

X Blue Cross and Blue Shield of Kansas City
X Good Health HMO, Inc. d/b/a Blue-Care

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GROUP CONTRACT

GROUP NAME: SYNERGY SERVICES INC
GROUP NUMBER: 25677000
EFFECTIVE DATE: JANUARY 1, 2015
PLAN YEAR/ANNIVERSARY DATE: JANUARY 1, 2016
STATE OF ISSUE: MISSOURI



Authorized Signature
Blue Cross and Blue Shield of Kansas City and/or its
subsidiaries

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PART I. PURPOSE

This document entitled Group Contract (herein referred to as “Contract”) is an agreement between the Employer, including affiliated entities, if any, identified in the Group application attached hereto (herein referred to as the “Employer”) and the company(ies) indicated on the cover page (herein referred to as the “Company.”) It specifies the terms upon which Health Care Services will be available as agreed upon by the Company and Employer. The Group Application, Employee Applications and Certificate(s) issued to the Employee are incorporated by reference in this document and made a part of the Contract. Any conflict between the Contract and the Certificate(s) will be resolved according to the terms which are most favorable to the Covered Person. The definitions contained in the Certificate(s) will have the defined meaning when used in this document with the first letter capitalized. The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

PART II. AGREEMENT

- A. EFFECTIVE DATE: This agreement will become effective between the Employer and the Company as of 12:01 a.m. Central Time on the effective date specified on the cover page.
- B. TERM: The initial term of this Contract between Employer and the Company will remain in effect for a period of twelve (12) consecutive months from the effective date unless otherwise terminated in accordance with Part III herein. Subsequent renewal terms will remain in effect for twelve (12) consecutive months.
- C. COVERED SERVICES: In consideration of the remittance of Premiums in accordance herein, Company agrees to arrange for Covered Services in accordance with the terms, conditions, limitations and exclusions of the Certificate(s) and subject to the terms, conditions and limitations specified herein.
- D. OPTIONAL RIDERS / AMENDMENT: Optional riders or amendments to the Contract and/or Certificate which the Employer has elected must be included in the Premium rate calculation and be signed by an officer of the Company in order to be effective.
- E. STATE OF ISSUE: This Contract is issued to Employer in the State specified on the cover page.
- F. PREMIUM PAYMENT: Premium payments are due and payable by the Employer on or before the Contract effective date. Subsequent Premium payments are due and payable by the Employer on or before the monthly Due Date. Except as specifically provided, in no event shall coverage become or remain effective until the Premium is received by the Company.
- G. PARTICIPATION REQUIREMENTS: The following participation requirements apply to eligible full-time employees and must be met and maintained by the Employer:

1) The following are the participation requirements for eligible full-time Employees after excluding:

- i) Persons covered under a group health plan, sponsored by an employer other than the employer specified on the cover page of this Contract, must request to waive coverage in writing and proof must be provided that each person for whom coverage is waived is covered under another employer-sponsored group health plan and/or;
 - ii) Persons covered as a COBRA qualified beneficiary and/or;
 - iii) Persons covered under an individual health insurance policy.
- a) ELIGIBLE FULL-TIME EMPLOYEE PARTICIPATION IF EMPLOYER CONTRIBUTES LESS THAN 100%

Number of Eligible Employees	Minimum % Participation
1-3	75%
4+	75%

b) ELIGIBLE FULL-TIME EMPLOYEE PARTICIPATION IF EMPLOYER CONTRIBUTES 100% TOWARDS EMPLOYEE PREMIUM

All eligible full-time Employees must be covered under the Contract.

- 2) Notwithstanding the above, for Groups with over 50 Employees, a minimum of 50% of all eligible Employees must be covered under the Contract at all times.
- 3) Upon renewal, total Employee enrollment must be at least 90% of the prior year's enrollment.
- 4) Upon renewal, if the Employer fails to meet and maintain the participation requirements, the Contract will terminate.
- 5) Notwithstanding the above, if the Employer has elected to offer the Company's voluntary dental plan, there are no participation requirements for such plan.

H. ELIGIBILITY REQUIREMENTS:

- 1) Owners, who otherwise meet the eligibility requirements of an Employee, are eligible for coverage under the Contract.
- 2) Classification of eligible Employees: All full-time Employees and owners working a normal work week of 30 hours per week or as otherwise stated in the Employer application and agreed to by the Company.

- 3) **Waiting Period:** The period of continuous employment required for eligibility as determined by the Employer and agreed to by Company in writing. Employer represents that the terms of any eligibility condition or Waiting Periods imposed by Employer will not exceed 90 days in a manner that violates the Affordable Care Act.

This Waiting Period will not apply if the Employee is terminated and rehired within 180 days if the Employee has previously satisfied the Waiting Period.

- I. **EMPLOYER CONTRIBUTION:** The Employer must contribute at least 75% of the total account Premium or at least 50% of the lowest Employee-only Premium for the BCBSKC plan offered by the Employer to its Employees.

The Employer agrees to notify Company in writing of any change in the level of Employer contribution at least 30 days prior to the effective date of such change.

Notwithstanding the above, if the Employer has elected to offer the Company's voluntary dental plan, there are no Employer contribution requirements for such plan and the Employee is responsible for 100% of the cost of his voluntary dental coverage.

- J. **WORKERS' COMPENSATION COVERAGE:** The Employer agrees to provide workers' compensation coverage for Employees and to notify Company when the carrier of such coverage is changed and when such coverage is terminated.

- K. **CONTRACT CHANGES:** The Company may change the terms and conditions of the Contract upon 31 days prior written notice as follows:

- 1) Coverage Changes:

- a) To conform with statutes of the state in which the Contract is issued for delivery;
- b) To conform with federal law;

- 2) Premium Changes:

The Company may change the Premium:

- a) Whenever the terms of the Contract are changed by the Company and the Employer;
- b) On any monthly Premium Due Date upon giving 31 days prior written notice to the Employer.

- 3) Acceptance by the Employer:

The Company will consider any change to be acceptable to the Employer if the Employer continues to pay Premium after the effective date of the Change.

- 4) The Contract and any amendments or riders thereto constitute the entire agreement between the parties and any change in the Contract must be signed by an officer of the

Company to be valid. No agent or representative has the authority to change the Contract or waive any of the provisions.

- L. ANNUAL ENROLLMENT PERIOD: The Annual Enrollment Period begins 30 days prior to the Group Contract Anniversary Date and ends 15 days after the Group Contract Anniversary Date.
- M. RETROACTIVE COVERED PERSON TERMINATION: Under the Affordable Care Act, Employer acknowledges that a Covered Person's coverage may not be terminated retroactively if such coverage has been paid for by the Employee. Employer will not request that Company terminate an individual's coverage retroactively to the extent Premium has been paid for by such Employee.

PART III. TERMINATION

- A. TERMINATION BY THE EMPLOYER: The Employer can terminate the Contract;
 - 1) By giving the Company written notice at least 31 days before the next Premium Due Date, which then becomes the termination date; and
 - 2) By paying the Premium to cover the 31 day period before the termination date.
- B. TERMINATION BY THE COMPANY: The Company can terminate the Contract for any one or more of the following reasons:
 - 1) Failure by the Employer to pay the required Premium by the end of the grace period (grace period is the 31 day period immediately following the monthly Premium Due Date);
 - 2) Fraud or intentional misrepresentation of a material fact under the terms of the coverage by the Employer;
 - 3) Failure to meet and maintain the Participation and/or Contribution requirements specified in this Contract;
 - 4) There is no longer any Covered Employee who resides, lives or works in The Company's Service Area;
 - 5) Upon 90 days prior written notice to the Employer and Covered Person if the Company discontinues offering all contracts similar to this Contract to all Employees regardless of the claims experience or Covered Person's health status; provided however, Company shall offer to Employer the option to purchase other group contracts which provide health care benefits and services; or
 - 6) Upon 180 days prior written notice if Company ceases doing business in the market, provided that the provisions of Kansas and Missouri law (including the obligation to provide notices to the regulatory authorities and the Employer groups, and Company does not re-enter the marketplace for 5 years from the date of notice) are met.

The Company will provide at least 31 days prior notice of termination of the Contract except when the termination is due to failure to pay the required Premium, or as provided in B.5 or B.6 above.

The Company may not terminate a Missouri Employer's Contract prior to the first anniversary date except for non-payment of the required premiums or the failure to meet continued underwriting standards. All of the above provisions will apply on and after the first anniversary date.

- C. REINSTATEMENT OF GROUP CONTRACT: In the event the Contract is terminated due to failure by the Employer to pay the required Premium timely, the Company has the right to decide whether or not to reinstate coverage.

PART IV. MISCELLANEOUS

- A. ACCESS TO EMPLOYEES: The Employer shall provide fair and reasonable access, to the Company, not less than 30 days prior to the effective date, to Employees for presenting and explaining the program. The access shall include, at a minimum, the opportunity for the distribution of educational literature, brochures, informational meetings and other relevant printed materials.
- B. OTHER HEALTH CARE PROGRAMS: If the Employer makes available to Employees enrollment in any other health care program (including, but not limited to, health maintenance organizations and preferred provider organizations), the Employer must give the Company written notification of this offer of other health care programs at least 60 days before the effective date of the other health care program.
- C. RECORDS: Employer shall furnish to Company on a monthly basis the information that Company may reasonably require for administration of the plan. In addition, Company may, at reasonable times, examine the Employer's pertinent records with respect to eligibility and Premium payments under this Contract.
- D. NOTICE: Any notices required by this Contract may be given to the Employer by first class mail addressed to the Employer contact on file with the Company or to a Covered Person by first class mail addressed to the Covered Person at the address on record at the Company and to the Company by first class mail addressed to:

President
Blue Cross and Blue Shield of Kansas City
2301 Main, P.O. Box 419169
Kansas City, MO 64141-6169

- E. LIMITATION OF AUTHORITY / ACCEPTANCE: No agent or broker is authorized to bind coverage, approve applications, modify benefits or alter or waive any rights or requirements of Blue Cross and Blue Shield of Kansas City and/or its subsidiaries. Acceptance by the Employer of any Contract issued shall constitute approval of its terms and of any corrections, additions, or changes.

Neither of the parties hereto nor any of their respective representatives or employees shall be construed to be the agent, the employee or representative of the other. None of the provisions of this Contract are intended to create nor shall any be construed to create any relationship between the parties other than that of independent entities.

- F. CERTIFICATES / SUMMARY OF BENEFITS AND COVERAGE: The Employer agrees to promptly deliver to covered Employees, Certificates issued by the Company and to receive on behalf of and forward promptly to covered Employees and/or Dependents all notices delivered by the Company for distribution to Employees and Dependents. Such notices may include the Summary of Benefits and Coverage (SBC) required under the Affordable Care Act. Delivery of SBCs shall be done in a timely manner that satisfies any applicable federal and/or state requirements.
- G. MERGER: This Contract contains the complete agreement between the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings between the parties hereto with respect thereto.
- H. WAIVER: Waiver of a term, condition or a breach of any provision of this Contract shall not be deemed a waiver of any other term, condition or a subsequent breach of the same or different provision.
- I. DISCLOSURES:

1) Associations

The Employer, on behalf of itself and its covered Employees, hereby expressly acknowledges its understanding that this Contract constitutes a Contract solely between the Employer and Blue Cross and Blue Shield of Kansas City, that Blue Cross and Blue Shield of Kansas City is an independent corporation operating under an agreement with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Kansas City to use the Blue Cross and Blue Shield Service Mark in a portion of the States of Missouri and Kansas, and that Blue Cross and Blue Shield of Kansas City is not contracting as the agent of the Association. The Employer further acknowledges that it has not entered into this Contract based upon representations by any person other than Blue Cross and Blue Shield of Kansas City and that no person, entity, or organization other than Blue Cross and Blue Shield of Kansas City shall be held accountable or liable to the Employer for any of Blue Cross and Blue Shield of Kansas City's obligations to the Employer created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Kansas City other than those obligations created under other provisions of this Contract.

2) Inter-Plan Arrangements (BlueCard Program and Others)

The Company has a variety of relationships referred to generally as "Inter-Plan Arrangements", with other Blue Cross and/or Blue Shield Licensees. These other Licensees are referred to generally as "Host Blues". Whenever Covered Persons access Health Care Services outside the geographic area the Company serves, the claim for those

services may be processed through one of these Inter-Plan arrangements, including the BlueCard Program, and presented to the Company for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The BlueCard Program available to Covered Persons under this Contract is described generally below.

Typically, Covered Persons, when accessing care outside the geographic area We serve, obtain care from providers that have a contractual agreement (i.e., are “participating providers”) with the Host Blue. In some instances, Covered Persons may obtain care from non-participating providers. Our payment practices in both instances are described below.

3) BlueCard Program

Under the BlueCard Program, when Covered Persons access Covered Services within the geographic area served by a Host Blue, the Company will remain responsible to the Employer 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 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.

4) BlueCard Program Liability Calculation Method Per Claim

The calculation of Covered Persons liability on claims for Covered Services processed through the BlueCard Program will be based on the lower of the provider’s billed charges for Covered Services or the negotiated price made available to the Company by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue Plan’s provider contracts. The negotiated price made available to the Company by the Host Blue may represent a payment negotiated by a Host Blue with a provider that is one of the following:

- a) An actual price. An actual price is a negotiated payment without any other increases or decreases, (“Actual Price”); or
- b) An estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated by the provider and other claim- and non-claim-related transactions and is determined by the Host Blue in accordance with Inter-Plan Programs policies. 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 (“Estimated Price”); or
- c) An average price. An average price is a percentage of billed charges for Covered Services representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers, and other claim- and non-

claim-related transactions (“Average Price”). Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either the Estimated Price or 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 Covered Person 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 State law may require a Host Blue either:

1. To use a basis for determining Covered Persons liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or
2. To add a surcharge.

Should either federal law or the law of the State in which Covered Services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Company would then calculate the Covered Person’s liability in accordance with applicable law.

5) BlueCard Program 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, healthcare provider/hospital audits, credit balance audits, utilization review funds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter Plan-Programs policies, which generally require correction on a claim-by claim or prospective basis.

6) Non-Participating Providers Outside the Company’s Service Area

Refer to the definition of Allowable Charge in the Certificate.

7) Your coverage does not include elective pregnancy termination coverage.

- J. **RETROACTIVITY**: No retroactive coverage or Premium changes will be made unless the Company gives prior written approval. Retroactive changes beyond 60 days will not be approved unless the Company is at fault. No retroactive coverage for an individual Covered Person shall be made by the Company to the extent such action would violate the Affordable Care Act.

K. REBATES: In the event that Company is required to pay a Medical Loss Ratio rebate as a consequence of the Affordable Care Act and/or applicable state law, all such rebates paid shall constitute a return of premium.

1. Cooperation in Determination of Rebate Amount. Employer agrees to cooperate with and assist the Company as necessary to ensure proper and accurate distribution of any rebate. Employer agrees that it will timely provide and update information requested by Company in the format requested by Company for the purpose of determining the amount of or distributing any rebate. This information may include, but is not limited to, Employer size, the amount of the premium paid by each Employee and by Employer during the applicable reporting year, and Employee address information.
2. Distribution by Employer for Church Plans not Subject to ERISA. - Company will distribute any rebate owed directly to the Employer. The Employer attests that any rebate paid by the Company will be used for the benefit of its current covered Employees using one of the following methods:
 - (a) Employer may reduce the Employees' portion of the Premium for all Employees covered under any group health policy offered by the Employer;
 - (b) Employer may reduce Employees' portion of the Premium for only those Employees covered by the Contract on which the rebate was based; or
 - (c) Employer may provide a cash refund only to Employees that were covered by the Contract on which the rebate is based.

All methods require that the rebate be used to benefit those Employees covered at the time the rebate is received by the Employer, not those Employees covered during the prior year upon which the rebate amount is determined.

L. REQUESTS FOR INFORMATION: The Employer must provide the Company with all information which the Company may reasonably require with regard to any matters pertaining to this Contract, including, but not limited to, information necessary to comply with state or federal laws and regulations. The Company has the right to request information at any time. An Employer's failure to provide requested information which the Company determines to be necessary may result in a penalty in an amount as determined by the Company to be assessed against the Employer.