## *Amendment for Premium Account 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 (the "Agreement"), in consideration of the mutual promises set out below, agree as follows:

The following provisions are incorporated as part of the Agreement. No modifications made or requested by the Account to the terms specified in this Amendment will be binding upon Blue Cross and Blue Shield unless the modifications are made in writing and signed by both parties. All other terms and conditions of the Agreement will continue in full force and effect.

**1. The following new Section is added to the Agreement.**

### 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.

**2. Section 5, "Health Care Services Furnished Outside of Massachusetts," of the Agreement is deleted and replaced by the following new Section 5.**

### 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 in compliance with the Inter-Plan Programs policies then in effect. 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 (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.

**(a) 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 adjustments 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.

**(b) 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 netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

**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.

**Out-of-Area Medicare Advantage Program.** Blue Cross and Blue Shield has relationships with Host Plans that participate in the Blue Cross and Blue Shield Association's (the Association's) out-of-area program for Members enrolled in a Medicare Advantage plan. This out-of-area program may be referred to as the "Association's Medicare Advantage Program." 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 Association's Medicare Advantage Program and presented to Blue Cross and Blue Shield for payment in accordance with the rules of the Association's Medicare Advantage Program policies then in effect. The Association's 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 either Blue Cross and Blue Shield negotiates with the provider or the Host Plan negotiates with its provider on behalf of Blue Cross and Blue Shield members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable charge.

# *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 2012 anniversary/renewal date unless terminated as described in Section 11. 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.


® Registered Marks of the Blue Cross and Blue Shield Association.

## 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 11(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.

**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.

**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.

## 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

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 in compliance with the Inter-Plan Programs policies then in effect. 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 (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.

**(a) 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. The BlueCard Program requires that the price submitted by a Host Plan to Blue Cross and Blue Shield is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

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.

**(b) 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 netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

**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.

**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 either Blue Cross and Blue Shield negotiates with the provider or the Host Plan negotiates with its provider on behalf of Blue Cross and Blue Shield members, if applicable. 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. 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 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 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. Medical Loss Ratio Calculation and Premium Rebates

Blue Cross and Blue Shield will calculate and report the medical loss ratio ("MLR") for its health plans that are in effect during a calendar year beginning on or after January 1, 2011, as required by the Patient Protection and Affordable Care Act ("PPACA"). For any health plan(s) in a market segment for which the MLR does not meet the minimum MLR standards for a given calendar year, Blue Cross and Blue Shield will issue premium rebates directly or through you, as described below, no later than August 1 of the following year.

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.

**Distribution of MLR Premium Rebates.** In the situations where premium rebates are required to be issued to you and your group subscribers, Blue Cross and Blue Shield may look to you for information including, but not limited to, premium contribution level and coverage history for your employees. Blue Cross and Blue Shield will send premium rebates to you for distribution to your employees who are entitled to an MLR premium rebate. An employee who is entitled to receive an MLR premium rebate ("MLR Rebate-Eligible Subscriber") means a current or former group subscriber who paid all or a portion of the premium for health care coverage offered under a Premium Account Agreement with Blue Cross and Blue Shield during the respective MLR reporting year for a health plan that is part of a market segment that did not meet the minimum MLR standards for that reporting year. You agree to provide Blue Cross and Blue Shield with any information Blue Cross and Blue Shield needs to calculate, administer and/or ensure distribution of MLR premium rebates and to meet regulatory requirements including but not limited to MLR reporting requirements. Blue Cross and Blue Shield will rely on you to distribute the MLR premium rebates to each of your MLR Rebate-Eligible Subscribers in a manner that meets statutory and regulatory requirements. You must distribute MLR premium rebates proportionately to your current and former MLR Rebate-Eligible Subscribers. Along with distributing the MLR premium rebate, you must provide detailed reporting information to Blue Cross and Blue Shield that is required to be maintained by Blue Cross and Blue Shield and reported to the federal government. The detailed reporting information you must provide to Blue Cross and Blue Shield includes, but is not limited to, all of the following: (i) the amount of the premium paid by each of your MLR Rebate-Eligible Subscribers, (ii) the amount of the premium rebate issued to each of your MLR Rebate-Eligible Subscribers, (iii) the amount of the rebate you retained, (iv) the amount of any unclaimed rebate and how and when it will be or was dispersed, and (v) any additional information Blue Cross and Blue Shield determines it needs to comply with MLR regulatory requirements. You must also include a description of the process you use for handling undeliverable or unclaimed rebates.

In the event that Blue Cross and Blue Shield elects, in its sole discretion, to issue MLR premium rebates directly to MLR Rebate-Eligible Subscribers, Blue Cross and Blue Shield will notify you. In order for Blue Cross and Blue Shield to issue MLR premium rebates directly to MLR Rebate-Eligible Subscribers, you will be required to provide the following information within 30 days of the written request you receive from Blue Cross and Blue Shield: (i) contribution information for your MLR Rebate-Eligible Subscribers, (ii) current addresses for current and former MLR Rebate-Eligible Subscribers, and (iii) information as to whether employee contributions are paid on a pre-tax basis (including social security numbers for MLR Rebate-Eligible Subscribers) or on a post-tax basis. Those MLR premium rebates due to MLR Rebate-Eligible Subscribers where the employer group fails to return the requested information may be treated by Blue Cross and Blue Shield as unclaimed premium rebates and reported as such to the federal government. These unclaimed premium rebates can be reissued at a later date upon receipt of the required information from the employer group. In addition, whether Blue Cross and Blue Shield distributes MLR premium rebates only to you or directly to MLR Rebate-Eligible Subscribers, you agree that you are solely responsible for any tax reporting and/or withholding obligations associated with the MLR premium rebates.

You agree to hold Blue Cross and Blue Shield harmless from and against any and all liability that may be imposed on, incurred or assessed against Blue Cross and Blue Shield by any person, party or entity under state or federal law in any way arising from or related to your responsibilities under this Agreement to distribute MLR premium rebates to your MLR Rebate-Eligible Subscribers or, if applicable, arising from or related to your responsibilities to provide the information necessary for Blue Cross and Blue Shield to distribute the MLR premium rebates to MLR Rebate-Eligible Subscribers including, but not limited to, fees, costs, expenses (including attorney's fees and other costs), damages, penalties, taxes and fines. By accepting this Agreement, you agree that you will perform the tasks Blue Cross and Blue Shield determines are required to ensure MLR premium rebates are distributed to MLR Rebate-Eligible Subscribers and to ensure that Blue Cross and Blue Shield is able to comply with regulatory requirements, including but not limited to MLR reporting requirements.

## Section 11. 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 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.

(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.