CONTRACT FOR:

[GROUP NAME]

Group Number: [Group Number]

[Name of Plan] Medical Plan

CONTRACT for:

[Legal Name] (The name of the group purchasing the Contract)

Regence BlueShield, an independent licensee of the Blue Cross and Blue Shield Association, agrees to provide the health care benefits described in this Contract to eligible employees of the Group named above, and their eligible dependents, who become enrolled under this Contract. The benefits to be provided and all other terms and conditions are set forth in this Contract, including the attached Booklet.

In this Contract, the terms "We," "Us," and "Our" refer to Regence BlueShield and the term "Group" means the organization named above whose employees may participate under this coverage. "Enrolled Employee" means an employee of the Group who is eligible under the terms of this Contract, has completed an enrollment form and is enrolled under this Contract. "Enrolled Dependent" means an Enrolled Employee's eligible dependent who is listed on the Enrolled Employee's application, has completed an enrollment form and is enrolled under this Contract. The term "Member" refers to an Enrolled Employee or an Enrolled Dependent. Other terms are defined where they are first used or in the definitions section in the back of the Booklet.

IN WITNESS WHEREOF, We, by Our duly authorized officer, have executed this Contract.

[Signature Graphic]
Plan President Name
Plan President Title
Plan Name

Regence BlueShield Contract

This Contract, including the Group's application, the Booklet and any amendments, endorsements or riders and any subsequent renewals thereof is the entire understanding between the Group and Regence BlueShield concerning the subject matter of this Contract. It states all the terms of the coverage and supersedes and cancels all and any prior contracts issued to the Group by Us. No modifications of or additions to this Contract will be binding upon Us unless set forth in an amendment, endorsement or rider issued by Us and signed by one of Our authorized officers.

NON-GRANDFATHERED

This coverage is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

GROUP ELIGIBILITY

The Group must continuously satisfy the requirements of this section, this Contract and the Group's application in order to become enrolled and remain enrolled under this Contract.

Group Qualification

In order to qualify as an employer and to maintain eligibility for this employer health insurance Contract, the Group must be a bona fide person (including sole proprietors or self-employed individuals), firm, corporation (including Limited Liability Corporations, or LLCs), partnership (including Limited Liability Partnerships (LLPs)), labor union or political subdivision. In order to be eligible, a Group must:

- accept billing on a consolidated basis and collect any required employee contributions via payroll deductions;
- be actively engaged in legal business activity;
- be licensed to conduct business in the state and obtain other business licenses as required by law;
- provide workers' compensation insurance to all employees legally required to be so insured;
- have employed an average of at least one employee during the previous calendar year, and employ at least one employee on the first day of the plan year. In all cases, a bona fide employer-employee relationship must exist in order for a Group to be eligible; and
- have a status as a legal entity with authority to contract for health insurance coverage and not be formed primarily for purposes of buying health insurance.

Employer Contribution and Employee and Dependent Participation

Coverage under this Contract is contingent upon the Group satisfying all eligibility, participation, Group size, contribution and other requirements as specified in the Group's application. Note that when calculating the participation requirements, We count only eligible employees who are not already covered by existing qualifying coverage.

MEMBER ELIGIBILITY

The following sections describe employee and dependent eligibility under this Contract. The Group agrees that We have the right to examine employee records for purposes of confirming any Member's employment status.

EMPLOYEE ELIGIBILITY

To enroll and remain eligible under this Contract, an individual must meet **all of the following requirements** on a continuous basis (except that eligibility commences or continues while an employee is otherwise eligible but is confined to a Hospital, Skilled Nursing Facility or extended care facility):

- have begun performing personal services for the Group;
- be and remain a permanent, active, full-time employee of the Group working the required number of hours;
- be classified by the Group as its employee for all purposes, including determination of eligibility for coverage under the group health plan;
- be covered by workers' compensation insurance as required by law;
- be paid on a regular, periodic basis through the Group's payroll system;

- have federal and state taxes (including FICA) withheld via payroll deduction;
- be in an employer/employee relationship as defined by federal tax law;
- have completed any applicable probationary period as required by the Group;
- have contributions toward the cost of coverage (if any) withheld via payroll deduction; and
- not be classified as a part-time, leased, temporary, seasonal or substitute employee, or as an independent contractor or a person whose earnings are reported on IRS Form 1099.

DEPENDENT ELIGIBILITY

Eligible dependents, which are described in detail in the Booklet, include an Enrolled Employee's legal spouse or qualified domestic partner and children of the Enrolled Employee or qualified domestic partner.

TERM, MODIFICATION, TERMINATION

Term

This Contract goes into effect on **[{**Month - spell out**}** dd, yyyy**]**. This is the Contract Effective Date. The date this Contract is renewed is the Renewal Date. The Renewal Date is **[{**Month - spell out**}** dd**]** of each year. The Contract will remain in effect from one Renewal Date to the next unless otherwise terminated as described in the "renewal and termination" provision.

Modification

We have the right to modify or amend any provision of this Contract, including premium rates, on any Renewal Date by giving the Group at least 30 days (or longer, as required by law) advance written notice. No modification or amendment will be effective until at least 30 days after such advance notice has been given. Any modification will be uniform within the product line and at the time of renewal.

However, when a change in the Contract is beyond Our control (e.g., legislative or regulatory changes take place, the Group size increases or decreases by ten or more percent or the Group initiates a benefit change), We may modify or amend the Contract on a date other than the Renewal Date, including changing the premium rates, as of the date of the change in the Contract. We will give the Group prior notice of a change in premium rates when feasible. If prior notice is not feasible, We will notify the Group in writing of a change of premium rates within 30 days after:

- the later of the effective date or the date of Our implementation of a statute or regulation;
- the Premium Due Date following Our knowledge of a Group size change of ten percent or more; or
- reaching agreement with the Group on a Group-initiated benefit change.

Provided We give notice of a change in premium rates within the above period, the change in premium rates shall be effective from the date for which the change in the Contract is implemented, which may be retroactive.

Payment of new premium rates after receiving notice of a premium change constitutes the Group's acceptance of a premium rate change.

Changes can be made only through a modified Contract, amendment, endorsement or rider authorized and signed by one of Our officers. No other agent or employee of Ours is authorized to change this Contract.

Renewal and Termination

The Contract is renewable at the option of the Group, except that We may discontinue or nonrenew this Contract with no less than 30 days written notice if there is no longer any Member covered through the Group who lives, resides or works in Our service area or in the area in which We are authorized to do business.

We may also discontinue this Contract or coverage for a Member on any Premium Due Date with written notice and/or re-rate and collect any additional funds from the Group as follows:

- For the Group's failure to pay the required premiums by the end of the grace period (also see "Payment of Premiums" below).
- For fraud or intentional misrepresentation of material fact by the Group.

- For the Group's failure to provide Us annual census information or failure to respond to Our written request for current status information including group size, participation and contribution.
- For the Group's failure to comply with Our minimum participation requirements or employer contribution requirements.

In addition, if We choose to discontinue offering coverage in the small group (one through 50 employees) and/or large group (over 50 employees) market, We will provide 180-days prior written notice to affected groups and Members.

In the event We eliminate the coverage described in this Contract for the Group and all other enrolled groups, We will provide 90-days written notice to the Group and all Members covered through the Group. We will make available to the Group, on a guaranteed issue basis and without regard to the claims experience of the Group or health status of any Member covered through it, the option to purchase all other group coverage(s) being offered by Us for which the Group qualifies.

The Group may terminate this Contract on any Premium Due Date upon 35 days prior written notice to Us.

The Group shall provide each Enrolled Employee 30 days prior written notice of termination and notify the Enrolled Employee and Enrolled Dependents of any right which may exist to continue coverage upon termination.

Retroactive Termination of Members

The Group may not retroactively terminate a Member except in cases of fraud or intentional misrepresentation of material fact. However, it may be possible for the Group to retroactively terminate a Member, if all of the following conditions are met: 1) the Contract covers only active employees (or those on COBRA); 2) the Member has paid no premium for coverage after the effective date of the cancellation; 3) the Member had no expectation of coverage after the requested effective date of cancellation; and 4) the retroactive cancellation is due to a delay in administrative record-keeping that occurred in the normal course of business. If a Member for which the Group requests retroactive termination incurs expenses and We pay claims after the requested termination date, premium is due and must be paid for that Member for the monthly period in which claims are incurred.

PREMIUMS

The date the monthly premium is due is the Premium Due Date. The premium amount will usually depend on the number of persons in a family who are to be enrolled (e.g., a rate is charged based on whether one, two or three or more persons are covered). A group may instead use a single rate (called a unit rate) that does not change no matter how many people in a family are enrolled.

Payment of Premiums

The Group must pay Us the premium for each Member before the Premium Due Date for each month this Contract is in effect. The Premium Due Date is the first of each month, regardless of the date coverage became effective.

Nonpayment of Premiums

If the Group does not pay the premium for the Group or any Member by the Premium Due Date, We will send the Group a notice that the premium is overdue. If the Group does not pay Us within 30 days of the Premium Due Date (the grace period), the Group's or Member's coverage may end automatically and without further prior written notice on the last day of the monthly period through which premiums are paid. If termination for nonpayment of premiums is effective later than the last date for which premium has been received by Us, We shall be entitled to collect premium for the period between the last date through which premium was paid and the effective date of termination.

In the event this Contract ends for nonpayment of premium, it may be reinstated at Our option and only by Our written agreement. Unless reinstated, this Contract shall remain terminated regardless of the fact that after the termination date We send monthly billing statements to the Group or, for security purposes, deposit payments received from the Group.

Subject to the provisions of this Contract, no person shall be entitled to coverage under this Contract during any period of time for which payment of the required premium on his or her behalf has not been made. Receipt by Us of any sum on account for any individual not entitled to coverage under this Contract during the period for which such premium has been paid shall not constitute Our acceptance of the individual.

Refunds of Premiums

If premiums are paid for someone who is not eligible for coverage, We shall refund the amount paid in error as long as no claims have been paid for expenses incurred during the period of noneligibility. If We have paid claims for the Member in question, premium is due and must be paid for that Member during the period in which claims are incurred.

In the event this Contract is terminated, We shall refund any unearned premiums to the Group. In the event this Contract is terminated because of material misrepresentation, We shall refund to the Group any unearned premiums less the amount of paid claims.

OUT-OF-AREA SERVICES

We have 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 the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Programs and presented to Us for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Contract are described generally below.

Typically, Members, when accessing care outside the geographic area We serve, obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from nonparticipating Providers. Our payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard Program, when Members access Covered Services within the geographic area served by a Host Blue, We will remain responsible to the Group for fulfilling Our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, Our action will be consistent with the spirit of this description.

Liability Calculation Method Per Claim

The calculation of the Member liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the participating Provider's billed covered charges or the negotiated price made available to Us by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's health care Provider contracts. The negotiated price made available to Us by the Host Blue may represent a payment negotiated by a Host Blue with a health care Provider that is one of the following:

- An actual price. An actual price is a negotiated payment without any other increases or decreases, or
- An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- An average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its health care Providers or a similar

classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to Providers or anticipated to be paid to or received from Providers). However, the amount paid by the Member is a final price; 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 Blue to Us is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

In some instances federal law or the laws of a small number of states may require Host Blues either (i) to use a basis for determining Member liability for covered medical expenses that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should either federal law or the law of the state in which health care services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, We would then calculate Member liability in accordance with applicable law.

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, health care Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue 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, the Member's claim for Covered Services may be processed through a negotiated national account arrangement with a Host Blue.

If We have arranged for (a) Host Blue(s) to make available (a) custom health care Provider network(s) in connection with this Contract, then the terms and conditions set forth in Our negotiated national account arrangements with such Host Blue(s) shall apply.

Member liability calculation will be based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price above) made available to Us by the Host Blue that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Our service area.

Nonparticipating Providers Outside Our Service Area

- Member Liability Calculation. When Covered Services are provided outside of Our service area by nonparticipating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's nonparticipating Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.
- Exceptions. In some exception cases, We may pay claims from nonparticipating Providers outside of Our service area based on the Provider's billed charge, such as in situations where a Member did not have reasonable access to a participating Provider, as determined by Us or by applicable state law. In other exception cases, We may pay such a claim based on the payment We would make if We were paying a nonparticipating Provider inside of Our service area, as described elsewhere in this Contract, where the Host Blue's corresponding payment would be more than Our in-service area nonparticipating Provider payment, or We may negotiate a payment with such a Provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating Provider bills and payment We will make for the Covered Services as set forth in this paragraph.

GENERAL PROVISIONS

Group Responsibilities

The Group agrees to the following:

- Handle and distribute enrollment materials in a timely manner and promptly provide to Us the information necessary to administer this Contract. There is an understanding and agreement that the Group's failure to provide information in a timely manner may substantially delay and/or jeopardize the enrollment of eligible Members.
- Restrict enrollment and payment of premiums through the Group to eligible Members.
- Make payroll deductions for and verify with Us the eligibility of any Member on a temporary leave of absence.
- Remit premiums for a terminating Member through the end of the monthly coverage period in which the Member terminates (except as provided under Refund of Premiums), unless otherwise agreed in advance in writing.
- Delete terminations from the billing and to notify Us of terminations in a timely manner and as part of the administrative record-keeping process that occurs in the normal course of business. The Group further agrees that any refund of the number of months of premiums paid by the Group in error or for an ineligible Member shall be made only if claims have not been paid.
- Provide each Member 30 days prior written notice of termination of this Contract, including any termination due to the Group's failure to pay premiums.
- Notify each Member of any right(s) that may exist to continue coverage upon termination, as provided by any applicable law or as otherwise described in the Booklet, and collect and forward associated timely enrollment forms and premiums.
- Provide those notices, in a timely manner, that a group health plan is required by law to provide (e.g., notices of a plan's preexisting condition exclusion or special enrollment rights provisions). The Group agrees to indemnify and hold Us harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to its failure to provide such legally-required notices.
- Report monthly the names of new Members, cancelled Members and Members electing any statutory continuance of coverage.
- Maintain workers' compensation coverage for all Members, as required by law.
- Maintain Group eligibility in accordance with the minimum standards of applicable statutory continuances of coverage, unless We have agreed in advance and in writing to the Group's use of standards more generous to Members.
- If We provide Our enrollment and/or change forms ("Forms") and/or any summary plan descriptions, benefit summaries and/or comparison sheets ("Documents") in an electronic medium for inclusion on the Group's internal intranet or by similar means, Group agrees that:
    - electronic access shall be limited to the Group's enrolling employees and covered employees and be restricted to a "read-only" or similar basis;
    - they will replace any hard-copy Forms that have been modified by Us;
    - the hard-copy documents on file with Us shall control in the event of any discrepancy; and
    - the Group remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g., distribution).

Notice Under This Contract

Any notice required under this Contract shall be deemed to be properly given if written notice is deposited in the United States mail or with a private mail carrier. Notices to an Enrolled Employee or to the Group shall be addressed to the Enrolled Employee or to the Group at the last known address appearing in Our records. If We receive a United States Postal Service change of address form for an Enrolled Employee, We will update Our records accordingly. Additionally, We may forward any notice for an Enrolled Employee to the Group administrator if We become aware that We do not have a valid mailing address for the Enrolled Employee.

Any notice to Us will not be deemed to have been given to and received by Us until physically received by Us. Notices the Group gives to Us must be sent to Us at Our principal mailing address of:

Regence BlueShield
P.O. Box 30271
Salt Lake City, UT 84130-0271

Choice of Forum
Any legal action arising out of this Contract must be filed in a court in the state of Washington.

Governing Law and Benefit Administration
The Contract will be governed by and construed in accordance with the laws of the United States of America and by the laws of the State of Washington without regard to its conflict of law rules. We are not the plan administrator, but are a health care service contractor that provides health care coverage to this benefit plan, and makes determinations for eligibility and the meaning of terms subject to Member rights under this benefit plan that include the right to appeal, review by an Independent Review Organization and civil action.

Arbitration
Any controversy or claim between the Group and Us arising out of or relating to this Contract, or the breach thereof, whether involving a claim in tort, contract or otherwise, shall be subject to final resolution through binding arbitration. The parties agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in King County, Washington, unless mutually agreed otherwise by the parties.

If any Member or former Member (or person claiming to be a Member or former Member) makes any claim or brings any action or proceeding arising out of or relating to this Contract to which We or the Group become a party, We and/or the Group agree to cooperate in the defense of such claim, action or proceeding and to resolve any controversy or claim between Us and the Group through arbitration under this paragraph only after the resolution of the Member's (or alleged Member's) claim.

No Waiver
The failure or refusal of either party to demand strict performance of this Contract or to enforce any provision will not act as or be construed as a waiver of that party's right to later demand its performance or to enforce that provision. No provision of this Contract will be deemed waived by Us unless such waiver is reduced to writing and signed by one of Our authorized officers.

Representations Are Not Warranties
In the absence of fraud, all statements made in an application by the Group or an enrollment form by an enrolled person shall be deemed representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written document signed by the Group or the enrolled person, a copy of which has been furnished to the Group or the enrolled person.

Our Receivership or Liquidation
If receivership or liquidation proceedings are commenced with respect to Us, and if this Contract has not otherwise been terminated, then the Group may suspend all further performance of this Contract pursuant to any applicable provisions of federal or state law. Any such suspension or further performance by the Group pending the assumption or rejection of the Contract shall not be deemed a breach of the Contract and shall not affect the Group's right to pursue or enforce any of the rights under this Contract or otherwise.

Funding
The Group shall adopt policies and procedures regarding the funding of the Group's payment obligations under this Contract. This includes the withholding of premiums by payroll deduction from Enrolled Employees' wages and/or the payment of the Group's contributions from the general assets of the Group. Amounts paid (either directly or withheld by payroll deduction) by Members for benefits under the plan

shall be used for the exclusive benefit of the Members and neither the Group nor the ERISA plan administrator shall divert such amounts for any purpose other than for the payment of the Group's obligations hereunder. Amounts paid (either directly or withheld by payroll deduction) by Members shall be transferred to Us by the Group prior to the payment of Group contributions from the general assets of the Group.

RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD ASSOCIATION

The Group on behalf of itself and its Members hereby expressly acknowledges its understanding that the Contract constitutes an agreement solely between the Group and Regence BlueShield, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association), permitting Us to use the Blue Shield Service Mark in the state of Washington, for those counties designated in Our Service Area, and that We are not contracting as the agent of the Association. The Group on behalf of itself and its Members further acknowledges and agrees that it has not entered into the Contract based upon representations by any person or entity other than Regence BlueShield and that no person or entity other than Regence BlueShield will be held accountable or liable to the Group or the Members for any of Our obligations to the Group or the Members created under the Contract. This paragraph will not create any additional obligations whatsoever on the part of Regence BlueShield other than those obligations created under other provisions of the Contract.

Certificates of Creditable Coverage

We will provide certificates of creditable coverage to Members terminating from the Group, unless the Group specifically notifies Us in writing that it will provide such certificates of creditable coverage to terminating Members. The Group understands and agrees that Our timely provision of certificates of creditable coverage depends upon the Group's prompt deletion of terminating Members from the Group's billing. It agrees to indemnify and hold Us harmless from any damages, loss, action, claim or suit (including court costs and attorney's fees) arising from or related to Our failure to provide a certificate of creditable coverage in a timely manner as a result of the Group's failure to promptly delete a terminating Member from the Group's billing.

Group Is Agent

The Group is the agent of the Members for all purposes under this Contract and not the agent of Regence BlueShield. Members are entitled to health care benefits pursuant to this agreement between Us and the Group. The Group agrees to act as agent for Members in acknowledging their agreement of the terms, provisions, limitations and exclusions contained in this Contract and the Booklet.

Medication Rebate

We participate in arrangements with medication manufacturers that allow Us to receive rebates based on the volume of certain prescription medications purchased on behalf of Members. Any rebates We receive from medication manufacturers are credited to reduce rate increases. We will withhold a percentage of the total rebate to cover Our costs of collecting and administering the rebate program.

COBRA CONTINUATION OF COVERAGE

This section applies only when the benefit plan is subject to the continuation of coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Certain circumstances, called qualifying events, give Members the right to continue this coverage beyond the time it ordinarily would have ended. COBRA continuation rights and obligations are governed by the COBRA law, as amended, and if there is any conflict between the provisions of this Contract and COBRA, COBRA's minimum requirements will govern. This section will automatically cease to apply when federal law requiring COBRA continuation no longer applies to the benefit plan. This section does not provide a full description of COBRA.

Who Is Eligible for COBRA Continuation and How Long it Lasts

If an Enrolled Employee's health coverage eligibility ends due to either of the following qualifying events, the Enrolled Employee may elect COBRA continuation coverage lasting up to 18 months after his or her coverage normally would have been lost:

- termination of the Enrolled Employee's employment (except termination for gross misconduct); or
- reduction in the Enrolled Employee's hours of employment.

Enrolled Dependents whose health coverage eligibility ends due to either of these qualifying events also may elect COBRA Continuation Coverage lasting up to 18 months.

If health coverage eligibility for any Enrolled Dependents ends due to any of the following qualifying events, those Enrolled Dependents may elect COBRA Continuation Coverage lasting up to 36 months after their coverage normally would have been lost:

- the Enrolled Employee's death;
- the Enrolled Employee dissolves his or her marriage (divorces) or terminates his or her domestic partnership;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the enrolled child loses eligibility as a child under this Contract.

By electing COBRA continuation, unless Enrolled Employees specify to the contrary, Enrolled Employees automatically continue benefits for themselves and their Enrolled Dependents. If COBRA continuation coverage is not desired for an Enrolled Employee or any Enrolled Dependent, each Member may independently elect such coverage on behalf of him or herself. Any election by the Enrolled Employee's spouse automatically continues coverage of the enrolled children, unless specified to the contrary.

COBRA continuation is available to domestic partners and their children on the same basis as it is available to a spouse and stepchild of an Enrolled Employee.

COBRA coverage following a termination of employment/reduction in hours qualifying event can be extended to a maximum of up to 29 total months if one of the Members in the family is determined to have been disabled for purposes of Title II or Title XVI of the Social Security Act at the time of the initial qualifying event or within the first 60 days of COBRA continuation coverage. To be eligible for the extension, a Member must provide the Group documentation of the Social Security Administration's disability determination within 60 days of the date it is made and while still within the 18-month continuation period. The disability extension extends to the family unit, even if only one of the Members is disabled.

An 18-month period of COBRA continuation following a termination of employment/reduction in hours qualifying event (or a 29-month COBRA continuation period involving such a termination/reduction followed by a disability extension) may be extended to a total period of up to 36-months for an Enrolled Dependent whose health coverage otherwise would end because of any of the following "second" qualifying events occurring within the first 18-month (or, if there has been a disability extension, 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee dissolves his or her marriage (divorces) or terminates his or her domestic partnership;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the enrolled child loses eligibility as a child under this Contract.

An event is only a "second" qualifying event if it would have ended the Member's health coverage eligibility if the original termination of employment/reduction of hours qualifying event had not already occurred. Except with regard to employer Chapter 11 bankruptcy as described below, in no event will COBRA continuation extend more than 36 months from the date coverage normally would have been lost due to the termination of employment/reduction in hours qualifying event. Members must provide the Group notice of the occurrence of one of these "second" qualifying events.

If an Enrolled Employee Is Retired and the Employer Files Chapter 11 Bankruptcy

COBRA also allows continuation of coverage if the Enrolled Employee is retired, the Group files a Chapter 11 bankruptcy petition, and a Member experiences a loss of coverage (or substantial reduction in coverage) within one year before or after the bankruptcy filing. Retired employees, and widows or

widowers of retired employees who died before the bankruptcy, may continue coverage for the remainder of their lifetimes. If the Enrolled Employee is retired and dies after the bankruptcy, Enrolled Dependents may continue coverage for up to 36-months after the Enrolled Employee's death.

If an Enrolled Employee Becomes Entitled to Medicare Before Electing COBRA

If the Enrolled Employee becomes entitled to Medicare before electing COBRA in connection with employment termination or a reduction in hours qualifying event, he or she may maintain both Medicare and up to 18-months of COBRA coverage and Enrolled Dependents may continue their COBRA coverage, until the later of:

- up to 18-months from the date coverage otherwise would be lost due to the termination of employment/reduction in hours; or
- up to 36-months from the date the Enrolled Employee became entitled to Medicare.

When COBRA Continuation Coverage Ends

COBRA continuation ends for Members as of the last day of the monthly premium payment period in which any of the following occurs:

- failure to make premium payments necessary to bring premiums current within 45 days of electing COBRA;
- failure to make the monthly premium payment within 30 days of its due date;
- the date, after election of COBRA, that a Member becomes covered by another group health plan that does not limit or exclude any preexisting condition the person might have (either because of no applicable preexisting condition or sufficient creditable coverage to eliminate any preexisting condition limitation), or become entitled to Medicare benefits;
- the date, after election of COBRA, that a Member becomes entitled to Medicare benefits;
- the date this Contract terminates; or
- the applicable period of COBRA continuation ends.

COBRA continuation will also end for Members when there is a final determination that a Member is no longer disabled for the purposes of Title II or Title XVI of the Social Security Act. In that case, COBRA continuation ends as of the later of:

- the last day of 18 months of continuation coverage; or
- the first day of the month that is more than 30 days following the date of the final determination of the nondisability.

This event terminates the continuation of all Members who had qualified to extend by virtue of the Member's disability. It's the Member's responsibility to notify the Group of such a final determination within 30 days of the day it is made.

When an Enrolled Employee Acquires a New Child While on COBRA

Children born to or placed for adoption with the Enrolled Employee while the Enrolled Employee is on COBRA may be added to COBRA coverage and have all the rights extended to Members who have elected COBRA. Addition of such children must occur in accordance with the terms of the "Who Is Eligible" section of the Booklet.

Notification Responsibilities

In order to preserve rights under COBRA, Members and the Group must meet certain notification, election and payment deadline requirements. It is therefore very important that Members keep the Group informed of the current address of all persons who are or may become qualified beneficiaries.

Members must inform the Group in writing within 60-days of divorce or legal separation, or a loss of eligibility of a child. The Group is responsible for notifying Members of the right to elect COBRA continuation due to any of the other qualifying events (for example, employee's death, termination of employment or reduction in hours or Medicare entitlement).

Once the Group is notified or aware of a qualifying event, it sends Members information concerning continuation options, including the necessary COBRA continuation election forms. Members have 60-days from the later of the date of the qualifying event or the date of the Group's notice to a Member in which to make an election.

As mentioned above, to be eligible for disability extension, a Member must provide the Group documentation of a Social Security disability determination within 60 days of the date it is made and while still within the 18-month COBRA continuation period following a termination or reduction of hours qualifying event. The determination must reflect that the Member was disabled for Social Security purposes at the time of the initial qualifying event or within the first 60-days of COBRA continuation. If a final determination is subsequently made that a Member is no longer disabled for Social Security purposes, the Member must provide the Group notice of that determination within 30 days of the date it is made.

To be eligible for an extension of the 18-month continuation that follows a termination of employment/reduction in hours qualifying event (or a 29-month COBRA continuation period involving such a termination/reduction followed by a disability extension), Members must notify the Group. Notification must occur within 30 days of the occurrence of any of the following "second" qualifying events causing a loss of coverage within that 18-month (or 29-month) period:

- the Enrolled Employee's death;
- the Enrolled Employee dissolves his or her marriage (divorces), terminates his or her domestic partnership or legally separates;
- the Enrolled Employee becomes entitled to Medicare benefits; or
- the enrolled child loses eligibility as a child under this Contract.

Paying Continuation Premium

If Members wish to continue coverage, they must pay for it. Premiums generally will reflect the total cost of the group health care coverage and up to a 2 percent administration fee. For Members who receive COBRA Continuation Coverage due to a Social Security disability determination, premiums and administration fees will be up to 150 percent of the total cost for coverage for the period of the disability extension (provided the disabled individual is among those continuing coverage). Coverage ceases if timely premium payments are not made. Members have a maximum of 45 days from the date that the election form is mailed to the Group to submit the first payment. This first payment must retroactively cover any period of time after the date coverage was terminated. All subsequent payments are due on the first day of the month for which coverage is to be provided or within a 30-day grace period thereafter.

If Members Do Not Elect COBRA Continuation

If Members do not elect COBRA continuation coverage, coverage will end according to the terms of this Contract and We will not pay claims for services provided on and after the date coverage ends. If Members do not elect and exhaust COBRA continuation coverage, they may jeopardize their future eligibility for an individual plan.

MEDICARE SECONDARY PAYOR RULES

The federal government has adopted Medicare secondary payer (MSP) rules for determining which are the primary and secondary payers when a Member is covered under both Medicare and a group health plan. The rules depend on:

- whether the Medicare eligible person is active or retired (or the spouse of such person);
- whether the person has Medicare because of reaching age 65, disability or end stage renal disease; and
- the size of employer sponsoring the group health plan.

In order to administer claims in compliance with the MSP rules, We need to know certain information. Accordingly, the Group must advise Us in writing within 30 days of a change in the number of employees as described in the following bulleted paragraphs:

- When the number of employees in a "current employment status" according to federal regulations increases to 20 or more, or decreases below 20. For purposes of this calculation, the Group will be considered to employ 20 or more employees if it has had 20 or more full- or part-time employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
- When the number of employees in a current employment status increases to 100 or more or decreases below 100. For purposes of this calculation, the Group will be considered to employ 100 or more employees if it had 100 or more full- or part-time employees on 50 percent or more of its regular business days in the previous calendar year.
- When an employee retires and eligibility under this Contract allows retired employees to remain enrolled.

The Group shall be responsible for claim amounts or penalties payable to the federal government resulting from noncompliance with the MSP rules caused by its failure to give Us notice of a Group size change under this provision.

ERISA

If this Contract is part of an employee welfare benefit plan regulated under the Employee Retirement Income Security Act of 1974 as amended (ERISA):

- The Group intends that this Contract be maintained for the exclusive benefit of the employees.
- The Group intends to continue this coverage indefinitely, but it also reserves the right to discontinue or change this coverage at any time. If the Group terminates this Contract for any reason and does not replace the coverage with comparable benefits, employees will receive ample notice. Employees will also receive instructions for converting their coverage to an individual plan.

Employees are entitled to certain rights and protection under ERISA. ERISA provides that all employees shall be entitled to:

- Examine without charge, at the plan administrator's office, all policy documents, including insurance policies and copies of certain documents filed by the plan administrator with the U.S. Department of Labor, such as detailed annual reports and policy descriptions.
- Obtain copies of documents governing the operation of the benefit plan upon written request to the plan administrator. The plan administrator may charge a reasonable fee for the copies.
- Continue, generally at their own expense, health care coverage of themselves, their spouses and children if coverage ends due to certain qualifying events. (Although ERISA does not extend continuation rights to employee's domestic partners and domestic partners' children, this Contract provides those individuals comparable rights if their coverage ends due to certain qualifying events.) Review the summary plan description and governing documents of the plan for rules and other details about such COBRA continuation rights.
- Reduce or eliminate periods that coverage for preexisting conditions is excluded under this Contract, providing they have creditable coverage from another benefit plan. Group plans and health insurance issuers should provide a certificate of creditable coverage, free of charge, when an employee loses that other coverage, when he or she becomes entitled to elect COBRA continuation under it, when COBRA continuation is exhausted, and if an employee requests one within 24 months after losing that other coverage. Without evidence of creditable coverage, an employee may not have coverage for preexisting conditions for up to nine months after the participant's Enrollment Date in this coverage.

In addition to creating rights for employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the benefit plan, called "fiduciaries," have a duty to do so prudently and in the interest of employees and their dependents. No one, including the employer, or any other person, may fire an employee or otherwise discriminate against one in any way to prevent an employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

If an employee's claim for a welfare benefit is denied (or ignored) in whole or in part, he or she must receive a written explanation of the reason for the denial. Employees have the right to obtain copies of related documents without charge and to appeal any denial within certain time frames. Under ERISA, there are steps they can take to enforce the above rights. For instance, if an employee requests certain materials from the plan administrator in writing and does not receive them within 30 days, the employee may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay an employee up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court. An employee may also do so if he or she disagrees with a decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order. If it should happen that fiduciaries misuse money, or if employees are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If an employee is successful, the court may order the person who an employee has sued to pay these costs and fees. If an employee loses, the court may order the employee who sued to pay these costs and fees, for example, if it finds the claim frivolous. If an employee has any questions about the benefit plan, he or she should contact the plan administrator. If an employee has any questions about this statement or his or her rights under ERISA, or if he or she needs assistance obtaining documents from the plan administrator, the employee should contact the nearest Field Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in the telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. Employees can also obtain publications about their ERISA rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.