

GROUP INSURANCE POLICY

issued by

WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA

GROUP INSURANCE POLICY

THIS GROUP INSURANCE POLICY (herein "**Agreement**") is issued by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, an Iowa mutual insurance company, (herein "**Wellmark**") to Account.

RECITALS

1. Account is the plan sponsor and plan administrator of either a small group health plan or a large group health plan within the meaning of and in accordance with applicable federal or state law for its common law employees and other eligible individuals and this Agreement is issued to Account as the "group policyholder".
2. Account desires that Wellmark provide group health insurance and services for its small group health plan or large group health plan and Wellmark is willing to provide such insurance and services subject to the terms and conditions set forth herein.

NOW, THEREFORE, it is hereby agreed as follows:

ARTICLE 1 AGREEMENT DEFINITIONS

- 1.1 "**Affordable Care Act**" or "**ACA**" means the Patient Protection and Affordable Care Act, enacted March 23, 2010, and the Health Care and Education Reconciliation Act, as amended, (collectively, "**ACA**"), including implementing regulations.
- 1.2 "**Agreement**" means this Group Insurance Policy, including any schedules, Exhibits, Benefits Document(s), amendments, employer contribution information form, Plan Member enrollment form(s), and any COBRA Administrative Services Agreement or Addendum.
- 1.3 "**Applicable Law**" means applicable federal statutes, regulations, and regulatory guidance, as well as applicable statutes, regulations, and regulatory guidance enacted, promulgated or issued by the state identified in section 9.10. Applicable Law may include, but is not limited to, ERISA, the ACA, HIPAA, COBRA, federal mental health parity requirements, the Transparency in Coverage final rule (85 Fed. Reg. 72158), the federal No Surprises Act, and the Consolidated Appropriation Act, 2021 ("**CAA**").
- 1.4 "**Benefits Document**" means the written document(s) available to Members that describe and define the terms, benefits, and limitations of the Plan and may be titled Benefits Certificate, Coverage Manual, or something similar. Account may at its option incorporate the Benefits Document into its ERISA Summary Plan Description.
- 1.5 "**Claims Paid**" means the dollar amount of Wellmark's payment for Incurred Claims.
- 1.6 "**COBRA**" means the group health coverage continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, including implementing regulations and similar state or federal laws.

- 1.7 **“Confidential Information”** means all non-public confidential or proprietary information, in any form, delivered or made available or otherwise accessed, collected, processed, stored, or transmitted (whether pursuant to this Agreement or otherwise) by one party or its affiliates, directors, officers, employees and agents (the **“Disclosing Party”**) to the other party, its affiliates, directors, officers, employees and agents (the **“Receiving Party”**). Confidential Information shall include, but not be limited to, Member information (including names, addresses and Social Security numbers), Protected Health Information, personally identifiable information, medical records, Plan claims data, payment data, and Wellmark Confidential Information. Confidential Information shall not include information which (a), at the time of disclosure, is available to the general public; (b) becomes at a later date available to the general public through no fault of Receiving Party and then only after such later date; (c) Receiving Party can demonstrate was in its possession before receipt from Disclosing Party; (d) Receiving Party can demonstrate was independently developed; or (e) is disclosed to Receiving Party without restriction on disclosure by a third party who has the lawful right to disclose such information.
- 1.8 **“Covered Charges”** means the dollar amount a health care provider bills a Member or Wellmark for Covered Services in accordance with the terms of the Benefits Document.
- 1.9 **“Covered Services”** means the medically necessary health care services provided to a Member as described in and covered by the applicable Benefits Document.
- 1.10 **“Effective Date”** means the date (beginning at 12:01 a.m., local time) specified on the group enrollment forms signed by the Account. This Agreement supersedes any prior Agreement issued by Wellmark to Account for the Plan.
- 1.11 **“Employer Consulting and Well-being Services”** means certain information and tools meant to help Members improve health, increase productivity and decrease absenteeism, and/or assisting employers with creating well-being solutions or wellness programs at their worksites for their Members. These services may include an online wellness center and wellness assessment; paper wellness assessment; telephonic health coaching; wellness screenings (biometrics); tobacco cessation coaching; wellness challenges; health program referrals; or debit card redemption.
- 1.12 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended, including implementing regulations.
- 1.13 **“Grandfathered Health Plan”** or **“Non-Grandfathered Health Plan”** mean the same as such terms are used in the ACA.
- 1.14 **“Health Services”** means educational and informational care management services Wellmark may provide to Members designed to encourage Members’ good health and help them make better health care decisions. Health Services are not clinical services. These services may include, but are not limited to, BeWell 24/7, pregnancy support, care management, or other programs.
- 1.15 **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended, including implementing regulations.
- 1.16 **“Host Blue”** means the local Blue Cross and/or Blue Shield plan or licensee in a geographic area outside of the Wellmark service area.

- 1.17 **“Incurred Claims”** means claims for payment of health care services that are provided to Members pursuant to the Plan with a date of service within the period of time this Agreement is in effect.
- 1.18 **“Incurred Date”** means the date health care services are provided to Members. With regard to inpatient hospital or facility services, the date of the Member's admission to the facility is considered as the Incurred Date.
- 1.19 **“Maximum Allowable Fee”** means a dollar amount Wellmark establishes using various methodologies for Covered Services and supplies. For Covered Services, this amount is developed from various sources, such as charges billed for the same service or supply by most health care providers within Iowa, economic indicators, or relative value indices developed or approved by Wellmark, and is based on the network participation and simplicity or complexity of the service provided. For medical services received outside of Iowa or South Dakota, the Maximum Allowable Fee is either determined in accordance with the section of this Agreement entitled Out-of-Area Services or is the amount as described in the preceding sentence.

For all dental procedures covered under this Agreement, the fee schedule is developed based on Wellmark's contracts with dentists, input from its dental consultants, and the charges billed for the same procedure by dentists in Iowa.

- 1.20 **“Member”** means a person, including a Plan Member's spouse or eligible dependent children, who is eligible and enrolled to receive health benefits under the terms of the Plan as determined and identified by Account, and as accepted by Wellmark.
- 1.21 **“Plan”** means the group health plan or plans established, sponsored and maintained by Account, the terms of which are described in the applicable Benefits Document.
- 1.22 **“Plan Member”** means a common law employee or other individual identified by Account as a person eligible and enrolled to receive health benefits under the Plan subject to the terms, conditions, and limitations described in the Plan documents and who is the applicant on a completed enrollment form that has been provided to and accepted by Wellmark.
- 1.23 **“Plan Year”** means, for the purpose of implementing ACA requirements, either the twelve month period commencing on the Effective Date of Account health plan's annual renewal with Wellmark or an alternative twelve month period, as designated by Account and communicated to Wellmark. In the event that Wellmark has not received the Plan Year designation from Account, the Plan Year is determined in accordance with the following:
- a. The deductible/limit year used under the Plan;
 - b. If the Plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year;
 - c. If the Plan does not impose deductibles or limits on a yearly basis, and either the Plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is Account's taxable year; or

- d. In any other case, the plan year is the calendar year.
- 1.24 **“Protected Health Information” or “PHI”** means the same as the term “protected health information” in 45 CFR §160.103.
- 1.25 **“Wellmark Confidential Information”** means any Confidential Information with respect to Wellmark’s systems, procedures, methodologies and practices used by Wellmark in connection with claims processing, claims payment or utilization management, together with the fees, terms, claim specific financial data, including but not limited to allowed amount, coinsurance amount, copayment amount, deductible amount, dispensing fee paid, ingredient cost paid, amount paid, claims submitted paid amount; payment arrangements, discounts with providers and pharmacies, rebates, and related information, as well as any strategic and competitively sensitive information and trade secrets, policies, procedures, and processes of Wellmark, the Blue Cross Blue Shield Association and its licensees. Wellmark Confidential Information also includes all information and data collected or developed by Wellmark related to claims, cost, utilization, outcomes, quality, and financial performance of the Plan in connection with this Agreement.

ARTICLE 2 RESPONSIBILITIES OF ACCOUNT

- 2.1 **Group Health Plan Compliance.** Account is the plan administrator and plan sponsor of the Plan for purposes of this Agreement and Applicable Law, and is responsible for group health plan design, eligibility, and compliance. Account will exercise its responsibilities in the time required by law and has full responsibility for all of the following:
 - a. Maintaining the Plan as either a small group health plan or a large group health plan; notifying Wellmark of changes in Plan size; determining Plan design;
 - b. Determining eligibility criteria for Members subject to certain Wellmark enrollment guidelines, including the requirements for locations or Members located outside of Iowa; Account is responsible for enrolling and canceling individuals in the Plan in accordance with such criteria and agrees to terminate coverage promptly for ineligible individuals;
 - c. Designating the Plan Year for the Plan;
 - d. Complying with all Applicable Laws, reporting and disclosure requirements related to this Agreement and applicable to Account as sponsor of a group health plan, including compliance with any applicable non-discrimination laws in connection with the plan, including but not limited to the following: furnishing Members with Plan documents or notices as may be required by law, including the summary of benefits and coverage (“**SBC**”), any notice of material modification, employer notice of the availability of coverage options under the health insurance marketplace, and applicable HIPAA notices relating to health coverage portability such as the Special Enrollment Notice. Account will also: (i) make available to Members on request the uniform glossary of insurance-related terms; (ii) comply with any applicable non-discrimination laws in the design and administration of the Plan; (iii) comply with the Mental Health Parity and Addiction Equity Act (“**MHPAEA**”) including, without limitation, MHPAEA’s requirements on Non-

Quantitative Treatment Limitations on mental health and substance use disorder benefits; (iv) to the extent Account has a public website, post the machine readable file link supplied by Wellmark on its public website; (v) to the extent Account has a public website, comply with balance billing disclosure posting requirements under Applicable Law; and (vi) furnish all notices and fulfill all requirements with regard to COBRA continuation coverage for the Plan, except to the extent any COBRA administration requirements have been expressly delegated to and agreed upon with Wellmark in a COBRA Administrative Services Agreement or Addendum;

- e. Delivering or making available Benefits Document(s) to Plan Members;
- f. Providing to Wellmark written notice of benefit selections, limitations, and exclusions, changes in the benefits or Plan size at renewal, or material modifications at any time during the Plan Year. Account shall provide such notice(s) in the time and manner required by Wellmark to fulfill the issuance of SBCs, preparation of Benefits Documents, or issuance of other required notices within the time required by law. Account acknowledges that the number of medical plan options available to Account and its Plan Members is subject to Wellmark group eligibility and enrollment guidelines and may be dependent on the number of Plan Members enrolling in medical coverage;
- g. If the coverage of any Member is terminated retroactively, Account represents that it either has not collected any premium contribution from the retroactively terminated Member, or has refunded any premium contribution to the retroactively terminated Member, for the period following the effective date of the termination;
- h. Payment of any state premium tax, use tax, health insurer fee, or similar tax, or any similar benefit or Plan-related charge, tax, surcharge or assessment, however denominated, that may be assessed on the Plan or related to the administration of the Plan, including any penalties and interest payable with respect thereto;
- i. Compliance with any income and employment tax withholding, depositing, and reporting obligations (including state or federal income tax withholding, FICA tax withholding, employer, FUTA taxes, and Form W-2 wage reporting) applicable to rewards incentives or value-added benefits that may be provided under this employer-sponsored group health plan to Members covered under the Plan. Account is responsible for including the value of any such incentives or value-added benefits as reported by Wellmark to Account in the applicable employees' wages for federal or state income tax, employment tax, and Form W-2 reporting purposes; and
- j. If the Account has a Grandfathered Health Plan, Account shall provide Wellmark with written notice, at least sixty (60) days prior to the effective date, of any change in the employer contribution information or any other information that may impact the Grandfathered Health Plan determination. Upon any renewal of this Agreement, Account shall provide a written representation to Wellmark regarding Account's contribution rate for the Plan Year covered by the renewal.
- k. Supplying information requested by Wellmark in the time, form, format, and manner required by Wellmark to assist Wellmark in filing the reports identified in Section 3.1(g) on Account's behalf; provided, however, that Account must give

Wellmark notice by March 1st if Account will file all or any part of such reports due in that calendar year directly with the Centers for Medicare and Medicaid (“CMS”).

2.2 Payment of Premium; Automatic Funds Withdrawal; Interest Charges on Late Payments.

- a. Wellmark shall bill Account the applicable monthly premiums for each Member and Account agrees to pay to Wellmark, at Wellmark’s office, in advance and when due, the full premium amounts billed for such Members’ health coverage. Such payment may be made by wire transfer, check, electronic (ebilling) payment, or automatic funds withdrawal and must be received in Wellmark’s offices before 2:00 p.m. Central Time on the due date. If Account elects automatic funds withdrawal, it shall execute the necessary authorization. Any portion of the premium that is deducted from Plan Members’ wages, salaries or commissions, as authorized by such Plan Members, shall be held by Account and shall be promptly delivered to Wellmark.
- b. If Account elects to authorize automatic funds withdrawal from a deposit account, the automatic withdrawal shall change periodically to correspond with the applicable premium, service fee, and any other applicable taxes or fees. Account’s authorization for automatic funds withdrawal shall include authorization for automatic withdrawal of any changed amount unless Account calls or provides its bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. Account will be responsible for any fee assessed by the bank for stop-payment orders made by Account.
- c. If Account fails to make premium payments in full when due, Wellmark may terminate this Agreement as provided in Section 7.4, Termination for Nonpayment of Premium, and shall impose an interest charge on the past due premium from the due date until payment is made in full at the then current prime rate as published periodically in the Midwest edition of The Wall Street Journal plus two percent (2%) per annum. Late fees are calculated on the entire premium amount due regardless of any partial payments. If Account’s payment is returned for insufficient funds, Wellmark reserves the right to impose additional fees, to the extent the additional fees are permitted by Applicable Laws. The acceptance by Wellmark of any late premium payments or partial payments shall not constitute a waiver of any rights under this Agreement. If Account fails to make payments when due for two or more consecutive months, Wellmark may impose additional late fees of up to eighteen percent (18%) per annum.

2.3 Enrollment Information; Account Size; Social Security Number Reporting; Information Requirements.

- a. Account agrees to furnish Wellmark with reports, data, and information, including but not limited to, the number of employees for purposes of determining group size, eligibility, enrollment information, physical home address, and Social Security number for each Member, benefit selection or benefit changes for the Plan, and information necessary for the administration of the Plan. Account shall provide all such information in a time, form, format, and manner required by Wellmark and is responsible for the timeliness, integrity, retention, and accuracy of information and

records provided to Wellmark. Account represents to Wellmark that it has accurately reported the average number of full-time, part-time, and seasonal employees it employed on business days during the preceding calendar year regardless of eligibility for the Plan.

- b. Account acknowledges that IRS Form 1095-B must be provided annually to Members and to the IRS. To accomplish correct reporting, Account shall provide to Wellmark in the time and manner requested the Account's legal name, Employer Identification Number ("**EIN**"), and the names and Social Security numbers of all Plan Members and Members. Account's failure to provide the required information may result in tax penalties including a \$50 penalty per violation.
- c. Wellmark shall be entitled to rely upon such information in determining any person's rights to benefits under the Plan, in determining the availability or renewability of health plans that may be offered to Account, in making required filings with state or federal government agencies, and in discharging its responsibilities under this Agreement. Account recognizes that its timely, accurate, and complete reporting of the information set forth in this section is necessary for Wellmark to perform its obligations under this Agreement and should that reporting be inaccurate, untimely, or incomplete, Wellmark shall be excused from the performance of its services affected by such inaccuracy or delay.
- d. Account shall provide Wellmark with enrollment information in a standard medium and layout using Wellmark's proprietary format, the HIPAA ANSI 834 standard format, or an application such as BluesEnroll, unless the parties agree in writing to a non-standard format or application. Account acknowledges that it may be responsible for additional fees if it uses a non-standard format or if Wellmark is required to perform a comparison study of the full eligibility file.

2.4 **Account Representation Regarding Eligibility; Notice of Persons Eligible for Coverage; Changes in Eligibility.** Account represents to Wellmark that the terms of any eligibility criteria, conditions, and/or waiting period imposed under the Plan are, and shall be for so long as this Agreement is in effect, in compliance with all Applicable Laws, including specifically, the prohibition on excessive waiting periods. Account shall enroll persons eligible for coverage in the Plan in advance of each person's effective date of coverage and shall provide Wellmark with each person's name, Plan selection, Social Security number, and other required identifying information. Account shall provide all initial enrollment information in advance of the Effective Date of this Agreement. As new persons become eligible, or as eligibility changes occur, including any special enrollment events that require a person to be offered coverage or changed to a different enrollment status such as COBRA, Account shall provide Wellmark with updated required information as such changes occur. Account shall provide Wellmark with enrollment updates no less often than weekly and in advance of the effective date of the change if possible. No requested eligibility, enrollment or coverage change shall be effective any earlier than three (3) months prior to the date Wellmark receives the required notice from Account.

2.5 **Notice of Persons Terminated or No Longer Eligible for Coverage; Account's Liability for Premiums or Claims Paid.** Account shall notify Wellmark of any person's termination or ineligibility for coverage under the Plan in advance of the effective date of the change if possible, but in any event no later than three (3) months following the requested date of coverage termination. No requested coverage termination shall be

effective any earlier than three (3) months prior to the date Wellmark receives the required notice from Account. If Incurred Claims have been paid prior to the date Wellmark is notified of the coverage termination for services after the effective date of a Member's termination and those payments are not or cannot be recouped, Account shall be responsible for the monthly premium or the Claims Paid prior to the date Wellmark is notified of the coverage termination.

- 2.6 **Medicare Secondary Payer ("MSP").** Federal law mandates coordination of health care benefits in certain instances where a Member is covered under both a group health plan and Medicare. Proper coordination of benefits in this context depends on obtaining and maintaining accurate and timely information regarding such dual health coverage. Pursuant to contract and Applicable Law, Wellmark provides information to Centers for Medicare and Medicaid Services ("**CMS**") regarding such dual health coverage for Members and Account's enrollment on a quarterly or more frequent basis.

Account shall gather and timely provide information to Wellmark regarding Account's size and status and Employer Identification Number ("**EIN**") (s), or concerning the Medicare enrollment of Members, Plan enrollment, and related information (including, without limitation, Member Social Security numbers), or such other information as requested by Wellmark for inclusion on the Confirmation of MSP form submissions and other disclosures. In the event Account does not timely provide such information to Wellmark, Account shall be solely responsible for its non-compliance with MSP laws and other requirements, including, without limitation, any damages, losses, taxes, interest charges, and administrative penalties (including, without limitation, any civil money penalties) that may be assessed or otherwise result in connection therewith (including, without limitation, any claims by Members, providers or other claimants), and mistaken payments to CMS on behalf of Medicare enrolled Members.

- 2.7 **Grandfathered Health Plan Representation.** In the event Account is being issued a new Agreement by Wellmark and the Plan is to be treated by Wellmark as a Grandfathered Health Plan, Account represents and warrants to Wellmark that (a) its prior health plan coverage was, immediately prior to termination of such coverage, a Grandfathered Health Plan, and (b) the Plan will include no changes that will result in loss of treatment as a Grandfathered Health Plan as of the Effective Date.

ARTICLE 3 WELLMARK'S RESPONSIBILITIES

- 3.1 **Determination of Claims; Administrative Services.** During the Term of this Agreement and subject to Account's payment to Wellmark, when due, of the premiums and other fees for coverage, Wellmark shall provide the health insurance coverage for Members and administrative services as specified in this section as follows:
- a. Wellmark shall provide Account with Benefits Document(s) setting forth the insurance protection, benefits, terms and conditions of the Plan for Account to make available to its Plan Members. If elected by Account, Wellmark will print Benefit Documents at Account's expense. Delivery of Benefits Documents to Members remains Account's responsibility;
 - b. Wellmark shall provide access to a network(s) of health care providers, and shall make information about the network and network providers available to Members,

and shall administer a provider directory response protocol, all in compliance with Applicable Laws;

- c. Wellmark shall prepare, print, and deliver identification cards to Plan Members;
- d. Wellmark will perform its administrative services specified in this Agreement in compliance with Applicable Laws, including, but not limited to, compliance with retention of records laws and non-discrimination in health plan administration laws;
- e. Wellmark shall make available to Account forms of ACA or HIPAA required notices, including the summary of benefits and coverage ("**SBC**") and applicable HIPAA notices relating to health coverage portability such as the Special Enrollment Notice. Wellmark shall make available the uniform glossary of insurance-related terms;
- f. Wellmark shall determine benefits and process Incurred Claims for health care services furnished Members in accordance with the terms, limitations and conditions set forth in the Plan, the Benefits Document(s), this Agreement, Applicable Laws, the terms of the applicable provider agreements, and the claims administration and medical policies of Wellmark, all of which may be revised from time to time. Processing of claims includes payment and reporting of benefits to providers or Members, coordination of benefits, and the monitoring, detection, and investigation of potentially wasteful, abusive or fraudulent Incurred Claims. Wellmark reserves the right to terminate individuals from the Plan that it has determined are ineligible for coverage. Except as provided in Sections 2.4 and 2.5 of this Agreement, Wellmark shall not be required to reprocess claims as a result of any changes made to information relating to a Member or the Member's benefits;
- g. Conditioned on Account supplying requested information as required in Section 2.1(k) or opting out of such services by March 1st of the reporting year, Wellmark will annually report Account's information in an aggregated manner on Schedules D-1 and D-2 that Wellmark files with CMS as required by Section 204 of the CAA and in accordance with Applicable Laws. Wellmark will directly or indirectly, through its pharmacy benefits manager, annually report Account's pharmacy benefit information in an aggregated manner on Schedules D-3 through D-8 in accordance with Applicable Laws;
- h. Wellmark shall maintain a single-level internal appeal procedure for Members to appeal adverse benefit determinations and shall have a process for responding to external review requests of final internal adverse benefit determinations, in accordance with applicable Plan and regulatory requirements; and
- i. Wellmark shall exercise its discretion to make determinations in connection with the administration of this Agreement and the Plan including, without limitation, determinations regarding whether health care services are medically necessary in accordance with Plan terms or whether charges for health care services are reasonable. Wellmark shall make determinations that are not arbitrary or capricious and such determinations shall be final and conclusive to the extent permitted by this Agreement, the terms of the Benefits Document, and by law.

- 3.2 **Health Services.** Wellmark may, at its sole discretion, offer or arrange for various proprietary Health Services to be available to Members for no additional cost. Account may, at its option, elect to purchase additional services. Health Services and their content are proprietary to Wellmark or its vendors, and may not be duplicated, modified or used for the benefit of any third party. Account does not have any right, title or interest in or to the Health Services or the intellectual property underlying such Health Services. Health Services may be changed, replaced, or discontinued from time to time and may be modified or removed at any time without notice or amendment of this Agreement.
- 3.3 **Value-Added Services; Identity Protection.** Wellmark, at its sole discretion, may offer or arrange for value-added services or benefits for Account and its Members, including, for example, Member Identity Protection services from a third party vendor. Identity Protection services are offered at no additional charge to Account or Members. Account may at its option accept or reject Identity Protection services for its Members. Value-added services are not insurance coverage, and Wellmark reserves the right to change, replace, or discontinue value-added services, including identity protection, from time to time without notice or amendment of this Agreement.
- 3.4 **Change of Premium.** The premium rates are effective as of the Effective Date, provided, however, that premiums or other fees may be changed by Wellmark at any time during the Term upon thirty (30) days advance written notice to Account or the member, as applicable. Premium rates will be changed at renewal. Any premium changes will be reflected on the monthly bill.

ARTICLE 4

CONFIDENTIAL INFORMATION; REPORTING; EXAMINATION OF RECORDS

- 4.1 **Use and Disclosure of Protected Health Information.** Account and Wellmark shall not disclose or use Members' Protected Health Information except in accordance with Applicable Law including, when required, receipt of proper authorization from the individual involved. In recognition of the fact that Confidential Information provided by Wellmark to Account may contain Members' personally identifiable financial or health information, including Protected Health Information (collectively, "**PII/PHI**"), the following additional provisions apply to Confidential Information containing PII/PHI:
- a. Any PII/PHI shall be used solely for payment and health care operations and shall not be disclosed or otherwise made available to any entity or person except those value-based programs, health care providers, business associates, employees, or agents who have a legitimate need to have knowledge of the PII/PHI or as otherwise permitted by law;
 - b. Safeguards shall be adopted by the parties as necessary to ensure that the confidentiality of such PII/PHI remains protected as required by Applicable Law; and
 - c. Employees and agents of the parties shall be instructed regarding the penalties for unauthorized disclosures of PII/PHI, not to use PII/PHI except to the extent required by the employee's or agent's job, and to use the PII/PHI only as allowed by law.

4.2 Non-Disclosure of Confidential Information.

- a. Subject to Section 4.1 and Applicable Law, the Receiving Party will: (i) not disclose Confidential Information to any third party that is not an agent, consultant or business associate of Wellmark without the written authorization of the Disclosing Party; (ii) use the same degree of care as for its own information of like importance, but at least use reasonable care, in safeguarding against disclosure of Confidential Information; and (iii) without unreasonable delay and in accordance with Applicable Law notify the Disclosing Party of any unauthorized use or disclosure of the Confidential Information and take reasonable steps to regain possession of the Confidential Information and prevent further unauthorized actions or other breach of this Agreement.
- b. If the Receiving Party is required to disclose Confidential Information pursuant to Applicable Law, statute, or regulation, or court order, for a purpose other than contemplated in this Agreement, the Receiving Party will give to the Disclosing Party prompt written notice of the request and a reasonable opportunity to object to such disclosure and seek a protective order or appropriate remedy. If, in the absence of a protective order, the Receiving Party determines, upon the advice of counsel, that it is required to disclose such information, it may disclose only Confidential Information specifically required and only to the extent compelled to do so.
- c. All Confidential Information remains the property of the Disclosing Party and will not be copied or reproduced without the express written permission of the Disclosing Party, except for copies that are necessary to fulfill the confidentiality obligations contained in this Agreement, to render the services under this Agreement, or as otherwise allowed under Applicable Law. Within ten (10) days of receipt of the Disclosing Party's written request, the Receiving Party will either (i) return all Confidential Information to the Disclosing Party along with all copies and portions thereof, or (ii) certify in writing that all such Confidential Information has been destroyed, except that a party may retain Confidential Information when obligated to do so as a matter of law.
- d. Wellmark Confidential Information is the property of Wellmark. Wellmark Confidential Information that is released by Wellmark to Account may only be used strictly for payment and health care operations (which includes various Account services performed by Wellmark, including Account-specific reporting and analytics, benchmarking, development of benefit designs, Wellmark performance/experience, pre-sales/retention, and audits). Wellmark Confidential Information shall not be disclosed by Account to any third party without the prior written authorization of Wellmark. Account shall not commingle Wellmark Confidential Information with data from other sources. Account, as the recipient of Wellmark Confidential Information, is prohibited from reselling Wellmark Confidential Information. To the extent Wellmark Confidential Information is disclosed in an aggregated format to Account, Account is prohibited from de-aggregating the data to identify Wellmark, the Account and/or individual Members. Wellmark may audit the Account to ensure compliance with the limitations on data use and disclosure that are set forth in this section. Account shall return or securely destroy the Wellmark Confidential Information it receives upon conclusion of the purpose for which it was disclosed.

- 4.3 **Wellmark's Ownership of Wellmark Confidential Information.** Wellmark retains all ownership and rights to Wellmark Confidential Information. Disclosure of Wellmark Confidential Information to the Account or any other Receiving Party does not alter Wellmark's ownership rights of Wellmark Confidential Information, does not create ownership rights for the Account or Receiving Party, and does not permit the Account or Receiving Party to disclose to any other party without Wellmark's prior written consent.
- 4.4 **Wellmark's Right to Use Confidential Information.** Wellmark shall have the right to de-identify or remove direct identifiers from the Confidential Information so that it no longer constitutes Protected Health Information, and so that such Confidential Information is no longer identifiable with respect to Account, and to aggregate such de-identified Confidential Information for any purpose whatsoever; provided that such use is in accordance with all Applicable Laws, including but not limited to HIPAA. Such Confidential Information, after it is de-identified or limited pursuant to HIPAA, shall no longer be subject to Section 4.2 and shall thereafter be Wellmark's property.
- 4.5 **Right to Examine Records; Audit.** Wellmark or its authorized representative may at its own expense examine or audit the financial, enrollment, eligibility, and claims records of Account reasonably related to the administration of this Agreement, as reasonably often as Wellmark deems appropriate, to reconcile eligibility and enrollment information and records, or to determine appropriate payment of benefits under the Plan. Such audit or examination if at Account's location, shall be conducted during regular business hours, upon reasonable advance written notice. The examination period will be limited to information relating to the most recent twenty-four (24) months only, if applicable.
- 4.6 **Website Access and Reporting.** Wellmark may provide Account while this Agreement is in force with secured access to Wellmark's website, web-based applications, or other electronic databases with respect to the Plan and Members for the purpose of Plan administration and health care operations, reporting, billing, or for self-service. Web-based applications or databases with Member and Plan specific Confidential Information may be hosted or supported by third parties on Wellmark's behalf. If Account or a third party acting on Account's behalf accesses such websites or information, Account is subject to and agrees to all of the terms and conditions, including the confidentiality requirements of this Agreement, and security restrictions and user requirements as established by Wellmark with respect to such access, as such terms are set forth in the applicable Terms and Conditions posted at Wellmark's website (Wellmark.com).
- 4.7 **Survival.** Any obligations of either party to the other under this Article of the Agreement survive any termination of this Agreement.

ARTICLE 5

PROVIDER PAYMENT ARRANGEMENTS; VALUE-BASED PROGRAMS

- 5.1 **Provider Payment Arrangements.** Wellmark will be responsible for negotiating and entering into separate payment arrangements with health care providers. Such provider payment arrangements and agreements shall apply to services by such providers for all Members entitled to benefits under plans insured or administered by Wellmark, including Members under this Plan.

Wellmark shall determine, in its sole discretion, the payment arrangements with health care providers including, without limitation, the Maximum Allowable Fees for Incurred Claims. Without limiting the foregoing, Wellmark may compensate providers pursuant to a variety of payment arrangements, including the following:

- a. Fee for service arrangements, including, without limitation, per diem and percent of charge arrangements;
- b. Fixed fee or other payment methodology that is based on pre-determined criteria; or
- c. Episode of care arrangements under which payment is based on a pre-established rate for a health care encounter, including, without limitation, a hospital stay or outpatient visit. In the event such an arrangement is utilized, consistent with the methodology established by Wellmark for such arrangement, Wellmark is not required to impose cost share responsibility on Members for each Covered Service Members receive. An episode of care arrangement payment may cover both Covered Services and non-Covered Services that are incidental to the Covered Services.

5.2 **Non-Contracting or Non-Network Providers.** If the applicable Benefits Document provides benefits for Covered Services rendered by health care providers that have not contracted with Wellmark or another Blue Cross and Blue Shield Plan (“**Non-Contracting Providers**”), Members may be liable to Non-Contracting Providers for any difference between the Covered Charges and the Maximum Allowable Fee and Members are responsible for paying the provider in full, except to the extent prohibited by Applicable Law, including the federal No Surprises Act.

5.3 **Premium Rebates.** In the event federal or state law requires Wellmark to pay Account or Plan Members a rebate for a portion of the annual premium payment, Wellmark will pay the Account the total rebate amount applicable to Account. In accordance with Applicable Law, the Account shall use the portion of the rebates attributable to the amount of premiums paid by Plan Members, if any, for the exclusive benefit of Plan Members so that the Plan Members receive the benefit of the rebates. The Plan Member portion of the rebates may be used to reduce the Plan Members' portion of the premiums in subsequent years or provided as a cash refund or, if the Plan is subject to ERISA, for other permissible Plan purposes.

Account shall develop and retain records and documentation evidencing its use of the rebates and shall provide such records to Wellmark upon request. If the Plan is neither a governmental plan nor a plan subject to ERISA, the Account agrees that it has provided or will provide Wellmark with written assurance that any rebates received by Account will be used to benefit current Plan Members.

5.4 **Pharmacy Benefits Management Services; Disclosure of Prescription Drug Rebates.** Wellmark contracts with a third party pharmacy benefits manager (“**PBM**”) to provide pharmacy benefits management services to Wellmark and its customers, including Account. The pharmacy benefits management services include pharmacy network contracting and administration, pharmacy claims adjudication, clinical services, and rebate management. Wellmark also contracts to procure and receive medical benefit rebates and pharmacy benefit rebates from pharmaceutical manufacturers, directly or indirectly

through PBM and/or group purchasing organization(s) (“**GPOs**”) (each, a “**Rebating Entity**”), for rebate-eligible prescription drug claims. Any rebates Wellmark receives from Rebating Entities for Members shall be retained by Wellmark. The rebates shall not be allocated or distributed in any manner to Account or to Members nor shall the rebates be taken into account in determining any applicable deductibles, coinsurance, copayment, or out-of-pocket maximum amounts for which a Member is responsible.

- 5.5 **Value-Based Programs.** A “**Value-Based Program**” is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Wellmark or Host Blues may enter into collaborative arrangements with Value-Based Programs under which the health care organizations participating in such programs are eligible for financial incentives relating to quality and cost-effective care to Wellmark Members. Identifiable Data regarding Account's Members may be included in information Wellmark or Host Blues provide to Value-Based Programs and used by the Value-Based Program and its providers.

ARTICLE 6

LIABILITY OF THE PARTIES

- 6.1 **Account's Liability.** Except as otherwise explicitly provided in this Agreement, Account agrees to release, hold harmless, and indemnify Wellmark and its employees, officers, and directors against any and all amounts, expenses, losses, liability, claims, lawsuits, injuries, damages, taxes, interest charges, administrative penalties, and other costs or obligations, including reasonable attorneys' fees and court costs, for which Wellmark may become liable:
- a. due to an allegation of a breach of confidentiality arising out of the release of Confidential Information to Account, the Plan, or a third party at Account's direction or arising out of any improper use of Confidential Information by Account or such third party;
 - b. due to Account's failure to timely provide requested information to Wellmark for inclusion on the Confirmation of MSP form submissions and other disclosures that relate to Account's size and status, EIN(s), the Medicare enrollment of Members, Account enrollment, and related information (including, without limitation, Member Social Security numbers), or such other information requested by Wellmark resulting in processing of claims not in compliance with MSP laws and other requirements in accordance with Section 2.6;
 - c. due to Account's failure to comply with Applicable Law relating to issuing or failing to issue the required notices in accordance with Section 2.1(d);
 - d. due to Account's failure or delay in providing complete, timely, and accurate reports, data, and information regarding group size and number of employees, eligibility, enrollment, and Social Security numbers for each Member, changes to Account name, EIN, address, benefit selection, limitations, exclusions, or benefit changes for the Plan, and other information necessary for Wellmark to prepare IRS Form 1095-B reporting to the Internal Revenue Service, or administer the terms, coordination of benefits, limitations, and exclusions contained in the Plan;

- e. due to Account's or its employees' or agents' negligence or material breach of their obligations under this Agreement, except to the extent that any such losses are caused by the negligence or willful misconduct of Wellmark; or
- f. arising from any other acts or omissions of Account that constitute a material breach of an obligation hereunder or which, in the aggregate, constitute a failure on the part of Account to perform its obligations under this Agreement in accordance with the provisions of this Agreement.

6.2 **Wellmark's Liability.** Except as otherwise explicitly provided in this Agreement, Wellmark agrees to release, hold harmless, and indemnify Account and its employees, officers, and directors against any and all amounts, expenses, losses, liability, claims, lawsuits, injuries, damages, taxes, interest charges, administrative penalties, and other costs or obligations, including reasonable attorneys' fees and court costs, for which Account may become liable arising from any allegation of a breach of confidentiality arising out of the release of Confidential Information to Wellmark or a third party at Wellmark's direction or arising out of any improper use of Confidential Information by Wellmark or such third party.

6.3 **Disclaimer of Warranties; Limitation of Liability.** EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, WELLMARK DOES NOT MAKE AND HEREBY DISCLAIMS ANY REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, REGARDING ANY OF THE SERVICES WELLMARK PROVIDES OR ARRANGES TO PROVIDE UNDER THIS AGREEMENT. IN NO EVENT SHALL WELLMARK BE LIABLE FOR INDIRECT, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR SPECIAL DAMAGES, LOSS OF DATA OR LOST PROFITS, EVEN IF WELLMARK HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. THE FOREGOING LIMITATION OF LIABILITY REPRESENTS THE ALLOCATION OF RISK BETWEEN THE PARTIES AS REFLECTED IN THE PRICING HEREUNDER AND IS AN ESSENTIAL ELEMENT OF THE BASIS OF THE BARGAIN BETWEEN THE PARTIES.

THE HEALTH SERVICES ARE EDUCATIONAL AND INFORMATIONAL TOOLS ONLY AND DO NOT CONSTITUTE CLINICAL SERVICES. HEALTH INFORMATION PROVIDED BY WELLMARK OR VENDORS OR THEIR AFFILIATES IS BASED ON MEDICAL LITERATURE. HOWEVER, USE OF SUCH INFORMATION IS NOT INTENDED TO REPLACE PROFESSIONAL MEDICAL ADVICE AND CARE FROM A HEALTH CARE PROFESSIONAL. THE HEALTH INFORMATION IS INTENDED TO HELP PEOPLE MAKE BETTER HEALTH CARE DECISIONS AND TAKE GREATER RESPONSIBILITY FOR THEIR OWN HEALTH, BUT MAY NOT RESULT IN ACTUAL ACHIEVEMENT OF THESE GOALS. ACCOUNT EXPRESSLY ACKNOWLEDGES AND AGREES THAT WELLMARK IS NOT RESPONSIBLE FOR THE RESULTS OF ITS MEMBERS' USE OF SUCH INFORMATION INCLUDING, BUT NOT LIMITED TO, MEMBERS CHOOSING TO SEEK OR NOT TO SEEK PROFESSIONAL MEDICAL CARE, OR MEMBERS CHOOSING OR NOT CHOOSING SPECIFIC TREATMENT. WELLMARK DOES NOT MAKE AND HEREBY DISCLAIMS ANY REPRESENTATION OR WARRANTY OF ANY KIND, EXPRESS OR IMPLIED, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, REGARDING THE HEALTH SERVICES, THEIR ABILITY TO REDUCE COSTS, OR IMPROVE OUTCOMES.

- 6.4 **Grandfathered Health Plan Disclaimer.** Account has the sole obligation to determine the status of its Plan as either a Grandfathered Health Plan or a Non-Grandfathered Health Plan.

Wellmark does not make any representation or warranty and Wellmark expressly disclaims any and all representations or warranties, oral or written, regarding the past, present, or future Grandfathered Health Plan status of the Plan.

No federal or state official has determined that this Plan qualifies as a Grandfathered Health Plan, and to the extent that this Plan is determined to be eligible as a Grandfathered Health Plan, Wellmark makes no representation or warranty that this status will be retained during the current Plan Year or any future renewal.

Wellmark is not responsible and shall not be liable for any claims, costs, liabilities, losses, penalties, damages or other expenses of any kind whatsoever that, directly or indirectly, arise from or relate to this Plan's past, present and future Grandfathered Health Plan status, lack thereof, or any changes regarding the Plan's past, present and future Grandfathered Health Plan status, including, but not limited to, any representation made by any employee, broker, agent, or independent contractor of Wellmark regarding this Plan's past, present and future Grandfathered Health Plan status.

- 6.5 **No Nondiscrimination Testing for Health Plans.** Wellmark will not determine whether coverage is discriminatory or otherwise in violation of nondiscrimination requirements of the ACA, Internal Revenue Code Section 105(h), or other applicable state or federal law. Wellmark also will not provide any testing for compliance with the ACA, Internal Revenue Code Section 105(h) nondiscrimination requirements, or other applicable state or federal law and will not be held liable for any penalties or other losses resulting from Account offering coverage in violation of any such provision. Notwithstanding the foregoing, Wellmark performs federal Mental Health Parity and Addiction Equity Act (MHPAEA) financial requirement testing ("substantially all" test / "predominant" test) for group health plans, unless Account has notified Wellmark in writing of its opt out of such testing.
- 6.6 **Survival.** The indemnities set forth in this Article, including any liability of either party to the other for indemnification, shall survive the termination of this Agreement.

ARTICLE 7 TERM AND TERMINATION

- 7.1 **Term of Agreement.** This Agreement shall become effective on the Effective Date and thereafter shall continue in force until replaced by a subsequently issued Agreement or terminated as provided in this Agreement.
- 7.2 **Termination by Account on Notice.** This Agreement may be terminated by the Account upon providing Wellmark ten (10) days prior written notice in the form, format, and manner required by Wellmark in advance of the termination date. In the absence of ten (10) days prior written notice by Account, Account shall be responsible for any and all fees and/or premiums billed by Wellmark. Account is solely responsible for notifying its Plan Members of the termination of this Agreement.
- 7.3 **Termination by Wellmark.** Wellmark may only nonrenew or discontinue this Agreement for one or more of the following reasons:

- a. Account fails to make payment on time and in full of fees and premiums as required under this Agreement;
- b. Account's fraud or intentional misrepresentation of a material fact under this Agreement, including the situation in which Account made a material representation to Wellmark in connection with the issuance of this Agreement and such representation is no longer accurate or correct;
- c. Account's noncompliance with Wellmark's minimum participation requirements;
- d. Account's noncompliance with Wellmark's minimum employer contribution requirements;
- e. Wellmark ceases to offer this type of small group or large group coverage in Iowa in accordance with Section 7.6;
- f. the Commissioner of Insurance for the state of Iowa finds that continuation of the coverage would not be in the best interest of the Members;
- g. the renewal or continuation of this Agreement would otherwise be prohibited by Applicable Law.

Account shall be deemed to be in noncompliance of subsection c or d, above regarding participation or contribution requirements, upon Account's failure to provide reasonable documentation requested by Wellmark to satisfy its inquiry.

7.4 Termination for Nonpayment of Premium. Wellmark may terminate this Agreement at any time, upon ten (10) days written notice to Account, if Account fails to make complete payments, including late fees, when due in accordance with this Agreement. Account is solely responsible for notifying its Plan Members of the termination of this Agreement for nonpayment or for any other reason. Wellmark, in its sole discretion, may permit Account to reinstate this Agreement upon payment of a reinstatement fee and all other outstanding amounts due.

7.5 Effects of Termination for Nonpayment. If Wellmark terminates this Agreement for nonpayment or for any other reason, Wellmark shall not pay any Incurred Claims for services received after the date of termination.

7.6 Uniform Termination of Coverage.

- a. If Wellmark decides to discontinue offering the type of coverage provided under this Agreement in the small and/or large group market, such coverage may be discontinued only if:
 - i. Wellmark provides notice to each Account, and all Plan Members under this type of coverage in such market of the discontinuation at least ninety (90) days prior to the date of discontinuation of such coverage; and
 - ii. Wellmark offers to each Account covered under this type of coverage in such market the option to purchase all (or, in the case of the large group

market, any) other coverage currently being offered by Wellmark to groups in such market.

- b. If Wellmark elects to discontinue all coverage in the small and/or large group markets in Iowa, it may discontinue coverage under this Agreement only if Wellmark provides notice to each Account, all Plan Members covered under such coverage, and the Commissioner of Insurance for the state of Iowa of such discontinuation at least one hundred eighty (180) days prior to the date of such discontinuance.

- 7.7 **Survival.** Any liability of either party to the other for amounts owed or owing under this Agreement, unless such amounts are de minimus, shall not be extinguished by the termination of this Agreement.

ARTICLE 8

BLUE CROSS AND BLUE SHIELD DISCLOSURES AND INTER-PLAN ARRANGEMENTS

- 8.1 **Blue Cross and Blue Shield Disclosure Statement.** Account on behalf of itself and its Members, hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between Account and Wellmark, which is an independent corporation operating under licenses from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "**Association**"), permitting Wellmark to use the Blue Cross and Blue Shield Service Marks in the state of Iowa, and that Wellmark is not contracting as the agent of the Association. Account on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Wellmark and that no person, entity, or organization other than Wellmark shall be accountable or liable to Account for any of Wellmark's obligations to Account created under this Agreement. This section shall not create any additional obligations whatsoever on the part of Wellmark other than those obligations created under other provisions of this Agreement.
- 8.2 **Account Locations or Members Outside of Iowa.** Account understands and agrees that Wellmark defines a National Account as a company headquartered and located in Iowa that also has employees in other states whose claims are processed through Inter-Plan Arrangements. If Account is headquartered in Iowa, any employees or persons associated with Account are eligible for coverage under the Account's Plan, including those employed or working at Account locations outside Iowa. If Account is not headquartered in Iowa, only those employees or individuals associated with the Iowa business locations are eligible for coverage under the Account's Plan, and coverage will be void for any persons associated with Account locations outside of Iowa. Eligibility of persons located outside of Iowa, or associated with Account locations outside of Iowa, is subject to Applicable Law and Association guidelines.
- 8.3 **Out-of-Area Services.** Wellmark has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "**Inter-Plan Arrangements**." These Inter-Plan Arrangements operate under rules and procedures issued by the Association. Whenever Members access health care services outside the geographic area Wellmark serves, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area Wellmark serves, Members obtain care from health care providers that have a contractual agreement (“**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 health care providers in the Host Blue geographic area that do not have a contractual agreement (“**nonparticipating providers**”) with the Host Blue. Wellmark remains responsible for fulfilling its contractual obligations to Account and Wellmark’s payment practices in both instances are described below.

- a. **BlueCard® Program.** The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services within the geographic area served by a Host Blue, the Host Blue will be responsible for contracting and handling all interactions with its participating providers. The financial terms of the BlueCard® Program are described generally below.
 - i. **Member Liability Calculation Method Per Claim.** Unless subject to a fixed dollar copayment, 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 charges for Covered Services or the negotiated price made available to Wellmark by the Host Blue.
 - ii. **Claims Pricing.** Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue’s provider contracts. The negotiated price made available to Wellmark by the Host Blue may be represented by one of the following:
 - a) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
 - b) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, 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
 - c) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed 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.

The Host Blue determines whether it will use an actual, estimated, or average price. Host Blues using either an estimated price or an average price may prospectively increase or reduce such prices to correct for over-

or underestimation of past prices (i.e., prospective adjustment may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or refunds received or anticipated to be received from providers). However, the BlueCard® Program requires that 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 method of claims payment by Host Blues is taken into account by Wellmark in determining Account's premiums.

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee. If applicable, Wellmark will include any such surcharge, tax or other fee in determining Account's premium.

b. **Nonparticipating Providers Outside Wellmark's Service Area; Member Liability Calculation.**

- i. **In General.** When Covered Services are provided outside of Wellmark's service area by nonparticipating providers, the amount(s) a Member pays for such services will 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 Wellmark will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.
- ii. **Exceptions.** In some exception cases, Wellmark may pay claims from nonparticipating providers for Covered Services outside of Wellmark's service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by Wellmark or by Applicable Law. In other exception cases, Wellmark may pay such claims based on the payment Wellmark would make if Wellmark were paying a nonparticipating provider for the same Covered Services inside of Wellmark's service area. This may occur where the Host Blue's corresponding payment would be more than Wellmark's in-service area nonparticipating provider payment. Wellmark may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Wellmark will make for the Covered Services as set forth in this paragraph.

c. **Blue Cross Blue Shield Global® Core.**

General Information. If Members are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter: "BlueCard® service area"), they may be able to take advantage of the Blue Cross Blue Shield Global® Core when accessing Covered Services. The Blue Cross Blue Shield Global® Core is not served by a Host Blue.

Inpatient Services. In most cases, if Members contact the Blue Cross Blue Shield Global® Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member claims to the Blue Cross Blue Shield Global® Core Service Center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact Wellmark to obtain precertification for non-emergency inpatient services.**

ARTICLE 9 MISCELLANEOUS

- 9.1 **Change of Agreement.** If Account makes changes in the Plan, Account shall give Wellmark sufficient advance notice of such changes. If Account makes any material changes in the Plan or in the health care benefits described in the Benefits Document, including the addition or deletion of benefits, or makes material changes in membership or eligibility requirements, such as a change in the number of enrolled individuals of ten percent (10%) or more, types of coverage offered, business entities covered, or offerings of other health insurers' coverage to eligible individuals, Wellmark shall have the right at its option to amend this Agreement, including an adjustment of premiums.
- 9.2 **Use of Trademarks and Names.** Wellmark and Account reserve the right to control the use of their respective corporate names and any other respective symbols, assumed names, trademarks, and service marks, presently existing or subsequently established. Wellmark and Account agree not to use the corporate name, symbol, assumed names, trademarks, or service marks of the other in advertising, promotional materials, or otherwise without the prior written consent of the other. Any previously approved usage shall cease immediately upon the termination of this Agreement and any materials using such names or marks are the property of the appropriate namesake and shall be returned to the appropriate property owner upon request or at the termination of this Agreement.
- 9.3 **Complete Agreement; Amendments.** This Agreement, including, without limitation, all Exhibits or amendments hereto, the employer contribution information form, and the COBRA Administrative Services Agreement or Addendum, if any, constitute the complete and exclusive agreement and statement of the relationship between the parties with regard to the subject matter of this Agreement and supersedes all related discussions, understandings, proposals, exhibits, amendments, prior and concurrent agreements, representations and warranties, whether oral or written, and any other communications between the parties in regard to the subject matter hereof. A copy of the Account's application, if any, is attached to this Agreement or shall be furnished to Account within thirty (30) days after the Agreement is issued. All statements made by the Account or by the Members are deemed to be representations and not warranties. No statement made by any person insured shall be used in any contest unless a copy of the document containing the statement is furnished to such person. This Agreement, including, without limitation, any Exhibits hereto, may be amended from time to time by Wellmark, and such amendments to this Agreement shall be effective only when the written amendment has been signed by an authorized representative of Wellmark and delivered in accordance with Section 9.9. This Agreement shall take precedence over any other documents that may be in conflict with it.

Notwithstanding the foregoing, if this Agreement supersedes a prior Agreement, health services with an Incurred Date prior to the Effective Date of this Agreement shall be processed pursuant to the terms of the applicable superseded Agreement.

- 9.4 **Force Majeure.** The parties to this Agreement shall be excused from any performance under this Agreement, other than payment of amounts due, for any period and to the extent they are delayed, restricted, or prevented from performing under this Agreement as a result of an act of God, war, civil disturbance, legislative enactment, court order, labor dispute, act of terrorism, or other cause beyond their reasonable control.
- 9.5 **Effectiveness of Agreement.** This Agreement shall be deemed to be effective and in full force as of the Effective Date upon the affixation of Wellmark's authorized signature below and the Account's payment to Wellmark of the premium required by this Agreement.
- 9.6 **Assignment.** The Agreement shall be binding on the parties and their respective successors and permitted assigns. Neither party may assign this Agreement to any third party, in whole or in part, without the prior written consent of the other; provided, however, Wellmark may assign this Agreement, in whole or in part, to any entity that controls, is controlled by, or is under common control with Wellmark.
- 9.7 **Waiver.** The failure of any party to enforce any terms or provisions of the Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the Agreement shall not be deemed or construed to be a waiver of such default. Any waiver of any provision of this Agreement, and any consent to any departure from the terms of any provision of this Agreement, shall be effective only in the specific instance and for the specific purpose for which made or given.
- 9.8 **Nature of Relationship; Authority of Parties.** Nothing contained in this Agreement and no action taken or omitted to be taken by Account or Wellmark pursuant hereto shall be deemed to constitute Account and Wellmark a partnership, an association, a joint venture or other entity whatsoever. Wellmark shall at all times be acting as an independent contractor under this Agreement. No party has the authority to bind the other in any respect whatsoever.
- 9.9 **Notices and Communication.** The parties shall be entitled to rely upon any communication or notice from the other in connection with this Agreement to be genuine, truthful, and accurate, and to have been authorized, signed, or issued by an officer or agent of such entity empowered to make such representation on behalf of the entity.

Any notice required or permitted to be given under this Agreement shall be in writing and shall be deemed given when delivered personally, placed in the U.S. mail (postage prepaid), delivered to a recognized courier service for delivery (delivery charges prepaid), or sent by electronic means and addressed to the last address furnished in writing. Until another address is furnished in writing, notice to Account may be addressed to the address as it appears in Wellmark's records.

Notice to Wellmark may be addressed:

Wellmark Blue Cross and Blue Shield of Iowa
Attention: Procurement and Contracts
1331 Grand Avenue
Des Moines, Iowa 50309-2901

- 9.10 **State of Issue; Applicable Law.** This Agreement is issued and delivered in the state of Iowa and is performed in Des Moines, Iowa. To the extent not superseded by the laws of the United States and without regard to any conflict of law rule, this Agreement shall be construed in accordance with and governed by the laws of the state of Iowa.

ARTICLE 10 DISPUTE RESOLUTION

10.1 Dispute Resolution; Mandatory Arbitration.

- a. In the event of any controversy or claim arising out of or relating to this Agreement, or the breach hereof (each a “**Dispute**”), prior to proceeding with arbitration under the further provisions of this Section, a party shall give notice (a “**Dispute Notice**”) to the other party setting out, in writing and in detail, the nature and specifics of the Dispute and a good faith estimated value of the Dispute. A meeting (which may be via teleconference or other electronic communications) between representatives of the parties must take place within 30 days after the date of delivery of the Dispute Notice in an attempt to resolve the Dispute through direct negotiations. The provisions of this paragraph and the remaining provisions of this Section are the sole and exclusive method of resolving any Disputes, and arbitration under this Section shall be mandatory except in the limited circumstances provided under paragraphs (j), (k) and (o) below and Section 10.2.
- b. If the Dispute has not been resolved by direct negotiations within 30 days after the date of delivery of the Dispute Notice, or such further time as the parties may mutually agree in writing, then either party may commence, and the Dispute shall be finally resolved by, binding arbitration administered by the American Arbitration Association (“**AAA**”) in accordance with the Commercial Arbitration Rules in effect at the time of the commencement of the arbitration (the “**Rules**”). The parties agree that the arbitrator(s), and not a court, will decide in the first instance all questions of substantive arbitrability, including without limitation the validity of this Section. **The parties do not consent to the incorporation of the AAA Supplementary Rules for Class Arbitration into the rules governing the arbitration of any Dispute (any such arbitration is referred to in this Section as the “Arbitration”), and hereby voluntarily and irrevocably waive any right to arbitrate any Disputes through representative or class arbitration. All Disputes will proceed in arbitration solely on an individual basis, and the authority of the arbitrator(s) to resolve any Dispute and to make written awards will be limited to the individual Disputes under this Agreement.**
- c. A party shall have the right to withdraw without prejudice a Dispute that it submitted to Arbitration prior to the appointment of the arbitrator(s) for the Arbitration. In such event, all of the provisions of this Section shall again apply with respect to such Dispute.

- d. This Agreement concerns matters in interstate commerce. The Arbitration shall be governed by the Federal Arbitration Act, to the exclusion of any state laws inconsistent therewith, and the Rules. In the event of a conflict, the Rules shall govern.
- e. No demand for arbitration of a Dispute may be made more than two (2) years after the Dispute arose.
- f. The Arbitration shall be conducted in English and shall take place in Des Moines, Iowa, unless the parties mutually agree in writing to an alternate location.
- g. If the monetary value of the Dispute as described in the Demand for Arbitration, or as the parties may otherwise mutually agree in writing, is equal to or less than \$1,000,000, then the number of arbitrators shall be one (1). The arbitrator shall be selected from the AAA's National Roster of Arbitrators in accordance with Rule R-12 of the Rules.
- h. If the monetary value of the Dispute as described in the Demand for Arbitration, or as the parties may otherwise mutually agree in writing, is greater than \$1,000,000, then either party may elect to have the tribunal consist of three arbitrators by notifying the AAA in writing of its election within seven (7) days after receiving the list of arbitrators from the AAA under Rule R-12(a). Each party shall have twenty (20) days after delivery of the foregoing notice of election to submit to the AAA the name of its co-arbitrator. If either party fails to timely nominate an arbitrator, the AAA shall make the appointment. The co-arbitrators shall have thirty (30) days, or such further period of time as the parties may mutually agree in writing, to nominate a chairperson of the tribunal. If the co-arbitrators fail to timely nominate a chairperson, the AAA shall appoint the chairperson from the National Roster of Arbitrators.
- i. Pursuant to Rule R-1 of the Rules, the parties agree that the Expedited Procedures under the Rules shall apply if the monetary value of the Dispute as described in the Demand for Arbitration is equal to or less than \$250,000.
- j. The parties shall not be precluded from seeking remedies in small claims court for Disputes within the scope of that court's jurisdiction.
- k. Prior to the appointment of the arbitrator(s), a party may elect either to make recourse to emergency relief under the Rules, or to seek from any court of competent jurisdiction, emergency, temporary, or preliminary injunctive relief, or an order in aid of arbitration; provided, however, that once a party has filed or served papers to seek recourse for emergency, temporary, or preliminary injunctive relief in either the arbitral or judicial forum, no party can seek or oppose any such relief from or in the other forum. The foregoing types of relief may only be sought within the Arbitration after the appointment of the arbitrator(s).
- l. A party may make a motion for summary adjudication of one or more particular claims or issues to be decided by the arbitrator(s).

- m. The arbitrator(s) must render a reasoned award, in writing, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.
- n. **The parties waive any claim for, and the arbitrator(s) shall not have any power to award, any punitive or exemplary damages, and each party hereby waives any right to seek or recover such damages with respect to any Dispute.** Each party shall bear its own costs and expenses of legal representation, including attorneys' fees, witness expenses, and costs associated with preparation and presentation of its case. All arbitration and administration fees and expenses, and all arbitrator costs and expenses shall be paid equally, regardless of which party prevails. Notwithstanding the foregoing, any party who fails or refuses to submit to arbitration following a demand by any other party shall bear all costs and expenses incurred by such other party in compelling arbitration of any Dispute.
- o. The existence and content of the Arbitration proceedings, documents produced during the Arbitration, submissions to the tribunal, including testimony and exhibits, and any rulings or award shall be kept confidential by the parties and members of the arbitral tribunal except (i) to the extent that disclosure may be required of a party to fulfill a legal duty, protect or pursue a legal right, or enforce or challenge an award in legal proceedings before a court or other judicial authority, (ii) with the written consent of all of the parties, (iii) where such information is already in the public domain other than as a result of a breach of this paragraph, (iv) as is necessary in communications with auditors or accountants retained by any party, or federal or state regulators, or (v) by order of the arbitral tribunal upon application of a party. The breach or threatened breach of this paragraph will cause immediate and irreparable harm to the non-breaching party and an adequate remedy at law for such harm may not exist. Accordingly, in the event of such breach or threatened breach, the non-breaching party shall have the right to seek specific performance by, or obtain injunctive or other equitable relief against, the breaching party as a remedy for any such breach or threatened breach. If the breach or threatened breach of this paragraph occurs prior to the conclusion of the Arbitration, the foregoing relief may only be sought within the Arbitration. If the breach or threatened breach of this paragraph occurs after the conclusion of the Arbitration, the foregoing relief may only be sought within any court of competent jurisdiction.
- p. The provisions of this Section 10.1 shall survive any termination of this Agreement.

10.2 **Jurisdiction and Venue; Waiver of Jury Trial and Punitive and Exemplary Damages.**

- a. If an arbitrator determines a particular Dispute is excluded from mandatory arbitration for any reason (including, but not limited to, by Applicable Law), the parties agree that the terms in this Section 10.2 will apply to any legal or equitable action brought in court because of such Dispute. Each of the parties submits to the jurisdiction and venue of the state or federal courts sitting in Des Moines, Polk County, Iowa, for any action or proceeding arising out of or relating to this Agreement, and each of the parties waives any defense of inconvenient forum to the maintenance of any action or proceeding in the state or federal courts sitting in Des Moines, Polk County, Iowa. **ACCOUNT AND WELLMARK HEREBY IRREVOCABLY WAIVE ALL RIGHT TO TRIAL BY JURY IN ANY ACTION,**

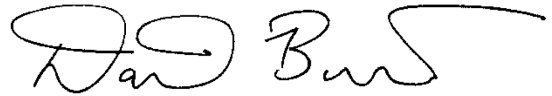
PROCEEDING OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT, OR ANY INSTRUMENT OR DOCUMENT IN CONNECTION THEREWITH. THE PARTIES ALSO WAIVE ANY CLAIM FOR AND ANY RIGHT TO SEEK OR RECOVER ANY PUNITIVE OR EXEMPLARY DAMAGES WITH RESPECT TO ANY DISPUTE.

- b. Notwithstanding Sections 4.7, 6.6, and 7.7, no legal or equitable action or claim may be brought against the parties for an action or claim arising under or relating to this Agreement more than two (2) years after the cause of action arose.
- c. The provisions of this Section 10.2 shall survive any termination of this Agreement.

IN WITNESS WHEREOF, this Agreement has been executed as of the Effective Date first stated above.

Wellmark, Inc., doing business as
Wellmark Blue Cross and Blue Shield of Iowa

By:

A handwritten signature in black ink, appearing to read "Dan Brown", written over a horizontal line.

David S. Brown
Executive Vice President, Chief Financial Officer
and Treasurer

NOTICE OF PROTECTION PROVIDED BY IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created under Iowa law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender and withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical-surgical or major medical insurance benefits
- \$300,000 in disability income protection insurance benefits
- \$300,000 in long-term care insurance benefits
- \$100,000 in other types of health insurance benefits

Annuities

- \$250,000 in annuity benefits, cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$350,000. Special rules may apply with regard to hospital, medical-surgical and major medical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at www.ialifega.org, or contact:

Iowa Life and Health Insurance
Guaranty Association
700 Walnut Street, Suite 1600
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. That information may be accessed from the "Helpful Links & Information" page located on the website of the Iowa Insurance Division at www.iid.iowa.gov.

The Association is subject to supervision and regulation by the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.