PREMIUM ACCOUNT AGREEMENT

This Premium Account 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 benefits in accordance with the underwriting guidelines detailed in *The Manual of Underwriting Guidelines for Group Business* and the health care benefits detailed in the subscriber certificates including riders (together referred to as "Subscriber Certificates") that describe your benefits plans. (Your benefits plans are those 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 the policy year.) 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 2008 anniversary/renewal date unless terminated as described in Section 10. 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 supersedes 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 time 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.

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 10(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.

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.

(a) 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).

(b) 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.

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) A permanent full-time employee regularly working 30 hours or more 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

(b) A permanent part-time employee regularly working at least 20 hours but less than 30 hours 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

(c) 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

(d) 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 in (a) above; or

(e) 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. 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 60 days to comply with this enrollment requirement or this Agreement will be subject to termination.

Section 5. Health Care Services Furnished Outside of Massachusetts

The BlueCard® Program. Blue Cross and Blue Shield participates in a program called BlueCard. Whenever Members access health care services outside of Massachusetts, the claim for those services may be processed through BlueCard and presented to Blue Cross and Blue Shield for payment in compliance with the BlueCard Program. Under BlueCard, when Members receive covered health care services in a geographic area served by a Host Blue Cross and/or Blue Shield Licensee (Host Plan), Blue Cross and Blue Shield will remain responsible for fulfilling the obligations of this Agreement. The Host Plan will be responsible only for providing services such as contracting with its participating providers, handling all interaction with its participating providers and, as applicable, 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 BlueCard 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 Blue Cross and Blue Shield pays to a Host Plan on 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, any other contingent payment arrangements and non-claims transactions (such as 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, any other contingent payment arrangements and non-claims transactions (such as 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 will, 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. However, the amount paid by the Member is a final price and will not be affected by this prospective adjustment.

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, the Host Plan 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 BlueCard, 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 third parties to assist in discovery or collection of recovery amounts. The fees of any such third party are subtracted from the recovery. Recovery amounts (net of fees), if any, will be applied, in accordance with the BlueCard Program, which generally requires correction on a claim-by-claim or prospective basis.

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. These provisions apply to employer groups with two or more employees.

Notice of Continuation of Coverage Rights. 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.

Notice of Election Rights. 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.)

Time Period for Member to Elect Continued Coverage. 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.

Payments for Continued Coverage. 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. Certificates of Group Health Plan Coverage

Under the creditable coverage rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), participants in group health plans are entitled to certificates of creditable coverage in certain circumstances. Blue Cross and Blue Shield agrees to provide a Certificate of Group Health Plan Coverage (Certificate) to your terminated Members in accordance with the provisions described in this Agreement.

Blue Cross and Blue Shield Responsibilities. Blue Cross and Blue Shield will provide a Certificate to Members who are terminated from your Blue Cross and Blue Shield health benefits plans when:

- The Member ceases coverage under your health benefits plan and becomes eligible for continued coverage as provided by federal law (COBRA) or, for employers not subject to COBRA, as provided by state law, or coverage would have been lost had the Member not elected to continue coverage under COBRA or state law, provided you promptly notify Blue Cross and Blue Shield of the Member's loss of coverage.
- The Member's continued coverage ends under COBRA or, for employers not subject to COBRA, under state law, provided you promptly notify Blue Cross and Blue Shield of the Member's termination.
- The terminated Member, or another health care plan or insurance carrier acting on his or her behalf, requests a Certificate, provided the request is received within 24 months of the date he or she terminated coverage under your health benefits plan.

In addition, Blue Cross and Blue Shield will provide a Certificate to a Member whose claim is denied because he or she has reached a lifetime limit on all benefits (if any).

Blue Cross and Blue Shield will provide a Certificate that specifies the Member's prior Blue Cross and Blue Shield coverage during the period, up to 18 months, prior to termination as shown on Blue Cross and Blue Shield's records. This Certificate will not include information as to any waiting period (probationary period) that you may impose on your employees before enrolling them in your health benefits plan. The Certificate will specify that such information is available directly from you.

Generally, Blue Cross and Blue Shield will mail all Certificates to the Member's last known address as shown on Blue Cross and Blue Shield records, both for employees and dependents. Blue Cross and Blue Shield will provide one Certificate in the case of a terminated family membership. However, if different Members under the family membership had different coverages and/or different beginning and ending dates during the 18 months prior to termination, a separate Certificate will be provided for each terminated Member.

Blue Cross and Blue Shield will not provide separate Certificates for separate dental or vision care policies (or riders).

Your Responsibilities. You will provide your terminated Members with Certificates describing prior coverage that was not provided or administered by Blue Cross and Blue Shield.

You will provide your terminated Members with information as to any waiting period (probationary period) you impose on employees.

You will promptly inform Blue Cross and Blue Shield whenever a Member loses coverage under a health benefits plan offered by Blue Cross and Blue Shield and becomes eligible for continued coverage as provided by federal

law (COBRA) or, for accounts not subject to COBRA, continued coverage under state law, as well as when COBRA coverage terminates, so that Blue Cross and Blue Shield can prepare and send the Certificates. If you do not promptly inform Blue Cross and Blue Shield of such a termination, you agree to provide the terminated Member with a Certificate.

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 under state or federal law due to your failure to provide certain information within your possession directly to your terminated Members, as provided for by this Agreement.
- 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 under state or federal law, due to your failure to provide information to Blue Cross and Blue Shield, as required by this Agreement, so that Blue Cross and Blue Shield may provide Certificates as provided herein.

Section 8. 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 9. 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 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 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 10. Termination

This Agreement is subject to termination in the following situations:

(a) 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.

(b) 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 only after Blue Cross and Blue Shield provides Members with prior written notice of their termination as described in the applicable Subscriber Certificate and as required by state and federal law.

You will 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 termination date. However, for any Medicare Advantage plan that you offer, this provision applies only to optional coverage you have elected to offer.

(c) Material breach, fraud or misrepresentation by either party. Termination will be effective immediately upon one party's written notice to the other.

(d) Insufficient enrollment. Blue Cross and Blue Shield will terminate this Agreement, as described in Section 4, if your covered employee participation falls below Blue Cross and Blue Shield's minimum enrollment requirements.

(e) 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.

(f) 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.

(g) 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(a), 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.

(h) 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.

Blue Cross and Blue Shield may terminate a particular product on your anniversary/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.