cross and Blue Shield will give you 60 days prior written notice. When you are subject to federal or state laws or regulations, these changes will be effective on the date you specify, provided Blue Cross and Blue Shield receives prior written notice. Blue Cross and Blue Shield will not be liable for any claims or damages that result from your failure to comply with any laws or regulations, including but not limited to the Medicare secondary payor laws or regulations. You agree to hold Blue Cross and Blue Shield harmless for any charges that may be assessed against Blue Cross and Blue Shield at any time due to your failure to comply with laws or regulations and especially the Medicare secondary payor provisions. For example, you must provide timely, accurate and complete Medicare secondary payor information for Blue Cross and Blue Shield to submit to the Centers for Medicare and Medicaid Services (CMS) as required by federal law. This information includes, but is not limited to, your employer identification number (EIN), employer size and Members' social security numbers. If you fail to provide timely, accurate and complete Medicare secondary payor information to Blue Cross and Blue Shield, you agree to hold Blue Cross and Blue Shield harmless for any charges that may be assessed against Blue Cross and Blue Shield for submitting inaccurate or incomplete information, unless due to an error by Blue Cross and Blue Shield.

Protection of Personal Information

Blue Cross and Blue Shield uses a written comprehensive information security program that includes appropriate security measures to protect personal information (as "personal information" is defined by Massachusetts regulations pertaining to standards for the protection of personal information of Massachusetts residents) in compliance with applicable Massachusetts data security regulations. This written information security program also complies with any applicable federal regulations. Blue Cross and Blue Shield will provide the required written notices in accordance with Massachusetts law.

Force Majeure

Blue Cross and Blue Shield shall not be in breach of the Agreement nor liable to you for failure to meet its obligations under this Agreement to the extent such failure or delay arises as a result of acts of God, fire, disaster, explosion, vandalism, storm, adverse weather conditions, strikes, labor disputes or disruptions, epidemics, pandemics, public health emergencies, wars, national emergencies, riots, civil disturbances, actions or inactions of government authorities, terrorist acts, lockout, border delays, failures or interruptions of utilities or telecommunications equipment or services, system failures or any other cause or event that is beyond the reasonable control of Blue Cross and Blue Shield (collectively a "Force Majeure Event").

Assignment

Blue Cross and Blue Shield has the right to assign, designate or delegate its rights and obligations under this Agreement in whole or in part to other entities.

Reports

Blue Cross and Blue Shield will not be responsible for determining if you are required to file annual reports, including but not limited to Form 5500, Schedule A information, in accordance with ERISA. It is your responsibility to notify Blue Cross and Blue Shield of such filing obligations and to request that Blue Cross and Blue Shield provide you with information needed to complete Form 5500, Schedule A. If you have 100 or more

eligible active employees (and/or retired employees, as applicable) enrolled in the benefits plans offered by Blue Cross and Blue Shield under this Agreement as of the end of your policy year, Blue Cross and Blue Shield will send information intended to assist you in completing Form 5500, Schedule A. This information will be sent to you within 120 days after the end of the policy year. In all other cases, you must specifically request that Blue Cross and Blue Shield provide this information.

Evidences of Coverage

Blue Cross and Blue Shield will provide an evidence of coverage (including any applicable riders to the evidence of coverage) to your covered employees in accordance with applicable Massachusetts law. You will be responsible for complying with the applicable provisions of ERISA, as it relates to preparing and providing your covered employees with copies of summary plan descriptions (SPDs) describing your health benefit plans and, as applicable, with copies of summaries of material modifications (SMMs).

When you elect to offer to your Medicare-eligible Members a Blue Cross and Blue Shield Medicare Advantage plan and/or Blue MedicareRx, a regional Medicare Prescription Drug Plan, an evidence of coverage (including any applicable riders to the evidence of coverage) will be provided to your enrolled eligible Members in accordance with the requirements of the Centers for Medicare and Medicaid Services (CMS). The evidence of coverage will define covered services and benefits and the rights and responsibilities of the enrolled Member.

Medicare Part D Prescription Drug Benefits

When you elect to offer to your Medicare-eligible Members a Blue Cross and Blue Shield Medicare Advantage plan that includes Part D drug benefits or Blue MedicareRx, a regional Medicare Prescription Drug Plan, you agree to all the requirements of the Centers for Medicare and Medicaid Services (CMS), regardless of any provisions in this Agreement to the contrary, as evidenced by your acceptance of this Account Agreement.

Uniform Premium Requirements. With respect to the premiums charged to Members for Part D drug benefits, you may determine how much of a Member's Part D monthly beneficiary premium you will subsidize, provided that: (i) if you subsidize different amounts for different classes of Members in a plan, such classes will be reasonable and based on objective business criteria, such as years of service, business location, job category and nature of compensation (for example, salaried and hourly), and different classes cannot be based on eligibility for the low income subsidy; (ii) the premium will not vary for individuals within a given class of Members; and (iii) a Member cannot be charged more than the sum of his or her standard Part D beneficiary premium and 100% of the premium for his or her supplemental prescription coverage (if any).

Low Income Subsidy (LIS). The low income premium subsidy that CMS pays on behalf of an LIS-eligible Member must be passed through to the Member. With respect to the premium contributions collected from your LIS-eligible Members, the monthly low income premium subsidy will first be used to reduce that portion of the premium paid for by the LIS-eligible Member, with any remaining portion of the premium subsidy amount then used to reduce the employer's premium contribution. In the event you offer a Medicare Advantage plan that includes Part D drug benefits, if the low income premium subsidy amount for which a Member is eligible is less than the portion of the monthly premium paid by the Member, then you should communicate to the enrollee the financial consequences for the Member enrolling in your Medicare Advantage plan as compared to enrolling in another Part D plan with a monthly premium equal to or below the low income premium subsidy amount.

Grandfathered Status under Federal Law

Group health plans in effect on March 23, 2010 may be eligible for grandfathered status pursuant to Section 1251 of the Patient Protection and Affordable Care Act, as modified by Section 2301 of the Health Care Reconciliation and Education Act of 2010 (PPACA), and 45 C.F.R. § 147.140. Group health plans that qualify for grandfathered status do not need to meet all of the requirements applicable to non-grandfathered health plans under PPACA. The changes to a group health plan that may affect its grandfathered status include, but are not limited to, the elimination of all or substantially all benefits to diagnose or treat a particular condition, an increase to the

percentage of cost-sharing requirement applicable to benefits under the policy, an increase to a fixed amount cost-sharing requirement applicable to benefits under the plan (beyond what is permitted by law for retaining grandfathered status), or the creation or modification of an annual or lifetime limit (beyond what is permitted by law for retaining grandfathered status). There are also other factors of which Blue Cross and Blue Shield may not be aware, that may affect a group health plan's grandfathered status. For example, changes by an employer the contribution rates for the group health plan's subscribers may result in the loss of grandfathered status for the group health plan. You must immediately notify Blue Cross and Blue Shield if you make any change to your contribution rates during the policy year. The requirements for maintaining the grandfathered status of a group health plan are subject to change as new standards and/or new interpretations of existing requirements are issued by federal or state agencies.

In the event you have 100 or more employees enrolled in Blue Cross and Blue Shield benefits plans, Blue Cross and Blue Shield will, upon receipt of necessary documentation, administer your plan design(s) as having grandfathered status. You are responsible for determining if your group health plan(s) qualify for grandfathered status. In the event that you inform Blue Cross and Blue Shield that you consider your group health plan(s) to be grandfathered group health plan(s), you represent and warrant that (i) the group health plan(s) were in effect on March 23, 2010 and (ii) you have determined that the group health plan(s) are eligible for grandfathered status. You must specify in writing the specific plan designs to be grandfathered. You are solely responsible for compliance with the disclosure and document retention requirements applicable to grandfathered plans under 45 C.F.R. § 147.140.

Blue Cross and Blue Shield makes no representation or warranty regarding the past, present, or future grandfathered status of your group health plan(s) or that your group health plan(s) are eligible for grandfathered status. In addition, to the extent that your group health plan(s) are eligible for grandfathered status, Blue Cross and Blue Shield makes no representation or warranty that this status will be retained during the current plan year or any future renewal period. Blue Cross and Blue Shield is not responsible and shall not be liable for any claims, costs, liabilities, losses, penalties, damages or other expenses of any kind that, directly or indirectly, arise from or relate to your group health plan(s)' past, present and future grandfathered status, lack thereof, or any changes regarding the group health plan's grandfathered status, including, but not limited to, any representation made by any employee, broker, agent, or independent contractor of Blue Cross and Blue Shield regarding the group health plan's grandfathered status.

Fees Negotiated with Non-Participating Providers

Blue Cross and Blue Shield may in certain select circumstances use a vendor to negotiate fees with non-participating providers for covered health care services received by Members. In these certain select circumstances, the negotiation will be performed on a claim-by-claim basis to reduce inpatient and outpatient institutional and professional costs and to eliminate member balance billing for amounts in excess of the negotiated fee. The Account acknowledges and agrees that, because the negotiation with a non-participating provider will be performed after a claim is incurred, Blue Cross and Blue Shield or its vendor may be exercising fiduciary discretion in deciding which claims to negotiate and in the actual negotiation. The Account grants full discretionary authority to Blue Cross and Blue Shield or its vendor to negotiate on its behalf with the non-participating provider.

Health Engagement Services and Programs

If you are an eligible account as determined by Blue Cross and Blue Shield, you may choose to have Blue Cross and Blue Shield administer certain health engagement services and programs (other than the Wellness Incentive Program as described in Section 8 of this Agreement) for your eligible employees. Generally, there will be an additional cost for these services. Blue Cross and Blue Shield will administer these health engagement services and programs according to the terms and conditions described in the "Health Engagement Administrative Services Agreement" which is included as Attachment 1 to this Agreement.

Account-Based Offerings

If you are an eligible account as determined by Blue Cross and Blue Shield, at an additional cost, you may choose to have Blue Cross and Blue Shield provide certain services in connection with a health reimbursement arrangement (HRA), medical flexible spending account (HC-FSA), dependent care flexible spending account (DC-FSA), health incentive account (HIA), transit spending account (TFS), parking spending account (PFS), and/or health savings account (HSA), collectively referred to as Account-Based Offerings. If elected, Blue Cross and Blue Shield, either directly or, if applicable to your arrangement with Blue Cross and Blue Shield, through its designated vendor(s), will provide these services according to the terms and conditions described in the "Account-Based Offerings Administrative Services Agreement" which is included as Attachment 2 to this Agreement.

Section 4
Enrollment Requirements

You must maintain with Blue Cross and Blue Shield a current and updated listing of covered employees. You will be responsible for all claims costs and expenses associated with failure to maintain an accurate and current listing with Blue Cross and Blue Shield, unless such claims costs and expenses are due to an error on Blue Cross and Blue Shield's part.

Eligibility of an Employee

In order to maintain health care coverage with Blue Cross and Blue Shield, an employee must meet the written eligibility requirements (such as length of service, active employment and number of hours worked) you impose as long as they do not conflict with Blue Cross and Blue Shield's eligibility requirements. An eligible employee as defined by Blue Cross and Blue Shield means:

- A permanent full-time employee regularly working 30 hours or more each week on average at the employer's usual place(s) of business and who is paid a salary or wage in accordance with state and federal wage requirements; or
- A permanent part-time employee regularly working at least 20 hours but less than 30 hours on average each week at the employer's usual place(s) of business and who is paid a salary or wage in accordance with state and federal wage requirements; or
- A disabled permanent full-time or part-time employee who is actively working despite the disability (including one who is engaged in a trial work period) and a disabled employee who is not actively working but whom the employer treats as an employee; or
- A former employee (or a former covered dependent of the employee of the group) who qualifies for continued group coverage under federal or state law, but only if the employer maintains Blue Cross and Blue Shield group coverage for permanent full-time employees as defined above; or
- A retired employee of the employer.

Enrollment of a Member

Newly hired employees who are eligible for group benefits can enroll in the benefits plan according to your eligibility requirements for coverage, provided that your requirements comply with Blue Cross and Blue Shield's eligibility and enrollment requirements. The effective date of an eligible employee's (or his or her dependent's) membership in the benefits plan may be the Member's initial eligibility date or your subsequent anniversary/renewal date, as long as: (a) Blue Cross and Blue Shield receives your written notice no later than 30 days after the Member's enrollment notification period applicable to membership modifications (as described in the Subscriber Certificate for your benefits plan); and (b) you pay the applicable premium charges.

Termination of a Member

The termination date of a covered employee's and/or his or her dependents' membership will be the date you specify, as long as Blue Cross and Blue Shield receives your written notice no later than 30 days after the Member's disenrollment notification period applicable to membership modifications (as described in the Subscriber Certificate for your benefits plan). This notification provision will apply except as otherwise required by federal or state law or specified in *The Manual of Underwriting Guidelines for Group Business*. When a Member is no longer eligible for group coverage he or she may have the option to continue coverage as provided by state or federal law. Section 6 of this Agreement explains your responsibilities.

Minimum Enrollment Requirement

To the extent permitted by law, Blue Cross and Blue Shield requires that, at all times, the minimum number of active employees (or retired employees, as applicable) as specified in *The Manual of Underwriting Guidelines for Group Business* participate as Members in the benefits plans offered by Blue Cross and Blue Shield. If your covered employee participation falls below this minimum enrollment requirement, Blue Cross and Blue Shield will give you at least 90 days to comply with this enrollment requirement or this Agreement will be subject to termination as permitted by law.

Section 5
Health Care Services Furnished Outside of Massachusetts

Blue Cross and Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access health care services outside of Massachusetts, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Blue Cross and Blue Shield for payment. The Inter-Plan Programs available to Members under this Agreement are described generally below. Typically, Members accessing care outside of Massachusetts obtain care from providers that have a contractual agreement (that is, are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (referred to in this Agreement as Host Plan or local Blue Cross and/or Blue Shield Plan). In some instances, Members may obtain care from non-participating providers. Members' health care benefits for participating and non-participating providers are fully described in the Subscriber Certificates for your benefits plans.

The BlueCard® Program

Under the BlueCard Program, when Members access covered health care services in a geographic area served by a Host Plan, Blue Cross and Blue Shield will remain responsible for fulfilling the obligations of this Agreement. The Host Plan will be responsible for providing such services as contracting with its participating providers and handling substantially all interactions with its participating providers and, as applicable, providing some managed care services.

Member Liability Calculation. The calculation of a Member's liability on claims for covered health care services received outside of Massachusetts and processed through the BlueCard Program will be based on the provider's actual charge or the negotiated price (allowed charge), whichever is less.

The methods used by a Host Plan to determine a negotiated price will vary among Host Plans based on the terms of each Host Plan's provider contracts. The negotiated price that a Host Plan passes on to Blue Cross and Blue Shield for a claim for covered health care services processed through BlueCard may represent:

- The actual price paid on the claim by the Host Plan to the health care provider; or
- An estimated price, determined by the Host Plan in accordance with the BlueCard Program, based on the actual price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, other contingent payment arrangements, and other claim- and non-claim-related transactions (such as interest on provider advances) with all of the Host Plan's health care providers or with one or more particular providers; or

- An average price, determined by the Host Plan in accordance with the BlueCard Program, based on a billed charges discount that represents the Host Plan's average savings expected after settlements, withholds, other contingent payment arrangements, and other claim- and non-claim-related transactions (such as interest on provider advances) with all of the Host Plan's health care providers or with one or more specific groups of providers. An average price may result in greater variation to the Member and the Account from the actual price than would an estimated price.

Those Host Plans that use either the estimated price or average price may, in accordance with the BlueCard Program, prospectively increase or reduce the estimated price or average price to correct for over- or underestimation of past prices (that is, prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to or received from providers). However, the amount paid by the Member is a final price and no future price adjustment will result in increases or decreases to the pricing of past claims.

Statutes in a small number of states may require a Host Plan to either (1) use a basis for calculating the Member's liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) add a surcharge. In these situations, Blue Cross and Blue Shield would then calculate the Member's liability for covered health care services consistent with the applicable state statute that is in effect at the time those services are furnished.

Return of Overpayments. Under the BlueCard Program, recoveries from a Host Plan or from participating providers of a Host Plan can arise in several ways. These may include (but are 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 Plan will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be calculated as a percentage of the recovery.

Value-Based Programs. Blue Cross and Blue Shield has included a factor in your premium for per member per month (PMPM) amounts, not attached to specific claims, billed to Blue Cross and Blue Shield by Host Plan for the following arrangements when applicable under this Agreement: Value-Based Programs.

Negotiated National Account Arrangements

As an alternative to the BlueCard Program, Member claims for covered health care services may be processed through a negotiated national account arrangement with a Host Plan. If Blue Cross and Blue Shield has arranged for Host Plans to make available custom provider networks in connection with this Agreement, then the terms and conditions set forth in Blue Cross and Blue Shield's negotiated national account arrangements with those Host Plans will apply. The calculation of a Member's liability on claims for covered health care services received outside of Massachusetts and processed through a negotiated national account arrangement will be based on the provider's actual charge or the negotiated price (allowed charge), whichever is less.

If Blue Cross and Blue Shield enters into a Negotiated National Account Arrangement with a Host Plan to provide Value-Based Programs to your Members, Blue Cross and Blue Shield will follow the same procedures for Value-Based Programs administration as noted in the BlueCard Program section.

Blue Cross Blue Shield Global® Core

Blue Cross Blue Shield Global Core and Members' health care benefits for non-participating providers are fully described in the Subscriber Certificates for your benefits plans. When Members receive covered health care services outside the United States, Puerto Rico, and the U.S. Virgin Islands, there is no available geographic area served by a Host Plan. In these instances, Members may be able to use Blue Cross Blue Shield Global Core to access non-participating providers.

Inter-Plan Medicare Advantage Program

Blue Cross and Blue Shield also participates in the Inter-Plan Medicare Advantage Program, the Inter-Plan Program for Members enrolled in a Medicare Advantage plan. In the event you elect to offer a Medicare Advantage plan to your Medicare-eligible Members, when Medicare Advantage Members access health care services outside of Massachusetts, the claim for those services will be processed through the Inter-Plan Medicare Advantage Program and presented to Blue Cross and Blue Shield for payment in accordance with the rules of the Inter-Plan Medicare Advantage Program policies then in effect. The Inter-Plan Medicare Advantage Program available to Members under this Agreement is described generally as follows. The cost of the covered health care service on which a Member's cost share liability (such as coinsurance) is based will be either:

- The Medicare allowable charge for covered services, or
- The amount the Host Plan negotiates with its provider on behalf of Blue Cross and Blue Shield members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable charge.

Section 6
Continuation of Group Coverage Under Federal or State Law

When a Member is no longer eligible for membership under your benefits plan, that Member may be eligible to continue this group coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA) or under Massachusetts state law. If this is the case, you are responsible for: (a) determining Member eligibility for continued group coverage; and (b) promptly notifying Blue Cross and Blue Shield of changes that impact a Member's eligibility for continued group coverage. These provisions apply to employer groups with two or more employees.

You must provide all employees with a notice of their continuation of coverage rights at the time they first enroll in your health benefits plan. These continuation of coverage rights are fully described in the Subscriber Certificates for your benefits plan.

When a Member becomes eligible to continue group coverage as provided by COBRA or state law, you must provide all required continuation of coverage notices to the Member. You must provide notice to the employee of his or her election rights within 14 days of knowledge of a qualifying event. (The employee must provide you with notice of divorce, legal separation or the loss of a dependent child's eligibility as described in the Subscriber Certificates for your benefits plan.)

You must allow employees 60 days from the qualifying event (or the day you provide notice, whichever is later) to make their continuation of coverage election. The day they make the election is their election date.

Once the qualifying event has occurred and you have informed the Member of his or her continuation of coverage rights, Blue Cross and Blue Shield requests that you terminate the Member immediately from your group, while the Member decides whether to accept or decline the continuation of coverage option.

If the Member accepts the continuation of coverage within the 60-day time period, he or she has 45 days from the election date to make the first payment to you. The first payment is for the period from the date the person's group coverage ended, through the current month. If the Member pays the premium to the paid-through date, he or she will have group coverage reinstated, retroactive to the qualifying event. Reinstatement will not be allowed if the payment is not received within the 45-day time period.

Once a Member has opted for continuation of coverage and has been reinstated in your group, Blue Cross and Blue Shield will bill you for the Member according to your regular monthly billing cycle. It is your responsibility to monitor and receive the Member's monthly payment.

Section 7
Summaries of Benefits and Coverage

Under section 2715 of the Public Health Service Act, created by the Patient Protection and Affordable Care Act (the Affordable Care Act) and as implemented by summary of benefits and coverage regulations, certain employer groups and their employees who are eligible to enroll in, or who are enrolled in, the employer group's health plan(s) are entitled to a Summary of Benefits and Coverage (and the uniform Glossary of Health Coverage and Medical Terms, which is available on the U.S. Departments of Labor and Health and Human Services Web sites as well as the Blue Cross and Blue Shield Web site) in certain circumstances on and after September 23, 2012. Blue Cross and Blue Shield will provide Summaries of Benefits and Coverage to you in accordance with the provisions described in this Agreement. You agree that Blue Cross and Blue Shield will not be responsible for providing Summaries of Benefits and Coverage to your employees.

Blue Cross and Blue Shield Responsibilities

For each of the Blue Cross and Blue Shield standard plan design(s) offered to your eligible employees under this Agreement, Blue Cross and Blue Shield will provide you with either a Web site address where you can obtain a copy of the standard Summary of Benefits and Coverage or, upon your request, a copy of the standard Summary of Benefits and Coverage in electronic (PDF) and/or printed format. Access to Summaries of Benefits and Coverage for standard plan designs will be available at least 60 days prior to your coverage effective date or your subsequent renewal date, or within seven business days of your request to Blue Cross and Blue Shield. In the event you have chosen to offer customized, non-standard Blue Cross and Blue Shield plan design(s) to your eligible employees under this Agreement, Blue Cross and Blue Shield will provide a copy of the Summary of Benefits and Coverage for each customized plan design to you in accordance with the Affordable Care Act and associated regulations.

If there are changes that necessitate updating the Summary of Benefits and Coverage after it is provided to you, Blue Cross and Blue Shield will provide the updated Summary of Benefits and Coverage to you within seven business days of the change(s) being identified, but only when the requested changes reflect health care benefits provided by Blue Cross and Blue Shield. Generally, any Summary of Benefits and Coverage provided by Blue Cross and Blue Shield will describe only the health care benefits provided under this Agreement and will not describe health care benefits that are provided by another carrier, organization, or entity.

Blue Cross and Blue Shield will not provide Summaries of Benefits and Coverage for senior plans (such as Managed Blue for Seniors, Medex, and Medicare Advantage plans) or for any standalone dental and/or vision plans.

Your Responsibilities

You will provide a complete Summary of Benefits and Coverage, along with the uniform Glossary of Health Coverage and Medical Terms to your employees as required by the Affordable Care Act and associated regulations. At the request of Blue Cross and Blue Shield, you agree to provide Blue Cross and Blue Shield with documentation to demonstrate compliance with these regulations.

In the event you choose to offer customized, non-standard Blue Cross and Blue Shield plan design(s) to your eligible employees under this Agreement, you agree to provide sufficient information to Blue Cross and Blue Shield in the time required for Blue Cross and Blue Shield to provide a copy of the Summary of Benefits and Coverage in accordance with the Affordable Care Act and associated regulations.

If you wish to request changes to the Summary of Benefits and Coverage provided to you by Blue Cross and Blue Shield, you must promptly notify Blue Cross and Blue Shield. You must inform Blue Cross and Blue Shield of the changes you are requesting to be made to the Summary of Benefits and Coverage to reflect the Blue Cross and Blue Shield health care benefits provided under this Agreement. If you do not promptly inform Blue Cross and

Blue Shield of such changes, you will be solely responsible for satisfying all the requirements for issuing the Summary of Benefits and Coverage.

In the event your group health plan is comprised of the plan design(s) offered under this Agreement plus one or more separate benefits plan(s) offered by a different carrier, organization, or entity, you will be responsible for combining, or arranging to have combined, the summary information into a single Summary of Benefits and Coverage or distributing multiple Summaries of Benefits and Coverage to each of your employees as required by the Affordable Care Act and associated regulations.

You agree to indemnify and hold Blue Cross and Blue Shield harmless from any liability, damages, expenses, fees and costs, including but not limited to any attorneys' fees or excise taxes, that may be imposed on, incurred by or assessed against you or Blue Cross and Blue Shield due to your failure to provide a complete and accurate Summary of Benefits and Coverage to each of your employees, in accordance with the Affordable Care Act and associated regulations.

Section 8
Wellness Incentive Program

In addition to the benefits plans offered under this Agreement, you may be eligible to offer a Blue Cross and Blue Shield wellness incentive program to Members who are enrolled in certain designated benefits plans. Your participation in the wellness incentive program is limited to those benefits plans that are designated by Blue Cross and Blue Shield as being eligible for the program. When you elect to offer the wellness incentive program to your eligible Members, subject to the program participation conditions as outlined in this section, you may qualify for a group wellness incentive award at the end of the policy year. (For the purposes of this section of the Agreement, "eligible Member" means an employee who is enrolled in one of the designated benefits plans for which you offer participation in the wellness incentive program prior to the end of the first six months of the policy year and who remains enrolled in one of the designated benefits plans at the end of the policy year. Eligible Member also means the employee's dependents to the extent that dependents are eligible to participate in the Blue Cross and Blue Shield wellness incentive program.)

To qualify for a group wellness incentive award, you must meet the following program participation conditions:

- You are a group eligible to offer the program as determined by Blue Cross and Blue Shield; and
- You elect to offer the Blue Cross and Blue Shield wellness incentive program to your Members who are eligible to participate in the program at the start of your policy year and you continue the program for eligible Members through the end of the policy year; and
- At least 20% of your Members who are eligible for the program must participate in the program during the policy year in which you offer the wellness incentive program; and
- You have a contract with Blue Cross and Blue Shield to provide welfare benefits in the policy year immediately following the policy year in which you offer the wellness incentive program; and
- This Agreement is not be terminated before the end of the policy year in which you offer the wellness incentive program.

When you offer a Blue Cross and Blue Shield wellness incentive program, Blue Cross and Blue Shield will determine if you qualify for a group incentive award within 90 days after the end of the policy year. Your group wellness incentive award will be calculated as a percentage of the total medical insurance premium you paid for the policy year for benefits plans for which you offer wellness incentive program participation, excluding any premium payments that are received by Blue Cross and Blue Shield after the end of the policy year. The percentage used to calculate your wellness incentive award will vary depending on how many of your eligible Members participate in the program during the policy year as follows: 1.25% when 20% to 49% of eligible Members participate; or 2.5% when 50% to 79% of eligible Members participate; or 7.5% when 80% to 100% of eligible Members participate. For the purpose of calculating your group wellness incentive award, an eligible Member who earns his or her individual maximum member wellness incentive payment in the policy year is considered to have participated in the program for that policy year.

If you qualify for a group incentive award, Blue Cross and Blue Shield will issue the incentive amount to you (by means of a credit and/or a check) once the incentive amount has been calculated. You are solely responsible for determining whether you have any obligation to distribute all or part of your group wellness incentive award to your employees, or to credit a portion of your group wellness incentive award toward their benefits, or otherwise to notify them of your group wellness incentive award. You agree to indemnify and hold Blue Cross and Blue Shield harmless from any and all actions that may be brought against you or Blue Cross and Blue Shield due to your failure to provide any required distribution of, credit, or notification about, your group wellness incentive award to your employees.

Section 9
Right to Examine Records

Blue Cross and Blue Shield reserves the right, after reasonable notice, to examine your entire membership records, including payroll records, at any time during regular business hours to verify that Blue Cross and Blue Shield's enrollment and participation requirements are being met. Blue Cross and Blue Shield agrees to preserve the confidentiality of these records.

Section 10
Payments for Coverage

Monthly Premium Charge

Under this Agreement, you will pay a monthly premium charge for each enrolled membership in exchange for health care benefits provided by Blue Cross and Blue Shield. You must pay the total of all billed premium charges to Blue Cross and Blue Shield by the due date indicated on each monthly invoice. If full payment of premium charges is not received on or before the due date, Blue Cross and Blue Shield will suspend all claim payments as of the last date through which you have paid premium charges to Blue Cross and Blue Shield.

In certain situations, premium rates may be subject to review by appropriate regulatory authorities. In the event that you are billed a premium rate that is higher or lower than a rate subsequently approved by a governing regulatory or judicial authority, Blue Cross and Blue Shield reserves the right to make appropriate adjustments retroactive to the beginning of your policy year or effective date of the premium rate adjustment. In addition, there may be times when Blue Cross and Blue Shield reduces your premium rate if you elect to combine your benefits plans offered under this Agreement along with certain other Blue Cross and Blue Shield ancillary products such as standalone dental and/or vision plans.

In the event you elect to offer a Medicare Advantage plan, you agree that the Medicare Advantage plan's benefits change on a calendar year basis. As a result, your Medicare Advantage plan's premium charge may change on each January 1 during your policy year. Since these premium charges have to be approved in advance by the Centers for Medicare and Medicaid Services (CMS), Blue Cross and Blue Shield will make a good faith effort to give you 30 days prior written notice of any change in your premium charge. However, if Blue Cross and Blue Shield does not receive CMS approval in time, Blue Cross and Blue Shield may not be able to give you 30 days prior notice. In this case, Blue Cross and Blue Shield will give you written notice of the change in the Medicare Advantage plan's premium charge as soon as possible.

Late Charge

Blue Cross and Blue Shield anticipates that payments for all charges will be received by the due date. If payment is not received by the due date that is indicated on your invoice, then Blue Cross and Blue Shield reserves the right to assess a finance charge on the amount that is past due. The finance charge will be calculated from the due date of the invoice at a rate of up to 1.5% per month.

Recalculation of Premium Charge

Although Blue Cross and Blue Shield does not expect your premium charges to change during your policy year, Blue Cross and Blue Shield reserves the right to increase them if necessary due to statutory mandates or regulatory requirements that in any way affect the amount of your costs under this Agreement (including any state statutes or regulations affecting Blue Cross and Blue Shield's provider contracts), a change of 10% or more in the number of covered employees or a change in the health care benefits provided under this Agreement. If the total enrollment under Blue Cross and Blue Shield's plans is below 50%, Blue Cross and Blue Shield reserves the right to recalculate the premium charges whenever there is a change of 5% or more in the number of covered employees. If your premium charges are to be increased, Blue Cross and Blue Shield will give you 60 days prior written notice.

Section 11
Medical Loss Ratio Calculation and Premium Rebates

The following provisions will apply with respect to Blue Cross and Blue Shield's calculation and reporting of the medical loss ratio ("MLR") for its health plans that are in effect during a calendar year beginning on or after January 1, 2011 and in the event Blue Cross and Blue Shield is required to issue any MLR premium rebates to you as required by the Patient Protection and Affordable Care Act ("PPACA").

The MLR is calculated separately for Blue Cross and Blue Shield's small and large group markets. Blue Cross and Blue Shield will categorize your group as small or large based on the information you provide to Blue Cross and Blue Shield in the Patient Protection and Affordable Care Act MLR Calculation Employer Group Size Survey form. Blue Cross and Blue Shield will also use this information when determining whether your group will be eligible for MLR premium rebates in the event that premium rebates are required to be issued.

You agree to provide Blue Cross and Blue Shield any information that Blue Cross and Blue Shield needs to comply with regulatory requirements related to calculation, administration, and/or reporting of MLR premium rebates. You also agree to distribute any premium rebates received from Blue Cross and Blue Shield in the manner required by applicable law and regulations. Before Blue Cross and Blue Shield will issue premium rebates to a non-governmental plan that is not subject to ERISA, Blue Cross and Blue Shield will require written assurance that the distribution of the premium rebate will be made in accordance with applicable regulations.

Section 12
Termination

Termination of This Agreement

This Agreement is subject to termination in the following situations:

- By You for Any Reason. You may terminate this Agreement as of any date you specify upon your 30 days prior written notice to Blue Cross and Blue Shield.

- Non-Payment of Premium Charges. Blue Cross and Blue Shield will terminate this Agreement if full payment of all premium charges you owe Blue Cross and Blue Shield is not received by Blue Cross and Blue Shield within 30 days after the due date. Termination will be effective as of the last date through which you have paid premium charges to Blue Cross and Blue Shield or as otherwise permitted by applicable law and/or regulation. Blue Cross and Blue Shield will send Members written notice of their termination and their options for continued coverage.

  You may be liable for claims incurred by Members between the last date through which you have paid all premium charges to Blue Cross and Blue Shield and the date Blue Cross and Blue Shield posts the termination (or the termination date, if different from the paid through date). However, for any Medicare Advantage plan that you offer, this provision may apply only to optional coverage you have elected to offer.

- Material Breach, Fraud, or Misrepresentation by Either Party. Either party may terminate this Agreement for material breach, fraud, or misrepresentation. Termination may be effective immediately upon one party's written notice to the other or, in the case of fraud or misrepresentation by you, termination may be effective as of your effective date or as of the date of the fraud or misrepresentation. The termination date will be determined by Blue Cross and Blue Shield, subject to applicable federal and state laws.

- Insufficient Enrollment. Blue Cross and Blue Shield may terminate this Agreement, as described in Section 4, Minimum Enrollment Requirement, if your covered employee participation falls below Blue Cross and Blue Shield's minimum enrollment requirements.

- Noncompliance with Applicable Laws. Blue Cross and Blue Shield will terminate this Agreement immediately if, by continuing this Agreement, Blue Cross and Blue Shield would not be in compliance with applicable state and local statutes, rules, regulations, ordinances, statements of policy and other types of directives that govern the conduct of the parties under this Agreement.

- No Longer a Massachusetts Employer. Blue Cross and Blue Shield will terminate this Agreement immediately in the event you cease to conduct business in Massachusetts or if you cease to be a corporation, partnership, individual proprietorship or other organization in business under the laws of Massachusetts.

- No Longer an Eligible Account/Employer. Blue Cross and Blue Shield will terminate this Agreement immediately in the event you cease to regularly employ within Massachusetts one or more permanent full-time employees, as defined in Section 4, Eligibility of an Employee, throughout the year (unless, under this Agreement, you offer benefits plans only to eligible retired employees). In addition, Blue Cross and Blue Shield has the right to terminate this Agreement immediately in the event that the majority of permanent employees covered under this Agreement cease to be employed within Massachusetts.

- Failure to File Appropriately. Blue Cross and Blue Shield will terminate this Agreement immediately in the event you cease to file state and federal income taxes as an ongoing commercial enterprise or, if you are a nonprofit organization, you do not file appropriately as a nonprofit entity in Massachusetts.

Termination of a Product

Blue Cross and Blue Shield may terminate a particular product on your renewal date, if Blue Cross and Blue Shield is withdrawing that product from the market. If this is the case, Blue Cross and Blue Shield will give you 90 days prior written notice.

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Health Engagement Administrative Services Agreement

Blue Cross and Blue Shield of Massachusetts, Inc. and/or, for HMO Blue plans, **Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.** (together referred to as Blue Cross and Blue Shield) and the **Account**, parties to a Premium Account Agreement, in consideration of the mutual promises set out below, agree as follows:

This Health Engagement Administrative Services Agreement applies to you only when you are an eligible employer group as determined by Blue Cross and Blue Shield and you have elected Blue Cross and Blue Shield to administer one or more health engagement services, including certain wellness and/or technology based programs, either directly or through its designated parties, to your eligible employees, including when applicable, eligible dependents. Blue Cross and Blue Shield will administer your health engagement services in accordance with the terms and conditions of this Health Engagement Administrative Services Agreement, your health engagement program and fees statement(s), and the Business Associate Agreement which is included as Attachment 3 to the Premium Account Agreement.

This Health Engagement Administrative Services Agreement will be effective for one policy year beginning on your anniversary/renewal date as specified in your Premium Account Agreement, unless these health engagement services are terminated as described in Section 3 of this Health Engagement Administrative Services Agreement. Blue Cross and Blue Shield will automatically extend its administration of these health engagement services for the next one-year renewal term and will issue you a new Agreement which may differ with respect to terms and conditions. If you do not want to extend these health engagement services with Blue Cross and Blue Shield for another one-year renewal term, you must give Blue Cross and Blue Shield written notice at least 30 days before this policy year ends.

The health engagement services provided under this Health Engagement Administrative Services Agreement are not a health care benefit as described in the Subscriber Certificates describing your benefits plans and the terms and conditions of the Subscriber Certificates do not apply to these health engagement services.

Section 1
Scope of Health Engagement Services

Blue Cross and Blue Shield has agreed to administer a health engagement program on your behalf under a self-funded arrangement in accordance with the health engagement program and fees statement(s) that is applicable for your policy year. Blue Cross and Blue Shield will administer your health engagement program as follows:

- <u>Eligible Employees Enrolled in a Blue Cross and Blue Shield Health Plan</u>. Blue Cross and Blue Shield will administer health engagement services for your eligible employees (and, if applicable, their eligible dependents) who are enrolled in a Blue Cross and Blue Shield health care plan and who live in the United States.

- <u>Eligible Employees Not Enrolled in a Blue Cross and Blue Shield Health Plan</u>. To receive health engagement services for your eligible employees (and, if applicable, their eligible dependents) who are not enrolled in a Blue Cross and Blue Shield health care plan and who live in the United States, you must provide an electronic health engagement participant eligibility file to Blue Cross and Blue Shield to authorize access to these health engagement services before the services will be administered. Your health engagement participant eligibility file must be formatted and structured in accordance with Blue Cross and Blue Shield's health engagement participant eligibility file and data field specifications, unless otherwise agreed to in writing by Blue Cross and Blue Shield.

- Employees Living Outside the United States. Blue Cross and Blue Shield will not initiate any form of correspondence regarding health engagement services for your employees (and, if applicable, their eligible dependents) who live outside of the United States.

Section 2
Payment Schedule and Total Compensation Amount

You agree to pay the total amount of charges owed to Blue Cross and Blue Shield for health engagement services as specified in the health engagement program and fees statement(s) that is applicable for your policy year. You must pay the full amount due to Blue Cross and Blue Shield within 30 days of receiving invoice(s). Blue Cross and Blue Shield anticipates that payments will be received within this 30-day time period. If payment is not received by Blue Cross and Blue Shield within this required time period, Blue Cross and Blue Shield reserves the right to suspend its administration of your health engagement services and assess a finance charge on the amount that is past due. The finance charge will be calculated from the due date of the invoice at a rate of up to 1.5% per month.

Blue Cross and Blue Shield will not retroactively adjust any reoccurring invoice due to member enrollment changes in these programs. In the event that any member enrollment changes in these programs occur after Blue Cross and Blue Shield issues the invoice, you will be responsible for all costs associated with these enrollment changes.

Any charges owed to Blue Cross and Blue Shield for these services are separate from, and not included in, the monthly premium charge you must pay for each membership in exchange for health care benefits provided by Blue Cross and Blue Shield under your Premium Account Agreement.

Section 3
Termination of Health Engagement Services

Blue Cross and Blue Shield's administration of the health engagement services described in this Health Engagement Administrative Services Agreement is subject to termination in any of the following situations:

- You or Blue Cross and Blue Shield terminate the administration of these health engagement services for any reason and as of any date, upon 30 days prior written notice to the other.
- You do not pay the full amount of all health engagement service fees you owe Blue Cross and Blue Shield within 30 days after the due date.
- You do not renew your Premium Account Agreement with Blue Cross and Blue Shield for another one-year policy term. In this situation, Blue Cross and Blue Shield's administration of the health engagement services described in this Health Engagement Administrative Services Agreement will end as of the same termination date.
- Your Premium Account Agreement with Blue Cross and Blue Shield is terminated for any of the reasons as described in Section 12 of the Premium Account Agreement. In any of these situations, Blue Cross and Blue Shield's administration of the health engagement services described in this Health Engagement Administrative Services Agreement will end as of the same termination date.
- You fail to comply with the mutually agreed upon communication plan, if one is included in your health engagement program and fees statement(s). Blue Cross and Blue Shield will notify you in writing of your failure to comply. If you fail to comply within 30 days of receipt of this written notice, your eligibility for these program(s) may be terminated.

In the event Blue Cross and Blue Shield's administration of these health engagement services is terminated, you must pay all charges that Blue Cross and Blue Shield bills you for all health engagement services administered through the date of termination.

In some instances, certain programs offered under this Health Engagement Administrative Services Agreement may include a multi-year pricing arrangement between you and Blue Cross and Blue Shield. If you elect a multi-year pricing arrangement, this arrangement is described in your health engagement program and fees statement(s). If you terminate the program prior to the completion of the multi-year pricing arrangement, you may be subject to an early termination penalty as described in your health engagement program and fees statement(s) unless your health engagement program is terminated because you do not renew your Premium Account Agreement with Blue Cross and Blue Shield for another one-year policy term.

Section 4
Excluded Health Engagement Services

Except as otherwise agreed to in writing between the parties, neither Blue Cross and Blue Shield nor its designated parties will provide any services not described in this Health Engagement Administrative Services Agreement or your health engagement program and fees statement(s), including but not limited to, if applicable, continuation of coverage administration as otherwise required under COBRA (including but not limited to the distribution of notices otherwise required under COBRA), and to the extent health engagement services are provided to eligible employees (and, if applicable, their eligible dependents) not enrolled in your health benefit plans, and Department of Labor Form 5500 preparation for these health engagement services.

Attachment 2

Account-Based Offerings Administrative Services Agreement

Blue Cross and Blue Shield of Massachusetts, Inc. and/or, for HMO Blue plans, **Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.** (together referred to as Blue Cross and Blue Shield) and the **Account**, parties to a Premium Account Agreement, in consideration of the mutual promises set out below, agree as follows:

This Account-Based Offerings Administrative Services Agreement applies to you only when you have elected Blue Cross and Blue Shield to provide certain services in connection with your Account-Based Offerings. Blue Cross and Blue Shield will administer these services in accordance with the terms and conditions of this Account-Based Offerings Administrative Services Agreement, your Group Setup Form and Fee Schedule or, when applicable, your Claim Reimbursement Request Form and Fee Schedule, and the Business Associate Agreement which is included as Attachment 3 to the Premium Account Agreement.

This Account-Based Offerings Administrative Services Agreement will be effective for one policy year beginning on your anniversary/renewal date as specified in your Premium Account Agreement, unless terminated as described in Section 7 of this Account-Based Offerings Administrative Services Agreement. Blue Cross and Blue Shield will automatically extend its administration of these services for the next one-year renewal term and will issue you a new Agreement which may differ with respect to terms and conditions. If you do not want to extend the administration of services with Blue Cross and Blue Shield for another one-year renewal term, you must give Blue Cross and Blue Shield written notice at least 60 days before this policy year ends.

You represent and warrant by your acceptance of this Account-Based Offerings Administrative Services Agreement that you have the authority as Plan Sponsor to enter into this Account-Based Offerings Administrative Services Agreement with Blue Cross and Blue Shield to provide administrative and/or financial services on behalf of your Account-Based Offerings.

Section 1
Election of Account-Based Offerings

To retain the administrative and/or financial services described in this Account-Based Offerings Administrative Services Agreement, you must first have established one or more of the following Account-Based Offerings:

- HRA, TFS, PFS, HC-FSA, or DC-FSA in connection with a program under the Internal Revenue Code of 1986, as amended (IRS Code) Sections 105, 125, 129, 132, and 213, for the benefit of your eligible employees (Covered Employees) and their eligible dependents (Covered Dependents), together referred to as Covered Persons.

- A high deductible health plan in accordance with Internal Revenue Code of 1986, as amended (IRS Code), Section 223 to enable Covered Employees to establish and contribute to a health savings account (HSA) to pay for qualified medical expenses for themselves (the Account Owner) and their eligible dependents.

In this Account-Based Offerings Administrative Services Agreement, each of your HRA, TFS, PFS, HC-FSA, or DC-FSA Account-Based Offerings is referred to as “the Plan.”

Section 2
Acceptance

This Account-Based Offerings Administrative Services Agreement will be considered accepted and binding by the parties when you sign your Group Setup Form or, when applicable, your Claim Reimbursement Request Form, or you pay your first month's service fees for Account-Based Offerings.

Section 3
General Terms and Responsibilities

Communication

Each party to this Account-Based Offerings Administrative Services Agreement will designate a contact person or persons with whom the other party may work on issues related to the administration of the Plan and/or HSAs and this Account-Based Offerings Administrative Services Agreement. Each party may rely upon any written or oral communication from the other party, its designated employees, agents, or authorized representatives.

Designated Vendors

You may elect to have Blue Cross and Blue Shield through its designated vendor(s) provide certain administrative and financial services for your Account-Based Offerings. Or, you may elect to have Blue Cross and Blue Shield provide certain services to the designated vendor that you have selected to administer your Account-Based Offerings.

You understand and agree that Blue Cross and Blue Shield intends to contract with subcontractors, including but not limited to its designated vendor(s), to perform certain services that Blue Cross and Blue Shield agrees to provide under this Account-Based Offerings Administrative Services Agreement.

Scope of Services

When you elect to have Blue Cross and Blue Shield administer your Account-Based Offerings, Blue Cross and Blue Shield will provide, either directly or through its designated vendor, administrative and financial services in accordance with the Group Setup Form you provide to Blue Cross and Blue Shield for services under this Account-Based Offerings Administrative Services Agreement.

When you elect to have your designated vendor administer your Account-Based Offerings, Blue Cross and Blue Shield will provide services in accordance with the Claim Reimbursement Request Form you provide to Blue Cross and Blue Shield for services under this Account-Based Offerings Administrative Services Agreement.

Provision of Data

When you elect to have Blue Cross and Blue Shield administer your Account-Based Offerings, you expressly authorize Blue Cross and Blue Shield to provide data, including Personal Information and Protected Health Information, to its designated vendors for the purpose of administering your Account-Based Offerings.

When you elect to have your designated vendor administer your Account-Based Offerings, you expressly authorize Blue Cross and Blue Shield to provide data, including Personal Information and Protected Health Information, to your designated vendors for the purpose of administering your Account-Based Offerings.

Confidentiality

In connection with the provision of administrative services under this Account-Based Offerings Administrative Services Agreement, the Account and/or certain third parties retained by the Account to perform administrative functions for the Plan (each a designee) may have access to certain information provided in accordance with this

Account-Based Offerings Administrative Services Agreement or otherwise, including but not limited to Blue Cross and Blue Shield's policies and procedures, that is confidential or proprietary to Blue Cross and Blue Shield or other Blue Cross and/or Blue Shield Licensees. The Account represents and warrants that it will use any such Confidential Information, or will require that any designee use any such Confidential Information, solely for the purpose of administering your Account-Based Offerings. However, Blue Cross and Blue Shield reserves the right to require that the Account and/or the designee enter into a confidentiality agreement with Blue Cross and Blue Shield prior to the release of certain information.

Indemnification Related to Use of Information

The Account and, to the extent permitted by law, the Plan will indemnify, defend and hold harmless Blue Cross and Blue Shield and/or other Blue Cross and/or Blue Shield Licensees as applicable from and against any and all liability, injury, loss, cost, damages, taxes, fines, penalties or expenses incurred by or asserted against Blue Cross and Blue Shield arising from or relating to (i) the disclosure of Confidential Information or Protected Health Information to the Account or a designee in accordance with the terms of this Account-Based Offerings Administrative Services Agreement (ii) any improper use or disclosure of Confidential Information or Protected Health Information by the Account, the Plan or a designee or (iii) any misrepresentation or failure by the Account, the Plan or a designee to perform any obligation described in this Account-Based Offerings Administrative Services Agreement, as hereby amended.

Amendments

Blue Cross and Blue Shield may amend this Account-Based Offerings Administrative Services Agreement from time to time upon written notice to you. Except as may otherwise be provided, all Amendments to this Account-Based Offerings Administrative Services Agreement will be considered accepted, unless you give Blue Cross and Blue Shield written notice of non-acceptance within 30 days of receipt of such Amendment, in which event Blue Cross and Blue Shield may terminate this Account-Based Offerings Administrative Services Agreement upon written notice to you. No modifications made or requested by you from the terms specified in this Account-Based Offerings Administrative Services Agreement will be binding upon Blue Cross and Blue Shield unless the modifications are agreed to in writing and signed by both parties.

Liability for Disbursements

You are solely liable for any amounts that are payable under the terms and conditions of the Plan, as provided in the written document(s) governing the Account-Based Offerings, and for any HSA contributions to Account Owners. Blue Cross and Blue Shield has no duty to incur any costs on behalf of the Plan or HSAs using Blue Cross and Blue Shield's own funds. Blue Cross and Blue Shield has no obligation to arrange for disbursements under the Plan or HSAs, except to the extent you make the required funds available in accordance with this Account-Based Offerings Administrative Services Agreement.

Legal or Tax Advice

Although Blue Cross and Blue Shield and its designated vendor(s), when applicable to your arrangement with Blue Cross and Blue Shield, may provide technical and other assistance on issues affecting HRAs/FSAs, TFSs, PFSs, and/or HDHPs and HSAs, you understand and acknowledge by your acceptance of this Account-Based Offerings Administrative Services Agreement that neither Blue Cross and Blue Shield nor its designated vendor(s) is providing legal or tax advice.

Reprocessed Claims

You acknowledge and agree that claims processed by Blue Cross and Blue Shield may be retrospectively adjusted as needed and that Blue Cross and Blue Shield will not be responsible for any losses resulting from such adjustments.

Your General Responsibilities

Under this Account-Based Offerings Administrative Services Agreement, your general responsibilities are:

- Group Setup Form (when applicable to your arrangement with Blue Cross and Blue Shield). When you elect to use Blue Cross and Blue Shield's designated vendor(s) to provide certain services for your Account-Based Offerings, you will provide Blue Cross and Blue Shield with a completed Group Setup Form that designates certain aspects of the Account-Based Offerings that you will make available to your eligible employees. Within 45 calendar days prior to your policy year under this Account-Based Offerings Administrative Services Agreement, and then for each subsequent renewal date, you must confirm or revise these designations by submitting (or resubmitting) your completed Group Setup Form to Blue Cross and Blue Shield. You may also revise these designations from time to time, as long as the revisions are submitted in writing to Blue Cross and Blue Shield and the revisions are agreed upon by both parties.

- Claim Reimbursement Request Form. When you elect to have Blue Cross and Blue Shield work with your designated vendor for your Account-Based Offerings, you will provide Blue Cross and Blue Shield with a completed Claim Reimbursement Request Form that designates certain aspects of the Account-Based Offerings that you will make available to your eligible employees.

- Cooperation. You will cooperate with Blue Cross and Blue Shield to the extent reasonably necessary to enable Blue Cross and Blue Shield to provide services in accordance with this Account-Based Offerings Administrative Services Agreement and will provide any information reasonably necessary for Blue Cross and Blue Shield's provision of services.

- Compensation Reduction Agreements. You will obtain compensation reduction agreements, as applicable, from Covered Employees and Account Owners.

- Change of Status or Termination. When applicable to your arrangement with Blue Cross and Blue Shield, you will provide written or electronic notice to Blue Cross and Blue Shield as soon as reasonably possible, but in no event later than 60 calendar days after you learn of: (a) any Covered Person's change of status or termination under the Plan; (b) any Account Owner's change of status or termination under a Blue Cross and Blue Shield HDHP; and (c) any change to any Covered Person's or Account Owner's eligibility information, including but not limited to name, address, and phone number.

- Final Eligibility Determinations. You will review all eligibility disputes and make all final decisions concerning an individual's eligibility status and effective dates of coverage.

- HIPAA Privacy Authorization. You will obtain and maintain records of authorization by each employee and dependent covered under the Account-Based Offerings that permit the exchange of Personal Information and Protected Health Information between and among you, Blue Cross and Blue Shield, and its Business Associate(s).

Blue Cross and Blue Shield General Responsibilities

When you elect to have Blue Cross and Blue Shield administer your Account-Based Offerings, Blue Cross and Blue Shield will provide administrative and financial services, either directly or through its designated vendor(s) as described in this Account-Based Offerings Administrative Services Agreement and in the following sections of your Group Setup Form: Customer Service, Covered Person and Account Owner Online Services, and Account Online Services. When you elect to have Blue Cross and Blue Shield work with your designated vendor for your Account-Based Offerings, Blue Cross and Blue Shield will provide services as described in this Account-Based Offerings Administrative Services Agreement and in your Claim Reimbursement Request Form.

Section 4
Payment of Service Fees

You agree to pay fees in accordance with the written Fee Schedule provided to you by Blue Cross and Blue Shield for services provided under this Account-Based Offerings Administrative Services Agreement. In the event these fees are subsequently changed, Blue Cross and Blue Shield will provide advance written notice to you. You must pay the total amount of charges for these services directly to Blue Cross and Blue Shield by a method and frequency agreed upon by both parties to this Account-Based Offerings Administrative Services Agreement.

Section 5
HSA
When Blue Cross and Blue Shield Administers Your HSA Using its Designated Vendor

When you designate HSA Account-Based Offerings in your Group Setup Form, Blue Cross and Blue Shield will provide administrative services consistent with the provisions described in this Section 5 and your Group Setup Form.

Under an HSA Account-Based Offering, you will offer a High Deductible Health Plan (HDHP) that meets the requirements of IRS Code, Section 223 to enable your eligible employees to establish and contribute to a health savings account (HSA) to pay for qualified medical expenses of covered persons. Blue Cross and Blue Shield through its designated vendor(s) will make HSAs available to your eligible individuals on terms and conditions agreed to by the individual (HSA Account Owner) in a depository agreement and other materials.

You understand that certain actions you take may make the HSA a “group health plan” under ERISA, HIPAA, and other federal or state laws. To prevent the HSA from being considered a group health plan, you may not engage in the following actions, which will constitute a modification of the Plan and will have a materially adverse effect on Blue Cross and Blue Shield’s or its designated vendor’s performance under the terms of this Account-Based Offerings Administrative Services Agreement: (i) require an employee to establish an HSA; (ii) limit the ability of an HSA Account Owner to rollover or transfer his or her HSA to another custodian or trustee, other than as permitted by the Internal Revenue Code; (iii) condition the use of HSA funds, other than as permitted by the Internal Revenue Code; (iv) attempt to influence the HSA Account Owner’s investment decisions with respect to HSA funds; (v) represent that the HSA is an employee welfare benefit plan established or maintained by you; or (vi) receive any consideration related to employees’ HSAs. Upon engaging in any of the activities described in this paragraph, you will promptly provide written notice to Blue Cross and Blue Shield and you will indemnify Blue Cross and Blue Shield under the terms of this Account-Based Offerings Administrative Services Agreement for any legal or other expenses Blue Cross and Blue Shield incurs in determining and carrying out Blue Cross and Blue Shield’s obligations as a result of your activities.

Nature of HSAs
You understand and agree that the Account Owner has all discretionary control for the management, investment, disposition, and control of HSA assets. Neither you nor Blue Cross and Blue Shield may take any actions that would limit an HSA Account Owner’s ability to transfer or rollover HSA funds from one custodian or trustee to another. In addition, neither you nor Blue Cross and Blue Shield may seek to control the investment of assets in an HSA or to restrict the ability of HSA Account Owner to withdraw funds from an HSA without regard to whether the HSA funds will be used to reimburse amounts paid by the individual for qualified medical expenses for the individual, the individual’s spouse, and any of the individual’s dependents, as defined in Internal Revenue Code, Sections 152 and 213(d). Each HSA Account Owner has sole responsibility for seeking and obtaining reimbursement for any expenditure from his or her HSA.

Tax Matters
You acknowledge that adverse tax consequences may arise from failure to comply with applicable law regarding establishing an HDHP, making an HSA available to employees, and making contributions to an HSA. For

example, without limitation, adverse tax consequences may arise from the improper maintenance of an HDHP, the improper holding of an HSA, the improper contribution of amounts to an HSA, and reimbursement from an HSA for expenditures that are not qualified medical expenses. Blue Cross and Blue Shield recommends you engage a qualified tax advisor to review, on your behalf, the federal, state, local and foreign tax consequences of establishing an HDHP, making an HSA available to employees, and, if applicable, making contributions to an HSA. In no event will Blue Cross and Blue Shield or its designated vendor(s) be liable for losses caused by failure of any party to adhere to tax requirements applicable to HDHPs and/or HSAs. In no event will Blue Cross and Blue Shield or its designated vendor(s) determine whether any expenditure meets the requirements of a qualified medical expense or provide tax advice on any matter.

Enrollment, Access Methods, and Other Administrative Services

You will provide Blue Cross and Blue Shield, within a reasonable period prior to the start of your policy year under this Account-Based Offerings Administrative Services Agreement, a list of individuals covered under an HDHP who desire to become HSA Account Owners, including any information Blue Cross and Blue Shield or its designated vendor(s) requires to complete the HSA enrollment process. You are responsible for obtaining each employee's assent to open an HSA in his or her name and to maintain records of that agreement in accordance with your own written record retention policies. After Blue Cross and Blue Shield receives this enrollment information, fulfillment materials to establish an HSA will be mailed to each prospective HSA Account Owner. HSA Account Owners will be provided with the options to use debit cards and/or online bill pay for accessing HSA funds. Each HSA Account Owner will choose the option(s) he or she wishes to use under the terms of their HSA agreement.

Blue Cross and Blue Shield directly or through its designated vendor(s) will provide limited administrative services to HSA Account Owners. Blue Cross and Blue Shield may, but will not be obligated to, provide incidental services to HSA Account Owners regarding their HSAs. These incidental services may include the sharing of publicly available guidance on HSAs or answering questions of general applicability about HSAs. In no event will Blue Cross and Blue Shield or its designated vendor(s) provide, or be obligated to provide, (i) tax advice of any type; (ii) advice concerning whether a particular expense constitutes a qualified medical expense; or (iii) investment advice of any type.

Employer Matching Contribution/Payroll Withholding

You may make matching or other contributions to an HSA Account Owner's HSA. You may also collect payroll withholding contributions from HSA Account Owners to facilitate employee contributions to HSAs. You will remit all of these contribution amounts as soon as practicable to Blue Cross and Blue Shield's designated vendor(s) for deposit into the HSA Account Owner's HSA.

Section 6
HRA/FSA/TFS/PFS
When Blue Cross and Blue Shield Administers Your HRA/FSA/TFS/PFS Using its Designated Vendor

When you designate HRA/FSA/TFS/PFS Account-Based Offerings in your Group Setup Form, Blue Cross and Blue Shield will provide administrative and financial services consistent with the provisions described in this Section 6 and your Group Setup Form.

Under HRA/FSA/TFS/PFS Account-Based Offerings, you will establish, maintain, and appropriately fund the HRA/FSA/TFS/PFS Plan and will be solely responsible for the operation and administration of the HRA/FSA/TFS/PFS Plan, except as expressly delegated to Blue Cross and Blue Shield in this Account-Based Offerings Administrative Services Agreement. You have sole ownership of, and authority over, HRA/FSA/TFS/PFS Plan assets, including sole control and management of funding, disposition, and use of HRA/FSA/TFS/PFS Plan assets.

You and Blue Cross and Blue Shield acknowledge that the Plan is an employee welfare benefit plan as defined in Section § 3(1) of ERISA that is subject to ERISA pursuant to ERISA § 4(a). You and Blue Cross and Blue Shield therefore acknowledge that the Plan is subject to Title II of HIPAA as a "health plan" and a "covered entity." Blue Cross and Blue Shield's responsibilities under this Account-Based Offerings Administrative Services Agreement are limited to those of a contract claims administrator providing the services specified in this Account-Based Offerings Administrative Services Agreement at the direction of Plan's administrators or fiduciaries. As such, Blue Cross and Blue Shield is a service provider, not a fiduciary, with respect to the Plan. The Plan Sponsor retains full and final authority and responsibility for the Plan and its operation. Blue Cross and Blue Shield is empowered to act on behalf of the Plan only as stated in this Account-Based Offerings Administrative Services Agreement or as mutually agreed in writing by you, the Plan, and Blue Cross and Blue Shield. You will be responsible for and bear the entire cost of compliance with all federal, state, and local laws, rules, and regulations, including any licensing, filing, reporting, and disclosure requirement, that may apply to the Plan. Blue Cross and Blue Shield will have no responsibility for or liability with respect to the Plan's compliance or non-compliance with any applicable federal, state, or local law, rule, or regulation. Blue Cross and Blue Shield does not insure or underwrite the liability of you or the Plan, and has no responsibility for or discretion with respect to determining the benefits provided by the Plan. You retain the ultimate responsibility for the benefits provided by and for the disbursements under the Plan and for all expenses incident to the Plan, except as Blue Cross and Blue Shield has specifically undertaken in this Account-Based Offerings Administrative Services Agreement.

Enrollment

You will determine each employee's eligibility for enrollment in the Plan and submit electronically to Blue Cross and Blue Shield all of the information necessary for enrolling employees in the Plan. This enrollment information must include eligible employees, effective date of coverage, demographic information, dependent information, plan options, payment options, start and termination dates, class of coverage, whether the eligible employee is a late enrollee, and other information identified in the Blue Cross and Blue Shield enrollment process. You will provide this information in a timely manner to allow Blue Cross and Blue Shield to provide services in accordance with this Account-Based Offerings Administrative Services Agreement. Blue Cross and Blue Shield through its designated vendor(s) will perform certain enrollment functions in order to facilitate enrollment of your employees in one or more of the Plans you offer. Blue Cross and Blue Shield through its designated vendor(s) will provide you (or your eligible employee, as applicable) with a member welcome kit prior to the start of your policy year.

Contribution Information

Prior to your policy year under this Account-Based Offerings Administrative Services Agreement, and then for each subsequent renewal date, you must provide to Blue Cross and Blue Shield the following information: each covered employee's annual FSA, TFS, and PFS contributions; and your contributions for each covered employee's FSA, TFS, PFS, and HRA. If any of this information changes during your policy year, you must promptly inform Blue Cross and Blue Shield of those changes.

Administrative Services

Blue Cross and Blue Shield through its designated vendor(s) will provide the services described in this Section 6 and in the following sections of your Group Setup Form: Claim Files, Online Reimbursement, Explanation of Benefits, Overpayments, FSA Grace Period or FSA Rollover, and Debit Card. Blue Cross and Blue Shield through its designated vendor(s) will process and adjudicate requests for disbursements for qualified medical expenses in accordance with your Group Setup Form to the extent the Plan design is consistent with Blue Cross and Blue Shield's designated vendor(s) existing reimbursement platform, and its internal claims review processing standards, which have been established in accordance with industry standards and in compliance with applicable rules and regulations. Blue Cross and Blue Shield through its designated vendor(s) will: (i) receive disbursement requests and supporting documentation and verify the eligibility of persons submitting the requests; (ii) review the requests and supporting documentation, and make an initial determination of the disbursement, if any, to which a covered person is entitled; (iii) arrange prompt disbursement, using funds you deposit with Blue

Cross and Blue Shield's designated vendor(s); and (iv) correspond with covered persons and providers of services to obtain information necessary to adjudicate disbursement requests. Disbursements may be made via checks, direct deposits, or direct payment to the provider of service.

Blue Cross and Blue Shield will cooperate with its designated vendor(s) to provide reasonable disbursement run-out services, as mutually agreed by the parties.

Blue Cross and Blue Shield through its designated vendor(s) will make the initial determination regarding any requests for disbursements by a Covered Employee and will decide the first appeal of any previously denied reimbursement request that is filed by a Covered Employee in accordance with the claims review process. You are responsible for deciding the final appeal. Under no circumstances is Blue Cross and Blue Shield or its designated vendor(s) the "claims fiduciary" under your Account-Based Offerings.

In the event that you terminate the Plan or terminate or non-renew this Account-Based Offerings Administrative Services Agreement, Blue Cross and Blue Shield through its designated vendor(s) will provide clean-up work on previously processed disbursement requests and perform account reconciliation for a reasonable period following termination or, in the case of non-renewal, following the run-out period. Blue Cross and Blue Shield's designated vendor(s) will not process disbursement requests submitted during the clean-up processing period.

Excluded Services

Except as otherwise agreed to in writing between the parties, neither Blue Cross and Blue Shield nor its designated vendor(s) will provide any services not described in this Account-Based Offerings Administrative Services Agreement or your Group Setup Form, including but not limited to: continuation of coverage administration as otherwise required under COBRA for the HRA and/or HC-FSA (including but not limited to the distribution of notices otherwise required under COBRA); and Department of Labor Form 5500 preparation for the HRA, TFS, PFS, and/or HC-FSA.

Section 7
Termination of This Account-Based Offerings Administration Services Agreement

Blue Cross and Blue Shield's administration of the Account-Based Offerings described in this Account-Based Offerings Administrative Services Agreement is subject to termination in any of the following situations:

- You or Blue Cross and Blue Shield terminate the administration of your Account-Based Offerings for any reason and as of any date, upon 60 days prior written notice to the other.
- You do not pay the full amount of all fees you owe under this Account-Based Offerings Administrative Services Agreement to Blue Cross and Blue Shield within 30 days after the due date.
- Blue Cross and Blue Shield ends its agreement with its designated vendor(s) to provide the administrative and financial services described in this Account-Based Offerings Administrative Services Agreement (when applicable to your arrangement).
- You do not renew your Premium Account Agreement with Blue Cross and Blue Shield for another one-year policy term. In this situation, Blue Cross and Blue Shield's administration of your Account-Based Offerings as described in this Account-Based Offerings Administrative Services Agreement will end as of the same termination date.
- Your Premium Account Agreement with Blue Cross and Blue Shield is terminated for any of the reasons as described in Section 12 of the Premium Account Agreement. In any of these situations, Blue Cross and Blue Shield's administration of your Account-Based Offerings as described in this Account-Based Offerings Administrative Services Agreement will end as of the same termination date.

In the event Blue Cross and Blue Shield's administration of your Account-Based Offerings is terminated, you must pay all charges you owe Blue Cross and Blue Shield for all services administered through the date of termination.

Business Associate Agreement

Blue Cross and Blue Shield of Massachusetts, Inc. and/or, for HMO Blue plans, **Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.** (together referred to as Blue Cross and Blue Shield) and the **Account**, parties to an administrative services agreement pursuant to Attachment 1 and/or Attachment 2, as applicable (each Attachment referred to as an Administrative Services Agreement) of the Premium Account Agreement, in consideration of the mutual promises set out below, agree as follows:

As a provider of certain administrative services, Blue Cross and Blue Shield may be considered your "business associate." The terms of this Business Associate Agreement apply only to those administrative services that Blue Cross and Blue Shield provides in connection with a Health Engagement Program and/or Account-Based Offerings as described in Attachment 1 and/or Attachment 2 of the Premium Account Agreement, as applicable, and only when those administrative services give rise to a business associate relationship under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Business Associate Agreement is to comply with (1) the Standards for Privacy of Individually Identifiable Health Information set forth at Title 45 of the Code of Federal Regulations (45 C.F.R.) Parts 160 and 164, Subparts A and E (the Privacy Rule) promulgated pursuant to HIPAA; (2) the Security Standards for the Protection of Electronic Health Information set forth at 45 C.F.R. Parts 160, 162 and 164 (the Security Rule) promulgated pursuant to HIPAA; and (3) the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

Disclosure and Use of Protected Health Information

Parties

Blue Cross and Blue Shield and the Account acknowledge that the Account enters into the terms of this Business Associate Agreement on behalf of itself and of its Health Engagement Program(s) and/or its HRA, TFS, PFS, HC-FSA, or DC-FSA Account-Based Offerings (the Plan).

Definitions

Terms used in this Business Associate Agreement will be defined as follows:

"Breach Notification Rule" will mean the Notification in the Case of Breach of Unsecured Protected Health Information rule set forth at 45 C.F.R., Parts 160 and 164, Subparts A and D, as amended from time to time.

"Electronic Protected Health Information" will have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103, limited to the information created or received by Blue Cross and Blue Shield from or on behalf of the Plan.

"HHS" will mean the United States Department of Health and Human Services.

"HITECH Act" will mean the Health Information Technology for Clinical and Economic Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

"Privacy Rule" will mean the Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R., Parts 160 and 164, Subparts A and E, as amended from time to time.

“Protected Health Information” will have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, limited to the information created or received by Blue Cross and Blue Shield from or on behalf of the Plan.

“Security Incident” will have the same meaning as the term “security incident” in 45 C.F.R. § 164.304.

“Security Rule” will mean the Security Standards for the Protection of Electronic Health Information set forth at 45 C.F.R. Parts 160, 162 and 164, as amended from time to time.

“Subcontractor” will have the same meaning as the term “subcontractor” in 45 C.F.R. § 160.103.

All other terms used in this Business Associate Agreement but not otherwise defined in the applicable Administrative Services Agreement will have the same meaning as those terms in the Privacy Rule or the Security Rule, as applicable.

Effective Dates

The provisions of this Business Associate Agreement applicable to the Privacy Rule, Security Rule, and HITECH Act are effective as of the respective mandated compliance dates or the effective date of the Premium Account Agreement, whichever is later.

Obligations of Blue Cross and Blue Shield

Under this Business Associate Agreement, Blue Cross and Blue Shield’s responsibilities are:

General. Blue Cross and Blue Shield will not use or disclose Protected Health Information other than as permitted or required by the Privacy Rule, the HITECH Act, the applicable Administrative Services Agreement, this Business Associate Agreement, or as required by law.

Information Safeguards. Blue Cross and Blue Shield will use commercially reasonable safeguards to prevent the use or disclosure of Protected Health Information other than as provided for by the applicable Administrative Services Agreement and this Business Associate Agreement. Blue Cross and Blue Shield will implement, maintain and use administrative, physical and technical safeguards for Electronic Protected Health Information in compliance with the Security Rule, as required by the HITECH Act.

Breaches and Security Incidents. Blue Cross and Blue Shield will report to Account, following discovery and without unreasonable delay, any incident that Blue Cross and Blue Shield determines, in its sole discretion, constitutes a “breach” of “unsecured protected health information,” as these terms are defined by the Breach Notification Rule.

With respect to any incident not subject to reporting in the paragraph above, Blue Cross and Blue Shield will report to the Plan any use or disclosure of Protected Health Information not provided for by the applicable Administrative Services Agreement and this Business Associate Agreement of which Blue Cross and Blue Shield becomes aware.

With respect to any incident not subject to reporting in the two paragraphs above, Blue Cross and Blue Shield will report to the Plan any Security Incident of which Blue Cross and Blue Shield becomes aware.

Subcontractors. Blue Cross and Blue Shield will require any Subcontractor that creates or receives Protected Health Information to engage in a written agreement requiring that the Subcontractor comply with the same restrictions and conditions that apply through this Business Associate Agreement to Blue Cross and Blue Shield with respect to such Protected Health Information. Blue Cross and Blue Shield will also require any Subcontractor that creates or receives Electronic Protected Health Information to agree in writing to comply with the Security Rule.

Access to Designated Record Set. Blue Cross and Blue Shield will provide access, at the request of the Plan, and on terms mutually agreeable to the Plan and Blue Cross and Blue Shield, to Protected Health Information in a Designated Record Set, to the Plan or, as directed by the Plan, to an individual in order to meet the requirements under 45 C.F.R. § 164.524.

Amendment of Designated Record Set. Blue Cross and Blue Shield will make amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 C.F.R. § 164.526 at the request of the Plan or an individual, on terms mutually agreeable to the Plan and Blue Cross and Blue Shield.

Access to Books and Records**.** Blue Cross and Blue Shield will make its internal practices, books and records relating to its use and disclosure of Protected Health Information received from the Plan, or created or received by Blue Cross and Blue Shield on behalf of the Plan, available to HHS for purposes of HHS determining compliance by the Plan with the Privacy Rule.

Documentation of Disclosures. Blue Cross and Blue Shield will document such disclosures of Protected Health Information and information related to such disclosures as would be required for the Plan to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

Accounting of Disclosures. Blue Cross and Blue Shield will provide to the Plan information collected in accordance with the "Documentation of Disclosures" subsection above to permit the Plan to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

Delegation. To the extent that the Plan delegates to Blue Cross and Blue Shield any obligation imposed on the Plan by the Privacy Rule, Blue Cross and Blue Shield will comply with the requirements of the Privacy Rule that apply to the Plan in the performance of such delegated obligation.

Permitted Uses and Disclosures of Protected Health Information

Blue Cross and Blue Shield may use and/or disclose Protected Health Information to perform its obligations under by the applicable Administrative Services Agreement and this Business Associate Agreement if such use or disclosure would not violate the Privacy Rule if done by the Plan. Notwithstanding the foregoing, Blue Cross and Blue Shield may also use or disclose Protected Health Information in accordance with the "Additional Permitted Uses and Disclosures of Protected Health Information" subsection below.

Additional Permitted Uses and Disclosures of Protected Health Information

Blue Cross and Blue Shield may:

- use Protected Health Information for the proper management and administration of Blue Cross and Blue Shield's operations or to carry out the legal responsibilities of Blue Cross and Blue Shield;
- disclose Protected Health Information for the proper management and administration of Blue Cross and Blue Shield's operations or to carry out the legal responsibilities of Blue Cross and Blue Shield, provided that: (i) the disclosures are required by law, or (ii) Blue Cross and Blue Shield obtains reasonable assurances from the person to whom the information is disclosed that said information will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Blue Cross and Blue Shield of any instances of which he or she is aware in which the confidentiality of the information has been breached;
- provide data aggregation services to the Plan as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B);
- report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1); and
- use and disclose Protected Health Information as permitted by law, including but not limited to disclosing Protected Health Information for medical research studies in accordance with federal law.

Obligations of the Plan

Notify Blue Cross and Blue Shield immediately of any limitation(s) in the Plan's notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Blue Cross and Blue Shield's use or disclosure of Protected Health Information.

Notify Blue Cross and Blue Shield immediately of any changes in, or revocation of, permission by an individual to use or disclose Protected Health Information, to the extent that such changes may affect Blue Cross and Blue Shield's use or disclosure of Protected Health Information.

Notify Blue Cross and Blue Shield immediately of any restriction to the use or disclosure of Protected Health Information that the Plan has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Blue Cross and Blue Shield's use or disclosure of Protected Health Information.

Permissible Requests by the Plan

The Plan will not request that Blue Cross and Blue Shield use or disclose Protected Health Information in any manner that would be impermissible under the Privacy Rule if done by the Plan, provided that the Plan may request that Blue Cross and Blue Shield use or disclose Protected Health Information in accordance with "Permitted Uses and Disclosures of Protected Health Information" and "Additional Permitted Uses and Disclosures of Protected Health Information" subsections above.

Disclosure of Protected Health Information to the Account

The Plan authorizes and permits Blue Cross and Blue Shield to disclose Protected Health Information to the Account. The Plan and the Account represent and warrant that:

- The Plan documents have been amended in accordance with 45 C.F.R. § 164.504(f)(2);
- The Plan has received a certification by the Account that the Plan documents have been amended to incorporate the provisions set forth in 45 C.F.R. § 164.504(f)(2)(ii) and that the Account agrees to comply with those provisions;
- The statement required by 45 C.F.R. § 164.520(b)(1)(iii)(C) has been included in the appropriate notice; and
- The Plan has otherwise satisfied all conditions set forth in state and federal law, including but not limited to the Privacy Rule, on disclosure of Protected Health Information by Blue Cross and Blue Shield to the Account.

Limits on Disclosure of Protected Health Information to the Account

Blue Cross and Blue Shield will disclose Protected Health Information in accordance with the "Disclosure of Protected Health Information to the Account" subsection above only to persons identified in the Plan documents as persons authorized to have access to Protected Health Information in order to carry out the administration functions that the Account performs for the Plan. The Plan will promptly provide Blue Cross and Blue Shield with a list of said persons.

Disclosure of Protected Health Information to Account's Designee

The Plan authorizes and permits Blue Cross and Blue Shield to disclose Protected Health Information to Designees retained by the Account to perform certain administrative functions for the Plan. Such functions may include analysis of claims processing accuracy and claims payment procedures, disease management and care coordination activities, and other functions that constitute either "payment" or "health care operations" as defined in the Privacy Rule (Plan Functions). Blue Cross and Blue Shield may disclose Protected Health Information to a Designee as directed in writing by the Account (on behalf of the Plan). By directing Blue Cross and Blue Shield to disclose Protected Health Information to a Designee, the Plan and Account represent and warrant that:

- The Account has executed an agreement with the Designee (the Designee BA) regarding the use and disclosure of Protected Health Information, which agreement is in compliance with all applicable federal,

state and local laws, including but not limited to the "business associate" requirements of the Privacy Rule, and the Security Rule;

- The Protected Health Information requested from Blue Cross and Blue Shield is the minimum necessary, as defined by the Privacy Rule, in order for the Designee to perform the Plan Functions, and the Protected Health Information will not be used or disclosed for any other purpose, including employment related purposes; and
- In the event that the Protected Health Information includes information relating to mental health or HIV/AIDS (Sensitive Data), any use and disclosure of Sensitive Data will be in compliance with applicable state law and the Account will obtain assurances from the Designee that the Designee will not release sensitive data to the Account or to any other party unless the Sensitive Data has been de-identified in accordance with 45 C.F.R. 164.514(b), as amended, and further that any such disclosure will be made only as permitted by applicable law and the terms of the Designee BA.

Termination for Breach

A violation by either party of a material term of the provisions of this Business Associate Agreement will be considered a material breach of your applicable Administrative Services Agreement with Blue Cross and Blue Shield. Your Administrative Services Agreement with Blue Cross and Blue Shield will then be subject to termination as described in Section 3 of Attachment 1 and/or Section 7 of Attachment 2, as applicable.

Effect of Termination

Upon termination of your Administrative Services Agreement and this Business Associate Agreement with Blue Cross and Blue Shield, Blue Cross and Blue Shield will retain all Protected Health Information in its possession in accordance with Blue Cross and Blue Shield's record retention policies, and will extend the protections of this Business Associate Agreement to the retained Protected Health Information.

Minimum Necessary

Blue Cross and Blue Shield will use, disclose, or request Protected Health Information in a Limited Data Set, if practicable.

Regulatory References

A reference in this Business Associate Agreement to a section in the Privacy Rule or the Security Rule means the section as in effect or as amended.

Survival

The provisions of this Business Associate Agreement will survive termination of your Administrative Services Agreement with Blue Cross and Blue Shield solely with respect to Protected Health Information retained in accordance with the "Effect of Termination" subsection above for so long as such information is retained.

Construction of Terms

The terms and conditions of this Business Associate Agreement will be construed in light of any applicable interpretation of and/or guidance on the Privacy Rule and the Security Rule issued by the HHS from time to time.