



**BlueCross BlueShield
of Illinois**

GROUP ADMINISTRATION DOCUMENT

WHEREAS, the “Policyholder” has purchased health care insurance from **Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the “Plan”) and has executed a Benefit Program Application; and

WHEREAS, the Benefit Program Application establishes the Group Number(s) of the Policyholder under the Policy and the Effective Date of Policy, and

WHEREAS, the Plan hereby accepts such Benefit Program Application, subject to the financial and administrative relationships and responsibilities of both parties for the purpose of providing health care benefits on behalf of eligible Covered Persons;

NOW, THEREFORE, the following provisions shall govern the relationship between the Plan and the Policyholder:

I. ENTIRE POLICY AND CHANGES TO THE POLICY

This Group Administration Document, including the addenda, if any, attached hereto; the Certificate Booklet; the Benefit Program Application; the benefit program and premium notification letter, if any; the Benefit Program Application Change Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Covered Persons constitute the entire contract of insurance. All statements made by the Policyholder and Covered Persons shall, in the absence of fraud, be deemed representations and not warranties, and no such statements shall be used in defense to a claim under the Policy, unless it is contained in a written application. No change in the Policy shall be valid until approved by an executive officer of the Plan and unless such approval is endorsed hereon or attached hereto. No agent has authority to change the Policy or to waive any of its provisions.

The issuance of this Group Administration Document supersedes all previous contracts or policies between the Policyholder and the Plan which are in force on the Effective Date of Policy as indicated on the Benefit Program Application.

II. CERTIFICATE BOOKLETS

The Plan will issue to the Policyholder, for delivery to each Insured, a Certificate Booklet stating the benefits, limitations, exclusions and requirements of the Policy.

III. PREMIUM PROVISIONS

A. Premium Rates

1. On the Effective Date of Policy, the Individual Coverage Premium (Insured only) and, when applicable, the Family Coverage Premium (Insured and one or more dependents) shall be the amounts specified in the Benefit Program Application; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, which shall be attached hereto and made a part of the Policy. Subsequent changes to the Individual and/or Family Coverage Premiums shall be specified in the Benefit Program Application; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, which shall be attached hereto and made a part of the Policy.
2. If Insured contributions for coverage are not required, the Policyholder agrees that all Eligible Persons will become covered and such persons will make no contributions to-

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

ward the cost of the coverage. If Insured contributions for coverage are required, the Policyholder agrees to give all Eligible Persons an opportunity to subscribe to the coverage and further agrees to pay the required premiums to the Plan and provide for the collection of any contributions from the persons to be covered through payroll withholding or otherwise. The term "Eligible Persons" as used herein shall mean, at a minimum, the percentage of enrolled eligible employees required for policy issuance and renewal, as specified on the Benefit Program Application.

B. Payment of Premiums

The first premium payment is due on the Effective Date of Policy. Subsequent premium payments are due and payable on the due date, which is the first day of each Premium Period. The Premium Period is specified in the Benefit Program Application.

C. Premium Computation

1. The premium payment due for the Policy on any premium due date is the aggregate amount composed of the Individual and Family Coverage premiums for all Insureds covered for the benefits provided under the Policy, as specified in the Benefit Program Application; the benefit program and premium notification letter, if any; or applicable rate summary(ies), if any. Further, if an Eligible Person becomes a Covered Person during a Premium Period or if a Covered Person's coverage is terminated during a Premium Period, the Plan will determine the premium due for such Covered Person for such period.
2. The Plan may establish a new premium for any of the individual or aggregate benefits of the Policy on any of the following dates or occurrences, upon which further premium payments, including the one then due, will be computed:
 - a. Any Policy anniversary, provided that the Plan notifies the Policyholder of such new premium at least thirty (30) days prior to such date;
 - b. Any premium due date, provided the Plan notifies the Policyholder of such new premium at least thirty (30) days in advance of such premium due date;
 - c. Whenever the benefits under the Policy are changed;
 - d. Whenever a class of persons is made eligible or is eliminated from eligibility;
 - e. Whenever the enrollment fluctuates by ten percent (10%) or more;
 - f. Whenever the Plan is obligated to pay any new taxes, Surcharges or other fees imposed upon or resulting from the Policy including, but not limited to, premium taxes or taxes on the Plan's benefits or services provided under the Policy; and
 - g. Whenever there is a legislative or regulatory mandate or requirement for a change in benefits which would require additional premium.
3. If the age of a Covered Person under the Policy upon which a particular premium is based has been misstated, the Policyholder shall be responsible for paying the Plan an adjusted amount which will provide the Plan with the correct premium calculated from the Coverage Date of the particular Covered Person.

D. Grace Period and Termination for Non-Payment

1. A grace period of thirty-one (31) days will be allowed for payment of any premium after the first payment. During such grace period the Policy will continue in force provided that the Policyholder has not, prior to the premium due date, given adequate timely written notice to the Plan that the Policy is to be terminated as of such premium due date.

In addition, if the Policyholder is in default of its obligation to make any premium payment as provided hereunder or if any other default hereunder has occurred and is continuing,

then any indebtedness from the Plan to the Policyholder (including any and all contractual obligations of the Plan to the Policyholder) may be offset and/or recouped and applied toward the payment of the Policyholder's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Policyholder.

2. If the Policyholder does not pay the premium during the grace period, the Policy will be terminated, at the Plan's option, on the last day of the grace period and the Policyholder will be liable to the Plan for the payment of all premiums then due, including those for the grace period.

E. Experience Refunds (Applicable to Premium Retrospective Funding Arrangements Only)

1. The Policyholder may be eligible for experience refunds as ascertained and apportioned by the Plan at each Policy anniversary date, provided the Policy has been continued in force by payment of all premiums to the anniversary date. The Plan will reasonably determine the distribution of the experience refunds unless otherwise agreed upon between the Plan and the Policyholder. However, the Plan will have no liability to the Policyholder, or any of the Covered Persons under the Policy, or any other person or entity for any alleged or actual improper use or application of such experience refunds.
2. If at any time the aggregate of any individual contributions made under the Policy exceeds the aggregate of premiums paid under the Policy (after giving effect to any experience reduction), such excess will be applied by the Policyholder for the sole benefit of Insureds, but the Plan will have no liability for any alleged or actual misapplication of such excess.

IV. GENERAL PROVISIONS

A. The Plan's Separate Financial Arrangements with Providers

The Policyholder's experience account under the Policy, if any, the maximum amount of benefits payable by the Plan under this Policy and all required deductible and Coinsurance amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or Provider's Claim Charge less the Average Discount Percentage ("ADP") for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between any Plan Provider and the Plan as referred to below.

The Plan hereby informs the Policyholder and all Covered Persons that it has contracts with certain Providers ("Plan Providers") for the provision of, and payment for, health care services to all persons entitled to health care benefits under individual certificates and group policies and contracts to which the Plan is a party, including the Covered Persons under the Policy, and that pursuant to the Plan's contracts with Plan Providers, under certain circumstances described therein, the Plan may receive substantial payments from Plan Providers with respect to services rendered to all such persons for which the Plan was obligated to pay the Plan Provider, or the Plan may pay Plan Providers substantially less than their Claim Charges for services, by discount or otherwise, or may receive from Plan Providers other substantial allowances under the Plan's contracts with them. The Policyholder understands that the Plan may receive such payments, discounts and/or other allowances during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

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

1. The Plan's Separate Financial Arrangements with Participating Prescription Drug Providers:

The Policyholder's experience account under the Policy, if any, the maximum amount of benefits payable by the Plan and all required Copayment, deductible and Coinsurance

amounts under this Policy shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Plan, whichever is less.

The Plan hereby informs the Policyholder and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including the Covered Persons under the Policy, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for prescription drugs dispensed to Covered Persons under the Policy.

The Policyholder understands that the Plan may receive such discounts during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the premium specified on the Benefit Program Application; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, as part of any experience rating refund, if applicable to this policy, or otherwise.

2. **The Plan's Separate Financial Arrangements with Pharmacy Benefit Managers:**

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

The Policyholder understands that the Plan may receive such rebates during the term of the Policy. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such rebates in excess of any amount that may be reflected in the premium specified on the Benefit Program Application; a benefit program and premium notification letter, if any; or applicable rate summary(ies), if any, as part of any experience rating refund, if applicable to this policy, or otherwise.

C. Services Rendered Out of Plan's Service Area

1. **BlueCard**

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

The following paragraph applies to benefit programs other than BlueCard point-of-service benefit programs:

The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

The following paragraph applies to BlueCard point-of-service benefit programs only: The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers, handling all interaction with its participating Providers and, if applicable, providing some managed care services. The financial terms of BlueCard are described generally below.

2. **Liability Calculation Method Per Claim**

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

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

- a. The actual price paid on the Claim by the Host Blue to the health care Provider ("Actual Price"), or
- b. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-Claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or
- c. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-Claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An average price may result in greater variation to the Covered Person and the Policyholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Person is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating the Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate the Covered Person's liability for any Covered Services consistent with applicable state statute in effect at the time the Covered Person received those Covered Services.

3. **Return of Overpayments**

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

4. Determinations of Covered Health Care Services (Applicable to BlueCard point-of-service benefit programs only)

If the Plan determines that health care services are covered, or the Policyholder's benefit plan covers health care services, coverage of those health care services cannot be denied based on the Host Blue's network protocols. However, under BlueCard, the Covered Person cannot be denied coverage of health care services received outside of the Plan's service area if the health care services (i) are covered by the network protocols of the Host Blue; and (ii) are not specifically limited or excluded by the Policyholder's benefit plan.

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

D. Records of Covered Person Eligibility and Adjustments

The Policyholder must furnish to the Plan data as may be required by the Plan regarding the Covered Persons who are to be covered under the Policy. Such data may include, without limitation, a list of Covered Persons who are to be covered under the Policy, completed application cards of the Insureds, information required by the Plan to identify dual coverage situations which are subject to Medicare Secondary Payer ("MSP") laws and information required for Certificate(s) of Creditable Coverage that will be issued by the Plan. It is the Policyholder's obligation to notify the Plan no later than thirty-one (31) days after the effective date of any change in a Covered Person's status under the Policy. All such notifications by the Policyholder to the Plan (including, but not limited to, forms and tapes) must be furnished in a format approved by the Plan and must include all information reasonably required by the Plan to effect such changes. Minor clerical errors in keeping or reporting data relative to coverage under the Policy will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. Examples of such minor clerical errors include, but are not limited to, errors appearing in an individual's name, address, or birth date as well as typographical errors. The term "minor clerical errors" as used herein does not include Policyholder errors which may materially affect an individual's coverage under the policy. It is further understood and agreed that the Policyholder is liable for any substantive error made by the Policyholder in keeping or reporting data which may materially affect an individual's coverage under the policy and for any benefits paid for a terminated Covered Person if the Policyholder had not timely notified the Plan of such Covered Person's termination.

During the term of the Policy and within one hundred eighty (180) days after the termination of the Policy, the Plan may, upon at least thirty (30) days prior written notice to the Policyholder, conduct reasonable audits of the Policyholder's membership records with respect to eligibility.

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

E. Third Party Data Release

In the event the Policyholder directs the Plan to provide data directly to its third party consultant and/or vendor, the Policyholder acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:

1. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section E., "Confidential Information").
2. Release of the Confidential Information may also reveal the Plan's confidential, business proprietary and trade secret information (for purposes of this Section E., "Proprietary Information").
3. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section E., collectively, "Information").
4. The third party consultant and/or vendor shall:
 - a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Policyholder.
 - b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Policyholder.
 - c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
 - d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
 - e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of the Policy or as required by law.
5. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
6. The third party consultant and/or vendor shall execute the Plan's then-current confidentiality agreement.
7. The Policyholder shall designate the third party consultant and/or vendor on the appropriate HIPAA documentation.
8. The Policyholder shall provide the Plan with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

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

F. Termination of a Covered Person's Coverage

1. If an Insured, with or without cause, ceases to be an Eligible Person, such Insured's coverage (and the coverage of other Covered Persons under Family Coverage) will automatically terminate at the expiration of the period for which the premium has been paid.
2. If a Covered Person ceases to meet the definition of Covered Person, such Covered Person's coverage will automatically terminate on the date that the event occurs which causes the Covered Person to no longer meet this definition. However, if such date falls

within a period for which premiums have been accepted by the Plan for such Covered Person, coverage will automatically terminate at the expiration of the period for which the premium has been paid.

3. A Covered Person's coverage under the Policy will automatically terminate at the expiration of the Premium Period in which such Covered Person becomes eligible for Medicare except for those benefits, if any, which are specifically provided under the Policy for Medicare eligible Covered Persons and coverage in accordance with MSP laws.
4. Termination of the Policy automatically terminates all the coverages of all Covered Persons. It is the responsibility of the Policyholder to notify all Covered Persons of the termination of the Policy, but all coverages will automatically terminate as of the effective date of termination of the Policy regardless of whether such notice is given.
5. No benefits are available to a Covered Person for services or supplies rendered after the date of termination of such Covered Person's coverage under the Policy, except as otherwise specifically provided in Benefit Sections of the Certificate Booklet.
6. If a Covered Person whose insurance terminates is entitled to exercise the conversion privilege specified in the Conversion Privilege section of the Certificate Booklet, it is the Policyholder's responsibility to present written notice of the existence of the conversion privilege to the Insured or to mail such notice to the Insured's last known address.

G. Certificate of Creditable Coverage

Unless otherwise directed by the Policyholder in writing, the Plan shall issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to the Plan by the Policyholder. The Policyholder may agree in writing to prepare and distribute such Certificate of Creditable Coverage, and in such instance, the Plan will not be required to duplicate provision of such Certificate of Creditable Coverage.

H. Notice and Proof of Claim

1. The Plan will not be liable under the Policy unless a Claim for benefits is furnished to the Plan at its office at 300 East Randolph Street, Chicago, Illinois, on or before December 31st of the calendar year following the year in which Covered Services were rendered. For purposes of this paragraph, Covered Services furnished in the last month of a particular calendar year shall be considered to have been furnished in the succeeding calendar year.
2. Upon written request to the Plan, the Insured will be provided with the forms necessary for filing Claims under the Policy. If such forms are not furnished within fifteen (15) days of the Plan's receipt of such request, the Insured shall be deemed, with respect to the particular Claim, to have complied with the requirements of the Policy pertaining to Claim forms upon submitting to the Plan within the time limit specified above for filing Claims, written notice including the Covered Person's name, age, sex and identification card number, the name and address of the Provider, the diagnosis or diagnoses, a specific itemized statement of the services rendered, including all dates of service, and the Claim Charge. An expense will be considered to have been incurred on the date the service or supply for which the Claim is made was rendered or received.
3. Failure to furnish a Claim to the Plan within the time limit specified above for filing Claims shall not invalidate or reduce any Claim if it were not reasonably possible to furnish the Claim within such time limit, provided such Claim is furnished to the Plan, as soon as possible and in no event, except in the absence of legal capacity, later than one (1) year from the time the Claim is otherwise required.

I. Payment of Claims and Assignment of Benefits

1. Under the Policy, the Plan has the right to make benefit payment either to the Covered Person or directly to the Provider of Covered Services. For example, the Plan may pay benefits to the Covered Person if such Covered Person receives Covered Services from a Non-Plan Provider. The Plan is specifically authorized by the Covered Person to determine to whom any benefit payment should be made.
2. Once Covered Services are rendered by a Provider, the Covered Person has no right to request the Plan not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, the Plan will have no liability to the Covered Person or any other person because of its rejection of such request.
3. A Covered Person's claim for benefits under the Policy is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person. Coverage under the Policy is expressly non-assignable and non-transferable and will be forfeited if the Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

J. Covered Person/Provider Relationship

1. The choice of a Provider is solely the choice of the Covered Person and the Plan will not interfere with the Covered Person's relationship with any Provider.
2. It is expressly understood that the Plan does not itself undertake to furnish Hospital or medical service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. The Plan is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services are not provided by the Plan and can only be legally performed by a Provider. Any contractual relationship between a Physician and a Plan Provider shall not be construed to mean that the Plan is providing professional service.
3. The use of an adjective such as Plan or Participating in modifying Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Plan, Participating or any similar modifier or the use of a term such as Non-Plan or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
4. Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to any Policyholder (other than as an individual Covered Person) or any Policyholder's ERISA Health Benefit Program.

K. Agency Relationships

Nothing in the Policy shall be construed to constitute the Policyholder as an agent of the Plan. The Policyholder is the agent of the Covered Persons.

L. Medicare Secondary Payer ("MSP") Provisions

1. The MSP Law

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

a. Scope of the Statute:

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- i. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
- ii. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
- iii. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the MSP statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on “current employment status,” as defined in the MSP statute and regulations.

b. The Non-Discrimination Provisions: Age and Disability:

The MSP statute prohibits GHPs from “take[ing] into account” that an individual covered by virtue of “current employment status” is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that “carves out” Medicare coverage (commonly known as a “carve-out” policy), or which supplements the available Medicare coverage (commonly known as “Medicare supplemental” or “Medigap” policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, “Medigap” and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on “current employment status,” and thus the MSP provisions do not apply.

c. ESRD:

The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP must pay primary for all covered health

care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., “carve-out”) or “Medigap” coverage in this context.**

d. Policyholder Obligations:

It is the obligation of the Policyholder to ensure that Covered Persons covered by the MSP statute are not improperly enrolled in “carve-out” or “Medigap” coverage under this Policy.

2. The New Information System

Improved Information Gathering:

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

Under the system, the Plan will provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that CMS can better detect dual coverage situations.

The Policyholder understands that the Plan may provide CMS periodically the information identified below pertaining to Medicare-eligible Covered Persons under the Policy. The Policyholder further agrees to cooperate and to require and facilitate its employees’ cooperation in supplying the Plan the following information.

Information on Medicare-Eligible Covered Persons

- Beneficiary Name
- Date of Birth
- Sex
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Insured (e.g., Insured, spouse of Insured, child of Insured, other relationship to Insured)
- Reason for Medicare Entitlement (e.g., age, disability or ESRD)

Information on Insured

- Insured Name
- Social Security Number
- Individual Certificate Number of Insured
- Current Employment/Retirement Status
- Medicare Coverage Effective Date

- Medicare Coverage Termination Date
- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only)
- Coverage (e.g., individual, family, family but not spouse)

Information on the Policyholder/Employer

- Name and address of employer that pays the bill for coverage

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

Further, to assure the continuing accuracy of the Plan's files, the Policyholder agrees that it is the Policyholder's responsibility to notify the Plan promptly of any change in the size of the Policyholder's work force or status of its employees that might effect the order of payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Policyholder's work force that place it in, or take it out of, the scope of the MSP statute. If the Plan does not receive such information from the Policyholder, the Plan will assume that all relevant factors remain unchanged and will process claims accordingly. The Policyholder acknowledges and agrees that the Plan will be using the information provided by the Policyholder and Covered Persons to update the Plan's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

The Plan may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in this Policy shall be construed as obligating the Plan to continue its participation in the Data Match system.

3. Disclosure Statement

The Policyholder acknowledges that the Plan has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the BlueCross and BlueShield Association and reviewed by CMS, which administers Medicare.

M. ERISA

This Section (M.) applies to any Group Policy which implements any employee welfare benefit plan as defined by Section 3 (2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1. The Policyholder (or (i) if the Policyholder is a trust, the grantor of such trust or (ii) if the Policyholder is an association, each member of such association who pays premiums under such Group Policy) has established and as sponsor maintains pursuant to other written documents a health benefit program ("Policyholder's ERISA Health Benefit Program") through the purchase of insurance for the benefit of its eligible employees or eligible members and their dependents, which Policyholder's ERISA Health Benefit Program is an "employee welfare benefit plan" within the meaning of ERISA. Notwithstanding anything contained in the employee welfare benefit plan document of the Group (or any Group member, if the Group is an association), the Group agrees that no allocation or

delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Group (or any Group member, if the Group is an association) is effective with respect to or accepted by the Plan except to the extent specifically provided and accepted in the Policy or as otherwise accepted in writing by the Plan. The administrator under ERISA for a Policyholder's ERISA Health Benefit Program is the Policyholder or such other persons (other than the Plan) appointed by the Policyholder (or (i) if the Policyholder is a trust, by the grantor of such trust or (ii) if the Policyholder is an association, by each member of such association who pays premiums under such Group Policy). Nothing in a Policyholder's ERISA Health Benefit Program will affect the obligations of the Plan with respect to this Group Policy. The Plan will not be required to examine the provisions of a Policyholder's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.

2. The Policy is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Policy is an asset of the Policyholder. No assets of the Plan or amounts which have been paid to the Plan under the Policy are assets of or under Policyholder's ERISA Health Benefit Program.

N. Service Mark Regulation

On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Policyholder and the Plan. The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits the Plan to use the Blue Cross and Blue Shield Service Mark in the Plan's service area and the Plan is not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into the Policy based upon representations by any person other than authorized persons of the Plan and that no person, entity or organization other than the Plan shall be held accountable or liable to the Policyholder for any of the Plan's obligations to the Policyholder created under the Policy. This paragraph shall not create any additional obligations whatsoever on the part of the Plan, other than those created under other provisions of this Group Administration Document.

O. Applicable Law

It is the intent of the parties to the Policy that it is entered into, executed in and will be subject to and interpreted by the laws of the state of Illinois, and in the event of any controversy between the Policyholder and/or any Covered Person and the Plan, this provision will apply.

P. Incontestability

After the Policy has been in force two (2) years from the date of its issue, no statement of the Policyholder shall be used to void the Policy; and no statement by any Insured shall be used to reduce or deny a Claim after the insurance coverage, with respect to which a Claim has been made, has been in effect two (2) years or more.

Q. Limitations of Actions

No civil action shall be brought to recover under the Policy or any individual Certificate pursuant to the Policy, prior to the expiration of sixty (60) days after a Claim has been furnished to the Plan in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Plan. No extension of the time granted under the "Notice and Proof of Claim" Provisions of the Policy shall in any way extend this "Limitation of Actions" Provision.

R. New Insureds

There shall be added from time to time to the group or class originally insured under the Policy, all new Eligible Persons of the Policyholder, members of the association or employees

of members eligible for coverage and applying for coverage in such group or class in accordance with the terms of the Policy.

S. Physical Examinations and Autopsy

The Plan at its own expense shall have the right and opportunity to examine the person of a Covered Person when and as often as it may reasonably require during the pendency of a Claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

T. Reimbursement Provision

If an Insured or an Insured's covered dependent incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Certificate Booklet, the Insured shall agree:

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

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

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

U. Severability

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy, and this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

V. Proprietary Materials

The Policyholder acknowledges that the Plan has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). The Policyholder shall not use or disclose to any third party Business Proprietary Information without prior written consent of the Plan. Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Plan may include the Policyholder in its list of clients.

W. Information and Medical Records

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

ties hereunder, the Plan shall not disclose such confidential Claim information without the authorization of the Covered Person or as otherwise required or permitted by applicable law.

2. The Plan may release to the Policyholder Claim information regarding the provision of Covered Services to Covered Persons and copies of records to the extent required or permitted by applicable law, including but not limited to HIPAA. Any information so obtained by the Policyholder shall be kept confidential, as required by applicable law.
3. The Policyholder acknowledges that each Covered Person agrees it is the Covered Person's responsibility to ensure that any Provider, Blue Cross and Blue Shield Plan, insurance company, employee benefit association, governmental body or program, or any other person or entity having knowledge of or records relating to (1) any illness or injury for which a Claim or Claims for benefits are made under the Policy, (2) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Plan, or its agent, and agrees that any such Provider, person or other entity may furnish to the Plan or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Plan may furnish similar information and records (or copies of records) to other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or other entities providing insurance-type benefits requesting the same. It is also the Covered Person's responsibility to furnish to the Policyholder and/or Plan information regarding the Covered Person's becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status in order that the Plan be able to make Claim payments in accordance with MSP laws.

V. NOTICES

Any notice given or required under the Policy or any individual certificate will be a written notice by mail or telegraph. If such notice is given to the Policyholder, it will be addressed to it at its office address stated in the Benefit Program Application. If such notice is given to the Plan, it should be addressed to the Plan at its office at 300 East Randolph Street, Chicago, Illinois 60601-5099. If such notice is given by the Plan to a Covered Person, it will be addressed to the Covered Person at the address as it appears on the records of the Plan or in care of the Policyholder. The Policyholder and the Plan may, by written notice served on the other, indicate a new address for giving such notice.

VI. RENEWABILITY OF THE POLICY

The Policy shall be renewable with respect to all Covered Persons except in the following instances:

- A.** Non-payment of required premiums;
- B.** A fraudulent act or practice or intentional misrepresentation by the Policyholder;
- C.** Noncompliance with the Plan's minimum participation requirements;
- D.** Noncompliance with the Plan's employer contribution requirements;
- E.** Termination of the benefit plan in accordance with Section VII., below;
- F.** Covered Persons' movement outside the Plan's service area; or
- G.** Cessation of Policyholder's membership in a bona fide association, but only if coverage is terminated uniformly without regard to the health status of any Covered Person.

VII. DISCONTINUANCE OF A PARTICULAR PRODUCT

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

- A.** Provides ninety (90) days advance notice to the Policyholder and Covered Persons;
- B.** Offers the Policyholder an option to purchase other coverage offered to other employers of similar circumstance, including, but not limited to, employer size; and
- C.** Acts uniformly without regard to the claims experience of the Policyholder or the health status of any existing, new or potentially new Covered Persons.

VIII. POLICYHOLDER NOTIFICATION TO COVERED PERSONS

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

IX. TERM AND TERMINATION OF THE POLICY

- A.** The Policyholder may terminate this Group Administration Document or the entire Policy on the first Policy anniversary or on any premium due date after the first Policy anniversary by giving written notice to the Plan at least thirty (30) days in advance.
- B.** The Policy will be terminated, at the Plan's option, for the Policyholder's non-payment of the appropriate premium when due.

X. ELECTRONIC DATA AND DOCUMENTS

In the event the Policyholder and the Plan exchange various data and information electronically, the Policyholder agrees to transfer on a timely basis all required data to the Plan via electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Plan, a copy of which shall be furnished to the Policyholder upon written request to the Plan. The Policyholder authorizes the Plan to submit reports, data, and other information to the Policyholder in the specified electronic format. In the event the Policyholder is unable or unwilling to transfer data in the specified electronic format, the Plan is under no obligation to receive or transmit the data in any other format.

The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by the Plan to the Policyholder for delivery to each Insured. In the event the Plan, provides to the Policyholder an electronic file of any document describing the benefits under, or the administration of, the Policy for the Policyholder's use, including, but not limited to, the Policyholder's posting of such documents on the intranet and/or internet, the Policyholder acknowledges and agrees that such electronic file is not intended to meet the Policyholder's requirements for compliance under ERISA.

The Policyholder further acknowledges and agrees that it is solely responsible for providing employees access, via the intranet, internet, paper copy or otherwise, to the most current version of any electronic file provided to the Policyholder by the Plan. In addition, in all instances, the electronic file of the most current document issued to the Policyholder by the Plan for use by the Policyholder is the legal document used to administer the Policy and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Policyholder is solely responsible for, and holds the Plan harmless from, any and all claims for loss, liability or damages arising from the use or posting of the electronic file on the intranet and/or internet.

The Policyholder agrees to indemnify and hold harmless the Plan and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs), liability or claim that may arise from or in connection with the electronic transfer of data from the Policyholder or the Policyholder's third party consultant and/or vendor to the Plan or from the Plan to the Policyholder, pursuant to Section IV. E. of this Group Administration Document, the

Policyholder's third party consultant and/or vendor, including liability arising out of erroneous, mis-directed, intercepted, incomplete or otherwise defective information and transfers of information, including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmissions and for any claim arising from the Policyholder's use or posting of electronic files on the intranet and/or internet.

XI. DEFINITIONS APPLICABLE TO THIS GROUP ADMINISTRATION DOCUMENT

Additional definitions applicable to the Policy are contained in the Certificate Booklet and the Policyholder's Benefit Program Application.

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

"Benefit Program Application ("BPA")" means the document, through which the Policyholder has applied for health care insurance from the Plan and by which renewals and/or rate or other Policy changes are documented. The BPA may also include a benefit program and premium notification letter, applicable rate summary(ies) and a Benefit Program Application Change Form.

"Certificate Booklet" means the document issued by the Plan to the Policyholder, via an electronic file or access to an electronic file, if applicable, as specified on the BPA, for delivery to each Insured. The Certificate Booklet describes the health care benefit program purchased by the Policyholder and being administered by the Plan pursuant to the Policy.

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

"Claim" means notification in a form acceptable to the Plan that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis and the Claim Charge for such service.

"Claim Charge" means the amount which appears on a Claim as the Provider's charge for service rendered to a patient, without further adjustment or reduction and irrespective of any separate financial arrangement between the Plan and the particular Provider. (See Section IV. (A) of this Group Administration Document regarding the *Plan's Separate Financial Arrangements with Providers.*)

"Claim Payment" means the benefit payment calculated by the Plan, upon submission of a Claim, in accordance with the benefits specified in the Certificate Booklet plus any related Surcharges. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person, irrespective of any separate financial ar-

rangement between the Plan and the particular Provider. (See Section IV. (A) of this Group Administration Document regarding the *Plan's Separate Financial Arrangements with Providers.*)

“Coinsurance” means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

“Copayment” means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

“Coverage Date” means the date on which a Covered Person’s coverage under the Policy commences.

“Covered Person” means the Insured, and if Family Coverage is in force, the Insured’s dependents as follows:

- (a) The Insured’s legal spouse.
- (b) The unmarried children of the Insured or the Insured’s legal spouse, including newborn children, children who are under the Insured’s legal guardianship, children who are in the custody of the Insured pursuant to an interim court order of adoption or placement of adoption, whichever occurs first, vesting temporary care of the children in the Insured, and legally adopted children, who are under the Limiting Age specified in the Benefit Program Application.
- (c) Children, as specified in (b) above, who have attained such Limiting Age but are incapable of self-sustaining employment by reason of mental retardation or physical handicap and are dependent upon the Insured or other care providers for support and maintenance, provided such children were Covered Persons prior to attaining the Limiting Age. Once the Plan has been notified of a Covered Person’s disability and dependence, or from the date of the first Claim filed on behalf of such disabled and dependent Covered Person, it may require proof of such Covered Person’s disability and dependency at reasonable intervals. For purposes of providing benefits under the Plan, Covered Person does not mean any person who is eligible for Medicare except as specifically stated in the Certificate Booklet.

“Covered Service” means a service and/or supply specified in the Certificate Booklet for which benefits will be provided.

“Effective Date of Policy” means the date specified by the Policyholder in the Benefit Program Application.

“Eligible Person” means an employee of the Policyholder as defined in the Benefit Program Application.

“Eligibility Date” means the date on which an Insured becomes eligible for coverage under the Policy.

“Family Coverage” means coverage for an Insured and one or more other Covered Persons under the Policy.

“Group Number(s)” means the number(s) specified on behalf of the Policyholder in the Benefit Program Application.

“Individual Coverage” means coverage under the Policy for the Insured only.

“Insured” means the person employed by the Policyholder to whom coverage under the Policy has been extended by the Policyholder and to whom the Plan has directly or indirectly issued an identification card bearing the group number of the Policyholder. For purposes of providing benefits under the Policy, Insured does not mean any person who is eligible for Medicare and who has elected Medicare as his/her primary coverage except as specifically stated in the Benefit Program Application.

“Limiting Age” means the age specified in the Benefit Program Application at which coverage is automatically terminated for covered unmarried children.

“**Medicare**” means the programs established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

“**Medicare Secondary Payer**” (“**MSP**”) means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

“**Net Claim Payment**” means the net benefit payment calculated by the Plan, upon submission of a Claim, in accordance with the benefits specified in the Certificate Booklet plus any related Surcharges. All Net Claim Payments shall be calculated on the basis of the Provider’s Eligible Charge for Covered Services rendered to the Covered Person, less the ADP if applicable, irrespective of any separate financial arrangement between the Plan and the particular Provider. (See Section IV. A. of this Group Administration Document regarding the *Plan’s Separate Financial Arrangements with Providers.*)

“**Plan**” means Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company.

“**Policy**” means this Group Administration Document between the Plan and the Policyholder including any addenda attached hereto; the Certificate Booklet; the Benefit Program Application; the benefit program and premium notification letter, if any; the Benefit Program Application Change Form, if any; the applicable rate summary(ies), if any; and the Individual Applications, if any, of the Insureds.

“**Policyholder**” means the: (1) employing entity [corporation, partnership, sole proprietor or other employer], or (2) association, or (3) trust which has executed the Benefit Program Application for the Policy. An ERISA Health Benefit Program may not be a Policyholder hereunder, but a sponsor of or trust implementing an ERISA Health Benefit Program may be a Policyholder hereunder.

“**Provider**” means any health care facility, person or entity duly licensed to render Covered Services to a Covered Person.

- (a) “**Plan Provider**” means a Provider which has a written agreement with the Plan to provide services to Covered Persons at the time services are rendered to a Covered Person.
- (b) “**Non-Plan Provider**” means a Provider which does not meet the definition of Plan Provider unless otherwise specified in the definition of a particular Provider.
- (c) “**Medicare Participating Provider**” means a Provider which has been certified by the Department of Health and Human Services for participation in the Medicare Program.

“**Service Mark**” means the names BLUE CROSS and/or BLUE SHIELD and the associated logos, along with all related or derivative marks including, but not limited to, any Blue Cross or Blue Shield formulations or designs.

“**Surcharges**” means state or federal taxes, surcharges or other fees paid by the Plan which are imposed upon or resulting from this Group Administration Document.

XII. NOTICE OF ANNUAL MEETING

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

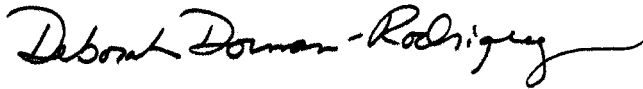
For purposes of the aforementioned paragraph the term “Member” means the group, trust, association or other entity to which this Policy has been issued. It does not include Insureds or Covered Persons under the Policy. Further, for purposes of determining the number of votes to

which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)."

IN WITNESS WHEREOF, the Plan hereby accepts the Benefit Program Application of the Policyholder.

Attest:

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



Secretary



President